Exhibit B - STAR+PLUS Scope of Work (SOW)
March 2024

RFP No. HHS0011062

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ARTICLE 1 INTRODUCTION

1.1 OVERVIEW OF STAR+PLUS

STAR+PLUS is a Texas Medicaid managed care program integrating the delivery of Acute Care services and Long-Term Services and Supports (LTSS). The STAR+PLUS Program, including the STAR+PLUS Home and Community-based Services (HCBS) program, operates under Section 1115 of the Social Security Act as part of a demonstration project. STAR+PLUS began as a Medicaid pilot project in Harris County and has since expanded to be statewide. As of January 2021, STAR+PLUS Managed Care Organizations (MCOs) served 528,703 Members statewide. Through this procurement, HHSC intends to continue to build on the Texas health care reforms accomplished through the STAR+PLUS Medicaid managed care program.

1.2 TERM

The initial term of any Contract resulting from this solicitation will be six (6) years. HHSC, at its sole option, may extend or renew the resulting Contract for a maximum of three (3) periods of two (2) years each. Except as provided below, the maximum Contract Term, including the Initial Contract Period and allowable renewals or extensions, is 12 years.

Following the Contract Term, HHSC may, if authorized by applicable law, extend the resulting Contract to address immediate operational or service delivery needs. A Contract extension under this section is subject to all requirements and limitations as may be provided under applicable law.

As discussed in further sections of this SOW, the MCO will begin serving Members on the Operational Start Date, which HHSC anticipates will be September 1, 2024.

1.3 ELIGIBLE POPULATION

The populations eligible for STAR+PLUS are described in 1 Tex. Admin. Code § 353.603.

1.4 DEFINITIONS AND EXHIBITS

Defined terms have the meaning described in **Exhibit A, Managed Care Uniform Terms and Conditions (UTC)**, and **Exhibit C, Uniform Managed Care Manual (UMCM)**, unless the context clearly indicates otherwise. Defined terms are capitalized, are proper nouns, or serve to define an acronym. Also, Services may not have been incorporated into **Exhibit C** at the time of the SOW's publication. In the event they have not been, such Services will be added as part of the current HHSC UMCM change process, and the Contract will be amended as appropriate. Additionally, as used in this SOW, unless the

context clearly indicates otherwise, the following terms and conditions have the meanings assigned below:

1915(c) waiver means any Medicaid waiver authorized by Section 1915 of the Social Security Act, 42 U.S.C. 1396n(c), that allows the State to provide certain services to specific populations under the State's Medicaid program.

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 Instrumental Activities of Daily Living (IADLs) or control the environment in which he or she lives.

Adult Foster Care (AFC) means personal care services, homemaker, chore, and companion services, and medication oversight provided in a licensed (where applicable) private home by an adult foster care provider who lives in the home. Adult foster care services are furnished to adults who receive these services in conjunction with residing in the home.

Adverse Benefit Determination means:

1. The denial or limited authorization of a Member or Provider requested service, 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 a 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;
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; or
8. Not including in a Member's Individual Service Plan (ISP) a STAR+PLUS HCBS service that is requested by the Member.

Assisted Living Facility (ALF) has the meaning assigned under Section 247.002, Health and Safety Code

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

Case Management for Children and Pregnant Women is a Medicaid service for children with a health condition/health risk, birth through 20 years of age and for women with high-risk pregnancies of all ages. This program helps these groups gain access to medical, social, educational, and other health-related services.

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

CHIP Perinate means a CHIP Perinatal Program Member identified prior to birth (an unborn child).

CHIP Perinate Newborn means a CHIP Perinate who has been born alive and whose family income meets the criteria for continued participation in the CHIP Perinatal Program.

Cognitive Rehabilitation Therapy means a STAR+PLUS HCBS service that assists a Member in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the Member to compensate for the lost cognitive functions.

Community-based Long-Term Services and Supports means services provided to Members in their home or other community based settings necessary to provide assistance with activities of daily living to allow the Member to remain in the most integrated setting possible. Community-based Long-term Services and Supports includes services available to all Members as well as those services available only to Members who qualify for the STAR+PLUS HCBS Program.

Community-Based Services means services provided to Members in a home or other community-based setting.

Community First Choice (CFC) means Personal Assistance Services (PAS) or acquisition, maintenance, and enhancement of skills; emergency response services and support management provided in a community setting for eligible Members who have received a Level of Care (LOC) determination from an HHSC-authorized entity.

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

Community Services Specialist Provider (CSSP) means a staff member of a Local Mental Health Authority (LMHA) who has documented full-time experience in the provision of Mental Health TCM and Mental Health Rehabilitative Services (MHR) prior to August 31, 2004. The provider must meet 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 MHR and demonstrated competency in the provision and documentation of MHR.

Comprehensive Provider Agency(ies) means an entity that provides or subcontracts for the delivery of the full array of Mental Health TCM and MHR, as defined in 1 Tex. Admin. Code pt.15, ch. 353, subch. P, § 353.1403.

Consumer Directed Services (CDS) has the meaning described in 1 Tex. Admin. Code § 353.2.

Court-ordered Commitment means a commitment of a Member to an inpatient mental health facility for treatment ordered by a court of law including orders pursuant to the Tex. Health & Safety Code, chs. 573–574; Tex. Code of Crim. Proc. ch. 46B.

Critical Incident Management System (CIMS) is an online reporting system to report and track incidents of ANE allegations and Critical Events or Incidents

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

Default Enrollment means the processes established by HHSC to assign an MCO to an Eligible who has not selected an MCO within the required timeframe in accordance with 1 Tex. Admin. Code § 353.403 .

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 BH disorders, or its replacement.

Employment Assistance means assistance provided as a STAR+PLUS HCBS program service to a Member to help the Member locate paid employment in the community. Employment Assistance includes:

1. identifying Member's employment preferences, job skills, and requirements for a work setting and work conditions;
2. locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements; and
3. contacting a prospective employer on behalf of an individual and negotiating the individual's employment.

Employment First means framework for systems change centered on the premise that all citizens, including individuals with disabilities, are capable of full participation in integrated employment and community life

Former Foster Care Child (FFCC) Member means a young adult who has aged out of the foster care system and has previously received Medicaid while in foster care. FFCC Members may be enrolled in the STAR+PLUS Program until the last day of the month of his or her 26th birthday.

Financial Management Services Agency (FMSA) means an entity that contracts with HHSC or an MCO to provide Financial Management Services (FMS) as described in 40 Tex. Admin. Code pt.1, ch. 41, subch. C, § 41.309(a) to an employer or designated representative.

Functionally Necessary Covered Services means Long Term Services and Supports provided to assist Members with activities of daily living based on a functional assessment of the Member's activities of daily living and a determination of the amount of supplemental supports necessary for the Member to remain independent or in the most integrated setting possible.

Habilitation has the meaning assigned in 1 Tex. Admin. Code pt.15, ch. 353, subch. A, § 353.2.

Habilitative and Rehabilitative Services means Health Care Services described in Section 2.6.33 that may be required by Members who fail to reach (habilitative) or have lost (rehabilitative) age-appropriate developmental milestones.

Health Home means a Designated Provider, including a Provider that operates in coordination with a Team of Health Care Professionals, or a Health Team selected by a Member with chronic conditions to provide Health Home Services.

Health Home Services means comprehensive and timely services that are provided by a designated Provider, a team of healthcare professionals operating with such a Provider, or a Health Team. Health Home Services include:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;
4. Member and family support (including Authorized Representatives);
5. Referral to community and social support services, if relevant; and
6. Use of health information technology to link services, as feasible and appropriate.

Home and Community Based Services (HCBS) means the HHSC program that provides home and community based services to aged and disabled adults as cost-effective alternatives to institutional care. Members who qualify for the STAR+PLUS HCBS program are eligible to receive the home and community-based services component of the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver.

Home and Community Support Services Agency (HCSSA) means an entity licensed by HHSC to provide home health, hospice, Medically Dependent Children Program services, CFC services, and Personal Care Services (PCS) provided to Members in a home or independent living environment.

Individual Service Plan (ISP) means an individualized and person-centered plan in which a Member enrolled in the STAR+PLUS Home and Community Based Services program operated by the MCO, with assistance as needed, identifies and documents his or her preferences, strengths, and health and wellness needs in order to develop short-term objectives and action steps to ensure personal outcomes are achieved within the most integrated setting by using identified supports and services. The ISP is supported by the results of the Member's program-specific assessment and must meet the requirements of 42 C.F.R. § 441.301.

Integrated Primary Care (IPC) means the systematic integration of BH and routine primary care services. It is an approach to care that integrates BH Services into primary care during the regular provision of primary care services. IPC occurs at the same time and by the same provider, or by the BH Services provider seeing the Member in tandem with the PCP.

The IPC is a model distinct from co-location of services, which is considered to be parallel care rather than integrated care. IPC is also distinct from sequential care, which denotes BH care that occurs either before or after the primary care and at the same or a different

location. Information on IPC, integrated physical and BH care, and other useful resources and tools can be found online at IPC Website.

Intellectual or Development Disability (IDD) includes many severe, chronic conditions that are due to mental and/or physical impairments. IDD can begin at any time, up to 22 years of age which usually lasts throughout a person's lifetime and the term includes related conditions.

IDD Waiver means the Community Living Assistance and Support Services Waiver program (CLASS), the Deaf-Blind with Multiple Disabilities Waiver program (DBMD), the Home and Community-Based Services Waiver program (HCS), or the Texas Home Living (TxHmL)waiver program.

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.

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

Local Intellectual and Developmental Disability Authority (LIDDA) has the meaning assigned in Health and Safety Code § 531.002(12).

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

Main Dental Home Provider, Main Dentist, or **Dental Home** means a Provider who provides a Dental Home to Members and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to Members; maintaining the Continuity of Care; and initiating referrals for care. Provider types that can serve as Main Dental Home Providers are FQHCs, Rural Health Clinics (RHCs), and individuals who are general dentists or pediatric dentists.

Medicaid for Breast and Cervical Cancer (MBCC) Member means a STAR+PLUS Member between age 18 and 65 in active treatment for breast or cervical cancer, or certain precancerous conditions, determined eligible by HHSC's Breast and Cervical Cancer Services program and receives recertification for continued services every six months.

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

Medicare Advantage Dual Eligible Special Needs Plans (MA Dual SNPs or D-SNPs) are Medicare Advantage Plans that provide Medicare services and coordination of Medicaid services through MCOs to Dual Eligibles with a chronic condition.

Member Hotline means the toll-free telephone line operated by the MCO as detailed in **Section 2.6.18.1.**

Member(s) with Special Healthcare Needs (MSHCN) means a Member 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.

All STAR+PLUS Members are considered MSHCN.

Mental Health Targeted Case Management (Mental Health TCM) 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 standardized assessment using either the Texas CANS or the Adult Needs and Strengths Assessment (ANSA) and other diagnostic criteria used to establish medical necessity.

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

Nurse Hotline means the toll-free telephone line operated by the MCO described in **Section 2.6.18.2.**

Nursing Facility (NF), sometimes referred to as 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 Facility Add-on Services means the types of services that are provided in the Nursing Facility setting by a Nursing Facility Provider or another Provider, but are not included in the Nursing Facility Unit Rate, including emergency dental services, physician-ordered rehabilitative services, customized power wheelchairs, augmentative communication devices, tracheostomy care for Members age 21, and ventilator care.

Nursing Facility Cost Ceiling means the annualized cost of serving a client in a nursing facility. A per diem cost is established for each Medicaid nursing facility resident based on the level of care needed, referred to as the resource utilization group (RUG). The per diem cost is annualized to achieve the nursing facility ceiling.

Nursing Facility Medicare Coinsurance means the State's Medicare coinsurance obligation for a qualified Dual Eligible Member's Medicare-covered stay in a Nursing Facility. Nursing Facility Medicare Coinsurance does not include the State's cost-sharing obligation for a Dual Eligible Member's Medicare covered Nursing Facility Add-on Services.

Nursing Facility Services means the services included in the Nursing Facility Unit Rate, Nursing Facility Medicare Coinsurance, and Nursing Facility Add-on Services.

Nursing Facility Level of Care means the determination that the level of care required to adequately serve a STAR+PLUS Member is at or above the level of care provided by a nursing facility.

Nursing Facility Unit Rate means the rate for the type of services included in the Medicaid Fee-for-Service daily rate for Nursing Facility Providers as defined by 40 Tex. Admin. Code § 19.2601, 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 applicable Nursing Facility staff rate enhancements as described in 1 Tex. Admin. Code § 355.308 and professional and general liability insurance add-on payments as described in as 1 Tex. Admin. Code § 355.312. The Nursing Facility Unit Rate excludes Nursing Facility Add-on Services.

Open Panel means Providers who are accepting new Members for the Program.

PCP Team means an interdisciplinary team that agrees to function as a Medical Home, of which the Member, Caregiver, Member's PCP, other Providers, SSCC staff, and Service Coordinator may be a part.

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.

Personal Care Services (PCS) means support services furnished to a Member 18 through 20 years of age who has physical, cognitive, or behavioral limitations related to the Member's Disability or chronic health condition that limit the Member's ability to accomplish ADLs, IADLs, or health-maintenance activities.

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

Preadmission Screening and Resident Review (PASRR) means a federally mandated program applied to all individuals seeking admission to a Medicaid-certified Nursing Facility. PASRR helps ensure that individuals are not inappropriately placed in nursing homes for long-term care and requires that all applicants to a Medicaid-certified nursing facility: (a) be evaluated for mental illness, intellectual disability, or both; (b) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and (c) receive the services they need in those settings.

Prescribed Pediatric Extended Care Center (PPECC) means a facility under Tex. Health & Safety Code § 248A.001(10) 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.

Private Duty Nursing (PDN) has the meaning assigned in 42 C.F.R. § 440.80.

Programs of All-Inclusive Care for Elderly (PACE) means a comprehensive medical and social services to certain frail, community-dwelling elderly individuals, for dual eligible as an alternative to nursing facility care, operated in specific counties.

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

Rate Period 1 means the 12-month period beginning on TBD and ending on TBD.

Rate Period 2 means the 12-month period beginning on TBD and ending on TBD.

Resource Utilization Group (RUG) means the level of care needed by nursing facility residents and the resources allocated for that level of care**.**

Respite means direct care services that relieve a primary Caregiver temporarily from caregiving activities for an STAR+PLUS HCBS-enrolled Member.

Service Area (SA) means an area as defined in the map in **Exhibit H.**

Service Coordination Hotline means an optional phone number provided by the MCO that connects Members with Service Coordination staff.

Service Plan means an individualized and Person-Centered plan, including an ISP, in which an individual, with assistance as needed, identifies and documents his or her preferences, strengths, and needs in order to develop short-term objectives and action steps to ensure personal outcomes are achieved within the most integrated setting by using identified supports and services.

Specialty Hospital means any inpatient hospital that is not a general Acute Care hospital.

STAR+PLUS, STAR+PLUS Program, or **Program** means the State of Texas' Medicaid managed care program in which HHSC contracts with MCOs to provide, arrange, and coordinate Medically Necessary and Functionally Necessary Covered Services to Medicaid for Breast and Cervical Cancer participants, adult Persons with Disabilities, and

STAR+PLUS Handbook means the handbook containing HHSC-approved policies and procedures related to the STAR+PLUS Program, including policies and procedures relating to the Texas Healthcare Transformation and Quality Improvement Program 1115 demonstration project. The STAR+PLUS Handbook includes additional requirements regarding forms, assessments, the STAR+PLUS Program, and guidance for the MCOs and HHSC staff for administrating and managing STAR+PLUS Program operations.

STAR+PLUS HCBS Program means the HHSC program that provides home and community based services to aged and disabled adults as cost-effective alternatives to institutional care in nursing homes. Members who qualify for STAR+PLUS HCBS are eligible to receive the home and community based services component of the Texas Healthcare Transformation and Quality Improvement Program 1115 demonstration project as described in Section 2.6.33 after the paragraph "The MCO also must provide, in addition to the above, the following Medically Necessary and Functionally Necessary Covered Services to Members who qualify for STAR+PLUS HCBS"

Target Population means the participants described in **Section 1.3.**

Texas Comprehensive Child and Adolescent Needs and Strengths (Texas CANS) means the comprehensive and developmentally appropriate child welfare assessment administered to Members ages 3-17 in the manner required by Tex. Fam. Code § 266.012.

The Joint Commission means the nonprofit organization that accredits certain types of medical services, which is comprised of a 21-member board of commissioners that include health care providers, educators, and advocates.

Type Program (TP) means a Medicaid program eligibility type assigned to persons determined eligible for Services through HHSC.

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

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

1.5 MISSION STATEMENT

HHSC's mission in this SOW is to:

1. Ensure continuous and uninterrupted delivery of integrated Covered Services, centralized Service Coordination, and the effective management of healthcare data and information;
2. Ensure Members receive person-centered, integrated, high-quality healthcare that holistically addresses their needs, resulting in improved-health outcomes; and;
3. Provide supports necessary to ensure Members are able to live in the least restrictive setting possible.

1.6 MISSION OBJECTIVES

The mission objectives of this SOW are as follows:

1.6.1 SERVICE COORDINATION

The integration of Acute Care services and LTSS is an essential feature of STAR+PLUS. The MCO must provide sufficient levels of qualified and competent personnel devoted to Service Coordination to meet the everyday needs of Members, including those with Intellectual or Developmental Disabilities (IDD) and Medicare-Medicaid or Dual Eligible Members.

1.6.2 CONTINUITY OF CARE

Members' transitions to their new MCO must be as seamless as possible for Members and their Providers. Established Member and Provider relationships, existing treatment protocols, and ongoing Service Plans must not be impacted significantly by this procurement.

1.6.3 NETWORK ADEQUACY AND ACCESS TO CARE

The MCO must have timely access to quality care through a Provider Network designed to meet the needs of the Members. The MCO must create and maintain a Network that provides all Members with prompt delivery of all STAR+PLUS Covered Services. The MCO must provide Members with access to qualified Providers within the travel distance, travel time, and waiting time for appointment standards defined in this SOW.

1.6.4 QUALITY

The MCO must ensure all Members receive quality services in the most efficient and effective manner possible. The MCO must provide high quality services in a professional and ethical manner. The MCO and Providers must implement new and creative approaches,

with approval from HHSC, that ensure quality services, cost-effective service delivery, and careful stewardship of public resources.

1.6.5 TIMELINESS OF CLAIM PAYMENT

The MCO's ability to ensure that Network Providers receive timely, accurate, and fair payment for rendered services is a critical component of STAR+PLUS. The MCO must comply with HHSC's claims adjudication requirements in a timely manner, as set forth in **Chapter 2 of Exhibit C.** HHSC will require strict adherence to claims adjudication standards. HHSC encourages MCOs to provide a no-cost alternative for providers to allow billing without the use of a clearinghouse. However, the MCO may not require providers to use a clearing-house.

1.6.6 BEHAVIORAL HEALTH SERVICES

The MCO must ensure Members have timely access to BH Services, such as mental health and SUD counseling and treatment, crisis hotlines, as well as timely and appropriate follow-up care. Crisis and non-crisis services must include Member choice options, which means the MCO cannot require Members to receive services through a sole source provider.

1.6.7 DELIVERY OF HEALTH CARE TO DIVERSE POPULATIONS

Member populations in Texas are as diverse as those of any state in the nation. The MCO must deliver all Covered Services without discrimination. The MCO must implement a Cultural Competency plan to avoid disparities in the delivery of Covered Services to diverse populations and provide services in a culturally competent manner.

1.6.8 DISEASE MANAGEMENT REQUIREMENTS

The MCO must provide a comprehensive DM program or coverage for 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.

1.7 SERVICE AREAS

HHSC distinguishes areas of Texas by SA. Respondents may bid on one or more SAs. If a Respondent proposes to participate in a SA, the Respondent must serve all counties in the defined SA. Maps and tables depicting the SA configuration for STAR+PLUS can be found in **Exhibit H.**

1.8 AUTHORITY

The Texas Legislature has designated HHSC as the sole state agency with the authority to administer Medicaid through managed care models in the State of Texas. Tex. Gov't Code chs. 531 and 533, and Tex. Hum. Res. Code ch. 32 provide that HHSC has authority to

contract with MCOs to carry out the duties and functions of the Medicaid managed care program as described by Title XIX of the Social Security Act. HHSC remains the only entity authorized to contract with an MCO and to modify any resulting Contract or otherwise further bind the State of Texas. The MCO must be authorized to enter into the Contract and the individuals signing the Contract must have authorization to bind the MCO.

ARTICLE 2 SCOPE OF WORK

2.1 REQUIRED FEDERAL AND STATE APPROVAL AND FUNDING

The SOW is contingent upon federal and state approvals and funding, including the CMS' approval and funding. Should any part of the SOW 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. The State must adjust Capitation Payments and Capitation Rates 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 the State 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 must be returned to the State. However, if the MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and the State 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.

2.2 REMEDIES AND LIQUIDATED DAMAGES

All areas of responsibility and all requirements of the MCO in the Contract will be subject to performance evaluation, review, and audit by HHSC. All responsibilities or requirements not fulfilled by the MCO may have remedies, and HHSC may assess damages, including liquidated damages. Refer to **Exhibit D**, **Deliverables/Liquidated Damages Matrix**, for particular liquidated damage values.

2.3 ANTITRUST

MCO will assign to HHSC all of MCO's state and federal antitrust claims and causes of action that relate to all goods, Services, or Deliverables provided for or related to the Contract.

2.4 MEMBER ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

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.

2.4.1 ELIGIBILITY DETERMINATION AND DISENROLLMENT

HHSC 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.

The MCO must notify HHSC within ten Business Days if an MCO becomes aware that a Member has moved outside of the SA or that a Member is no longer Medicaid-eligible, for example, if the Member has moved outside of the State or is deceased the MCO must inform HHSC.

2.4.2 MEMBER ENROLLMENT

HHSC or its designee will enroll eligible individuals in the STAR+PLUS Program. See **Section 1.3** for eligible populations. HHSC will establish procedures for enrollment into participating MCOs and PCPs, including enrollment periods and time limits within which enrollment must occur. Beneficiaries will have at least 15 calendar days from the date notification is mailed to choose an MCO, and PCP according to 1 Tex. Admin. Code § 353.403(b). To enroll in an MCO, the Member's permanent residence must be located within the MCO's SA. HHSC or its designee will use HHSC's default assignment methodologies, as described in 1 Tex. Admin. Code § 353.403 to enroll individuals who do not select an MCO or PCP.

HHSC or its designee will electronically transmit to the MCO new Member information and change information applicable to active Members.

As described in the following sections, special conditions may also apply to enrollment and span of coverage for the MCO.

2.4.2.1 RESPONSIBILITY AFTER TEMPORARY LOSS OF MEDICAID ELIGIBILITY

Members who are disenrolled because they are temporarily ineligible for Medicaid will be automatically reenrolled into the same MCO, if available. Temporary loss of eligibility is defined as a period of six months or less.

If Medicaid eligibility is re-activated after being terminated in error, then HHSC will retroactively enroll the Member with the MCO that the member was previously enrolled with to avoid a gap in managed care coverage. The retro-enrolled Members will be sent in a daily file to the MCO, and the MCO must upload the daily Enrollment File into the MCO's system within 24 hours of receipt.

2.4.3 MEMBER DISENROLLMENT

HHSC or its designee will disenroll eligible individuals in the STAR+PLUS Program. The MCO is not allowed to induce or accept disenrollment from a Member. The MCO must refer the Member to HHSC or its designee.

A Medicaid MCO has a limited right to request that a Member be disenrolled from the MCO without the Member's consent. HHSC must approve any MCO request for disenrollment of a Member for cause. MCO must take reasonable documented measures to correct Member behavior prior to requesting disenrollment. Reasonable documented measures may include providing education and counseling regarding the offensive acts or behaviors. HHSC must approve any MCO request for disenrollment of a Member for cause under the following circumstances:

1. Member misuses or loans Member's MCO membership card to another person to obtain services.
2. Member's behavior is disruptive or uncooperative to the extent that Member's continued enrollment in the MCO seriously impairs the MCO's or Provider's ability to provide services to either the Member or other Members, and the Member's behavior is not related to a developmental, intellectual, or physical Disability or BH condition.
3. Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow the MCO to treat the underlying medical condition).

HHSC must notify the Member of HHSC's decision to disenroll the Member if all reasonable measures have failed to remedy the problem.

If the Member disagrees with the decision to disenroll the Member from MCO, HHSC must notify the Member of the availability of HHSC's State Fair Hearing process.

MCO cannot request a disenrollment based on an adverse change in the Member's health status or utilization of services that are Medically Necessary for treatment of a Member's condition.

2.4.3.1 ENROLLMENT FOR INFANTS BORN TO PREGNANT WOMEN IN STAR+PLUS

If a newborn is born to a Medicaid-eligible mother enrolled in a STAR+PLUS MCO, HHSC or its designee will enroll the newborn into that MCO's STAR MCO product, if one exists. If the STAR+PLUS MCO does not have a STAR product but the newborn is eligible for STAR, the newborn will be enrolled in traditional FFS Medicaid and given the opportunity to select a STAR MCO.

2.4.4 SPAN OF COVERAGE

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 or any other factor.

2.4.4.1 OPEN ENROLLMENT

HHSC will conduct continuous open enrollment for Medicaid Eligibles.

2.4.4.2 ENROLLMENT CHANGES DURING AN INPATIENT STAY

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).

	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 same Program	Former MCO	New MCO
4.	Member Moves between MCO programs	Former MCO	New MCO

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+PLUS, the date of Discharge from the Hospital for mental health stays includes extended stay Days, as described in the Texas Medicaid Provider Procedures Manual.

2.4.4.3 EFFECTIVE CHANGES DUE TO SSI STATUS

When an adult STAR Member qualifies for SSI, the Member will move to STAR+PLUS or the Dual Demonstration, if applicable. When a child STAR Member qualifies for SSI, the Member will move to FFS or STAR Kids. **Section 2.4.4.11** describes how HHSC will determine the effective date of the Member's SSI status.

2.4.4.4 DISENROLLMENT FROM MANAGED CARE DURING AN INPATIENT STAY IN A HOSPITAL

When a Member moves from an MCO Program to FFS during an Inpatient Stay in a Hospital, the former MCO remains responsible for the Hospital facility charge, and FFS is

responsible for all other Covered Services beginning on the effective date of FFS coverage. The former MCO 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.

2.4.4.5 RESPONSIBILITY FOR COSTS INCURRED AFTER LOSS OF MEDICAID ELIGIBILITY

MCOs are not responsible for the cost of services incurred on or after the effective date of loss of Medicaid eligibility.

2.4.4.6 ENROLLMENT CHANGES DURING A CHEMICAL DEPENDENCY TREATMENT FACILITY STAY

The following table describes payment responsibility for Medicaid enrollment changes that occur during a stay in a residential SUD treatment facility or residential detoxification for SUD treatment facility (collectively, Chemical Dependency Treatment Facilities - CDTF), beginning on the Member's Effective Date of Coverage with the New MCO.

	Scenario	**CDTF 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	New MCO	New MCO
3.	Member moves between MCOs	Former MCO	New MCO
4.	Member moves between MCO Programs	Former MCO	New MCO

The responsible party will pay the CDTF charge until the earlier of: (a) date of Discharge from the CDTF or (b) loss of Medicaid eligibility. The New MCO may evaluate for medical necessity of the CDTF stay prior to the end of the authorized services period.

2.4.4.7 DISENROLLMENT FROM MANAGED CARE DURING A CDTF STAY

When a Member moves from an MCO Program to FFS during a CDTF stay, the former MCO remains responsible for the CDTF charge, and FFS is responsible for all other Covered Services beginning on the effective date of FFS coverage. The former MCO will pay the CDTF charge until the earlier of: (1) date of Discharge, or (2) loss of Medicaid eligibility.

2.4.4.8 ENROLLMENT CHANGES DURING A NURSING FACILITY STAY

The following table describes payment responsibility for Medicaid enrollment changes that occur during a Nursing Facility (NF) stay, beginning on the Member's Effective Date of Coverage with the New MCO.

	Scenario	Nursing Facility Unit Rate and/or Medicare Coinsurance	All Other Covered Services
1.	Member moves from FFS to STAR+PLUS or Dual Demonstration	New STAR+PLUS or Dual Demonstration MCO	New STAR+PLUS or Dual Demonstration MCO
2.	Member moves between STAR+PLUS MCOs	New STAR+PLUS MCO	New STAR+PLUS MCO
3.	Member moves between Dual Demonstration MCOs	New Dual Demonstration MCO	New Dual Demonstration MCO
4.	Member moves from STAR+PLUS to Dual Demonstration	New Dual Demonstration MCO	New Dual Demonstration MCO
5.	Member moves from Dual Demonstration to STAR+PLUS	New STAR+PLUS MCO	New STAR+PLUS MCO
6.	Member moves from STAR+PLUS or Dual Demonstration to FFS	FFS	FFS

2.4.4.9 ENROLLMENT CHANGES WITH CUSTOM DURABLE MEDICAL EQUIPMENT, ADAPTIVE AID OR AUGMENTATIVE DEVICE PRIOR AUTHORIZATION

The following table describes payment responsibility for Medicaid enrollment changes that occur when a PA exists for custom Durable Medical Equipment (DME), Adaptive Aids, or augmentative device, before the delivery of the product.

	Scenario	Custom DME	All Other Covered Services
1.	Member moves between MCOs or MCO Programs	Former MCO	New MCO
2.	Member moves from FFS to MCO Program	New MCO	New MCO

2.4.4.10 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 STAR+PLUS HCBS program, before completion of the modification.

	Scenario	Minor Home Modification	All Other Covered Services
1.	Member moves between STAR+PLUS MCOs or Dual Demonstration MCOs	Former MCO	New MCO

2.4.4.11 EFFECTIVE DATE OF SSI STATUS

SSI status is effective on the date HHSC's eligibility system identifies a Member as Type Program 13 (TP 13). HHSC will update the eligibility system within 45 Days of official notice of the Member's SSI status by the SSA. Once HHSC has updated the State's eligibility system to identify the STAR, CHIP, or CHIP Perinate Newborn Member as TP13, following standard eligibility cut-off rules, HHSC will enroll the Member in the appropriate Program (STAR Kids, STAR+PLUS, or the Dual Demonstration).

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

2.4.4.12 MEMBER DISCHARGES FROM A FACILITY IN ONE SERVICE AREA TO THE COMMUNITY IN ANOTHER SERVICE AREA

The Member's MCO at the time of Discharge must work with HHSC, community organizations, and the Member's chosen MCO in the new SA to ensure the Member's health care and community LTSS needs are met until the Member's enrollment in the new MCO takes effect. The current MCO must work with Providers in the new SAs to arrange limited contractual relationships to ensure services are delivered and providers are reimbursed upon the Members move to the new SA. The current MCO and the Member's selected MCO must coordinate the Member's care until the enrollment change takes effect.

2.4.5 VERIFICATION OF MEMBER ELIGIBILITY

MCOs are 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 providers. All such external vendors must contract with the State and obtain eligibility information from the State.

2.5 TRANSITION PHASE SCOPE

This section includes the requirements for the Transition Phase, which begins on the Effective Date and includes those activities that must take place between the Effective Date and the Operational Start Date.

2.5.1 INTRODUCTION

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

1. Define project management and reporting standards;
2. Establish communication protocols between HHSC and the MCO;
3. Establish contacts with other HHSC contractors;
4. Establish a schedule for key activities and milestones; and
5. Clarify expectations for the content and format of Deliverables.

The MCO must timely and successfully complete each of the Transition Phase tasks per the approved Transition Plan, including, but not limited to:

1. Providing all materials requested by HHSC, or its designee;
2. Providing access to all facilities, systems, staff, etc.; and
3. Clearly specifying and requesting information needed from HHSC, or other contractors, in a manner that does not delay the schedule or work to be performed.

The Transition Phase includes Readiness Reviews, which must be completed to HHSC's satisfaction no later than 30 Days prior to the Operational Start Date, unless otherwise indicated throughout **Section 2.5** or agreed upon by HHSC.

No later than 30 Days after the Effective Date the MCO must submit an initial Transition Plan, and thereafter throughout the Transition Phase, the MCO must update the Transition Plan and submit these updated plans to HHSC on a monthly basis for review. HHSC may require more frequent reporting as it determines necessary.

If there are changes that occur to the information after the deadlines listed above, the MCO must notify HHSC within five Business Days. HHSC will have the sole discretion to accept or reject updates to information.

The MCO must successfully complete each of the Transition Phase tasks per the approved Transition Plan.

During the Transition Phase, the MCO must remedy any identified Transition Phase deficiencies within 10 Days of HHSC's request. The MCO must notify HHSC of any deficiencies upon discovery. If any errors or deficiencies are evident during the Transition Phase, the MCO must implement an HHSC-approved resolution procedure to address and resolve the errors or deficiencies prior to the Operations Phase.

The MCO must secure advanced written approval from HHSC for a delay in the Operational Start Date or a delay in the MCO's compliance with the applicable Readiness Review requirements.

The MCO is required to mitigate risk associated with not being prepared for the Operations Phase in coordination with HHSC with consideration of the following high-level processes:

1. At the start of Readiness Review, HHSC will identify key events based on a Deliverable timeline that the MCO must achieve by a specified time;
2. To ensure the MCO is on track to meet Readiness Review milestones, HHSC may conduct Readiness Review meetings on a weekly basis;
3. If the MCO consistently fails to meet the established Readiness Review milestones, it will be identified as high-risk and targeted for increased technical assistance;

4. Upon MCO's remediation of the issues identified by HHSC to HHSC's satisfaction, the MCO status will change to "Go;" and
5. Readiness Review will occur prior to the Operational Start Date, and if at this point the MCO is identified as a "No-Go" then the Operational Start Date may be delayed in HHSC's sole discretion.

2.5.2 ADMINISTRATION AND KEY PERSONNEL

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.

No later than ten Days after the Effective Date, the MCO must:

1. Designate and identify Key Personnel that meet the requirements in **Section 4.02 of Exhibit A**;
2. Provide résumés of each Key Personnel and the percent of allocated time Key Personnel are dedicated to the Contract;
3. Report on any organizational information that has changed since submission of the MCO's Proposal and oral presentation, such as updated job descriptions and updated organizational charts, if applicable;
4. The MCO must also provide information on the anticipated maximum caseload per Service Coordinator (i.e., number of Members per Service Coordinator);
5. Provide the organizational chart for Material Subcontractors; and
6. Provide necessary information for HHSC to confirm the identity and determine the exclusion status of the MCO and their Material Subcontractors as well as any owner or person with a controlling interest or who is an agent or managing employee of the MCO through routine checks of federal databases as required in 42 C.F.R. § 438.608(c).

2.5.3 READINESS REVIEW

During the Readiness Review, the MCO must satisfy the requirements identified in the subsections below. HHSC reserves the right to update the Readiness Review requirements and related reporting at any time prior to and during the Contract Term.

2.5.3.1 STATEMENT REGARDING ANY MATERIAL CHANGE IN FINANCIAL CONDITION

No later than 60 Days prior to the Operational Start Date, the MCO must submit a statement identifying any material changes in its financial condition. The MCO and its ultimate parent entity must definitively state whether either entity has, or has not, experienced any material financial deterioration subsequent to submission of its Proposal or not disclosed in its Proposal. This statement must also state if there are, or are not, any known or potential issues with respect to changes in ownership or control. The MCO must not submit "not applicable," "N/A," or a similar response, or leave blank.

If either the MCO or its ultimate parent entity has experienced any such material financial deterioration, then the statement must also identify and briefly describe any changes to the financial statements, including changes to net worth, cash flow, loss of contracts, credit, audit issues, regulatory issues, and legal issues, major contingencies, and any known potential material issues.

2.5.3.2 DOCUMENTATION DEMONSTRATING THE SECURING OF ALL REQUIRED BONDS

No later than 60 Days before the Operational Start Date, the MCO must submit documentation demonstrating it secured all required bonds in accordance with TDI rules, Tex. Ins. Code ch. 843, and **Article 15 of Exhibit A**.

2.5.3.3 EMPLOYEE INCENTIVE PAYMENT PLAN

If a MCO intends to include claim Employee Bonus or Incentive Payments as allowable administrative expenses, the MCO must furnish a written Employee Bonus or Incentive Payment Plan to HHSC. The written plan must include a description of the MCO's criteria for establishing bonus or incentive payments, the methodology to calculate bonus or incentive payments, the timeframe for measuring the performance (Measurement Period),and the timing of bonus or incentive payment. The Employee Bonus or Incentive Payment Plan and description must be submitted during the Transition Phase, no later than 60 Days before the Operational Start Date of the Contract. Thereafter, the MCO must submit the Employee Bonus or Incentive Payment Plan annually to HHSC prior to the start of the plan's Measurement Period.

HHSC reserves the right to disallow all or part of a plan that it deems inappropriate. Any such payments are subject to audit, and must comply with UMCM **Chapter 6**.

2.5.3.4 UPDATED INFORMATION ON MATERIAL SUBCONTRACTORS

No later than 60 Days prior to the Operational Start Date, the MCO must submit an updated listing of Material Subcontractors. Material Subcontractors include Affiliates and non-Affiliates. Additional documentation may be required at HHSC's discretion. This updated list must, at a minimum, include the following:

1. The Material Subcontractor's legal name, trade name, acronym, dba, and any other name under which the Material Subcontractor does business, or has done business, in the past five years;
2. The full and exact legal name of the Material Subcontractor's ultimate parent;
3. All of the MCO's estimated annual payments to each Material Subcontractor that may be included, directly or indirectly, in any FSR submitted by the MCO under the Contract or any other HHSC contract, including separate amounts for each Material Subcontractor;
4. The physical address, mailing address, and telephone number of the Material Subcontractor's headquarters and the name of its chief executive officer;

5. A definitive statement regarding whether the Material Subcontractor is an Affiliate of the MCO or an unrelated third party;
6. If the Material Subcontractor is an Affiliate:
    a. The name of the Material Subcontractor's parent organization, and the Material Subcontractor's relationship to the MCO;
    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 MCO would procure under the proposed Subcontract;
    c. A description of the proposed method of pricing under the Subcontract;
    d. A statement as to whether there is, or is not, any anticipated mark-up, margin, profit, or amount in excess of actual costs incurred by the Material Subcontractor that is anticipated to be included in the pricing;
    e. The number of employees, both staff and management, who are dedicated full-time to the Affiliate's business. Do not include any staff or management that have other duties in addition to working on this specific Affiliate's business;
    f. Whether the Affiliate's office facilities are completely separate from the MCO and the MCO's ultimate parent. If Affiliate's office facilities are not completely separate from the MCO and MCO's owner, identify the approximate number of square feet of office space that are dedicated solely to the Affiliate's business;
    g. 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 legally employed by a different legal entity such as an ultimate parent corporation. The employee's Form W-2 identifies the name of the corporation and is indicative of the actual employer.
7. Whether the Material Subcontractor or any of its Affiliates had a managed care contract with a state, federal, or governmental agency terminated or not renewed for any reason within the past five years. In such instance, the MCO must describe the issues, the parties involved, and provide the name, title, email address and telephone number of the principal contact for the party with whom the contract was held. The MCO must also describe any corrective action taken by the Material Subcontractor to prevent any future occurrence of the problem that may have led to the termination or non-renewal; and
8. Necessary information for the State to confirm the identity and determine the exclusion status of the MCO's Material Subcontractors as well as any owner or person with a controlling interest or who is an agent or managing employee of the MCO through routine checks of federal databases as required in 42 C.F.R. § 438.608(c).

The MCO must list the Material Subcontractors in descending order of estimated MCO annual payments to the Material Subcontractor across all HHSC contracts, wherein such payments may be included, directly or indirectly, in an FSR.

2.5.3.5 CARVE-IN READINESS

The MCO must participate in Readiness Review as dictated by HHSC for the expansion of Medicaid managed care to populations currently served by FFS.

2.5.3.6 SYSTEMS READINESS AND TRANSFER OF DATA

HHSC will provide a test plan to the MCO outlining the activities the MCO needs to perform prior to the Operational Start Date. The MCO must be prepared to assure and demonstrate system readiness. During systems readiness, the MCO must:

1. Submit a systems readiness plan for HHSC approval 30 Days after the Contract Effective Date to test and validate the interfaces among trading partners for the operational and administrative areas listed in **Section 2.6.30**;
2. Plan and execute system readiness test cycles with all trading partners, to include all interfaces based on the activities provided in systems readiness plan, nine months prior to the Operational Start Date;
3. Accept secure transmission of data files and information among trading partners per the file structure, with data elements, and on a frequency specified in HHSC's JIPs located in a centralized secure file transfer site designated by HHSC;
4. Demonstrate to HHSC that systems services will not be disrupted or interrupted during the Operations Phase by successfully completing all tasks in the systems readiness plan;
5. Coordinate with HHSC, other trading partners, and contractors to ensure the business and systems continuity for the processing of all healthcare claims and data;
6. Satisfy internet website and portal requirements described in **Section 2.6.20**;
7. Submit to HHSC descriptions of data flow, process flow, and interfaces for each key business process described in **Section 2.6.30**;
8. Submit documentation on systems and facility security as defined in the Security Management Plan;
9. Provide a summary of external audit reports, including findings and corrective actions, relating to the MCO's MIS and subsystems. The summary must include any Service Organization Controls (SOC) 1 examinations, formerly called Statement on Standards for Attestation Engagements (SSAE) 16 audits, that have been conducted in the 3 years prior to the Effective Date;
10. Provide additional documentation to support the readiness of systems as requested by HHSC;
11. Install and test all hardware, Software, and telecommunications infrastructure required to support the Contract;
12. Define and test modifications to the MCO's system(s) required to support the business functions of the Contract;
13. Produce data extracts and receive all electronic data transfers and transmissions; and
14. Demonstrate the ability to produce the 837 encounter file 90 Days prior to the Operational Start Date.

The MCO must clearly define and document the policies, processes, and procedures required to support day-to-day systems operations. The MCO must develop, and submit for HHSC review and approval, the following information no later than 120 Days prior to the Operational Start Date:

1. Disaster Recovery Plan;
2. BCP;
3. Security Management Plan;
4. Joint Interface Plan;
5. Risk Management Plan;
6. Systems Quality Assurance Plan; and
7. Change Management Plan.

The BCP and the Disaster Recovery Plan may be combined into one document. At any time during the Contract Term, the MCO must provide updated plans within 15 Business Days of HHSC's request.

The Disaster Recovery Plan must include an inclement weather plan to minimize any disruption to NEMT Services during weather that does not constitute a disaster but could impact travel.

HHSC will assess the MCO's understanding of its responsibilities, the MCO's capability to assume the MIS functions required under the Contract, and whether the MCO can commence operations under the Contract.

2.5.3.7 OPERATIONS READINESS

The MCO must clearly define and document the policies and procedures to support day-to-day business activities related to the provision of Covered Services, including coordination with Subcontractors. The MCO must clearly document all policies and procedures to produce Contract Deliverables. The MCO must develop, document, and maintain its approach to Quality Assurance.

During Readiness Review, the MCO must perform the following activities or develop and submit to HHSC the following Deliverables as well as, any additional items HHSC deems necessary to ensure readiness, in accordance with the HHSC operations readiness Deliverables timeline:

1. Operations procedures and associated documentation to support the MCO's proposed approach to conducting operations activities in compliance with the Contract;
2. A comprehensive plan for Network adequacy that includes a list of all contracted and credentialed Providers, in a format approved by HHSC. At a minimum, the list must include the Provider types identified in Tex. Gov't Code § 533.005(a)(21)(B). The plan must include a description of additional contracting and Credentialing activities scheduled to be completed before the Operational Start Date;
3. A comprehensive plan to recruit and retain Providers statewide to meet the minimum requirements for psychiatrists, psychologists, and BH therapy providers;

4. A comprehensive plan describing how the MCO will identify and respond to NEMT Services provider capacity issues, including how the MCO will recruit and retain NEMT Services providers statewide as necessary to meet Members' needs;
5. A plan documenting how the MCO will track Provider certifications and trainings how the MCO will indicate these designations in the Provider directory, and what system is in place to encourage additional Providers to receive these trainings and certifications from the MCO;
6. A Member Services staff training curriculum, and a Provider training curriculum and related materials, and provide documentation demonstrating compliance with training requirements (*e.g.*, attendance rosters dated and signed by each attendee or other written evidence of training). Training must include privacy, Service Coordination, Member advocacy, internal MCO appeal process, HHSC State Fair Hearing process, Covered Services, VAS, warm transfer, medical necessity, Member harm identification, issue escalation, the STAR+PLUS HCBS program, reporting suspected ANE, prohibitions related to restraint and seclusion, and community resource navigation;
7. A coordination plan documenting how the MCO will coordinate its business activities with those activities performed by HHSC or its contractors, the MCO's PBM and other Material Subcontractors, if any. The coordination plan must include identification of coordinated activities and protocols for the Transition Phase;
8. A plan for providing BH Services, including oversight and management of any Subcontracted BH Services. The plan must also address strategies, structures, and incentives for coordinating behavioral and physical Covered Services at the organizational and practitioner level;
9. A Service Coordination plan that addresses requirements provided in **Section 2.6.49.1**.
10. Develop and submit training materials for Service Coordinators. The MCO must provide for HHSC's review and approval, all policies and procedures for ensuring Service Coordination workflows, and procedures for assuring Service Coordinators have reasonably manageable workloads and access to appropriate resources;
11. A coordination plan for ongoing coordination with HHSC or its contractors, including strategies for sharing information and resolving issues;
12. Drafts of the Member handbook, Provider directory, and Member ID card for HHSC's review and approval. The materials must meet the requirements specified in **Section 2.6.17** and include the critical elements defined in the **Chapter 3 of Exhibit C.** The MCO must submit a final Member handbook, Provider directory, and Member ID card incorporating all changes required by HHSC;
13. The required number of the final Provider directories to the HHSC EB by the due date specified by HHSC to meet the enrollment schedule.
14. Drafts of the Provider manual and Provider Contract templates to HHSC for review and approval. The materials must meet the requirements specified in **Section 2.6.8,** and include the critical elements defined in **Chapters 3** and **8 of Exhibit C.** The MCO must submit a final Provider manual and final Provider Contract templates incorporating all changes required by HHSC;

15. The MCO's proposed MCO Internal Appeal and Complaint System to HHSC provided in **Section 2.6.34**;
16. The MCO's proposed Provider appeals and Complaints system provided in **Section 2.6.33.1**;
17. The MCO's proposed Utilization Management (UM) processes provided in **Chapter 15 of Exhibit C**;
18. The MCO's proposed Encounters processes provided in **Section 2.6.30.2**;
19. The MCO's proposed processes affecting claims provided in **Section 2.6.30.3**;
20. Demonstrate toll-free telephone systems and reporting capabilities for the Member-facing hotlines in accordance with **Section 2.6.18** and no less than 60 Days prior to the Operational Start Date;
21. A written Fraud, Waste, and Abuse (FWA) compliance plan for approval in accordance with **Chapter 5** of **Exhibit C**, unless otherwise approved by HHSC. In addition, **Section 2.6.31** provides the requirements of the FWA compliance plan, including the requirements for Special Investigative Units (SIUs);
22. Complete hiring and training of STAR+PLUS Service Coordination staff provided in **Section 2.6.49** no later than 45 Days prior to the Operational Start Date;
23. Submit a written plan for providing pharmacy services identified in **Section 2.6.53**, including proposed policies and procedures for:
    a. Routinely updating formulary data within two Business Days following receipt of HHSC's daily files and off-cycle upon HHSC's request;
    b. PA of drugs, including how HHSC's Preferred Drug Lists (PDLs) will be incorporated into PA systems and processes. The MCO must adopt HHSC's PA processes, criteria, and edits unless HHSC grants a written exception. HHSC's approval is required for all clinical edit policies;
    c. Implementing drug UR;
    d. Monitoring the use of psychotropic medications;
    e. Overriding standard drug UR criteria and clinical edits when Medically Necessary based on the 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 PA inquiries and other inquiries regarding pharmacy services; and
    g. Monitoring the MCO's PBM Subcontractor, including:
        i. 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.
        ii. A written attestation by the PBM Subcontractor in the plan stating, in the three years preceding the 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.

24. A privacy notice, commonly referred to as Notice of Privacy Practice (NPP), as required by HIPAA, including 45 C.F.R. § 164.520;
25. A Cultural Competency plan for approval. The plan must align with the federal and State standards as described in **Section 2.6.19.1**; and
26. A plan documenting the process it will use to ensure continuation of Covered Services and access to OON providers.

At HHSC's request, the MCO must provide HHSC with certain operating procedures and updates to documentation to support the provision of Medically Necessary Covered Services and provide assurance of 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 its Proposal, and in its Transition Phase documentation.

2.5.3.8 MEMBER ENROLLMENT DURING TRANSITION

Beginning three months prior to the Operational Start Date, HHSC will provide the MCO a monthly Member Prospective Enrollment File (PME).

The MCO must:

1. Coordinate and comply with the appropriate file layouts and timelines for transfers between the MCO and HHSC; and
2. Load the monthly PME and process changes as needed for Member enrollment.

2.5.3.9 OTHER REPORTS FOR ORGANIZATIONAL AND FINANCIAL READINESS REVIEW

During the Readiness Review, the MCO must update the organizational and financial information previously submitted to HHSC.

2.5.4 PRIORITIZATION PLAN

The MCO must provide a prioritization plan that outlines the priority of the populations six months prior to the Operational Start Date, as well as Continuity of Care. Information about the assessments required in STAR+PLUS is located in **Section 2.6.58.** See information on interest list reduction reports at https://hhs.texas.gov/about-hhs/records-statistics/interest-list-reduction.

2.5.5 CONTINUITY OF CARE

During the Transition Phase, HHSC will ensure the MCO receives files identifying Members with existing PAs for services. The MCO must describe the process it will use to ensure continuation of these services in its Transition Plan**,** including the management of OON provider transitions. The MCO is also required to ensure that Providers in the SAs

are educated about and trained on the process for continuing these services prior to the Operational Start Date.

As applicable, the MCO is also required to ensure that Members being transferred to a new MCO as part of an HHSC initiative, and who have service authorizations (including LTSS) at the time of implementation, are guaranteed continued authorization of those services with their provider regardless of provider's network status for up to six months after the transfer, or until the new MCO completes all requisite assessments, develops a service plan or ISP, and issues new authorizations. During Transition, HHSC will ensure the MCO receives a file identifying these Members to the MCO for this purpose. The MCO is required to work with HHSC and other MCOs to ensure all necessary authorizations are in place within the MCO's system(s) for the continuation of LTSS at transfer and for up to six months thereafter. The MCO must describe the process it will use to ensure continuation of current LTSS in its Transition Plan as noted in **Section 2.6.52.5.** The MCO is required to ensure that LTSS Providers are educated about and trained regarding this process prior to the Operational Start Date.

2.5.6 TEXAS DEPARTMENT OF INSURANCE LICENSURE, CERTIFICATION OR APPROVAL

The MCO must be licensed by TDI in accordance with the Texas Insurance Code or certified as an ANHC formed in compliance with Tex. Ins. Code ch. 844. The MCO must receive TDI licensure, certification, or approval, as applicable, for all zip codes in each SA the MCO serves no later than 60 Days after the Effective Date. If the MCO fails to provide proof of the required licensure, certification, or approval from TDI by this deadline, HHSC may terminate the Contract at no additional cost to HHSC and with no penalty for HHSC.

If the MCO fails to secure licensure, certification, or approval from TDI, or if the MCO fails to contract with the CMS by the established deadlines, then HHSC may terminate the Contract. If the MCO fails to provide proof of the required licensure, certification, or approval from TDI by this deadline, HHSC may terminate the Contract at no additional cost to HHSC and with no penalty for HHSC.

The MCO must indemnify, in accordance with **Exhibit A,** HHSC for all costs incurred by HHSC or its authorized representatives prior to termination and for any and all costs relating to replacing the MCO. Such costs include, without limitation, the cost of securing a replacement vendor, as well as the cost of any claim or litigation, that is reasonably attributable to the MCO's failure to receive the requisite contracts, licensures, certifications, and approvals.

2.5.7 MCO ACCREDITATION

The MCO must achieve accreditation with either NCQA or URAC by September 1, 2022. The MCO may choose the accreditation option most appropriate to its organization and the populations it serves.

2.6 OPERATIONS PHASE SCOPE

This section describes SOW requirements for the Operations Phase of the Contract which begins on the Operational Start Date. HHSC will notify the MCO of the Operational Start Date after the completion of Readiness Review.

HHSC may require the MCO to perform activities and submit Deliverables for Readiness Review during the Operations Phase, for example if the MCO begins providing a new service or benefit, expands into a new Managed Care Program or SA, or implements a Major Systems Change after the Effective Date.

At HHSC's request, the MCO must provide operating procedures and updates to documentation to support the provision of Covered Services through the Contract Term. The MCO must provide Covered Services to Members enrolled with the MCO on and after the Operational Start Date.

See **Section 2.6.60** for additional requirements regarding qualified Dual Eligible Members. The MCO is responsible for all requirements set forth in **Exhibit A** and **Exhibit C,** which are incorporated into the Contract for all purposes. HHSC may modify these documents as it deems necessary.

2.6.1 ADMINISTRATIVE SERVICES

The MCO must perform the administrative services outlined in **Sections 2.6.2** through **2.6.34**.

2.6.2 ADMINISTRATIVE AND CONTRACT MANAGEMENT

The MCO must comply, to the satisfaction of HHSC, with all provisions set forth in the Contract, and all applicable provisions of State and federal laws, rules, regulations, and waivers at all times during the Contract Term. Within 10 Business Days of HHSC's written request, the MCO must provide written updates to any information contained in its Proposal, or any information provided by MCO that is determined by either Party to be incomplete, inadequate, erroneous, or missing. HHSC will have the sole discretion to accept any such updates to any information in the Proposal.

2.6.3 OPERATIONS PHASE READINESS, OPERATIONAL, AND TARGETED REVIEWS

HHSC may conduct desk or onsite reviews related to Contract performance. HHSC may also require MCOs to submit detailed policies and procedures 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 changes:

2. Major System Change;
3. Processing system changes, including changes in Material Subcontractors performing MIS, UM, Service Coordination, or claims processing functions;
4. Carve-ins of new membership; and
5. Carve-ins of new Services.

HHSC will determine, in its sole discretion, whether the proposed changes will require a desk review or an onsite review.

If the MCO makes a change to any other operational systems, or undergoes any major transition, it may be subject to additional Readiness Review(s). HHSC will determine, in its sole discretion, whether the proposed changes will require a desk or onsite review and are subject to HHSC desk review and onsite review of the MCO's facilities, as necessary, to test readiness and functionality prior to implementation. The MCO must not implement any changes to its MIS or supporting systems without prior HHSC approval of the Major Systems Change.

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 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 the Material Subcontractor's performance. Refer to **Section 2.5** for additional information regarding Readiness Reviews and **Section 4.08(3) of Exhibit A** for information regarding Readiness Reviews of the MCO's Material Subcontractors.

2.6.4 FUTURE INITIATIVES

HHSC may, at its discretion, add new services or populations to STAR+PLUS at any time. The federal government or Texas Legislature may also direct new populations or services to be added to STAR+PLUS. The MCO must participate in Readiness Reviews dictated by HHSC for the expansion of Medicaid managed care to populations or services currently served or delivered by the FFS system or new populations or services. One such expansion is the STAR+PLUS Pilot Program, described in **Section 2.6.4.1 of this SOW**.

HHSC has developed a 10-year system-wide plan outlining HHSC's approach to transition its information technology and data-related services and capabilities into a more modern, integrated, secure, and effective environment. The MCO may be required to interface with multiple systems during the modernization effort.

2.6.4.1 STAR+PLUS PILOT PROGRAM

HHSC will implement a pilot in STAR+PLUS to test person-centered strategies and improvements under a capitated model per Tex. Gov't Code, ch. 534. The STAR+PLUS Pilot Program (Pilot Program) will test delivery of LTSS for adults with IDD, traumatic brain injury, acquired brain injury and similar functional needs.

The Pilot Program will operate in one SA selected by HHSC. HHSC's selection of a Pilot Program SA will be prioritized in the following order:

1. Bexar;
2. MRSA Northeast; and
3. Tarrant.

The Pilot Program's start date will align with the Contract's Operational Start Date. The Pilot Program must operate for 24 months and may operate longer. HHSC will evaluate Pilot Program outcomes and report findings to the Legislature. Participating MCOs will have additional reporting requirements for the duration of the Pilot Program.

2.6.5 HHSC PERFORMANCE REVIEW AND EVALUATION

In accordance with **Section 10.01 of Exhibit A,** HHSC, at its discretion, will review, evaluate, and assess the development and implementation of the MCO's policies and procedures related to the timely and appropriate delivery of Services and Deliverables as required under the Contract. Reviews, evaluations, assessments, and the corrective actions taken by the MCO may include but are not limited to the following:

1. The MCO's reviews of its own policies and procedures, and ensuing corrective actions taken, including demonstration by the MCO that the corrective action(s) or intervention(s) included in the Corrective Action Plan (CAP) have been completed or implemented using a method approved or provided by HHSC;
2. The MCO's workflows;
3. The MCO's use of PAs, including adherence to timeliness requirements and appropriateness of medical necessity determinations;
4. The UM program, including MCO internal Utilization Review policies and processes;
5. The potential for overutilization or underutilization of services;
6. Assessment and Service Plans;
7. Service Coordination and delivery of Services; and
8. 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, case notes, and service locations or facilities that are related to the Services and Deliverables provided under the Contract.

2.6.6 MATERIAL SUBCONTRACTORS

The MCO or its designee will conduct routine monitoring of each Material Subcontractor that is also a delegated entity or a third-party administrator, in accordance with its assessed risk process, to ensure compliance with the performance of all delegated functions. The MCO must maintain a monitoring plan for each Material Subcontractor that is also a delegated entity or a third-party administrator.

The MCO must maintain documentation as to the compliance of the Material Subcontractor with all requirements defined in the monitoring plan. This documentation must contain evidence that all appropriate and necessary actions were taken to correct any noncompliance.

The MCO must allow HHSC to attend meetings between the MCO and its Material Subcontractors and/or to receive the minutes from these meetings upon request. Upon request, the MCO must provide a final report of the routine monitoring results.

2.6.7 PROVIDER CREDENTIALING AND RE-CREDENTIALING

This section does not apply to NEMT Services providers.

The MCO must use the Texas Association of Health Plans' (TAHP's) contracted Credentialing Verification Organization (CVO) as part of its Credentialing and re-Credentialing process regardless of membership in the TAHP. The CVO is responsible for receiving completed applications, attestations, and primary source verification documents. The MCO retains the sole responsibility for Credentialing and re-credentialing the Provider. Credentialing and re-credentialing documentation must be submitted to HHSC upon request.

At least once every three years, the MCO must review and approve the credentials of all licensed and unlicensed Providers participating in the MCO's Provider Network. The MCO may enter into a Subcontract with another entity to which it delegates Credentialing activities if the delegated Credentialing is maintained in accordance with the NCQA delegated Credentialing requirements and 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 42 C.F.R §§ 438.12 and 438.214, 28 Tex. Admin. Code §§ 11.1902 and 11.1402(c), relating to provider notice and Credentialing. The re-Credentialing process must take into consideration Provider performance data, including Member Complaints and appeals, quality of care, and UM. See requirements in **Section 2.6.16**.

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 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 MCO may only contract with a NF that is licensed, certified, and has a valid certification, license, and Medicaid contract with HHSC, and that meets the NF Credentialing standards outlined in **Chapter 8 of Exhibit C.** The MCO must use HHSC established Credentialing criteria and minimum performance standards for NFs seeking to participate in the STAR+PLUS Program in accordance with Tex. Gov't Code § 533.00251(e). The MCO may refuse to contract with a NF that does not meet these standards.

The MCO must ensure that an Assisted Living Facility or an Adult Foster Care Provider, as a condition of contracting or credentialing to provide Medicaid home and community-based services, is in compliance with 42 C.F.R §.441.301(c)(4)(vi).

2.6.7.1 EXPEDITED CREDENTIALING PROCESS

This section does not apply to NEMT Services providers.

The MCO must comply with the requirements of Tex. Ins. Code ch. 1452, subchs. 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 Tex. Gov't Code § 533.0064, that allows applicant providers to provide Covered 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 (LCSWs);
4. Licensed Professional Counselors (LPCs);
5. Licensed Marriage and Family Therapists (LMFTs); and
6. Psychologists.

The MCO must allow providers to qualify for expedited Credentialing if the provider:

1. Is a member of an established health care Provider group that has a current contract in place with an MCO;
2. Is a Medicaid enrolled provider;
3. Agrees to comply with the terms of the contract between the MCO and the health care provider group; and
4. Submits all documentation and information required by the MCO in a timely manner as necessary for the MCO to begin the Credentialing process.

The MCO must also establish and implement an expedited Credentialing process for NF Providers that successfully underwent a change of ownership. The MCO's expedited Credentialing requirements for such NFs must only include requirements 2 and 4 above in the preceding paragraph. An applicant provider must also agree to comply with the terms of the contract between the MCO and the NF.

Additionally, 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.

2.6.7.2 MINIMUM CREDENTIALING REQUIREMENTS FOR UNLICENSED OR UNCERTIFIED LONG-TERM SERVICES AND SUPPORTS PROVIDERS

Before contracting with unlicensed LTSS providers or LTSS providers not certified by HHSC or another required HHS Agency, the MCO must ensure that the provider:

1. Has not been convicted of a crime listed in Tex. Health & Safety Code § 250.006;
2. Is not listed as "unemployable" in the Employee Misconduct Registry or the Nurse Aide Registry maintained by HHSC 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 by searching or ensuring a search of such registries is conducted:
    a. U.S. Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE); and
    b. HHSC Office of the Inspector General (HHSC OIG) Texas Exclusions Database;
4. Is knowledgeable of acts that constitute ANE of a Member;
5. Is instructed on and understands how to report suspected ANE;
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 demonstration project, the details of which are located at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83231.

2.6.7.3 BOARD CERTIFICATION STATUS

The MCO must maintain a policy that encourages participation of board-certified PCPs and specialty physicians in the Network. The MCO must make information on the percentage of board-certified PCPs and specialty physicians, by specialty, in its Network available to HHSC upon request.

2.6.8 PROVIDER RELATIONS INCLUDING MANUAL, MATERIALS, AND TRAINING

The MCO must maintain a provider relations staff within each SA that the MCO serves to provide technical assistance to providers and NEMT Services providers having issues with claims denials or rejections, and to facilitate the exchange of information between providers and NEMT Services providers and the Complaints, claims processing, and provider relations systems. The MCO must ensure its provider relations staff are proficient regarding appropriate claims submission requirements, coding updates, electronic claims transactions, and Electronic Funds Transfer (EFT) to resolve provider issues promptly.

The MCO must designate a dedicated provider relations email address and telephone number for provider relations issues requiring additional follow up or escalation and include this information in the Provider manual. The MCO must provide an email response or returned phone call to the providers or NEMT Services providers within three Business Days of receipt of each Inquiry; an auto-generated or pre-recorded response acknowledging the Inquiry does not qualify as meeting this requirement.

The MCO must provide a named provider relations specialist to each NF Services Provider, adult foster care Provider, and Assisted Living Facility (ALF) in the MCO's Network. The named provider relations specialist may be assigned to more than one NF Services Provider; however, the MCO must have the same number of named provider relations specialists available to NF Services Providers as the number of SAs served by the MCO. The MCO may request an exception to this requirement for SAs with low membership. The named specialist must be proficient in billing processes for NF Services and other residential services and able to resolve Provider billing and payment Inquiries. The MCO must display on its Provider portal a contact number for NF Services Providers to call regarding their named provider relations specialists. The named specialist must be proficient in billing processes for NF Services and other residential services and able to resolve Provider billing and payment Inquiries.

The MCO must provide a named provider relations specialist to all other Providers and NEMT Services providers, upon request. If a named provider relations specialist changes, the MCO must notify impacted Providers and NEMT Services providers within five Days of the change. Notification may be in writing, by email, or posted in the Provider portal. The notification must include the new provider relations specialist's name, phone number, and email address.

2.6.8.1 PROVIDER MANUAL

The MCO must prepare and issue a Provider manual, including any necessary specialty manuals, e.g. BH Services and NF Services, to all Providers. The MCO must issue copies of the Provider manual to Providers within five Business Days from inclusion of the Provider into its Network. The Provider Manual must contain the critical elements defined in **Chapter 3 of Exhibit C,** including sections relating to the special requirements of the STAR+PLUS Program.

The MCO must secure HHSC approval for any substantive revisions to the Provider manual, including the initial version, before the MCO publishes or distributes the manual to Providers.

2.6.8.2 PROVIDER MATERIALS

The MCO must ensure its Provider Materials comply with State and federal laws governing Medicaid materials. **Chapters 3 and 4 of Exhibit C,** set forth material and submission requirements. HHSC may require discontinuation or correction of any Provider Materials, including those previously approved by HHSC. Provider Materials include the MCO's Provider manual, training materials regarding Program requirements, and mass communications directed to all or a large group of Providers (e-mail or fax "blasts"). Provider Materials do not include written correspondence between the MCO and a Provider regarding individual business matters.

2.6.8.3 PROVIDER TRAINING

The MCO must provide training to all Providers and their staff regarding the requirements of the Contract and the population of the STAR+PLUS Program.

The MCO must ensure Providers complete such training within 30 Days of placing a newly contracted Provider on active status. The MCO must provide ongoing training through web-based sessions and regional outreach to new and existing Providers, upon request, and as required by the MCO or HHSC to comply with the Contract. The MCO must make available to Providers a variety of web-based training modules. The MCO must maintain and make available upon request enrollment or attendance rosters dated and signed by each attendee or other written evidence of training of each Provider and their staff.

The MCO must establish ongoing Provider training that includes the following topics:

1. Covered Services, including any limitations, and the Provider's responsibilities for providing and coordinating those services;
    a. Special emphasis must be placed on areas that vary from commercial coverage rules, e.g., LTSS and DME/medical supplies, pharmacy services and processes, including information regarding outpatient drug benefits, HHSC's drug formulary, preferred drugs, PA processes, and 72-hour emergency supplies of prescription drugs, claims processing;
    b. Special emphasis on BH Services including: SUD treatment options, including opioid use disorder treatment; Screening, Brief Intervention, and Referral to Treatment (SBIRT), as described in **Chapter 7 of Exhibit F, Texas Medicaid Provider Procedures Manual (TMPPM)**; mental health treatment; MHR and the availability of Mental Health TCM for qualified Members;
    c. Special emphasis on the availability of PAS and CFC services for qualified Members;
    d. Education on the health-related social needs screening tool and community based resources to address members' needs as required in 2.6.54, as well as

the processes for making and tracking referrals to community organizations for the coordination of Non-capitated Services as required in Section 2.6.45.9; and

e. How a provider should notify the MCO about court-ordered psychiatric services or SUD treatment.

2. Medical Home Services Model and the IPC model;
3. Requirements of the Contract;
4. Specific training related to UM reviews, FWA, including oversight activities such as pre-payment reviews, audits, and monitoring;
5. Information regarding Service Coordination including how and when to contact the Member's Service Coordinator;
6. The MCO's Quality Assurance and Performance Improvement (QAPI) program and the Provider's role in such a program;
7. The MCO's policies and procedures, especially regarding PAs, Network and OON referrals;
8. Member cost-sharing obligations, limitations on Covered Services, VAS, and prohibitions on balance-billing Members for Covered Services;
9. Cultural Competency training based on federal and State requirements, including the need for Providers and their staff to address Members and Caregivers with dignity, sensitivity, and respect;
10. Working with Members with IDD and the availability of additional training resources specific to working with Members with IDD;
11. THSteps 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;
12. NEMT Services available to Members;
13. The importance of updating contact information to ensure accurate Provider directories and the Medicaid online Provider lookup;
14. Missed appointment referrals and assistance provided by the THSteps Outreach and Informing Unit;
15. HHSC policies related to MCO Retaliation;
16. The role of the MCO Service Coordinators and provider relations specialists;
17. Information on Discharge planning, transitional care, and other educational programs related to LTSS settings;
18. The importance of advance directives and how the MCO can facilitate advance directives;
19. For residential services providers, HHSC and the MCO's policies related to psychotropic prescription monitoring;
20. Providers' obligation to identify and report a Critical Event or Incident, such as ANE, to HHSC related to LTSS delivered in the STAR+PLUS Program;
21. MCO and HHSC complaints and appeals processes;
22. Claims processing and policies specific to the MCO including claims data element requirements, recoupments, Member rights and responsibilities, primary coverage requirements and under what circumstances a Member may be responsible for some

fees, Discharge disposition codes for Hospitals, Continuity of Care, Transfers from hospitals, and span of coverage;

23. Administrative issues such as detailed claims filing and how to receive assistance with claims, including the processes regarding claims appeals and recoupments;
24. Services available to Members; and
25. For NF Providers, the billing process for the NF Unit Rate and the authorization and billing processes for NF Add-on Services, Medicare Part A NF readmissions, and Medicare Part B therapy, with a description of the MCO's authorization response; the requirement **Chapter 8 of Exhibit C** to notify the MCO within one Business Day of an adverse change in medical condition and other events; and the requirement to submit Form 3618 or Form 3619, as applicable, no later than 72 hours after a Member's admission or Discharge from the NF, in compliance with 26 Tex. Admin Code § 554.2615 and **Chapter 8 of Exhibit C,** or immediately, if the 72-hour submission requirement is expired.

Training in all the topics above must be offered and made available within a reasonable time after the date the Provider begins providing services and in accordance with **Section 2.5.3.7**.

The MCO must consult with experts in the healthcare field, including medical advisory committees, to determine which additional topics may be relevant to Providers in providing services to Members.

All Provider training and education materials and associated presentations specific to Medicaid benefits, services and programs must be submitted to HHSC for approval prior to use.

2.6.9 STAR+PLUS HANDBOOK

The MCO must comply with **Exhibit E, the STAR+PLUS Handbook** that contains HHSC-approved policies and procedures related to the STAR+PLUS Program. The STAR+PLUS Handbook includes additional forms, assessments, and MCO requirements, including coordination requirements with HHSC staff.

2.6.10 PROVIDER HOTLINE

The MCO must operate a toll-free telephone line for Providers and NEMT Services providers during normal business hours, which are, for purposes of this section, Business Days from 8:00 a.m. to 5:00 p.m. local time for the SA. The Provider Hotline must be staffed with personnel who are knowledgeable about Program-specific requirements, Covered Services, Non-capitated Services, Case-by-case Services, and VAS. The Provider Hotline may serve other MCO Programs if the Provider Hotline staff are knowledgeable about all MCO Programs. The Provider Hotline may serve multiple SAs if the Provider Hotline staff is knowledgeable about all SAs, including the Provider Network in each SA.

Provider Hotline staff must be able to respond to Provider questions regarding specialty referrals and to arrange for consultations with MCO clinical staff, Service Coordinators, or other Providers. For example, a PCP with a Member in their office may call with a need

for an immediate consult with MCO clinical staff or a BH Services Provider and Provider Hotline staff must be able to make the appropriate connection.

The MCO must ensure that during non-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 address non-business hour Inquiries from Providers seeking to verify enrollment for a Member with an Urgent Condition or an Emergency Medical Condition. The MCO must ensure its Providers do not require such verification prior to providing Emergency Services.

The MCO must ensure that the Provider Hotline meets the following minimum performance requirements for the STAR+PLUS Program:

1. Average hold time: no more than two minutes; and
2. Call abandonment rate: no more than seven percent (7%) of the calls are abandoned.

The MCO must conduct ongoing call Quality Assurance to ensure these standards are met. The MCO must submit performance reports summarizing call center performance for the Provider Hotline as indicated in **Chapter 5 of Exhibit C.** If the MCO's Provider Hotline serves more than one Medicaid program administered by the MCO, the MCO must have the capability to report hotline performance by program and SA.

If the MCO subcontracts with a Behavioral Health Organization (BHO) that is responsible for Provider Hotline functions related to BH Services, the BHO's Provider Hotline must meet the requirements of the MCO described in **Section 2.6.18.4 and 2.6.10** and the MCO must provide the Deliverables regarding the BHO's performance.

2.6.11 PROVIDER ADVISORY GROUPS

The MCO must establish and conduct quarterly meetings with its Provider advisory group(s). Membership in the Provider advisory group(s) must include Acute Care, LTSS, and pharmacy Providers. The MCO also must establish and conduct quarterly meetings with its NEMT Services providers. The MCO is not required to conduct quarterly meetings of Providers and NEMT Services providers simultaneously. The MCO must maintain a record of Provider and NEMT Services Provider advisory group meetings, including agendas and minutes, for the time period established in **Article 8 of Exhibit A**.

The MCO or its designee must obtain feedback from Providers regarding the delivery of NEMT Services. The MCO must ensure records documenting Provider feedback about the delivery of NEMT Services are maintained in accordance with the retention period and requirements of **Article 8 of Exhibit A** and provided to HHSC upon request.

2.6.12 PROVIDER REIMBURSEMENT

The MCO must pay for all Medically Necessary and functionally necessary Covered Services provided to Members. The MCO must ensure its Provider Contracts include a complete description of the payment methodology or amount, as described in **Chapter 8**

of Exhibit C. The MCO must identify in its Provider Contract if it is using the Texas Medicaid fee schedule or another source to set Provider rates.

The MCO must ensure its Provider Contracts require Providers to comply with the requirements of Tex. Gov't Code § 531.024161 regarding reimbursement of claims based on orders or referrals by supervising Providers.

The MCO must pay OON providers using the Medicaid methodology as defined by HHSC in 1 Tex. Admin. Code pt. 15, ch. 353, subch. A, § 353.4 and ensure claims payments are timely and accurate as described in **Section 2.6.30.3**, and **Chapter 2 of Exhibit C**.

The MCO must require tax identification numbers (TINs) from all Providers. The Provider may use the federal TIN of the residential treatment center where he or she is an employee and provides services. The MCO is required to do back-up withholding from all payments to Providers who fail to give TINs or who give incorrect numbers.

MCO must ensure payments to all Providers comply with all applicable State and federal laws, rules, and regulations, including 42 U.S.C. § 1396a(a)(80) related to the prohibition on payments to institutions or entities located outside of the United States.

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 Tex. Gov't Code § 533.005(a)(25), the MCO must not implement significant, non-negotiated, across-the-board Provider and NEMT Services provider reimbursement rate reductions unless:

1. The MCO requests and 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 made by the MCO or its Subcontractor that applies to all similarly-situated Providers or types of Providers. This requirement includes across-the-board rate reductions to pharmacy provider reimbursements, including reductions due to changes in PBM subcontractor networks or PBM provider networks.

The MCO must submit a written request for an across-the-board rate reduction to HHSC's director of Managed Care Compliance and Operations (MCCO) and provide a copy to the appropriate HHSC 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 acknowledge or 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.

The MCO must give Providers at least 30 Days' written notice of changes to the MCO's fee schedule, excluding changes derived from changes to the Medicaid fee schedule, before implementing the change. If the MCO fee schedule is derived from the Medicaid fee schedule, the MCO must implement fee schedule changes no later than 30 Days 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.

The MCO may deny a claim submitted by a Provider for failure to file in a timely manner as provided for in **Chapter 2 of Exhibit C** and 1 Tex. Admin. Code § 354.1003.

The MCO must not pay any claim submitted by a Provider excluded or suspended from the Medicare, Medicaid, or CHIP programs, or with debts, settlements, or pending payments due to HHSC, the State, or federal government. Furthermore, the MCO must not pay any claim submitted by a Provider after HHSC OIG determines there is a credible allegation of Fraud for which an investigation is pending, unless HHSC OIG has good cause not to suspend payments or to suspend payment only in part.

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, with the following exceptions:

1. This limitation does not apply in cases of provider FWA that the MCO did not discover within the two-year period following receipt of a claim.
2. This limitation does not apply when the officials or entities identified in **Section 8.02(3) of Exhibit A,** conclude an examination, audit, investigation review, or inspection of a provider more than two years after the MCO received the claim.

If an exception to the two-year limitation applies, the MCO may recoup related payments from providers only if approved by HHSC.

If 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 the MCO is due a refund from the Provider, the MCO must send the Provider written notice of the basis and specific reasons for the recovery no later than 30 Days after it completes the audit. If the Provider disagrees with the MCO's request, the MCO must give the Provider an opportunity to appeal and may not attempt to recover the payment until the Provider has exhausted all appeal rights. If the MCO recouped the payment and did not allow the Provider time to appeal, the MCO must repay the Provider for funds recouped.

The MCO must inform all Providers about the information required to submit a claim at least 30 Days prior to the Operational Start Date and as a provision within the Provider Contract.

The MCO must not require a Provider to submit documentation that conflicts with the requirements of 28 Tex. Admin. Code pt. 1, ch. 21, subchs. C and T.

The MCO must ensure the Provider Contract specifies that Program violations arising out of performance under the agreement are subject to administrative enforcement by the HHSC OIG as specified in 1 Tex. Admin. Code pt.15, ch. 371, subch. G.

2.6.12.1 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 claims for the

purpose of conducting any necessary research on the claims or to adjust the claims, if appropriate. The MCO must not include NF Unit Rate claims as part of a Project. For NF Unit Rate claims, see **Chapter 8 of Exhibit C.**

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.

Projects must be reported in the manner described in **Chapter 5.6 of Exhibit C**. Interest for claims included in a Claims Project must be included in the monthly Claims Summary Report described in **Chapter 5.24 of Exhibit C.** Projects exceeding 60 Days, without prior approval, are subject to any remedies under the Contract.

2.6.12.2 NATIONAL CORRECT CODING INITIATIVE

Effective for all claims filed, the MCO must comply with the requirements of 42 U.S.C. 1396b(r), regarding mandatory State use of the National Correct Coding Initiative, including all applicable rules, regulations, and methodologies implemented as a result of this initiative. See **Chapter 2.4 of Exhibit C**.

2.6.12.3 ELECTRONIC FUNDS TRANSFER

The MCO must offer Providers EFT for claims payment or other direct deposit operations, such as paycheck deposits, as a safe alternative to paper checks. The MCO must make EFT available to Providers whether claims are filed electronically or in hard copy. The MCO must process EFT using HIPAA national standards for electronic payment and remittance advice. (See CMS.gov.)

2.6.12.4 PROVIDER OVERPAYMENTS

In accordance with 42 C.F.R. § 438.608(d)(2), the MCO must require, through Provider Contracts, that Providers and NEMT Services providers report to the MCO in writing any Overpayments and the reason for the Overpayment, and when applicable, to return the Overpayment to the MCO within 60 Days after the date on which the Overpayment was identified. For purposes of this section, "identified" refers to the date upon which the Provider has or should have, through the exercise of Reasonable Diligence, determined that an Overpayment was received and has quantified the amount of the Overpayment.

In seeking to recover a provider overpayment that is connected to an Electronic Visit Verification (EVV) visit transaction, the MCO must comply with 1 Tex. Admin. Code § 353.1453.

2.6.12.5 COMPREHENSIVE HOSPITAL INCREASE REIMBURSEMENT PROGRAM (CHIRP)

MCO must meet all Comprehensive Hospital Increase Reimbursement Program (CHIRP) requirements outlined in 1 Tex. Admin. Code §§ 353.1301 and 353.1306.

MCOs must increase base payment rates for inpatient and outpatient services performed in the MCO's Network CHIRP hospitals by the uniform percent associated with the CHIRP participating hospital's class and SA as directed by HHSC. The MCO must increase base payment rates only to Hospitals geographically located in SAs where the MCO has been selected to provide Services under the Contract.

In paying the rate increase, MCOs will be responsible for meeting all Uniform Hospital Rate Increase Program requirements outlined in 1 Tex. Admin. Code §§ 353.1301 and 353.1306.

The rate increase does not apply to CHIRP participating hospital services provided to Dual Eligibles where Medicare is the primary payor.

With the exception of CHIRP participating rural hospitals, which are defined in 1 Tex. Admin. Code § 353.1305(b), the rate increase does not apply to non-emergent care provided in a hospital emergency department.

The rate increase does not apply to claims for COVID-19 testing, diagnosis, or treatment.

If an MCO enters into a new Provider Contract with a CHIRP participating hospital in a participating SA, the MCO will pay using the rate enhancement associated with the CHIRP participating hospital's class. If CHIRP participating hospital changes class during a particular program period, the MCO will continue to pay the CHIRP hospital using the rate enhancement for the class to which the CHIRP hospital belonged at the commencement of that particular program period.

HHSC may recoup the amount of a disallowance by CMS from MCOs, Hospitals, or governmental entities as allowed by 1 Tex. Admin. Code § 353.1301(j). HHSC may recoup the amount of Overpayments from MCOs and MCOs may recoup the amount of Overpayments from CHIRP-participating hospitals as allowed by 1 Tex. Admin. Code § 353.1301(k). For all CHIRP-related recoupments, improper payments, and Overpayments, MCOs must follow the processes outlined in **Exhibit C**.

MCOs must assist CHIRP participating hospitals in collecting information necessary to complete CHIRP reporting obligations for all years in which the CHIRP is in effect.

2.6.12.6 PROVIDER PREVENTABLE CONDITIONS

The MCO must identify Present on Admission (POA) indicators as required in **Chapter 2** of **Exhibit C,** and must reduce or 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 **Exhibit F, TMPPM.**

As a condition of payment to Hospital providers, the MCO must require providers to report provider preventable conditions on institutional claims using appropriate POA indicators. MCOs must include all identified POA indicators on Encounter Data submitted to HHSC. Upon request by HHSC, MCOs must report the amount of provider payments reduced, denied, or recouped from an individual provider for the requested service dates for provider preventable conditions that were not POA.

2.6.12.7 MINIMUM FEE SCHEDULE FOR RURAL HOSPITAL

MCOs must adopt HHSC's Medicaid minimum fee schedule for rural hospitals, as defined in Tex. Gov't Code § 531.02194. 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 the HHSC website.

2.6.12.8 FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

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 Covered Services using the prospective payment methodology described in Social Security Act §§ 1902(bb) and 2107(e)(1) of the Social Security Act, 42 U.S.C. 1396a (Section 1902), 1397gg (Section 2107). Because the MCO is responsible for the full payment amount in effect on the date of service for RHCs, cost settlements or wrap payments will not apply.

When the MCO negotiates payment rates with FQHCs for 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. The MCO may elect to pay the FQHC wrap payment at the time of claim adjudication and must make the wrap payment 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 Covered Services, at a time that is outside regular business hours, the MCO must reimburse the FQHC, RHC, or public clinic for 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, outside regular business hours has the meaning given to it in 1 Tex. Admin. Code pt.15, ch. 353, subch. A, § 353.2, as required by 1 Tex. Admin. Code pt.15, ch.353, subch. E, § 353.407.

An OON FQHC's claim is subject to the same claim standards requirements as the MCO's Providers.

If a Member visits an OON Indian Healthcare Provider (IHCP) enrolled as an FQHC for Covered Services, the MCO must reimburse the OON IHCP a full Encounter rate as if the provider were a Network Provider. The MCO must pay this Encounter rate 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.

2.6.12.9 SUBMISSION OF SERVICE AUTHORIZATION

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, including medical documentation supporting certain NEMT Services requested by the Member. The fax line and Provider portal must be available 24 hours per Day, seven Days a week.

2.6.13 MINIMUM WAGE REQUIREMENTS FOR ATTENDANTS

The MCO must comply with 1 Tex. Admin. Code, pt. 15, ch. 355, subch. H, § 355.7051.

2.6.14 ELECTRONIC VISIT VERIFICATION

The MCO must comply with Title 1, Chapter 354, Subchapter O of the Texas Administrative Code and applicable chapters of the UMCM, including Chapter 8.7.

The MCO must require Providers, CDS employers, and FMSAs to use an EVV system in accordance with the EVV requirements described in 1 Tex. Admin. Code, pt.15, ch. 354, subch. O.

The MCO must require the use of EVV for home health care services in accordance with HHSC-established deadlines. The home health care services that will be required to use EVV are identified in the Procurement Library.

2.6.15 MANAGED CARE ORGANIZATION TERMINATION OF PROVIDER CONTRACTS

The MCO must notify HHSC in writing within five Days prior to MCO termination of the following Provider Contracts:

1. A PCP Provider Contract that impacts more than 10% of Members; or
2. Any Provider Contract that impacts more than 10% of its Network for the SA.

The MCO must also notify HHSC of all Provider Contract terminations in accordance with **Chapter 5 of Exhibit C.**

Additionally, the MCO must give written notice of Provider termination to each Member who receives his or her primary care, or who is seen on a regular basis, i.e., two or more visits, by that Provider as follows:

1. For a Provider disenrolled by HHSC, the MCO must provide written notice to affected Members no later than five Days following disenrollment;
2. For involuntary terminations of a Provider, i.e., terminations initiated by the MCO, the MCO must provide notice to the Member within 15 Days after receipt or issuance of the termination notice unless State or federal law, including Tex. Ins. Code § 843.308, permits or requires notice to be provided under a different timeframe. In cases of imminent harm to Member health, the MCO must immediately give HHSC and the Member notice that the Provider will be terminated even if a final termination notice to the Provider has not been issued.
3. For voluntary terminations of a Provider, i.e., terminations initiated by the Provider, the MCO must provide notice to the Member 30 Days prior to the termination effective date. In the event that the Provider sends untimely notice of termination to the MCO making it impossible for the MCO to send Member notice within the required timeframe, the MCO must provide notice as soon as practical; but no later than 15 Days after the MCO receives notification to terminate from the Provider.

The MCO must send notice of termination of a Provider to:

1. All its Members in a PCP's panel; and
2. All its Members who have had two or more visits with the Provider for home-based or office-based care in the past 12 months prior to termination.

2.6.16 PROVIDER PROTECTION PLAN

The MCO must comply, as required by Tex. Gov't Code § 533.0055, with the requirements of HHSC's Provider protection plan for reducing administrative burdens placed on Providers and NEMT Services Providers, as applicable and ensuring efficacy in Network enrollment and reimbursement. The MCO must have a Provider protection plan that complies with the following standards:

1. Responds to authorization requests within three Days of routine requests and in compliance with **Section 2.6.26**.
2. Provides for timely and accurate claims adjudication and claims payment in accordance with **Chapter 2 of Exhibit C.**
3. Educates and trains Providers on the requirements for claims submission and appeals, including the corresponding MCO's policies and procedures. See also **Section 2.6.8.**
4. Ensures Member access to care, in accordance with **Section 2.6.36**.
5. Ensures prompt Credentialing, as required by **Section 2.6.6.**
6. Ensures compliance with State and federal standards regarding PAs, as described in **Sections 2.6.26 and 2.6.53.2**.
7. Ensures no Retaliation by the MCO staff against a Provider for filing appeals, grievances, or Complaints against the MCO on the Provider's or Member's behalf.
8. Provides 30 Days' notice to Providers before implementing changes to policies and procedures affecting the PA process. In the case of suspected FWA by a single Provider, the MCO may implement changes to policies and procedures affecting the PA process for that single Provider without the required notice period.

9. Includes other measures developed by HHSC or measures developed by the MCO and approved by HHSC.

2.6.17 MEMBER SERVICES

The MCO must maintain a Member Services department to assist Members and their family members or guardians in obtaining Covered Services for Members. The MCO must maintain employment standards and requirements (e.g., education, training, and experience) for Member Services department staff and provide a sufficient number of staff for the Member Services department to meet the requirements of **Section 2.6.17 and 2.6.18**, including Member Hotline response times and Linguistic Access capabilities.

2.6.17.1 MEMBER MATERIALS

The MCO must design, print, and distribute Member ID cards and a Member handbook to Members at no cost to Members. No later than the fifth Business Day following the MCO's receipt of an Enrollment File, the MCO must mail a Member ID card and a 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. Provider Directories must not include NEMT Services Providers.

All Member Materials must be at or below a sixth grade reading level as measured by the appropriate score on the Flesch reading ease test. Member Materials must be written and distributed in English, Spanish, and any Prevalent Language in the SA, as specified by HHSC. HHSC will provide the MCO with reasonable notice of Prevalent Languages in the MCO's SAs.

All Member Materials must be available in a format accessible to the visually impaired, which may include large print (font size no smaller than 18 point), braille, and compact disc (CD) or other electronic format. Member Materials must comply with the requirements set forth in **Chapters 1, 3**, and **4** of **Exhibit C,** including required critical elements and any applicable Marketing policies and procedures.

The MCO must ensure Member Materials critical to obtaining Covered Services, including Provider directories, Member handbooks, appeal and grievance notices, and denial and termination notices, are created using a font size no smaller than 12 point. The MCO must ensure these Member Materials include large print (conspicuously visible) taglines in the Prevalent Languages in the SA explaining the availability of written translation or oral interpretation to understand the information provided; the toll-free and Teletypewriter/Telecommunications Device for the Deaf (TTY/TDY) telephone number of the MCO's Hotline; and information on how to request Auxiliary Aids and Services, including the provision of materials in alternative formats. Auxiliary Aids and Services and

materials in alternative formats must be made available upon request of the Member at no cost to the Member or to HHSC.

The MCO must submit Member Materials to HHSC for approval prior to publication or distribution, including revisions to previously approved Member Materials. See **Chapters 3 and 4 of Exhibit C**, for material and submission requirements. HHSC reserves the right to require discontinuation, revision, or correction of any Member Materials, including those previously approved by HHSC. The MCO must adhere to other requirements specified in 42 CFR § 438.10 associated with Member Materials management.

The MCO's Member Materials and other communications cannot contain discretionary clauses, as described in Tex. Ins. Code § 1271.057(b).

2.6.17.2 MEMBER IDENTIFICATION CARDS

All Member ID cards must include all the critical elements identified in **Chapter 3 of Exhibit C.**

The MCO must reissue a Member ID card within seven Days, at no charge and for any reason that results in a change to the information disclosed on the Member ID card.

2.6.17.2.1 MEMBER HANDBOOK

The MCO must ensure the Member handbook satisfies the Member Materials requirements specified by **Section 2.6.17.1**, and must include critical elements in **Chapter 3 of Exhibit C.**

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 such change in Covered Services.

2.6.17.3 PROVIDER DIRECTORY

This section does not apply to NEMT Services providers.

The MCO must have a quality assurance plan and have a process in place to compare the information in the master Provider file provided by HHSC or its designee with the MCO's Provider directory.

On an annual basis, the MCO must verify the accuracy of Provider directory information for a statistically valid random sample of its Network PCPs and specialists. When the MCO identifies a discrepancy, the MCO must assist the Provider through the process of updating inaccurate information with HHSC or its designee. The MCO 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 report in **Section 2.6.36.4**, 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 or its designee in a timely fashion

or immediately upon request by the MCO. The MCO must use United States Postal Service (USPS) address standards when entering Provider information into the Provider directory.

The Provider directory, including substantive revisions, must be approved by HHSC before publication and distribution. Substantive revisions are revisions to the information required by **Chapter 3 of Exhibit C,** except for information contained in the Provider listings and indices and any additional information that the MCO adds to the directory at its discretion.

The Provider directory must comply with HHSC's marketing policies and procedures, as set forth in the **Chapter 4 of Exhibit C.**

The Provider directory must meet the Member Materials requirements specified by **Section 2.6.17.1**, and must include critical elements in **Chapter 3 of Exhibit C.**

The Provider directory must include only Providers Credentialed by the MCO in accordance with **Section 2.6.6**. If the MCO contracts with limited Provider Networks, the Provider directory must comply with the requirements of 1 Tex. Admin. Code § 11.1600(b)(12), relating to the disclosure and notice of limited Provider Networks.

2.6.17.3.1 HARD COPY PROVIDER DIRECTORY

The hard copy Provider directory must contain the required critical elements of **Chapter 3 of Exhibit C.**

The MCO must update the Provider directory in accordance with 42 C.F.R. § 438.10(h)(3)(i) or as directed by HHSC. The MCO must make the updates available to existing Members and Authorized Representatives upon request. The MCO must inform Members that the Provider directory is available in paper form without charge upon request of the Member or Authorized Representative. The MCO must provide the specified number of hard copy provider directories to the HHSC Administrative Services Contractor each quarter.

The MCO must send the most recent Provider directory, including any updates, to Members upon request and provide it within five Business Days of the request. The MCO must, at least annually, provide written communication to its Members to inform them of the most recent such Provider directory. The MCO is responsible for all Provider directory mailings.

2.6.17.3.2 ONLINE PROVIDER DIRECTORY

The MCO must have an online Provider directory to provide an electronic Provider look-up search of its Provider Network. The MCO must have policies and procedures with respect to its Provider Network database, which must include predictable scheduled algorithms for systematically updating the database. The online Provider directory must be updated on at least a weekly basis to reflect the most current 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.

Upon request, the MCO must send Members an electronic version of the Provider directory by SA via email within five Business Days of the Member's request and simultaneously inform Members that the Provider directory is available in paper format without charge upon the Member's request.

The online Provider Directory must comply with the requirements set forth in **Chapter 3 of Exhibit C** and comply with modern accessibility standards as referenced in 42 C.F.R. § 438.10(d).

2.6.18 REQUIREMENTS COMMON TO ALL MEMBER-FACING HOTLINES

All Member-facing hotlines, including the Member Hotline, Nurse Hotline, BH Crisis Services Hotline, and NEMT Services Hotline, as well as any dedicated toll-free Service Coordination phone numbers as described in **Section 2.6.49.3,** are subject to the requirements of this section. Any of the MCO's Member-facing hotlines may serve multiple MCO Programs and SAs if the Member-facing hotline staff are knowledgeable about all the MCO Programs and SAs served by those hotlines.

All Member-facing hotlines must utilize a "no wrong door" approach and be able to conduct a "warm transfer" between hotlines, such as between the Member Hotline and the Nurse Hotline. Members must not be instructed to hang-up and dial a new phone number once they have placed a call to a Member-facing hotline. The MCO may choose to employ one Member-facing phone number with menu options, rather than maintaining separate phone numbers for each hotline. If the MCO chooses this strategy, it must meet the unique reporting requirements for each hotline and Members should encounter no more than two prompts before connecting to a human.

All Member-facing call center staff must be properly trained, competent, and knowledgeable about the STAR+PLUS Program and population.

The MCO must ensure all Member-facing hotline staff are able to associate a Member with their assigned Service Coordinator, explain Service Coordination, and be able to warm transfer a Member directly to their assigned Service Coordinator if they have one, or to Service Coordination staff.

The MCO must ensure that Member-facing hotlines meet Cultural Competency requirements, described further in **Section 2.6.19.1,** and that Member-facing hotlines staff appropriately handle calls from callers who speak Prevalent Languages in the SA(s) the MCO serves, including Spanish; calls from individuals who are deaf or hard-of-hearing, or have limited communication skills; and calls from Members with an IDD. To meet the Cultural Competency requirements, the MCO must employ Member Services and BH services staff who are bilingual in English and Spanish, must provide oral interpretation services to all Member-facing hotline callers free of charge, and must secure the services of other contractors as necessary to meet these requirements.

The MCO must provide personal health information through Member-facing call centers to only those persons who can identify themselves through the caller verification process approved by HHSC. The MCO must ensure all Member-facing call center staff treat callers with dignity and respect the callers' needs for privacy.

The MCO must process all incoming Member calls in a timely and responsive manner. The MCO must not impose call duration limits and must allow calls to be of sufficient length to ensure adequate information is provided to the Member. The MCO must ensure all Member-facing hotlines, and transfers within and among its Member-facing hotlines, meet the following minimum performance standards for STAR+PLUS in each SA:

1. Speed call answered: at least 99% of all calls are answered on or before the fourth ring or an automated call pick-up system is used;
2. Busy signal rate: no more than one percent of incoming calls receive a busy signal for the Member Services call center and zero percent of incoming calls receive a busy signal for the BH Services hotline;
3. Queue hold rate: at least 80% of calls must be answered within 30 seconds measured from the time the call is placed in queue after the caller's last automated menu selection;
4. Call abandonment rate: no more than seven percent (7%) of the calls are abandoned; and
5. Average hold time: no more than two minutes.

The MCO must conduct ongoing call Quality Assurance monitoring to ensure these performance standards are met. The MCO must submit performance reports summarizing hotline performance for its Member-facing hotlines as indicated in **Chapter 5 of Exhibit C**. If the MCO's Member-facing hotlines serve multiple MCO Programs and SAs, the MCO must have the capability to report hotline performance by MCO Program and SA in which it participates.

HHSC may conduct onsite monitoring of the MCO's Member Hotline, Nurse Hotline, NEMT Services hotline, BH Crisis Services Hotline functions, as well as functions of any dedicated Service Coordination phone numbers.

The provisions applicable to Member-facing hotlines apply to the MCO or its Subcontractors. If the MCO Subcontracts for a Member hotline function – such as having a BHO operate the BH Hotline – the MCO must ensure the Subcontractor meets the Contract requirements for those functions.

2.6.18.1 MEMBER HOTLINE

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

The MCO must ensure that, during non-business hours, the Member Hotline is answered by an automated system that provides callers with operating hours, instructions regarding how to access the Nurse Hotline, BH Service Hotline, Service Coordination Hotline, and NEMT Services Hotline, and instructions on what to do in cases of emergency. The MCO must ensure that all Member Hotline recordings are available to callers in English, Spanish, and any Prevalent Languages in the SAs that the hotline serves. A voice mailbox must be

available during non-business hours for callers to leave messages. The MCO's Member Hotline staff must return Member calls received by the automated system on the next Business Day.

If the Member Hotline does not have a voice-activated menu system, the MCO must have a menu system that will accommodate Members who cannot access the system through other physical means, such as pushing a button. The MCO must ensure that its menu system directs callers to the most appropriate team or hotline to resolve the Member's call.

The MCO must ensure Member Hotline staff receive training regarding Member clinical issues that necessitate a warm transfer of a Member, Member's LAR, or Member's Authorized Representative, to Nurse Hotline staff, BH Crisis Services Hotline staff, or the Member's assigned Service Coordinator.

To ensure service standards are achieved, the MCO must implement a call and customer service monitoring plan.

The MCO must ensure all Member Hotline staff are:

1. Able to converse with Members with IDD, with responses free of cultural bias;
2. Knowledgeable about Covered Services, including BH Services, THSteps, STAR+PLUS HCBS services, NEMT Services, pharmacy, dental, and vision services, and limitations, VAS, and health education initiatives as described in **Section 2.6.19**, and offered by the MCO;
3. Able to answer non-technical questions pertaining to the role of the PCP and about the Medical Home Services Model, Health Homes, and IPC, as applicable;
4. Able to give information about and schedule appointments with Providers in a particular area;
5. Knowledgeable about FWA including the HHSC Office of the Inspector General's Lock-in Program (OIG-LP), the MCO's special investigative unit, and the requirements to report any conduct that, if substantiated, may constitute FWA;
6. Trained regarding the federal and state Cultural Competency standards in accordance with **Section 2.6.19.1**, including arranging for interpreter services;
7. Trained regarding Service Coordination, further described in **Section 2.6.49,** and how to transfer Members to Service Coordinators;
8. Knowledgeable about how to identify and report a Critical Event or Incident such as ANE to the appropriate state agency; and
9. 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 OIG-LP can fill prescriptions at a non-designated pharmacy provider in an emergency situation; and
    c. Processes for obtaining DME, related services, and addressing common problems with DME.

All Member Hotline staff must also be:

1. Trained to assist a Member, Member's Authorized Representative, or Member's LAR with scheduling an appointment with a Provider during the Provider's hours

of operation and within the Member's availability, in accordance with **Section 2.6.36.2**. The Member Hotline staff must assist with scheduling non-emergency appointments with the Provider and the Member, Member's Authorized Representative, or Member's LAR. Member Hotline staff must offer Members the opportunity to participate in a facilitated three-way call between the Member, Member's Authorized Representative, or Member's LAR and a Provider's office to schedule an appointment. The MCO may choose to dedicate a subset of Member Hotline staff for this purpose. If the Member does not want assistance with scheduling non-emergency appointments, the MCO must document Member's refusal and offer a list of Network Providers, including offering the Member a Provider directory at no cost to the Member;

2. Able to answer non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services;
3. 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+PLUS population may be eligible;
4. Knowledgeable and trained in issues related to family and child abuse and how to assist Members seeking safety, care, and services as well as how to transfer calls to the appropriate MCO staff person;
5. Trained to advise Members on Covered Services and Non-capitated Services, as appropriate to their needs, and connect Members with MCO Service Coordinators and Providers to obtain services; and
6. Able to provide information on how to file Member MCO Internal Appeal and Complaints.

2.6.18.2 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 including State-approved holidays. The Nurse Hotline must be staffed with RNs who are knowledgeable about the Program and population, Covered Services, Non-capitated Services, and Provider resources. Nurses must be available to answer calls 24 hours per day and able to respond to callers seeking clinical information, guidance on specialty referrals, or requests for specialty Provider consultations.

Nurses must have access to an on-call licensed BH clinician 24 hours a day, 7 Days a week, 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.

In addition, the Nurse Hotline staff must be:

1. Knowledgeable about Covered Services, including BH Services, LTSS, pharmacy and vision.
2. Knowledgeable about the Medical Home Services Model, Health Homes, and IPC.
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 family and child abuse and how to assist Members seeking safety, care, and services. Knowledgeable of crisis services and supports.
6. Able to give information about Providers in a particular geographic or SA.
7. Trained regarding Cultural Competency.
8. Trained to handle and properly refer BH crises.
9. Able to answer clinical and non-clinical questions pertaining to accessing services that the MCO does not provide such as:
    a. arranging Non-capitated Services as appropriate;
    b. connecting the Member to community and social service resources; and
    c. facilitating, or leveraging MCO Service Coordination to arrange, community-based case management services for which the STAR+PLUS population may be eligible.
10. Able to respond to Member questions regarding specialty referrals and to arrange for consultations with MCO clinical staff, Service Coordinators, or other Providers. For example, a Member may call from their PCP office with a need for an immediate consult between the PCP, MCO clinical staff, or a BH Services Provider.
11. Able to respond to questions regarding the DM programs.
12. Trained regarding:
    a. Emergency prescription process and what steps to take to immediately address Members' problems when pharmacies do not provide a 72-hour supply of emergency medicines. 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;
    b. The HHSC OIG-LP pharmacy override process to ensure Member access to Medically Necessary outpatient drugs; and
    c. Processes for obtaining DME, related services, and addressing common problems with DME.

2.6.18.3 SERVICE COORDINATION HOTLINE

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

The number, if not regional, must have the capabilities of warm transferring to the MCO's regional office. The hotline must have the capability for a Member, their family, or a Provider to leave a message during non-business hours. Any messages for the Service

Coordination hotline staff or MCO Service Coordinators must be returned within two Business Days.

2.6.18.4 BEHAVIORAL HEALTH SERVICES HOTLINE

The MCO must operate a toll-free BH Hotline staffed by trained personnel 24 hours a Day, seven Days a week, answered by a live voice. The MCO must ensure its BH Services Hotline staff includes or has access to qualified BH Services professionals (LPHAs, or QMHP-CS clinically supervised by a LPHA) to assess Urgent BH Situations, BH crisis or Emergency BH Conditions.

The MCO must ensure the BH Hotline staff assist Members by coordinating Emergency BH Services, BH crisis services, and services for Urgent BH Situations, which may be arranged through Mobile Crisis Teams. The MCO must ensure hotline staff who answer BH-related calls are trained to handle calls related to Urgent BH Situations, BH crisis, and Emergency BH Conditions. The MCO's BH Services Hotline must not be answered by an answering machine.

The MCO must not impose maximum call duration limits and must allow calls to be of sufficient length to ensure adequate information is provided to the Member. The BH Services Hotline must meet Cultural Competency requirements, described further in **Section 2.6.19.1,** and provide Linguistic Access to all Members, including the interpretive services required for effective communication.

The MCO may choose to incorporate the functionality and requirements of the BH Hotline into its Member Services hotline by having options and procedures in place for warm transfers of BH Services-related calls, including calls for Emergency BH Services, BH crisis services, and services for Urgent BH Situations, to appropriate BH Hotline staff. However, the MCO must submit BH Services Hotline performance reports separately as required by **Chapter 5 of Exhibit C.**

2.6.18.4.1 SPECIAL INSTRUCTIONS FOR LIMITED COUNTIES

The requirements in this section are necessary for compliance with *Frew v. Hawkins, 540 US 431 (2004)*.

In addition to Member Hotline reporting requirements found in **Section 2.6.29**, the MCO must provide HHSC with "trunk reports" regarding NEMT Services, as described in **Exhibit C, Chapter 16**. Trunk refers to telephone lines that are routed through a carrier network. Trunk reports are only required for the following counties:

1. Chambers;
2. Hardin;
3. Jasper;
4. Jefferson;
5. Liberty;
6. Newton;
7. Orange;
8. Polk;

9. San Jacinto;
10. Tyler; and
11. Walker.

The MCO will make trunk reports available to HHSC upon request for all trunks used to answer Member calls about NEMT Services, as applicable. The MCO must require the trunk vendor to provide and report the following information:

1. Number of trunks available;
2. Number of call attempts;
3. Number of blocked or overflow call attempts; and
4. Number of trunks out of service.

The MCO must back up all data reports from the trunk vendor as applicable. It is the responsibility of the MCO to ensure its reporting system and trunks are configured in a manner that will enable the MCO to track the performance measures specified by HHSC. The MCO must ensure receipt and backup of all trunk reports data provided by the trunk vendor. This backup will occur before any data is purged.

2.6.19 MEMBER EDUCATION

The MCO must develop educational materials and implement health education initiatives that educate Members, their Authorized Representatives, LARs, or guardians about, at a minimum:

1. How the MCO system operates, including the role of the PCP, how to obtain referrals for services, and access to OON providers;
2. Covered Services and limitations described **in Section 2.6.35** ;
3. Any VAS and Case-by-case Services offered by the MCO, as described in **Sections 2.6.41 and 2.6.42**;
4. The value of screening and preventive care, and other Medical Home services;
5. The MCO's Complaints and Internal Appeals process and how to request a State Fair Hearing;
6. Contacting the MCO's Member-facing hotlines;
7. HHS Office of the Ombudsman, including the Managed Care Assistance Team and the Office of State Long-term Care Ombudsman, and their contact information;
8. HHS Consumer Rights and Services and their contact information;
9. Service Coordination, the role of the Service Coordinator, how to request one, and how to contact one;
10. Member copayment responsibilities (as applicable);
11. Suicide prevention;
12. Identification and health education related to obesity;
13. Discharge planning, transitional care, and other education programs on all available LTSS settings for NF Members;
14. Non-capitated Services, including Case Management for Children and Pregnant Women;
15. Service delivery options, including Consumer-Directed Services and the Service Responsibility Option (SRO) for LTSS;

16. How to obtain Covered Services, including:
    a. Emergency Services;
    b. OB/GYN services and specialty care, including oncology;
    c. BH Services;
    d. DM services;
    e. Treatment for pregnant Members, Members residing in NFs, MBCC Members, and other special populations;
    f. LTSS;
    g. 72-hour supplies of emergency prescriptions from pharmacies enrolled with HHSC as Medicaid providers;
    h. For Members in the OIG-LP, outpatient drugs in an emergency situation;
    i. CFC services; and
    j. NEMT Services.

The MCO must at a minimum provide written notice to all Members that includes:

1. A description of Service Coordination, including, but not limited, to the function of the Service Coordinator, accessing LTSS, the Member's right to and process for filing a Complaint about his or her Service Coordinator, and the minimum standards for Service Coordination set forth by HHSC;
2. The MCO's dedicated toll-free Service Coordination phone number, if applicable, and their named Service Coordinator's contact information;
3. The availability of an annual wellness exam as a covered benefit; and
4. Third party insurance and provider Medicaid enrollment requirements due to the Affordable Care Act.

Unless the Member's Authorized Representative, LAR, or guardian, as appropriate, specifies another preference of communication, the MCO must notify, in writing, all Members with a named Service Coordinator of:

1. The name of their Service Coordinator;
2. The way to contact their Service Coordinator;
3. The minimum number of contacts they will receive every year and how to request more or fewer contacts; and
4. The types of contacts they will receive.

The MCO must provide a range of health promotion and wellness information and activities for Members in formats that meet the needs of all Members. The MCO must propose, implement, and assess innovative Member education strategies for wellness care and immunization as well as general health promotion and prevention. The MCO must conduct wellness promotion programs to improve the health status of its Members. The MCO may cooperatively conduct health education classes for all enrolled Members with one or more MCOs also contracting with HHSC in the SA. The MCO must work with its Providers to integrate health education, wellness, and prevention training into the care of each Member.

The MCO also must provide condition and disease-specific information and educational materials to Members, including information on its Service Coordination and DM programs described in **Section 2.6.49** and **Section 2.6.50**. Condition and disease-specific

information must be oriented to various groups within the STAR+PLUS eligible population, such as persons with Disabilities and non-English speaking Members.

Per Tex. Health & Safety Code § 48.052(c), the MCO may employ or contract with certified Community Health Workers or Promotoras, as described in Tex. Health & Safety Code § 48.052, to conduct outreach and Member education activities.

2.6.19.1 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 plan must be developed in adherence to the federal and State Cultural Competency standards in the format as required by HHSC as described in **Chapter 16 of Exhibit C**. The Cultural Competency plan must adhere to the following:

1. Title VI, 42 U.S.C. § 2000d et seq., Civil Rights Act guidelines;
2. the Americans with Disabilities Act;
3. 28 C.F.R. § 36.303 and 42 C.F.R. § 438.206(c)(2); and
4. 1 Tex. Admin. Code § 353.411.

Additionally, the Cultural Competency plan must detail how the MCO will implement each component of the federal and State standards and how its implementation of these standards impact implementation of the principal standard from the U.S. Department of Health & Human Services' National Culturally and Linguistically Appropriate Services (CLAS) Standards: "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."

The Cultural Competency plan must describe how the individuals and systems within the MCO organization will effectively provide Services to people of all cultures, races, ethnic backgrounds, languages, communications needs, Disabilities, and religions, in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

The plan must be made available to the MCO's Providers.

At HHSC's request, the MCO must update the plan to incorporate new or amended requirements based on HHSC guidance. In that event, the MCO has 60 Days to submit the updated plan to HHSC for approval.

2.6.19.1.1 COMPETENT INTERPRETER SERVICES

The MCO must arrange and pay for Competent Interpreter services, including written, spoken, and sign language interpretation, for Members to ensure effective communication regarding treatment, medical history, and health conditions. The MCO must maintain policies and procedures describing the process by which Members, a LAR, as applicable, and the Members' Providers can access Competent Interpreter services, including written, spoken, and sign language interpretation when the Member 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, LAR, or Provider.

Upon a Provider, Member, or LAR request, in-person interpreters for scheduled appointments must be arranged as quickly as possible, with "rush" appointments available for Urgent Conditions. For Routine Care, in-person requests will be scheduled according to the requested date and time, or upon the next availability of the interpreter for the requested language, including American Sign Language (ASL). If an in-person interpreter is not available for the requested date and time, the MCO must notify and coordinate with the Provider and Member, and offer alternative interpretation options, such as OPI, video remote interpretation, or the earliest availability of an in-person interpreter. Members may select an in-person interpreter whether they require ASL or another language. The MCO may recommend, but not require, an advance notice timeframe for arranging an in-person interpreter. MCOs must make a good faith effort to arrange an in-person interpreter when one is requested, regardless of the advance notice.

2.6.19.2 ADVISORY GROUP

The MCO must establish a Member advisory group consisting of Members, their Authorized Representatives, caregivers, or advocates. An advisory group must meet and conduct quarterly meetings in each SA in which the MCO operates. A representative from the MCO must be present at each quarterly meeting of this advisory group. Membership in the Member advisory group(s) must include at least five Members, three of whom represent Members receiving LTSS, their Authorized Representatives, caregivers or advocates not employed by the MCO and who attend each meeting. The MCO must maintain a record of Member advisory group meetings, including agendas and minutes and any actions taken in accordance with the retention period and requirements of **Article 8 of Exhibit A** and provide them to HHSC upon request.

2.6.19.3 MEMBER SERVICE EMAIL ADDRESS

The MCO must have a secure email address through which a Member or Provider may contact the MCO to receive assistance with identifying Providers and schedule an appointment for the Member or accessing services. The MCO must, within one Business Day, acknowledge a request for assistance 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. Member Services staff must provide the Member or Provider the requested information within three Business Days following the receipt of the email.

2.6.19.4 MEMBER ADVOCATES

The MCO must provide Member Advocates to assist Members. Member Advocates must be physically located within the Member's SA, unless an exception is approved by HHSC. Member Advocates must inform Members of the following:

1. Their rights and responsibilities;
2. The Complaint process;
3. The appeal process;
4. Covered Services available to them, including preventive services; and
5. 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 MCO 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.

2.6.19.5 MEMBER ELIGIBILITY RENEWAL ASSISTANCE

The MCO must provide eligibility renewal assistance for Members whose eligibility is about to expire. The MCO must adhere to minimum requirements set in **Chapter 16 of Exhibit C.**

2.6.20 MANAGED CARE ORGANIZATION WEBSITE

The MCO must develop and maintain a website consistent with HHSC standards, Tex. Ins. Code § 843.2015, and all other applicable State and federal laws and regulations, Accessibility Standards, guidelines, policies, and procedures, to provide the following minimal general information about:

1. The MCO and its Network, including an online Provider directory as outlined in **Chapter 3 of Exhibit C;**
2. The STAR+PLUS Program;
3. The MCO's Member Services, its Complaints and MCO Internal Appeals process;
4. An updated Member handbook; and
5. A link to the STAR+PLUS Contract.

The MCO must comply with the Texas Department of Information Resources (DIR) guidance for all web development and publications, which include bilingual and accessibility requirements, in compliance with 1 Tex. Admin. Code pt.10, chs. 206 and 213.

The MCO's website must also meet the required critical elements of **Chapter 3 of Exhibit C** and comply with State and federal Accessibility Standards, guidelines, policies, and procedures for all work products, including Section 508 compliance in accordance with Accessibility Standards; and 29 U.S.C. § 794.

The website must contain a link to financial literacy information on the Texas Office of Consumer Credit Commissioner webpage. The MCO must also maintain a mobile optimized site for mobile device use. The MCO may develop a page within its existing website to meet the requirements of this section.

The MCO must minimize download and wait time, and not use tools or techniques that require significant memory, disk resources, or special user interventions. The MCO must develop mobile device applications in addition to tools that take advantage of efficient data access methods, reduce server load, and consume less bandwidth.

The MCO must provide a publicly-accessible, region specific, searchable copy of its Provider directory on the website.

The MCO's website must comply with HHSC's Marketing policies and procedures, as set forth in the **Chapter 4 of Exhibit C**.

The website's content must include for providers:

1. Training program schedules and topics, and directions for Provider enrollment in training, including continuing education credits for training on issues related to the Members;
2. Information on how to apply to become a Provider;
3. Information on Cultural Competency and how to provide culturally sensitive care; and
4. Information on the 24-hour Nurse Hotline and how to seek specialty consultations and referrals.

HHSC may require discontinuation, revision, or correction of any Member Materials posted on the MCO's website, including those previously approved by HHSC.

The MCO must provide clear and obvious information on their Member-facing website regarding the availability of the 24/7 BH services support through its hotline. The information should specify that a licensed mental health professional is available to support a Member during a BH crisis.

2.6.20.1 ELECTRONIC INFORMATION RESOURCES

All EIR that is provided by the MCO in the delivery of the information and services requested in this SOW must provide equivalent access to HHSC staff and the public as required under Title I and Title II of the ADA, 42 U.S.C. § 12101 et seq., through compliance with the revised standards in 36 C.F.R. pt. 1194 (March 23, 2018) for Section 508 of the Rehabilitation Act of 1973, 29 U.S.C. § 798. This includes conformance with the WCAG Version 2.0 at levels A and AA.

The MCO must provide a completed Voluntary Product Accessibility Template (VPAT) indicating evidence of conformance for each Information and Communications Technology (ICT)/EIR product developed or indicating compliance with technical and functional standards. The VPAT can be found in the Procurement Library.

All electronic email, documents, or reports provided to fulfill any part of this SOW must also meet the standards in these requirements.

To assure adherence to all standards and guidelines in accordance with Section 508 of the Rehabilitation Act, 29 U.S.C. § 798, and compliance with the ADA 42 U.S.C. § 12101 et seq., contractor accessibility testing must be validated through either testing by HHSC accessibility staff or testing by an independent third party.

2.6.20.2 MEMBER PORTAL

Each STAR+PLUS 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. PA requests status;
3. PA determinations;
4. Results from STAR+PLUS assessments and screening tools;
5. Service Plans and ISPs;
6. Name and phone number of the Member's Service Coordinator;
7. Provider Search;
8. Requests to change PCP;
9. Contact information for technical support;
10. Print and request Member ID cards; and
11. Copies of any Notices of Action sent to the Member in the last 12 months.

MCOs must post the above required documents to the Member's Member Portal within seven Days of receiving or finalizing the document.

2.6.20.3 PROVIDER PORTAL

The MCO must provide a Provider portal with the objective of reducing the administrative burden on Providers at no cost to the Providers as described in **Chapter 3 of Exhibit C.** The Provider portal must be available 24 hours per Day, seven Days a week.

The Provider portal must support online claims processing, both single claims and batch processing.

To facilitate the exchange of clinical data and other relevant documentation, the Provider portal must provide a secure exchange of information between the Provider, MCO, and Subcontractor of the MCO, if applicable.

The Member eligibility verification information in the Provider portal available to NF Services Providers must include data elements related to service authorization, Resource Utilization Group (RUG) levels and applied income for current Members at the time the data elements are received by the MCO. The MCO must upload this Member eligibility verification data into their Provider portals within 48 hours of receiving the eligibility file from HHSC. The Provider portal available to NF Services Providers must keep online automated data for the most current 24 months.

If the MCO and its BHO maintain separate Provider portals for physical health and BH Services Providers, the MCO must comply with the requirements in **Chapter 16 of Exhibit C.** The Provider portal functionality must include at least the following:

1. Member eligibility verification;
2. Submission of electronic claims;

3. PA requests;
4. Updates to Provider profiles;
5. Password reset functionality;
6. Claims appeals and reconsiderations;
7. Exchange of clinical data and other documentation necessary for PA and claim processing; and
8. An online process through the Provider portal for Providers to access the following information related to a Member with the Member's consent:
    a. Functional and medical needs assessments as described in **Section 2.6.58**;
    b. The Member signature page, as applicable;
    c. The name and phone number of the Member's Service Coordinator; and
    d. ISP or Service Plan as described in **Exhibit E** and **Section 2.6.57**, as applicable.

If a Provider is authorized to deliver Covered Services to a Member, the Provider must be able to access, view, and print the Member's functional assessment and Service Plan or ISP for which the Provider holds an authorization, and have access to the information identified in accordance with **Section 2.6.57**. To the extent possible, the Provider portal should support both online and batch processing as applicable to the information being exchanged. To facilitate the exchange of clinical data and other relevant documentation, the Provider portal must provide a secure exchange of information among the Provider, MCO, and Subcontractor, if any.

2.6.21 SMART PHONE APPLICATION

The MCO must agree to facilitate access to selected data in the MIS through secure communications between a Smart Phone Application (App) and the MIS. All functionality in the App must be HIPAA compliant, including offline storage of Member data on the Member's device. Offline storage is not required by HHSC.

The MCO must ensure Members are required to authenticate themselves to the MIS using multi-factor authentication such as providing their Primary Account Numbers (PAN) or usernames and Personal Identification Numbers (PIN) or passwords through secure connection between the Members' smart phones and the MIS. The MCO must ensure the App meets industry standards for secure data transmission and must be approved by HHSC.

The MCO must provide the App for web services and platforms (e.g. iOS, Android, and web) as directed by HHSC. The MCO must ensure that, upon successful verification of the PAN (or username) and PIN (or password), the App securely provides users the following features that allow users the ability to:

1. View current case and personal information, including:
    a. Provider visits;
    b. Vaccinations;
    c. Prescription drugs;
    d. Lab results; and
    e. Service Plans and ISPs;

2. Search for Providers;
3. Request a PCP; and
4. Update their security profile, including modification to demographics and reset of application password.

2.6.22 CMS INTEROPERABILITY AND PATIENT ACCESS

The MCO is 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 accessible at:

http://hl7.org/fhir/

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).

2.6.23 PAYER-TO-PAYER DATA EXCHANGE

The CMS Interoperability and Patient Access Final Rule also requires Medicaid managed care plans and CHIP managed care entities to comply with an individual's request to have their health data transferred from payer to payer by January 1, 2022.

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. Medicaid managed care plans and CHIP managed care entities must be in compliance with the federal requirements by January 1, 2022.

2.6.24 MARKETING AND PROHIBITED PRACTICES

The MCO must comply with all applicable federal and state laws, rules, regulations, polices, and guidance regarding marketing, gifts, and other inducements, including:

1. 15 U.S.C §§ 6101-6108;
2. 15 U.S.C §§ 7701-7713;
3. 42 U.S.C. § 1396u-2;
4. 16 C.F.R. Part 310;
5. 16 C.F.R. Part 316;
6. 42 C.F.R. § 422.2264;
7. 42 C.F.R. § 423.2264;
8. 42 C.F.R. § 438.104;
9. 42 C.F.R. § 457.1224;
10. Tex. Gov't Code §§ 531.02115 and 533.008;
11. 1 Tex. Admin. Code pt. 15, ch. 353, subch. E, § 353.405;
12. 1 Tex. Admin. Code pt. 15, ch. 354, subch B, § 354.1452;
13. 1 Tex. Admin. Code pt.15, ch.354, subch. F, div. 4, § 354.1871;
14. 1 Tex. Admin. Code pt. 15, ch. 370, subch. G, § 370.601;

15. 1 Tex. Admin. Code pt. 15, ch. 371, subch. G, div. 2, § 371.1669; and
16. U.S. Department of Health and Human Services Office of the Inspector General Special Advisory Bulletin: Offering Gifts and Other Inducements to Beneficiaries, August 2002; and
17. Marketing policies and procedures as set forth by HHSC in **Chapter 4 of Exhibit C.**

2.6.25 QUALITY IMPROVEMENT AND PERFORMANCE EVALUATION

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 implement the Medical Home Services Model, an IPC model for medical needs. The MCO must work in collaboration with Providers to actively improve the quality of care provided to Members, consistent with the MCO's 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.

2.6.25.1 PERFORMANCE MEASURES

The MCO must provide all Services and Deliverables under the Contract at an acceptable quality level to HHSC and in a manner consistent with acceptable industry standards, customs, and practices. The MCO must provide to HHSC all information necessary to analyze the MCO's provision of quality care to Members using measures to be determined by HHSC.

2.6.25.2 QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI)

The MCO must develop, maintain, and implement a QAPI program consistent with the Contract, 42 C.F.R. § 438.330, and TDI requirements, including 28 Tex. Admin. Code, pt. 1, ch. 11, subch. T.

The MCO must submit a QAPI program annual summary using the QAPI template found in **Chapter 5 of Exhibit C**.

The MCO must inform participating physicians and other Providers about the QAPI program and related activities on a consistent basis. The MCO must include a requirement in its Provider Contracts that ensures Provider cooperation and participation with the MCO's QAPI program.

As part of the QAPI program, the MCO must be accredited by a nationally recognized accreditation organization, either URAC or NCQA as required by Tex. Gov't Code § 533.0031. The MCO must provide HHSC or its EQRO a copy of its most recent accreditation review in accordance with 42 C.F.R. § 438.332. HHSC may use information from an accreditation organization in its oversight processes.

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

1. Evaluate performance using objective quality indicators;
2. Foster data-driven decision making;
3. Recognize that opportunities for improvement are unlimited;
4. Solicit Member and Provider input on performance and QAPI activities;
5. Support continuous ongoing measurement of clinical and non-clinical effectiveness and Member satisfaction;
6. Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements;
7. Support programmatic improvements of clinical and non-clinical processes and Member satisfaction based on findings from ongoing measurements; and
8. Support re-measurement of effectiveness and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

2.6.25.2.1 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM STRUCTURE

The MCO must maintain a well-defined QAPI program 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 MCO's Medical Director must have substantial involvement in QAPI program activities. The MCO must ensure that the QAPI program structure:

1. Is organization-wide, with clear lines of accountability within the organization;
2. Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, other clinicians, and non-clinicians;
3. Includes annual objectives or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and
4. Evaluates the effectiveness of clinical and non-clinical initiatives.

2.6.25.2.2 CLINICAL INDICATORS

The MCO must collect clinical indicator data. The MCO must use such clinical indicator data in the development, assessment, and modification of its QAPI program.

2.6.25.2.3 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT 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 detailed files documenting the work of the Subcontractors. The files must be available for review by HHSC and the EQRO upon request.

2.6.25.2.4 BEHAVIORAL HEALTH INTEGRATION INTO QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

The MCO must integrate BH into its QAPI program and include a systematic and on-going process for monitoring, evaluating, and improving the quality and appropriateness of BH Services provided to Members. The MCO must collect data and monitor and evaluate improvements to physical and BH outcomes resulting from the integration of BH and physical health to improve the Member's overall care and health outcomes.

2.6.25.2.5 CLINICAL PRACTICE GUIDELINES

The MCO must adopt and maintain not less than two evidence-based clinical practice guidelines. Such practice guidelines must be:

1. Based on valid and reliable clinical evidence;
2. Consider the needs of the Members;
3. Adopted in consultation with Providers; and
4. Reviewed and updated, as appropriate.

The MCO must maintain practice guidelines based on Members' health needs and opportunities for improvement identified as part of the QAPI program. The MCO must coordinate the development and maintenance of clinical practice guidelines with other HHSC MCOs in a SA to avoid 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 such point that 90 percent or more of the Providers are consistently in compliance based on MCO measurement findings. The MCO must employ substantive Provider motivational incentive strategies to improve Provider compliance with clinical practice guidelines. The MCO's decisions regarding UM, Member education, coverage of services, and other areas included in the practice guidelines must be consistent with the MCO's clinical practice guidelines.

2.6.25.2.6 PROVIDER CREDENTIALING AND PROFILING

In accordance with **Section 2.6.6**, the MCO must review and approve the credentials of all licensed and unlicensed Providers participating in the MCO's Network. As part of the QAPI program, the MCO must report annually to HHSC the results of any Credentialing activities conducted during the previous reporting year. The MCO must use the QAPI form in **Chapter 5 of Exhibit C** or other method specified by HHSC upon request for this report.

If the MCO wishes to move to a preferred Provider arrangement, the MCO must profile all Providers of the service for a period of no less than 12 months. The results of the Provider profiles must be used to determine the Provider or Providers selected for a preferred Provider arrangement. If an MCO enters into a preferred Provider arrangement, the MCO must notify Members of the arrangement in writing at least 30 Days in advance of execution of the arrangement, consistent with **Chapter 4 of Exhibit C**. The MCO must

also develop and implement a process whereby Members have the opportunity to opt out of the preferred Provider arrangement and use another Provider. The MCO must provide clear written instructions on how a Member may opt out of using the preferred Provider. The MCO must manage the opt out process, including the receipt and review of all Member requests, and may not delegate any process steps to its Providers.

For preferred Provider arrangements already in effect prior to the issuance of HHSC guidance, the MCO must provide notification to impacted Members and provide clear written instructions on how the Member may opt out of using the preferred Provider. Furthermore, the MCO may not change a Member's Provider without notifying the Member of the change and providing clear written instructions on how the Member may opt out of using the Provider.

The MCO must conduct PCP and other Provider profiling activities at least annually. As part of its QAPI program, the MCO must describe the methodology it uses to identify which and how many Providers to profile and to identify measures for profiling such 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;
2. Involving the medical 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, or group Benchmarks for areas profiled, where applicable; the MCO can compare the performance of its Providers to providers delivering similar types of services in other states; and
4. Providing feedback to individual PCPs and Providers regarding the results of their performance and the overall performance of the Network.

2.6.25.3 NETWORK MANAGEMENT

The MCO must:

1. Use the results of its Provider review activities to identify areas of improvement for individual PCPs and Providers, or groups of Providers;
2. Establish Provider-specific Quality Improvement goals for priority areas in which a Provider or Providers do not meet established MCO standards or improvement goals;
3. Develop and implement incentives to motivate Providers to improve performance on profiled measures, which may include financial and non-financial incentives;
4. At least annually, measure and report to HHSC on the Network and individual Provider's progress, or lack of progress, towards such improvement goals, and submit a plan to HHSC for quarterly monitoring of Providers who are not meeting goals; and
5. Implement action plans and modify incentives for Providers who are not meeting improvement goals and conduct quarterly evaluations of the Provider's progress

until the Provider has met improvement goals or the MCO determines the Provider Contract should be terminated.

2.6.25.4 PHYSICIAN INCENTIVE PLANS

The MCO must not make payments under a physician incentive plan if the payments are designed to induce Providers to reduce or limit Covered Services to Members. If the MCO implements a physician incentive plan under 42 C.F.R. § 438.3(i), the plan must comply with all applicable requirements, including 42 C.F.R. §§ 422.208 and 422.210.

If the physician incentive plan places a physician or physician group at a substantial financial risk for services not provided by the physician or physician group, the MCO must ensure adequate stop-loss protection and conduct and submit annual Member surveys no later than five Business Days after the MCO finalizes the survey results. Refer to 42 C.F.R. § 422.208(d) for information concerning "substantial financial risk" and 42 C.F.R. § 422.208(f) for information concerning "stop-loss protection."

The MCO must make information regarding physician incentive plans available to Members upon request, in accordance with **Chapter 3 of Exhibit C**. In responding to a request, 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.
2. If the physician or physician group is at substantial financial risk, proof that the physician or group has adequate stop-loss coverage, including the amount and type of stop-loss coverage.
3. If the physician incentive plan covers services that are not furnished by a physician or physician group:
    a. The type of incentive arrangement, e.g., withhold, bonus, capitation;
    b. The percent of the withhold or bonus, if applicable; and
    c. The panel size and the method used if patients are pooled; the MCO must secure HHSC approval for the method used if patients are pooled.

2.6.25.4.1 DIRECTED PAYMENT PROGRAMS (DPPS)

DPPs are set forth below.

2.6.25.4.1.1 QUALITY INCENTIVE PAYMENT PROGRAM

MCO must meet all Quality Incentive Payment Program (QIPP) requirements outlined in 1 Tex. Admin. Code §§ 353.1301 and 353.1302.

HHSC will provide a NF with its facility-specific baseline as well as the national Benchmark for each of the quality metrics by mid-August of each year, the specific date to be determined by HHSC.

Each month, HHSC will provide each MCO data on whether the NF achieved its reporting and quality metric requirements and the payment amount calculated by HHSC according to the methodology in 1 Tex. Admin. Code § 353.1302(h)(2). The MCO must pay the NF the HHSC-calculated payment amount no later than 20 Days after the date the MCO receives the achievement data and payment amount from HHSC.

Each quarter, HHSC will assess NF performance and issue to the MCO facility-specific data with the associated payment amount on an accompanying scorecard template within 15 Days of the end of each quarter, unless data are not available in which case 15 Days after data are available. HHSC will also provide the MCO with the portion of the QIPP per member per month associated with the achievement.

HHSC will resolve directly with a NF any issues a NF may have with its monthly achievement data, QIPP scorecard, or the per Member per month associated therewith. MCOs will resolve directly with NF any issues the NFs may have with a payment received from the MCO if the amount of such payment is different from the amount calculated by HHSC.

A NF is considered paid on the date of: (1) issue of a check for payment and its corresponding remittance and status report or explanation of payment to the Provider by the MCO; or (2) the electronic transmission, if payment is made electronically. MCOs must attest to meeting these timely payment requirements in compliance with **Chapter 5.20 of Exhibit C.**

For all QIPP-related recoupments, improper payments, and overpayments, MCOs must follow the processes outlined in **Chapter 8 of Exhibit C.** HHSC may recoup the amount of overpayments from MCOs and MCOs may recoup the amount of overpayments from NF Providers as allowed by 1 Tex. Admin. Code § 353.1302(k).

2.6.25.4.1.2 NURSING FACILITY INCENTIVES

The MCO will implement NF incentive program(s). The goal of the program(s) will be to reduce potentially preventable events, as defined in Tex. Gov't Code § 536.001(18), unnecessary institutionalization, and acute care costs. The program(s) will also encourage NF culture change, including the development of resident-centered service delivery and improvements to NF physical plant features. Any NF incentive program will comply with 42 C.F.R. § 438.60. If the MCO's NF incentive program includes any metrics utilized in HHSC's QIPP, the MCO must require NFs participating in QIPP to achieve a higher Benchmark for payment that is associated with better performance on those metrics than that of the QIPP Benchmarks. The MCO must ensure that all of its Network NF Providers

serving the MCO's NF members have equal opportunity to participate in a NF incentive program, regardless of facility occupancy or licensed capacity, or the number or percentage of total residents as Members. The MCO must have built-in protections in any of its NF incentive programs to safeguard against activities that are intended to influence Member choice of health plan or provider. The MCO must be able to demonstrate those safeguards and compliance with this section upon request from HHSC.

2.6.25.4.1.3 SAFETY NET HOSPITALS

HHSC must provide a list to the MCO annually that identifies the hospitals that are awarded incentive payments based on exemplary performance on Potentially Preventable Complications (PPCs) and Potentially Preventable Readmissions (PPR), as defined in Tex. Gov't Code § 536.001(17) & (20), based on HHSC's methodology for those award determinations. This list will contain the hospital's National Provider Identification (NPI), name, and amount of the incentive payment earned. HHSC must build in costs for these incentives into the MCO Capitation Payments.

HHSC shall provide a list, annually, to the MCO that identifies hospitals with poor performance on the PPCs and PPRs based on HHSC's methodology for these disincentive determinations. This list will contain the hospital's NPI, name, and amount of payment reduction. The MCO may pass down payment reductions to the hospitals identified by HHSC to encourage improved performance. HHSC shall build in reductions to the MCO Capitation Payments by the amounts of these hospital disincentives.

2.6.25.4.1.4COMPREHENSIVE HOSPITAL INCREASED REIMBURSEMENT PROGRAM

MCO must meet all Comprehensive Hospital Increase Reimbursement Program (CHIRP) requirements outlined in 1 Tex. Admin. Code §§ 353.1301 and 353.1306.

MCOs must increase base payment rates for inpatient and outpatient services performed in the MCO's Network CHIRP-participating hospitals by the uniform percent associated with the CHIRP-participating hospital's class and SA as directed by HHSC. The MCO must increase base payment rates only to CHIRP-participating hospitals geographically located in SAs where the MCO has been selected to provide Services.

The rate increase does not apply to CHIRP-participating hospital services provided to Dual Eligibles where Medicare is the primary payor.

With the exception of CHIRP-participating rural hospitals, which are defined in 1 Tex. Admin. Code § 353.1306(b), the rate increase does not apply to non-emergent care provided in a CHIRP-participating hospital emergency department.

The rate increase does not apply to claims for COVID-19 testing, diagnosis, or treatment.

If an MCO enters into a new Provider Contract with a CHIRP-participating hospital in a participating SA, the MCO will pay using the rate enhancement associated with the CHIRP-participating hospital's class. If a CHIRP-participating hospital changes class during a particular program period, the MCO will continue to pay the CHIRP-participating hospital using the rate enhancement associated with the CHIRP-participating hospital's

class at the commencement of that particular program period. For purposes of this section, program period is defined in 1 Tex. Admin. Code § 353.1306.

HHSC may recoup the amount of a disallowance by CMS from MCOs, Hospitals, or governmental entities as allowed by 1 Tex. Admin. Code § 353.1301(j). HHSC may recoup the amount of Overpayments from MCOs, and MCOs may recoup the amount of Overpayments from CHIRP-participating hospitals as allowed by 1 Tex. Admin. Code § 353.1301(k). For all CHIRP-related recoupments, improper payments, and Overpayments, MCOs must follow the processes outlined in **Exhibit C Chapter 8**.

MCOs must assist CHIRP-participating hospitals in collecting information necessary to complete CHIRP reporting obligations for all years in which the CHIRP is in effect.

2.6.25.4.1.5 TEXAS INCENTIVES FOR PHYSICIANS AND PROFESSIONAL SERVICES (TIPPS)

MCOs must satisfy all Texas Incentives for Physician and Professional Services (TIPPS) requirements outlined in 1 Tex. Admin. Code §§ 353.1301 and 353.1309. For purposes of this section, program period is defined in 1 Tex. Admin. Code § 353.1309; however, notwithstanding the definition of program period in § 353.1309, the start date of the program period may be a date other than September 1. HHSC will notify the MCO of the start date of the program period prior to that start date.

MCOs must make HHSC-calculated payments to a TIPPS participating physician group for achieving meeting its reporting and quality metric requirements according to the payment methodology associated with the TIPPS-participating physician group class and TIPPS program component as outlined in 1 Tex. Admin. Code §§ 353.1309 and 353.1311.

HHSC will provide the MCO with data on whether TIPPS-participating physician groups achieved met reporting and quality metric requirements according to the payment methodology associated with the TIPPS-participating physician group's class and TIPPS program component as outlined in 1 Tex. Admin. Code §§ 353.1309 and 353.1311. The MCO must pay the TIPPS-participating physician group the HHSC-calculated payment amount no later than the date specified by HHSC.

A TIPPS-participating physician group is considered paid on the date of: (1) issue of a check for payment and its corresponding Remittance and Status (R&S) Report or explanation of payment to the Provider by the MCO; or (2) the electronic transmission, if payment is made electronically.

HHSC will resolve directly with a TIPPS-participating physician group any issues a TIPPS-participating physician group may have with its reporting and quality metric achievement data. MCOs will resolve directly with a TIPPS-participating physician group any issues the TIPPS-participating physician group may have with a payment received from the MCO.

For all TIPPS-related recoupments, improper payments, and Overpayments, MCOs must follow the processes outlined in UMCM Chapter 8.6, section 2.33 Right to Recover and Recoupment. HHSC may recoup the amount of Overpayments from MCOs, and MCOs may recoup the amount of Overpayments from TIPPS-participating physician groups as allowed by 1 Tex. Admin. Code § 353.1301(k). HHSC may recoup the amount of a

disallowance by CMS from MCOs, TIPPS-participating physician groups, or governmental entities as allowed by 1 Tex. Admin. Code § 353.1301(j).

2.6.25.4.1.6 RURAL ACCESS TO PRIMARY AND PREVENTATIVE SERVICES (RAPPS)

MCOs must satisfy all Rural Access to Primary and Preventive Services (RAPPS) requirements outlined in 1 Tex. Admin. Code §§ 353.1301 and 353.1315. For purposes of this section, program period is defined in 1 Tex. Admin. Code § 353.1315; however, notwithstanding the definition of program period in § 353.1315, the start date of the program period may be a date other than September 1. HHSC will notify the MCO of the start date of the program period prior to that start date.

MCOs must provide an increased payment or a percentage rate increase for certain services performed in the MCO's Network RAPPS-participating rural health clinics associated with the RAPPS-participating rural health clinic's class and RAPPS-program component as outlined in 1 Tex. Admin. Code § 353.1315.

MCOs must make HHSC-calculated payments to a RAPPS-participating rural health clinic according to the payment methodology associated with the RAPPS-participating rural health clinic's class and RAPPS program component as outlined in 1 Tex. Admin. Code §§ 353.1315 and 353.1317.

HHSC will provide the MCO with data on whether RAPPS-participating rural health clinics have met the program requirements associated with the RAPPS-participating rural health clinic's class and RAPPS program component as outlined in 1 Tex. Admin. Code §§ 353.1315 and 353.1317. The MCO must pay the RAPPS-participating rural health clinic the HHSC-calculated payment amount no later than the date specified by HHSC.

HHSC will resolve directly with a RAPPS-participating Rural Health Clinic any issues a RAPPS-participating Rural Health Clinic may have with its reporting and quality metric data. MCOs will resolve directly with a RAPPS-participating Rural Health Clinic any issues the RAPPS-participating Rural Health Clinic may have with a payment received from the MCO.

A RAPPS-participating Rural Health Clinic is considered paid on the date of: (1) issue of a check for payment and its corresponding Remittance and Status (R&S) Report or explanation of payment to the Provider by the MCO; or (2) the electronic transmission, if payment is made electronically.

For all RAPPS-related recoupments, improper payments, and Overpayments, MCOs must follow the processes outlined in UMCM Chapter 8.6, section 2.33 Right to Recover and Recoupment. HHSC may recoup the amount of Overpayments from MCOs, and MCOs may recoup the amount of Overpayments from RAPPS participating Rural Health Clinics as allowed by 1 Tex. Admin. Code § 353.1301(k). HHSC may recoup the amount of a disallowance by CMS from MCOs, RAPPS participating Rural Health Clinics, or governmental entities as allowed by 1 Tex. Admin. Code § 353.1301(j).

2.6.25.4.1.7 DIRECTED PAYMENT PROGRAM FOR BEHAVIORAL HEALTH SERVICES (DPP BHS)

MCO must meet all Directed Payment Program for Behavioral Health Services (DPP BHS) requirements outlined in 1 Tex. Admin. Code §§ 353.1301 and 353.1320.

MCOs must provide a monthly uniform dollar increase and a uniform percentage rate increase for all or a subset of services performed in the MCO's Network DPP BHS-participating community mental health centers and local behavioral health authorities associated with the DPP BHS-participating community mental health center or local behavioral health authority's class and DPP BHS program component as outlined in 1 Tex. Admin. Code § 353.1320.

MCOs must make HHSC-calculated payments to a DPP BHS-participating community mental health center or local behavioral health authority for achieving meeting its reporting and quality metric requirements according to the payment methodology associated with the DPP BHS-participating community mental health center or local behavioral health authority's class and DPP BHS program component as outlined in 1 Tex. Admin. Code §§ 353.1320 and 353.1322.

HHSC will provide the MCO with data on whether DPP BHS participating community mental health centers and local behavioral health authorities met reporting and quality metric requirements according to the payment methodology associated with the DPP BHS community mental health center class and DPP BHS program component as outlined in 1 Tex. Admin. Code §§ 353.1320 and 353.1322. The MCO must pay the DPP BHS participating community mental health center the HHSC-calculated payment amount no later than the date specified by HHSC.

A DPP BHS participating community mental health center is considered paid on the date of: (1) issue of a check for payment and its corresponding Remittance and Status (R&S) Report or explanation of payment to the Provider by the MCO; or (2) the electronic transmission, if payment is made electronically.

HHSC will resolve directly with a DPP BHS participating community mental health center or local behavioral health any issues a DPP BHS participating community mental health center or local behavioral health authority may have with its reporting and quality metric data. MCOs will resolve directly with a DPP BHS participating community mental health center or local behavioral health authority any issues the DPP BHS participating community mental health center may have with a payment received from the MCO.

For all DPP BHS related recoupments, improper payments, and Overpayments, MCOs must follow the processes outlined in UMCM Chapter 8.6, section 2.33 Right to Recover and Recoupment. HHSC may recoup the amount of Overpayments from MCOs, and MCOs may recoup the amount of Overpayments from DPP BHS participating community mental health centers and local behavioral health authority as allowed by 1 Tex. Admin. Code § 353.1301(k). HHSC may recoup the amount of a disallowance by CMS from MCOs, DPP BHS participating community mental health centers, local behavioral health authority, or governmental entities as allowed by 1 Tex. Admin. Code § 353.1301(j).

2.6.25.5 ALTERNATIVE PAYMENT MODELS WITH PROVIDERS

HHSC requires the MCOs to transition the provider payment methodologies from volume-based payment approaches, i.e. fee for service, to value-based alternative payment models (APMs), increasing year-over-year percentages of provider payments linked to measures of quality and/or efficiency, or maintaining every year the percentage achieved the year before. The APMs should be designed to improve health outcomes for Members, empower Members and improve experience of care, lower healthcare cost trends and incentivize Providers.

The MCOs must demonstrate satisfactory progress towards advancing APM initiatives within an APM Performance Framework. MCOs will earn credit by meeting or making minimum progress on benchmarks in the APM Performance Framework components listed below. Specifications and benchmarks of the framework are detailed in UMCM Chapter 8 APM Performance Framework Technical Specifications.

APM Performance Framework Components:

1. Achieve a minimum Overall APM Ratio and a Risk-Based APM Ratio. The ratios are expressions of APM-based provider payments relative to total provider payments. The calculations and yearly benchmarks for the APM Target Ratios, are delineated in UMCM Chapter 8.
2. Implement APMs that promote improvements in priority areas and quality measures specified by HHSC in UMCM Chapter 8. Examples of HHSC priority areas include maternal health and improved birth outcomes, Behavioral Health integration, and addressing social drivers of health.
3. Implement processes to support and incentivize Providers. The MCOS must engage and support Providers' efforts to implement value-based care models and reward high-performing Providers, as defined by MCO. To achieve this support, the MCO must:
    a. Share data and performance reports with Providers on a regular basis and provide or make available the data Providers need to coordinate care in an APM. MCOs must provide evidence of these reports and processes upon request by HHSC.
    b. Dedicate enough resources for Provider outreach and negotiation, assistance with data and/or report interpretation, and other activities to support Provider's improvement.
    c. To the extent possible collaborate with other MCOs within the same Service Area on the development of standardized formats for the Provider performance reports and data exchanged with Providers and align quality measures. MCOs are encouraged to sponsor or support collaborative learning opportunities for Providers in a Service Area.
4. Submit to HHSC its inventories of APMs with Providers by September 1st of each year. The reporting will be completed using the data collection tool in UMCM Chapter 8 Alternative Payment Models Data Collection Tool (DCT). The DCT will

capture APM activity for the previous year and will be used to calculate the APM ratios and determine whether the MCOs have achieved minimum progress on the components of the APM Performance Framework. Some requirements in the DCT will vary by program. Provider types include, but are not limited to, primary care providers, specialists, hospitals, long term services and supports providers, Chemical Dependency Treatment facilities, pharmacies, and pharmacists. Upon request by HHSC, the MCOs shall submit to HHSC underlying data for the information reported on the data collection tool (e.g., names of providers, NPIs, TPIs, etc.). HHSC will post on its web site basic information from reported APMs.

5. Evaluate the impact of APMs on utilization, quality and cost, as well as return on investment (ROI).

    a. The MCOs must evaluate the impact of their APMs. Upon request, the MCO must report on methodologies used for APM evaluations along with results and findings related to the APM's impact on utilization, quality, costs, provider satisfaction, or ROI.

    b. The MCOs must report to HHSC, annually, the net financial impact to Providers of APMs, including the sum of incentive payments, shared savings, and payment reductions. The financial impact to Providers should be reported in the DCT for each APM and Medicaid program.

    c. The MCOs are encouraged to develop and continually update a strategic plan for advancing value-based care and APMs to advance quality and efficiency.

MCOs must obtain HHSC approval of all APMs altering the outpatient drug benefit (pharmacy and clinician-administered) in advance of implementation. MCOs must provide a brief description of the program including its general goal, a description of how the APM will operate, information on how providers are impacted, information on how members are impacted, and the target implementation date. Proposals must be submitted to HHSC Pharmacy Operations inbox at vdp-operations@hhsc.state.tx.us.

If the MCO's DCT does not adhere to HHSC requirements or is not submitted by the required deadline, or if the MCO does not demonstrate minimum required progress within the APM Performance Framework, the MCO shall be required to submit a corrective action plan and may be subject to additional contractual remedies, including liquidated damages.

2.6.25.5.1 MCO ALTERNATIVE PAYMENT MODEL WITH CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS (CCBHCS)

MCOs must work with Certified Community Behavioral Health Clinics (CCBHCs) to establish an Alternative Payment Model (APM) arrangement consistent with the requirements in UMCM Chapter 16.

2.6.25.6 NON-PHARMACY PREFERRED PROVIDER AGREEMENT

A preferred provider arrangement is a contracted agreement between the MCO and one or more Providers. After the effective date of the agreement, services specified in the

agreement will be delivered to Members by the Provider(s) in the preferred provider arrangement.

If an MCO enters into a preferred provider arrangement, the MCO must notify Members of the arrangement in writing at least 60 Days in advance of effective date of the arrangement. The MCO must also develop and implement a process whereby Members have the choice to opt out of using the preferred provider arrangement and use another Network Provider. The MCO must provide clear written instructions on how a Member may opt out of using the preferred provider arrangement. The MCO must manage its opt out process, including the receipt and review of all Member requests, and may not delegate any process steps to its Providers. For preferred provider arrangements in effect prior to September 1, 2021, MCO must provide notification to its impacted Members that gives clear written instructions on how the Member may opt out of using the preferred provider. Furthermore, the MCO may not change a Member's provider without notifying the Member of the change and providing clear written instructions on how the Member may opt out of using the Provider.

When implementing a preferred provider arrangement, the MCO must notify Providers through its internet website, at minimum every time such an arrangement is implemented. The MCO must coordinate with other Network Providers of the Covered Service during the transition to ensure Continuity of Care.

The MCO must provide to the HHSC health plan manager all the Member and provider notices pertaining to the new preferred provider arrangement at least 90 Days before initiating any such arrangement. The MCO must ensure notices comply with UMCM Chapter 4. To be counted as an APM under Section 2.6.24.5, a preferred provider arrangement must be based on a provider's performance on metrics of quality or value and meet the requirements set forth in Section 2.6.24.5.

2.6.25.7 PERFORMANCE INCENTIVES AND DISINCENTIVES

Performance incentives and disincentives are subject to change by HHSC over the course of the Contract. The methodologies required to implement these incentives and disincentives will be refined by HHSC after collaboration with the MCO. The MCO must not pass along to providers financial disincentives or sanctions imposed on the MCO, except on an individual Provider basis and related to the individual Provider's inadequate performance. For further information, refer to **Section 2.8.8**.

2.6.25.7.1 PERFORMANCE PROFILING

HHSC will distribute information on key performance indicators to MCOs on a regular basis, identifying an MCO's performance, and comparing that performance with HHSC's standards or external Benchmarks. For example, HHSC will post performance results on its website, where they will be available to both stakeholders and members of the public.

2.6.25.7.1.1 PERFORMANCE INDICATOR DASHBOARD FOR QUALITY MEASURES

HHSC will track key indicators of MCO performance through the use of a performance indicator dashboard for quality measures, described in **Chapter 10 of Exhibit C.** HHSC will compile the performance indicator dashboard based on MCO submissions (see **Chapter 10 of Exhibit C,** data from the EQRO, and other data available to HHSC. The performance indicator dashboard is not an all-inclusive set of performance measures; HHSC will measure other aspects of the MCO's performance as well. However, the performance indicator dashboard assembles performance indicators that assess many of the most important dimensions of the MCO's performance, and includes measures that, when publicly shared, will also serve to incentivize excellence.

2.6.25.7.1.2 DEFAULT METHODOLOGY FOR MEDICAID MANAGED CARE ORGANIZATIONS

HHSC may revise its default methodology for enrollees who do not select an MCO based on MCO performance. HHSC's default methodology is described in 1 Tex. Admin. Code § 353.403.

2.6.25.7.2 FINANCIAL INCENTIVES AND DISINCENTIVES

Financial incentives and disincentives are set forth below.

2.6.25.7.2.1 MEDICAL PAY-FOR-QUALITY

Under the medical pay for quality (P4Q) program, HHSC will place each MCO at risk for a percentage of the Capitation Payment(s). 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 2.8**. Then, at the end of the medical P4Q data collection period (which is a calendar year), HHSC will evaluate the MCO's performance and assign points and dollar amounts using the measures and methodology set out in **Chapter 6 of Exhibit C.**

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

MCOs must report actual Capitation Payments received on the FSR during the FSR Reporting Period that are at risk (i.e., the MCO will not report Revenues at a level equivalent to, for example, 96 percent of the payments received, leaving some percentage 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 Expense**.**

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.

HHSC will resolve directly with a NF any issues a NF may have with its monthly achievement data, QIPP scorecard, or the per Member per month associated therewith. MCOs will resolve directly with NFs any issues the NFs may have with a payment received from the MCO if the amount of such payment is different from the amount calculated by HHSC.

HHSC may recoup the amount of overpayments from MCOs in accordance with 1 Tex. Admin. Code § 353.1301(k) and MCOs may recoup the amount of overpayments from NF Providers as allowed by 1 Tex. Admin. Code § 353.1302(k).

2.6.25.7.2.2 Additional Incentives and Disincentives

HHSC will evaluate all performance-based incentive and disincentive methodologies annually and in consultation with the MCOs. HHSC may modify the methodologies as needed, or develop additional methodologies, as funds become available, or as mandated by court decree, statute, or rule to promote and recognize MCO performance under the Contract. The MCO must participate in any incentive or disincentive programs or methodologies as determined by HHSC.

2.6.25.8 Frew Incentives and Disincentives

As required by the *Frew v. Young Corrective Action Order: Managed Care,* the MCO will be subject to incentives and disincentives in the Contract. The incentives and disincentives and corresponding methodology are set forth in **Chapter 12 of Exhibit C**.

2.6.25.9 Collaboration with the External Quality Review Organization

The MCO must collaborate with the 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.

The MCO must supply claims data to the EQRO, or another vendor identified by HHSC, in a format identified by HHSC in consultation with the MCO. The MCO must supply the EQRO, or another vendor identified by HHSC, medical records for focused clinical reviews conducted by the EQRO, or another vendor identified by HHSC.

The MCO must work collaboratively with HHSC and the EQRO to annually measure HHSC-selected HEDIS measures that require chart reviews. The MCO must conduct chart reviews for HEDIS hybrid measures and submit results to the EQRO in a format and timeline specified by HHSC. The MCO is responsible for all costs associated with these reviews.

The MCO must comply with any data requests from the EQRO, including data required for these activities:

1. Performing medical record review;
2. Performing Encounter Data validation for data certification purposes; and
3. Calculating measure results using Encounter and enrollment data.

2.6.25.10 PERFORMANCE IMPROVEMENT PROJECTS

HHSC seeks to accelerate the MCO's improvement efforts in areas of high priority. One of HHSC's methods for accelerating improvement is to annually establish with the MCO a series of Performance Improvement Projects (PIPs). The MCO must be committed to making its best efforts to achieve the goals of the established projects. These projects must be specified and measurable. The projects must reflect areas that present significant opportunities for performance improvement.

PIPs must be designed, conducted, and reported in a methodologically sound manner in accordance with **Chapter 10 of Exhibit C**. HHSC will determine the PIP topics, and the MCO must complete the PIP templates in accordance with **Chapter 10 of Exhibit C**. The MCO must also complete progress reports as outlined in the **Chapter 10 of Exhibit C**.

Once finalized and approved by HHSC, the PIPs will become part of the MCO's annual plan for its QAPI program and will be incorporated by reference into the Contract. HHSC anticipates that incentives and disincentives will be linked to some of the measures in the Performance Indicator Dashboards, as found in **Chapter 10 of Exhibit C**.

The MCO must conduct one PIP in collaboration with other MCOs, dental contractors, or community organizations in SAs for which they have a contract.

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 **Chapter 10 of Exhibit C**. HHSC will compile the Performance Indicator Dashboard based on MCO submissions, data from the EQRO, and other data available to HHSC. HHSC will share the Performance Indicator Dashboard results with the MCO annually.

2.6.25.11 MANAGED CARE ORGANIZATION QUALITY RATING SYSTEM

HHSC is required by 42 C.F.R. §§ 438.334 and 457.1240 and Tex. Gov't Code § 536.051 to adopt an annual quality rating system for MCOs. HHSC may prominently display the results on HHSC's website or a website maintained by HHSC's designee. Additionally, HHSC may provide the results to Members through other methods at HHSC's election.

If the MCO requests the recalculation or any other modifications to the quality measure data or Member-level results, HHSC may charge the MCO any costs related to preparing the data for the MCO.

2.6.26 UTILIZATION MANAGEMENT

This section provides the UM requirements of the MCO. The MCO must have a written UM program description, which includes, at a minimum:

1. Procedures to evaluate the need for Medically Necessary Covered Services and Functionally 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 conducting an annual review to ensure UM clinical criteria are based on accurate, up-to-date, evidence based, and peer-reviewed clinical criteria;
4. The procedure for amending the UM clinical review criteria; and
5. The staff position functionally responsible for the day-to-day management of the UM function.

2.6.26.1 POLICIES AND PROCEDURES

The MCO and its Subcontractors must have in place and follow written UM policies and procedures for processing requests for initial and continuing authorizations of services. The UM policies and procedures must comply with 42 C.F.R. § 438.210 and include:

1. A list of staff positions responsible for the day-to-day management of the UM program and their functions.
2. The MCO's clinical review criteria used to determine medical necessity for Covered Services, the sources used to develop the clinical review criteria, and the method for periodically reviewing and amending the clinical review criteria.
3. The processes and rationale used to make coverage determinations, including partial approvals, partial denials, and administrative determinations. For the purposes of this section, administrative determinations means coverage determinations made without a medical necessity evaluation.

The MCO must also include in the UM policies and procedures the methods used to ensure:

1. Compliance with Tex. Ins. Code ch. 4201 and Tex. Gov't Code ch. 533;
2. Clinical PA determinations for outpatient pharmacy benefits are made by Texas-licensed pharmacists or pharmacists licensed in another state acting under the supervision of a Texas-licensed pharmacist, working under the direction of the Medical Director;
3. PA determinations to deny or limit services are made by physicians licensed in Texas working under the direction of the Medical Director;
4. The PA process does not result in undue delays in services;
5. Qualified personnel are available to respond to UM inquiries 7:00 a.m. to 6:00 p.m. local time throughout the State, Monday through Friday, with a telephone system capable of accepting UM inquiries outside of these hours, and that the MCO responds to voice messages within one Business Day after the message is recorded;
6. Information is kept confidential and secure in accordance with **Article 9 of Exhibit A**, whether in the custody of the MCO, the MCO's Subcontractors, or when being transmitted by any means;
7. PA and concurrent review determinations are made and supervised by formally educated and currently licensed medical professionals with same or similar specialty as the ordering Provider, such as physicians, nurses, or therapists, who have subject area knowledge and relevant patient care experience; and that these medical professionals work and supervise others only within the scope of their education and licensure;
8. The routine assessment of effectiveness and efficiency of the UM program;

9. Evaluation of the appropriate use of new and existing medical technologies, including medical procedures, drugs, and devices;
10. Members receive Medically Necessary and appropriate services, targeting areas of suspected inappropriate service utilization, including overutilization and underutilization;
11. Routine generation of Provider profiles regarding utilization patterns and compliance with UM criteria and policies;
12. Member and Provider utilization is compared with norms for comparable individuals;
13. Inpatient admissions, ER use, ancillary services, and out-of-state services are routinely monitored;
14. Peer-to-peer consultation is provided among the MCO's Providers and between Providers and the MCO's clinical staff;
15. The MCO uses the Texas Resilience and Recovery Utilization Management Guidelines for Mental Health TCM and MHR;
16. Ensure that when Members are receiving BH Services from LMHA that the MCO is using the same UM guidelines as those prescribed for use by LMHAs on the DSHS website: https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual; and
17. Suspected cases of Provider, OON provider, or Member FWA are referred to the HHSC OIG as required by **Section 2.6.31**; and
18. Inter-rater reliability is tested when making PA determinations.

In accordance with the requirements in **Chapter 16 of Exhibit C** the MCO must share UM data among all relevant MCO employees, including both physical and BH staff, or, if applicable, between the MCO and Subcontractor contracted with the MCO to manage BH Services.

2.6.26.2 UM DETERMINATIONS

In making UM determinations, the MCO must make a reasonable effort to obtain all necessary information, including pertinent clinical information, and consult and communicate with the provider as appropriate. When making UM determinations, the MCO must comply with the requirements of 42 C.F.R. § 456.111 Beneficiary Information for Hospitals) and 42 C.F.R. § 456.211 (Beneficiary Information for Mental Hospitals), as applicable.

UM that requires direct contact with the actual Provider must be scheduled at times convenient to the Provider's schedule, so as not to interrupt regular clinical care duties.

The MCO must issue coverage determinations in accordance with 42 C.F.R. § 438.210(d), TDI requirements, and within the following timelines after receipt of a request for services or equipment:

1. Within one Business Day of receiving the request for concurrent hospitalization decisions;

2. Within one hour of receiving the request for post-stabilization or life-threatening conditions, except the MCO must not require PA for Emergency Medical Conditions and Emergency BH Conditions;
3. For a Member who is hospitalized at the time of the request, within one Business Day 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 OON provider, Provider of Acute Care inpatient services, or a Member;
4. Within three Business Days for all other PA requests. For PA requests received with insufficient or inadequate documentation, the MCO must follow timeframes set forth in **Chapter 3 of Exhibit C**.

The MCO must have a process in place that allows a Provider to submit a PA or service authorization request for services up to 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 must ensure compensation to individuals or entities conducting UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services, as required by 42 C.F.R. § 438.210(e). The MCO must also ensure that the quality of Covered Services is not adversely impacted by financial and reimbursement-related processes and decisions.

2.6.26.3 CRITERIA FOR DETERMINING MEDICAL NECESSITY

In accordance with 42 C.F.R. § 438.236, the MCO must adopt practice guidelines that meet the following requirements:

1. Are based on evidence-based guidelines or a consensus of providers in the particular field;
2. Consider the needs of the Members;
3. Are adopted in consultation with contracted healthcare professionals; and
4. Are reviewed and updated periodically as appropriate or as requested by HHSC.

The criteria for determining Medically Necessary Covered Services must be no more restrictive than that used in the Medicaid State Plan and **Exhibit** F; and must meet the requirements of the Plan and the amount, duration, and scope of services outlined in **Exhibit F** and **Exhibit E**, including quantitative and non-quantitative treatment limits.

The decisions for medical necessity must be consistent with the practice guidelines adopted by the MCO. The MCO must disseminate the guidelines to all affected Providers and, upon request, to Members.

2.6.26.4 MEDICAL DIRECTOR

Any decision to deny a PA request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician under the direction of the

Medical Director, as defined in **Section 4.04 of Exhibit A**, who has appropriate expertise in addressing the Member's medical, BH, or LTSS needs.

The MCO must ensure that the Medical Director, or his or her designee:

1. Is available by telephone 24 hours a Day, 7 Days a week, for UM determinations;
2. Possesses expertise with BH Services, or has ready access to such expertise to ensure timely and appropriate BH medical decisions for Members, including after regular business hours;
3. Is authorized and empowered to represent the MCO regarding clinical issues, UM, and quality of care inquiries;
4. Exercises independent medical judgment in all decisions relating to the medical necessity;
5. Makes all determinations involving denial or limitation of services in accordance with **Section 2.6.26.5**; and
6. Makes all determinations regarding UM appeals, including appeals of PA denials for outpatient pharmacy benefits.

For purposes of this section, the MCO must ensure that the Medical Director's designee is:

1. A physician that meets the qualifications for a Medical Director; or
2. For PA determinations for outpatient pharmacy benefits, is a Texas-licensed pharmacist working under the direction of the Medical director.

2.6.26.5 Compliance with State and Federal Prior Authorization Requirements

For Medicaid, the MCO must adopt PA requirements that comply with State and federal laws governing authorization of Covered Services and prescription drug benefits, including 42 U.S.C. § 1396r-8 and Tex. Gov't Code §§ 531.073 and 533.005(a)(23). In addition, the MCO must comply with Tex. Hum. Res. Code § 32.073 and Tex. Ins. Code §§ 1217.004 and 1369.304, which require the MCO to use national standards for electronic PA of prescription drug and Covered Services and accept PA requests submitted using TDI's standard form.

In the case of service code, procedure code, or benefit change that affects a current PA issued to a provider, the MCO must provide guidance to the provider holding the PA no less than 45 Days prior to effective date of the change. If the change is a result of a service code, procedure code, or benefit change adopted by HHSC, the MCO must issue notice of the change by the later of:

1. 45 Days prior to the effective date of the change; or
2. Within 10 Business Days of receiving notice of the change from HHSC.

The MCO may choose to reissue PAs or publish guidance to providers on updating current PAs. Such PA information must be sufficient for providers to accurately bill for services. The MCO must establish and document a plan to inform all impacted providers of the changes. The MCO must be able to demonstrate that each impacted provider is notified of the changes within the prescribed timeframe through broadcast messages or individual

notifications. The MCO must provide a copy of the plan and any associated notifications to HHSC upon request.

2.6.27 Special Supplemental Nutrition Program for Women, Infants, and Children

The MCO must, through its Provider 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. 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 described in **Section 2.6.19**.

2.6.28 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 healthcare or NEMT Services rendered prior to the date of the Member's Effective Date of Coverage in that MCO. Medicaid is the payer of last resort for Covered Services, unless an exception applies under federal law or HHSC policy. If a Member is entitled to coverage for specific services payable under another insurance plan and the MCO paid for such Covered Services, the MCO must obtain reimbursement from the responsible insurance entity not to exceed 100 percent of the value of Covered Services paid by the MCO. See Sections, "Third Party Liability and Recovery and Coordination of Benefits," for additional information regarding coordination of benefits and recoveries from third parties. When Medicaid provider rates are increased as a result of a legislative appropriation, MCOs must increase Provider rates as required by HHSC to the extent allowed by federal laws and regulations.

2.6.28.1 Capitation Rate Payment

Refer to **Section 2.8** and **Chapter 6 of Exhibit C** 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.

2.6.28.2 Third Party Liability, Recovery, and Coordination of Benefits

Medicaid is the payer of last resort for Covered Services when coordinating benefits with all other insurance coverage unless an exception applies under federal law or HHSC policy. Coverage provided under Medicaid will pay benefits for Covered Services that remain unpaid after all other insurance coverage has been paid. For providers with written reimbursement arrangements with the MCO, the MCO must pay the unpaid balance for Covered Services up to the agreed rates. For OON 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 OON payment.

The MCO is responsible for establishing and documenting a plan and process, referred to as the "Third Party Liability Managed Care Organization Action Plan (TPL- MCO Action Plan)" in accordance with **Chapter 5 of Exhibit C** 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, MCOs, PBMs, 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 a Member 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.

The MCO must submit the TPL MCO Action Plan to the Office of Inspector General-Third Party Recoveries (OIG-TPR) in accordance with UMCM Chapter 5, no later than September 1 for the upcoming SFY 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 Third-Party Recoveries (TPR) that the MCO is expected to recover may be factored into the Capitation Rate setting process. HHSC will provide the MCO, by plan code, a daily Member file, (also known as a TPR Client Insurance 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 or its designee 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. HHSC's TPR Client Insurance File will be considered the system of record for TPR. The MCO is required to share other insurance information for its enrolled Members with HHSC that differs from or is not included on the HHSC TPR Client Insurance File, in accordance with **Chapter 5 of Exhibit C.**

The MCO must provide financial reports to HHSC, as stated in **Section 2.6.27.1.2**, in accordance with **Chapter 5 of Exhibit C.**

The MCO must provide all TPR reports to OIG-TPR at the frequency stated in and in accordance with **Chapter 5 of Exhibit C.**

MCOs must communicate to liable third parties their responsibilities under Texas Human Resources Code §32.0424, to include:

1. responding to an MCO inquiry within 60 Days regarding a claim for payment for Covered Services submitted to the liable third party no later than the third anniversary after the date the Covered Services were provided;
2. except as provided in §32.0424(b-2), accepting authorization from the MCO for Covered Services that require prior authorization and were previously paid by the

MCO as if the MCO's authorization is a prior authorization made by the liable third party for Covered Services; and

3. the prohibition of denying a claim submitted by the MCO for which payment was made solely on the basis of:
    a. the date of submission of the claim;
    b. the type or format of the claim form;
    c. a failure to present proper documentation at the point of service that is the basis of the claim; or
    d. except as provided in §32.0424(b-2), a failure to obtain prior authorization for Covered Services.

The prohibition on denying a claim under this subsection is limited to claims submitted by the MCO no later than the third anniversary of the date the Covered Services were provided and any action by the MCO to enforce HHSC's right to the claim is commenced not later than the sixth anniversary of the date the MCO submits the claim.

The MCO has 120 Days from the date of adjudication of a claim that is subject to TPR to attempt recovery of the costs for services that should have been paid through a third party. The MCO must obtain recovery of payment from a liable third party and not from the Provider unless the Provider received payment from both the MCO and the liable third party.

The MCO must provide to HHSC, by the 10th Day of each month, a report indicating the claims for which the MCO has billed and/or made a recovery up to the 120th Day from adjudication of a claim that is subject to TPR. After 120 Days, HHSC will attempt recovery for any claims in which the MCO did not attempt recovery and will retain, in full, all funds received as a result of any HHSC-initiated TPR. The MCO is precluded from attempting to bill for any recovery after 120 Days from claim adjudication date. Any collections by the MCO billed after 120 Days from the claim adjudication date must be sent to OIG-TPR in the format described in **Chapter 5 of Exhibit C**. The MCOs must 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 **Chapter 5 of Exhibit C**.

HHSC retains the responsibility to pursue, collect, and retain recoveries of all resources and insurances other than health insurance wherein payments have been made on behalf of a Member. These resources and other insurances include, but are not limited to: casualty insurance, liability insurance, estates, child support, and personal injury claims. The MCO must pay valid claims for Covered Services provided to MCO Members who have, or may have, resources and insurance other than health insurance. Since HHSC retains the right of recovery for such resources and insurances other than health insurance, the MCO is not permitted to cost avoid or seek recovery for such items. Should the MCO receive payment

on a claim in which resources or insurances other than health insurance are utilized, the MCO must send the payment to OIG-TPR in the format prescribed in Chapter 5 of Exhibit C. Members with these other resources shall remain enrolled in the MCO.

Nothing in this section authorizes MCO to proceed with litigation or file suit on behalf of or in the name of HHSC or the State.

2.6.29 REPORTING REQUIREMENTS

The following sections provide reporting requirements required of the MCO.

2.6.29.1 GENERAL REPORTING REQUIREMENTS

The MCO must provide and must require its Material 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 as reasonably requested by the HHSC;
2. Any information in its possession sufficient to permit HHSC to comply with the Federal Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997), or other federal or State laws, rules, and regulations; and
3. Ad hoc reports requested by HHSC.

All information must be provided in accordance with the timelines, definitions, formats, and instructions as specified by HHSC. Where practicable, HHSC may consult with MCOs to establish time frames and formats reasonably acceptable to both parties.

The MCO must provide the reports specified in **Chapter 5 of Exhibit C.** This chapter includes a list of required reports, and a description of the format, content, file layout, and submission deadlines for each report.

Any Deliverable or report not listed in **Chapter 5 of Exhibit C** but referenced in the Contract 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 the financial data, Encounter Data, and other measurement data has been reviewed and is true and accurate to the best of the certifying person's knowledge. Such certification may not be delegated.

2.6.29.2 MANAGED CARE ORGANIZATION DELIVERABLES RELATED TO MANAGEMENT INFORMATION SYSTEM REQUIREMENTS

The MCO must comply with all applicable JIPs, as modified or amended, and all required file submissions for HHSC or its designee, EB, EQRO, or other business partners. The JIPs

are posted in a centralized secure file transfer site designated by HHSC. See **Chapter 7 of Exhibit C**.

The MCO must submit plans and checklists related to MIS to HHSC according to the format and schedule identified in the **Chapter 5 of Exhibit C.** Additionally, if a systems Readiness Review is triggered by one of the events described in **Section 2.6.30**, the MCO must submit all of the plans referenced in **Chapter 5 of Exhibit C**, in accordance with an HHSC approved timeline.

2.6.29.3 ACCOUNTING AND REPORTING REQUIREMENTS

The MCO's accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with FAR, Generally Accepted Accounting Principles (GAAP), **Section 2.8**, and the cost principles contained in HHSC's Cost Principles document in **Chapter 6 of Exhibit C.** If HHSC guidelines, rules, regulations, and provisions of this SOW are in conflict with GAAP, HHSC guidelines, rules, regulations or provisions, then FAR will prevail. HHSC 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 the Contract separate and apart from other corporate accounting records;
2. Maintain records for all claims payments, refunds, and adjustment payments to Providers and OON providers, Capitation Payments, interest income, and payments for Administrative Services or functions, and must maintain separate records for medical and administrative fees, charges, and payments;
3. Ensure and provide access to HHSC and/or its auditors or agents to the detailed records and supporting documentation for all costs incurred by the MCO. The MCO must ensure such access to its Subcontractors, including Affiliates, for any costs billed to or passed to the MCO with respect to an MCO Program; and
4. 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.

The MCO will reimburse HHSC if reimbursement is sought from the MCO 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 "agreed upon procedures" are at HHSC's sole discretion.

2.6.29.3.1 GENERAL ACCESS TO ACCOUNTING RECORDS

The MCO must provide authorized representatives of the State and federal governments full access to all financial records, subcontracts, and accounting records related to the performance of the Contract. See **Article 8 of Exhibit A** for additional requirements.

The MCO and its subcontracted Affiliates 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. Such access is guaranteed at all times during the performance and retention period of the Contract, and will include both announced and unannounced inspections, on-site audits, and the review, analysis, and reproduction of reports produced by the MCO.
3. Make copies, at no cost to HHSC, of any accounting records or supporting documentation relevant to the Contract, including Provider Contracts, available to State and federal governments or their agents within seven Business Days, or as otherwise specified, of receiving a written request for specified records or information. If such documentation is not made available as requested, the MCO must reimburse the requesting party 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 of such accounting records.
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. Failure to provide such required documentation and information in a timely manner may be deemed to be a material breach of the Contract.

2.6.29.3.2 FINANCIAL REPORTING REQUIREMENTS

At HHSC's request and pursuant to the Contract, the MCO must provide financial reports by MCO Program and SA to support Contract monitoring as well as State and federal reporting requirements. All financial information and reports submitted by the MCO become property of HHSC. HHSC may, at its discretion, release such information and reports to the public at any time and without notice to the MCO. In accordance with State and federal laws regarding Member confidentiality, HHSC will not release any Member-identifying information contained in such reports.

Any required data submitted by the MCO in a Portable Document Format (PDF) must be in a text-searchable version. Joint Photographic Experts Group (JPEG) and Graphics Interchange Format (GIF) formats are not permitted. All data submitted by the MCO must be text-searchable. Where expressly permitted by HHSC, signature pages may be submitted in a non-text-searchable format.

The MCO must submit all applicable required financial reports as detailed in **Chapter 5.3 of Exhibit C,** and the Contract using the templates in **Chapter 5 of Exhibit C.**

2.6.30 MANAGEMENT INFORMATION SYSTEM REQUIREMENTS

The MCO must maintain a MIS and subsystems, located in the United States, including the hardware, Software, network, interfaces, and communications systems with the capability

and capacity to support the following list of operational and administrative areas for the performance of the Services and Deliverables. If the MCO subcontracts a MIS function, the MCO must ensure that the Subcontractor's MIS complies with the requirements of this section.

1. Eligibility management;
2. Enrollment management;
3. Provider management;
4. Member management;
5. PA processing;
6. Claims processing;
7. Encounters processing;
8. Financial processing;
9. Telephony management;
10. UM;
11. Quality management;
12. TPR management;
13. Deliverables management;
14. Audit function management; and
15. Ad hoc and standard reporting management.

The MCO's MIS must meet the Contract requirements, including all applicable State and federal laws, rules, regulations, standards, and guidelines. The MIS must have the capacity and capability to capture and utilize various data elements required for MCO administration.

HHSC will provide the MCO with pharmacy data on the MCO's Members on a weekly basis through the HHSC Vendor Drug Program (VDP) or, should these services be outsourced, through a designee of HHSC. HHSC will provide a sample format of pharmacy data to Contract awardees.

The MCO must have a MIS that can be adapted to changes in business practices or policies within the timeframes negotiated by the Parties. The MCO is required to cover the cost of such MIS modifications through the Contract Term.

The 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). The MCO must validate addresses to the master Provider file provided by HHSC through the Provider Enrollment and Management System (PEMS).

The MCO must ensure the MIS interfaces with HHSC LTSS screener system.

The MCO must provide HHSC's staff prior written notice via email of Major Systems Changes to its MIS 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 the Contract and **Section 4.08 of Exhibit A.**

The notification must detail the following:

1. The aspects of the MIS that will be changed and date of implementation;
2. How these changes will affect the Provider and Member community, if applicable
3. The communication channels that will be used to notify these communities, if applicable;
4. A detailed implementation plan and schedule of proposed changes; and
5. A contingency plan in the event of downtime of the MIS or substantial non-performance of the system.

These Major Systems Changes are subject to HHSC desk review and onsite review of the MCO's facilities as determined by HHSC and as specified in **Section 2.6.3**, to test readiness and functionality prior to implementation. If HHSC notifies the MCO that a desk and/or onsite review is required, HHSC-approval must be received of the Major Systems Change prior to implementation of the changes to its MIS or supporting systems. HHSC has sole discretion to modify or waive the notification requirement.

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 approved change. The MCO must provide HHSC with the names of official points of contact for MIS issues on an ongoing basis.

Additionally, the MCO's MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan.

The MCO is required to participate in work groups and regular calls related to MIS and convened by HHSC.

In accordance with **Chapter 16 of Exhibit C**, the MCO must share and integrate service authorization data among all relevant MCO employees, including both physical and BH staff, or, if applicable, between the MCO and the BHO.

2.6.30.1 SYSTEM-WIDE FUNCTIONS

The MCO's MIS must include the following key business processing functions and features, which must apply across all subsystems:

1. Process secure electronic data transmission or media to add, delete, or modify Member records with accurate begin and end dates;
2. Track Covered Services received by Members through the MIS and accurately and fully maintain those Covered Services as HIPAA compliant Encounter Data transactions;
3. Transmit or transfer Encounter Data transactions on electronic media in the HIPAA format to HHSC or its designee 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 an MIS or subsystem failure;
6. Employ industry standard medical billing taxonomies, procedure codes, and diagnosis codes, to describe services delivered and Encounter Data transactions produced;

7. Accommodate the coordination of benefits;
8. Produce standard Explanation of Benefits (EOBs);
9. Pay financial transactions to Providers in compliance with federal and State laws, rules, and regulations;
10. Ensure that all financial transactions are auditable according to GAAP guidelines;
11. Ensure that FSRs comply with **Chapter 6 of Exhibit C**, with respect to segregating costs that are allowable for inclusion in HHSC-designed financial reports;
12. Relate and extract data elements to produce report formats in **Chapter 5 of Exhibit C**, or as required by HHSC;
13. Ensure that written processes and procedures manuals document and describe all manual and automated system procedures and processes for the MIS;
14. Maintain and cross-reference all Member-related information with the most current Medicaid Provider number; and
15. Ensure that the MIS is able to integrate pharmacy data from HHSC's VDP files, available through the Virtual Private Network (VPN), into the MCO's Member data.

2.6.30.2 ENCOUNTER DATA

The MCO must provide complete and accurate Encounter Data that reflects information received on claims for all Covered Services, including VAS. The MCO must submit Encounter Data in accordance with:

1. The requirements in 42 C.F.R. §§ 438.242, and 438.818; and
2. The format and data elements as described in the most current version of HIPAA-compliant 837 Companion Guides, NCPDP format for pharmacy, and Encounters Submission Guidelines.

The MCO must adhere to the method of transmission, the submission schedule, and any other requirements specified in the **Chapter 5 Exhibit C.** The MCO must submit Encounter Data transmissions monthly and include all Encounter Data and Encounter Data adjustments processed by the MCO within the preceding month. The MCO must ensure that HHSC receives complete and accurate Encounter Data no later than 30 Days after the month in which the claim was Adjudicated. The MCO must submit pharmacy Encounter Data no later than 25 Days after the date of adjudication and include all Encounter Data and Encounter Data adjustments processed by the MCO.

For reporting Encounter Data 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 obtained from the master Provider file or as directed by HHSC for Encounter Data submissions.

The MCO must ensure Encounter Data quality validation incorporates assessment standards developed jointly by the MCO and HHSC. The MCO must make original records and data available for inspection by HHSC for validation purposes upon HHSC request. The MCO must correct and resubmit Encounter Data that does not meet quality standards within a time period specified by HHSC.

At HHSC's request, the MCO must submit an Encounter Data file to HHSC's EQRO, in the format provided in **Chapter 5 of Exhibit C.**

2.6.30.3 CLAIMS PROCESSING REQUIREMENTS

The MCO must administer an effective, accurate, and efficient claims payment process in compliance with State and federal laws, rules, and regulations, and the Contract, including the claims processing procedures contained in **Chapter 2 of Exhibit C.** The MCO must process and Adjudicate all claims for Covered Services that are filed within the time frames specified in **Chapter 2 of Exhibit C,** pharmacy claims that are filed in accordance with the timeframes specified in **Chapter 2 of Exhibit C,** and NF claims that are filed in accordance with the timeframes specified in **Chapter 2 of Exhibit C.**

The MCO must employ a fully automated claims processing system where a minimum of 60 percent (60%) of claims are auto-adjudicated (adjudicated with no manual intervention). If the MCO is not able to achieve these performance standard, it must submit a plan and corresponding timeline for HHSC review and approval that improves the MCO's claims processing system to a level that achieves the standards. The MCO must maintain and follow the HHSC-approved plan and corresponding timeline.

The claims processing system must:

1. Register the date a claim is received by the MCO;
2. Register the detail of each claim transaction or action, including date of service, at the time the transaction occurs;
3. Have the capability to report each claim transaction by date and type to include interest payments;
4. Maintain information at the claim and line detail level;
5. Maintain adequate audit trails;
6. Report accurate claims performance measures to HHSC; and
7. Maintain online and archived files.

The MCO must keep online automated claims payment history for the most current 18 months. The MCO must keep online automated NF 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 **Section 8.01 of Exhibit A.** The MCO must ensure all claims data can be easily sorted and are produced in formats as requested by HHSC. Claim transactions for pharmacy services must be in the NCPDP B1/B2 formats and all claim transactions must be in the 837/835 format.

2.6.30.3.1 ELECTRONIC DATA INTERCHANGE

The MCO must offer its Providers and Subcontractors the option of submitting and receiving claims information through a HIPAA compliant Electronic Data Interchange (EDI) that allows for automated processing and adjudication of claims. The MCO must offer EDI processing as an alternative to the filing of paper claims. The MCO 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, pt. 1, ch. 21, subchs. C and T.

HHSC may require the MCO to receive initial electronic claims through an HHSC-contracted vendor. The MCO must allow Providers to send claims to this vendor who will then redirect the claims to the appropriate payor. The MCO's interface must allow receipt of these electronic submissions. The MCO must provide and maintain a system to receive claims from an HHSC designated claims portal. The MCO must allow Providers to send claims directly to the MCO or its Subcontractor.

The MCO must be able to receive, load, and read Enrollment Files received from HHSC in the 834 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 format.

The MCO must make any policies affecting claims adjudication and claims coding and processing guidelines available to Providers for the applicable provider type. MCOs must notify Providers within 90 Days of changes to these claims policies and guidelines.

2.6.31 FRAUD, WASTE, AND ABUSE

An MCO is subject to all State and federal laws and regulations relating to FWA in health care and the Medicaid and CHIP 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 FWA.

1. The MCO is subject to and must meet all requirements in Tex. Gov't Code §§ 531.113, 531.1131, and 533.012 and 1 Tex. Admin. Code pt. 15, ch. 353, subch F, ch. 370, subch. F as well as all laws specified in the Contract.
2. The MCO must submit a written Fraud, Waste, and Abuse compliance plan to HHSC OIG for approval each year per 1 Texas Admin. Code 353.502. The plan must be submitted 90 Days prior to the start of the State Fiscal Year. See Section 7, "Transition Phase Requirements" for requirements regarding timeframes for submitting the original plan
3. The MCO must require all employees who process Medicaid claims, including Subcontractors, to attend annual training as provided by HHSC per Tex. Gov't Code § 531.105.
4. The MCO must perform pre-payment review for identified providers as directed by HHSC OIG.
5. When requested by the HHSC OIG, the MCO will be required to provide employees to participate in administrative proceedings or other judicial proceedings pursued by the HHSC OIG. Such employees must be knowledgeable about the subject matter on which they are 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.
6. For the purposes of NF and Hospital Utilization Reviews, **Section 2.6.31.4** also applies to HHSC requests.
7. With regard to NEMT Services, when monitoring for FWA, the MCO must consider whether appropriate medical documentation supports use of:

a. Other demand response transportation services in areas where public transportation services are an available option; and
b. Transportation to obtain care outside of the Member's SA.

8. Failure to comply with any requirement of this section and **Section 2.6.29.1** may subject the MCO to liquidated damages and/or administrative enforcement pursuant to 1 Tex. Admin. Code pt. 15, ch. 371, subch. G, in addition to any other legal remedy available by law to HHSC or HHSC OIG.

2.6.31.1 SPECIAL INVESTIGATIVE UNITS

In order to facilitate cooperation with HHSC OIG, the MCO must establish and maintain a SIU, either in-house or by contract with another entity, to investigate possible acts of FWA 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 pt. 15, ch. 353, subch. F and ch. 370, subch. F.
2. The MCO must maintain a full-time SIU manager dedicated solely to the Texas Medicaid program to direct oversight of the SIU and FWA activities.
3. The MCO SIU must employ or Subcontract, at minimum, one full-time investigator, in addition to the SIU manager, who is dedicated solely to the services provided under the Contract. The investigator must hold credentials such as certification from the Association of Certified Fraud Examiners, an accreditation from the National Health Care Anti-Fraud Association, or have a minimum of three years Medicaid or CHIP FWA investigatory experience.

2.6.31.2 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), Federal Bureau of Investigation, the Office of the Texas Attorney General, TDI, or other units of State government.

1. Each MCO must designate one primary and one secondary contact person for all HHSC OIG records requests. Each MCO must also identify a central group email inbox that will receive all HHSC OIG records requests. HHSC OIG records requests will be sent to the central group email inbox and also may be sent to the designated MCO contact person(s) in writing by e-mail, fax, or mail, and will provide the specifics of the information being requested (see below).

2. The MCO must respond to the appropriate HHSC OIG staff member within the timeframe designated in the request. If the MCO is unable to provide all of the requested information within the designated timeframe, the MCO may request an extension in writing (e-mail) to the HHSC OIG requestor no less than two Business Days prior to the due date.
3. The MCO's response must include 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 **Chapter 18 of Exhibit C**.

The most common requests include, but are not limited to:

1. 1099 data and other financial information – three Business Days;
2. Claims data for sampling and recipient investigations – ten Business Days;
3. Urgent claims data requests – three Business Days (with HHSC OIG manager's approval);
4. Provider education information – ten Business Days;
5. Files associated with an investigation conducted by an MCO – 15 Business Days;
6. Provider profile, UR summary reports, and associated provider education activities and outcomes – as indicated in the request;
7. Member and/or pharmacy data as required by HHSC OIG;
8. Requests submitted to the MCO/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, VAS, and CCP services provided through THSteps – as needed; and
10. Other time sensitive requests – as needed.

2.6.31.3 CLAIMS DATA SUBMISSION REQUIREMENTS

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.

1. The MCO and its Subcontractors shall comply with industry-accepted Clean Claim standards for all data submissions to HHSC OIG, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper Adjudication of all paid and denied claims. In the event

that the MCO or its Subcontractors denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the MCO and its Subcontractors are required to submit all available claims data, for such denied claims, to HHSC OIG without alteration or omission;

2. The MCO and its Subcontractors shall submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by HHSC OIG, in order to support comprehensive financial reporting, utilization analysis, and investigative efforts;
3. The MCO and its Subcontractors shall submit processed claims data according to standards and formats as defined by HHSC OIG, complying with standard code sets, and maintaining integrity with all reference data sources including provider and Member data. All data submissions by the MCO and its Subcontractors will be subjected to systematic data quality edits and audits on submission to verify not only the data content, but also the accuracy of claims processing;
4. Any batch submission from an MCO or its Subcontractors which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the MCO and its Subcontractors for immediate correction. Re-submittals of rejected files, or notification of when the file will be resubmitted shall be completed within five Business Days. Due to the need for timely data and to maintain integrity of processing sequence, should the MCO or its Subcontractors fail to respond in accordance with this section, the MCO and its Subcontractors shall address any issues that prevent processing of a claims batch in accordance with procedures specified and defined by HHSC OIG:
5. The MCO and its Subcontractors shall supply 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 its plan; and
6. 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 pt. 15, ch. 371, subch. G or liquidated damages as specified in **Exhibit C**.

2.6.31.4 PAYMENT HOLDS AND SETTLEMENTS

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 Provider is under investigation based upon credible allegations of Fraud, depending on the allegations at issue.

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 of receipt of the HHSC OIG notice. 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.

The MCO must also report all of the following information to HHSC OIG after it suspends payments to the Provider:

1. Date the suspension was imposed;
2. Date the suspension was discontinued;
3. Reason for discontinuing the suspension;
4. Outcome of any appeals;
5. Amount of Adjudicated Medicaid payments held, and, if applicable;
6. 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 **Chapter 5 of Exhibit C** and provide this information to HHSC OIG upon request.

The MCO must follow the requirements set forth in any settlement agreement involving an MCO's Provider and HHSC OIG. The MCO must withhold the designated percentage of funds to be paid toward an identified overpayment. Upon HHSC OIG request, the MCO must forward the held funds to HHSC OIG, Attn: Senior Case Analyst.

For payment suspensions initiated by the MCO, the MCO must report the following information to HHSC OIG:

1. The nature of the suspected Fraud;
2. Basis for the suspension;
3. Date the suspension was imposed;
4. Date the suspension was discontinued;
5. Reason for discontinuing the suspension;
6. Outcome of any appeals;
7. The amount of payments held;
8. The percentage of the hold, and, if applicable;
9. The good cause rationale for imposing a partial payment suspension.

MCOs must maintain all documents and claims 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 **Section 2.6.31** and all State and federal laws and regulations relating to FWA in healthcare and the Medicaid and CHIP programs are subject to administrative enforcement by HHSC OIG as specified in 1 Tex. Admin. Code pt. 15, ch. 371, subch. G.

2.6.31.5 TREATMENT OF RECOVERIES BY THE MCO FOR FRAUD, WASTE AND ABUSE

The MCO must comply with all State and federal laws pertaining to Overpayment recoveries from Providers and procedures to detect and prevent FWA, including, but not limited to, 42 C.F.R. § 438.608(d) and Tex. Gov't 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 FWA. The MCO must comply with the requirements of 1 Tex. Admin. Code § 353.1454.

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.

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, 31 U.S.C. §§ 3729-3733, Texas Medicaid Fraud Prevention Act, Tex. Hum. Res. Code ch. 36, or similar laws. The recovery of an Overpayment by an MCO from a provider does not preclude the prosecution of non-recovery from a provider under the Federal False Claims Act, Texas Medicaid Fraud Prevention Act, or similar laws.

Upon discovery of FWA the MCO shall:

1. Submit a referral using the Fraud referral form through the Waste, Abuse, and Fraud Electronic Reporting System (WAFERS); and
2. Proceed with recovery efforts per 1 Tex. Admin. Code § 353.505.

The MCO may retain recovery amounts pursuant to Tex. Gov't Code § 531.1131(c) and (c-1).

Pursuant to Tex. Gov't 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:

1. 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;
    a. 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.
    b. 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;
2. The improperly paid funds have already been recovered by HHSC OIG.

The MCO must report at least annually, or at the request of the HHSC OIG, the status of its recoveries of overpayments in the manner specified by the HHSC OIG.

2.6.31.6 FALSE CLAIMS ACT AND WHISTLEBLOWING

In accordance with 42 U.S.C. § 1396a(a)(68), an MCO that receives or makes 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, that 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 statements, and whistleblower protections under such laws, as described in 42 U.S.C. § 1396a(a)(68)(A);
2. Include in the MCO's or Subcontractor's written policies detailed provisions regarding the MCO's or Subcontractor's policies and procedures for detecting and preventing FWA; and
3. Include in any employee handbook, a specific discussion of the laws described in 42 U.S.C. § 1396a(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 FWA.

2.6.31.7 LOCK IN ACTIONS

The 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-LP and the MCO's policies and procedures about overutilization of prescription medications, including how NEMT Services are delivered to Members subject to the OIG-LP. The MCO must submit documentation on an annual basis demonstrating how the MCO complies with HHSC OIG-LP policies and procedure requirements. The MCO must submit the information 90 Days prior to the start of each SFY in conjunction with its FWA compliance plan, see **Section 2.6.31**.

2.6.32 COMPLAINTS AND MANAGED CARE ORGANIZATION INTERNAL APPEALS FOR PROVIDERS

The following sections outline minimum requirements for the Complaints and MCO Internal Appeals process for Providers. The MCO must provide information, including the information specified in 42 C.F.R. § 438.10(g)(2)(xi), about the MCO Internal Appeal and Complaint System to all Providers and Material Subcontractors at the time they enter into a contract with the MCO. This process must be reviewed and approved in writing by HHSC or its designee. This section (and its subsections) applies to NEMT Services providers unless stated otherwise.

2.6.33 PROVIDER COMPLAINTS

The MCO must develop, implement, and maintain a system for tracking and resolving all provider Complaints. The MCO's tracking system must include the status and final disposition of each provider Complaint.

The MCO must resolve 98% of provider Complaints within 30 Days from the date the Complaint is received.

The MCO must also resolve provider Complaints received by HHSC in accordance with **Chapter 3 of Exhibit C.**

2.6.33.1 PROVIDER APPEAL OF MANAGED CARE ORGANIZATION CLAIMS DETERMINATIONS

The MCO must develop, implement, and maintain a system for tracking and resolving all provider claims payment appeals, as required by Tex. Gov't Code § 533.005(a)(15). Within this process, the MCO must respond fully and completely to each Provider's claims payment appeal and:

1. Establish a tracking mechanism to document the status and final disposition of each Provider's claims payment appeal;
2. Provide written notice to the Provider of the outcome of the appeal; and
3. Allow LTSS providers to appeal claims that the MCO has not paid or denied by the 31st Day following receipt of the claim.

In addition, the MCO's process must comply with the requirements of Tex. Gov't Code § 533.005(a)(19).

The MCO must resolve 98% of provider claims payment appeals within 30 Days from the date the appeal is received.

The MCO must enter into agreements with OON physicians to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeals. The physician resolving the dispute must not be an employee of the MCO's Medicaid, CHIP, or Medicare lines of business; but may be an employee in the MCO's commercial lines of business. The MCO must ensure the determination of the physician resolving the dispute must be binding on the MCO and the provider. The MCO must ensure the physician resolving the dispute is licensed to practice medicine in the State of Texas and holds the same specialty or a related specialty as the appealing provider. If required by HHSC, the MCO must submit to and comply with the decision of an independent review process established by HHSC for final determination on these disputes.

2.6.34 MEMBER COMPLAINT AND APPEAL SYSTEM

The MCO must develop, implement, and maintain a system for tracking, resolving, and reporting all Member Complaints and MCO Internal Appeals regarding its services, processes, procedures, staff, and the denial or limited authorization of a requested service. This requirement includes tracking, resolving, and reporting the type or level of service

and the denial, in whole or in part, of payment for services. The system must comply with the requirements in applicable federal and State laws and regulations, including 42 C.F.R. pt. 431, subpt. E, and pt. 438, subpt. F and the provisions of 1 Tex. Admin. Code pt. 15, ch. 357 relating to the STAR+PLUS MCO. For the purposes of this section, Member communications meeting the definition of a Complaint must not be categorized by the MCO as any form of Inquiry or request. 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.

The Complaint and MCO Internal Appeal process must include a Complaint process, an appeal process, and access to the HHSC's EMR and the 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.

The MCO must accept Complaints or appeals filed by Providers and Caregivers on behalf of a Member if authorized by the Member or Member's LAR.

The MCO must ensure that 98% of Member Complaints are resolved within 30 Days from the date the Complaint is received by the MCO. HHSC will refer Member Complaints that it receives to the MCO for resolution.

The MCO must resolve Member Complaints received by HHSC no later than the due date indicated on HHSC's notification form. HHSC will provide MCOs up to 10 Business Days to resolve such Complaints, depending on the severity and urgency of the Complaint and no more than the maximum Days allowed as stated in **Chapter 3** of **Exhibit C**. The MCO may seek an extension to the 10 Business Days from HHSC and provide a valid reason for the extension. The request must include the requirements in **Chapter 3** of **Exhibit C**. HHSC may, in its reasonable discretion, grant a written extension if the MCO demonstrates good cause.

The MCO must ensure that standard MCO Internal Appeals, and Expedited MCO Internal 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 must respond fully and completely to each Expedited MCO Internal Appeal and establish a tracking mechanism to document the status and final disposition of each such appeal.

The MCO must designate an officer of the MCO who has primary responsibility for ensuring that Complaints are resolved in compliance with written policy and within the required timeframe. For purposes of this section, an officer of the MCO means a president, vice president, secretary, treasurer, or chairperson of the board for a corporation, the sole proprietor, the managing general partner of a partnership, or a person having similar executive authority in the organization.

The MCO must have a routine process to detect patterns of Complaints. The MCO's 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 all Prevalent Languages identified by HHSC, at no more than a sixth-grade reading level.

The MCO must include a written description of the Complaint process in the Member handbook. The MCO must maintain and publish in the Member handbook at least one toll-free telephone number with TTY/TDD and interpreter capabilities for making Complaints. The MCO must provide such oral interpretive service to callers free of charge.

The MCO's process must require that every Complaint received in-person, by telephone, or in writing, be acknowledged and recorded in a written record and logged with the following details:

1. A description of the reason for the Complaint;
2. The date received;
3. The date of each review or, if applicable, review meeting;
4. Resolution at each level of the Complaint, if applicable;
5. Date of resolution at each level, if applicable; and
6. Name of the Member for whom the Complaint was filed.

In accordance with 42 C.F.R. § 438.416, the MCO must accurately maintain the records in a manner accessible to HHSC and available upon HHSC's request.

For Complaints that are received in-person or by telephone, the MCO must provide Members or his or her Authorized Representative, LAR, or guardian with written notice of resolution if the Complaint cannot be resolved within one Business Day of receipt. As TDI does not require the reporting of issues described in 28 Tex. Admin. Code pt. 1, ch. 3, subch. KK, § 3.9202(2)), the MCO must 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 filing a Complaint.

The MCO must cooperate with HHSC to resolve all Member Complaints. Such cooperation may include providing information or assistance to HHSC Complaint staff at no cost to HHSC.

The MCO must provide designated Member Advocates, as described in **Section 2.6.19.4**, to assist Members in understanding and using the MCO's Complaint system. The MCO's Member Advocates must assist Members in writing or filing a Complaint and monitoring the Complaint through the MCO's Complaint process until the issue is resolved.

2.6.34.1 MANAGED CARE ORGANIZATION INTERNAL APPEAL PROCESS FOR MEMBERS

The MCO must develop, implement, and maintain an MCO Internal Appeal procedure that complies with State and federal laws and regulations, including 42 C.F.R. pt. 431, subpt. E and pt. 438, subpt. F, as well as comply with provisions of Tex. Ins. Code chs. 843 and 4201, except as set forth herein. The MCO Internal Appeal procedure must be the same for all Members. When a Member or his or her Authorized Representative, LAR, or guardian

expresses orally or in writing any dissatisfaction or disagreement with an Adverse Benefit Determination, the MCO must regard the expression of dissatisfaction or disagreement as a request to appeal an Adverse Benefit Determination.

The provisions of Tex. Ins. Code ch. 4201, relating to an appeal to an IRO, do not apply to a Medicaid recipient. HHSC uses the EMR process provided in 42 C.F.R. § 438.408(f)(1)(ii).

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 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 MCO Internal Appeal as provided in **Section 2.6.34.2**, the MCO must complete the entire standard appeal process within 30 Days after receipt of the initial written or oral request for MCO Internal Appeal. The timeframe for an MCO Internal Appeal may be extended up to 14 Days if the Member or Member's LAR 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 Member did not request an extension, the MCO must provide the Member written notification as to why the MCO needs additional time.

The MCO must have policies and procedures in place outlining the Medical Director's role in the MCO Internal Appeal process. The Medical Director must have a significant role in monitoring, investigating, and hearing MCO Internal 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, nor a subordinate of any such individual, 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 2.6.19.4** to assist Members and their LARs in understanding and using the MCO Internal Appeal process. The MCO's Member Advocates must assist Members in writing or filing an MCO Internal Appeal and monitoring the MCO Internal Appeal through the MCO's Internal 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 such oral interpretive service to callers free of charge.

The MCO's process must treat every oral request for an MCO Internal Appeal in the same manner as a written request. 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 appeals or grievance.
2. The date received.
3. The date of each review or, if applicable, review meeting.
4. Resolution at each level of the MCO appeal or grievance, if applicable.
5. Date of resolution at each level, if applicable.
6. Name of the covered person form whom the MCO appeal or grievance was filed.

The records must be accurately maintained in a manner accessible to the state and available upon request to CMS.

During the MCO Internal Appeal process, the MCO must provide the Member and Member's LAR 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 and Member's LAR 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 Member's LAR the opportunity, before and during the MCO Internal Appeal process, to examine the Member's case file, including medical records and any other documents considered during the MCO Internal Appeal process. The MCO must include, as parties to the MCO Internal Appeal, the Member and Member's LAR or the legal representative of a deceased Member's estate.

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 MCO Internal Appeal, if all of the following criteria are met:

1. The Member or Member's LAR, as applicable, files the MCO Internal Appeal in a timely manner, as defined in the Contract and in accordance with 42 C.F.R. §§ 438.402(c)(1)(ii) and (c)(2)(ii);
2. The appeal involves the termination, suspension, or reduction of a previously authorized service;
3. The Covered Services were ordered by an authorized Provider;
4. The original period covered by the original authorization has not expired; and
5. The Member or Member's LAR timely requests an extension of the benefits.

If, at the Member's or Member's LAR's request, the MCO continues or reinstates the Member's benefits while the MCO Internal Appeal is pending, the benefits must be continued until one of the following occurs:

1. The Member or Member's LAR withdraws the MCO Internal Appeal or request for State Fair Hearing;
2. Ten Days pass after the MCO mails the notice resolving the MCO Internal Appeal against the Member, unless the Member, within the ten-Day timeframe, has

requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is issued; or

3. A State Fair Hearing officer issues a hearing decision adverse to the Member or the time period or service limits of a previously authorized service have been met.

In accordance with State and federal regulations, if the final resolution of the MCO Internal 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 such costs from the Member without written permission 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 Internal 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 MCO Internal 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 PA 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 appealing an Adverse Benefit Determination.

2.6.34.2 EXPEDITED MANAGED CARE ORGANIZATION INTERNAL APPEALS

In accordance with 42 C.F.R. § 438.410, the MCO must establish and maintain an expedited review process for MCO Internal Appeals, when the MCO determines a request from a Member or Member's LAR or the Provider indicates (in making the request on the Member's behalf or supporting the Member's or Member's LAR's request) that taking the time for a standard resolution could jeopardize the Member's life or health, or ability to attain, maintain, or regain maximum function. The MCO must follow all requirements for the MCO Internal Appeals as set forth in **Section 2.6.34.1**, except where differences are specifically noted herein. The MCO must accept oral or written requests for Expedited MCO Internal Appeals. An MCO must provide the Member and Member's LAR access to the Member's case file, free of charge, and in a timeframe that aligns with an Expedited MCO Internal Appeal process.

In instances where a Provider indicates, or the MCO determines, that the standard timeframe may jeopardize the Member's life or health, or ability to attain, maintain, or regain maximum function, the MCO must approve, modify, or deny a provider's PA or concurrent request for Covered Services, and send the appropriate notice of the Adverse Benefit Determination, in a timeframe which is appropriate for the nature of the Member's

condition. However, in no circumstance can such be more than 72 hours from the receipt of the request, except where the MCO must complete the investigation and resolution of an MCO Internal 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 Expedited MCO Internal Appeal relating to an ongoing emergency or denial of continued hospitalization, the timeframe for notifying the Member and Member's LAR of the outcome of the Expedited MCO Internal Appeal may be extended up to 14 Days if the Member or Member's LAR 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 and Member's LAR written notice of the reason for delay if the Member or Member's LAR did not request the delay.

If the decision is adverse to the Member, the MCO must follow the procedures relating to the notice in **Section 2.6.34.7**. The MCO is responsible for notifying the Member, and Member's LAR 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 HHSC, the Member and the Member's LAR indicating how the decision was made, prior to HHSC's expedited State Fair Hearing and/or EMR. If the MCO fails to render a decision within the required timeframe, the Member is deemed to have exhausted the Expedited MCO Internal Appeals process. The Member may initiate a State Fair Hearing.

The MCO is prohibited from discriminating or taking punitive action against a Member or Member's LAR 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 or Member's LAR'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.

2.6.34.3 ACCESS TO STATE FAIR HEARING AND EXTERNAL MEDICAL REVIEW (EMR) FOR MEDICAID MEMBERS

The MCO must inform Members and Members' LARs that, after exhausting the MCO Internal Appeal process, they can access the State Fair Hearing process, with or without an EMR. 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(f). 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 MCO must provide the IRO the same set of records the MCO reviewed to determine service denial. EMRs will be conducted by 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 is responsible for notifying the provider of the EMR decision within timeframes specified by HHSC.

If a Member requests a State Fair Hearing, the MCO will complete and submit the request via the Texas Integrated Eligibility Redesign System (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 enter the request into TIERS, along with MCO Internal Appeal decision supporting documentation, and submit the request via TIERS to the HHSC Intake Team with three days of the Member's request for an EMR.

Within five Days of notification that the State Fair Hearing is set, the MCO must 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.

2.6.34.4 Independent Review Organization Reimbursement for External Medical Reviews

The MCO is responsible for all IRO costs for EMRs related to Adverse Benefit Determinations of medical necessity. The IRO must reimburse HHSC for such costs within the timeframes specified by HHSC. The MCO must not pass any IRO-related costs on to providers or Members.

The MCO will reimburse the IRO, at a rate calculated by HHSC, for an EMR HHSC assigns to the IRO which the Member subsequently withdraws prior to or on the 10-Day due date of the IRO EMR decision.

2.6.34.5 Notices of Adverse Benefit Determination and Disposition of Appeals for Medicaid Members

The MCO must notify the Member and HHSC, in accordance with 1 Tex. Admin. Code ch. 357 whenever the MCO makes an Adverse Benefit Determination. The notice must, at a minimum, include any information required by UMCM Chapter 3 regarding notices of actions and incomplete prior authorization requests.

2.6.34.6 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 15 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 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 appeal if he or she disagrees with that decision; and
    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 Action), on the date that the timeframes expire.
6. For expedited MCO Internal Appels of PA decisions, within the timeframes specified in 42 C.F.R. § 438.210(d); and
7. All timeframes required in UMCM Chapter 3.

2.6.34.7 NOTICE OF DISPOSITION OF APPEAL

The MCO must provide written notice of disposition of all appeals, including Expedited MCO Internal Appeals, to the Member and Authorized Representative acting on behalf of the Member to ensure the Member has an adequate opportunity to request a State Fair Hearing/EMR within 10 Days. The notice must include the results and date of the appeal resolution. For decisions not wholly in the Member's favor, in accordance with 42 C.F.R. § 438.408(e), the notice must also 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; and
5. Any other information required by 1 Tex. Admin. Code pt.15, ch. 357 that relates to an MCO's notice of disposition of an appeal.

2.6.34.8 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 standard 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. If the MCO denies a request for expedited resolution of an appeal, the MCO must transfer the appeal to the timeframe for standard resolution as provided in this section and make reasonable efforts to give the Member and Member's LAR prompt oral notice of the denial and follow up within two Days with a written notice.

2.6.34.9 NEMT SERVICES COMPLAINTS AND APPEALS

All of the requirements found in **Section 2.6.34**, including its subsections, apply to NEMT Services, with the following exceptions:

1. The MCO Medical Director is not required to review Appeals related to NEMT Services in accordance with **Section 2.6.34**, unless the MCO action being appealed is related to a medical issue.
2. No specific clinical expertise is required in accordance with **Section 2.6.34** for reviewers of Appeals related to NEMT Services.

Chapter 3 of Exhibit C do not apply to NEMT Services.

2.6.35 COVERED SERVICES

The MCO is responsible for assessing, authorizing, arranging, coordinating, and providing the following non-exhaustive, high-level listing of Covered Services, including NF Services and Community-based LTSS, in accordance with the requirements of the Contract and subject to modification due to changes in federal and State law and regulation. Covered Services include all State plan services and other services specified in the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver (see hhs.texas.gov), including the following:

1. Emergency and non-emergency ambulance services;
2. Audiology services, including hearing aids, for adults and children;
3. BH Services, including:
    a. Inpatient mental health services for adults and children. Inpatient psychiatric hospital services provided in a free-standing psychiatric hospital to Members under age 21 or ages 65 and older are a covered Medicaid benefit and there is not a day limitation for services;
    b. MHR and Mental Health TCM for individuals who are not fully dually eligible in Medicare and Medicaid
    c. Outpatient mental health services for adults and children;
    d. Psychiatry services;

e. Counseling services for adults (21 years of age and over);
f. Collaborative Care Model services
g. SUD treatment services, including:
    i. Outpatient services, including:
        (1) Assessment;
        (2) Withdrawal management services;
        (3) Counseling (individual and group); and
        (4) MAT;
    ii. Residential services, which may be provided in a CDTF in lieu of an Acute Care inpatient Hospital setting, including:
        (1) Residential withdrawal management; and
        (2) Residential treatment (including room and board)

4. Prenatal care provided by a physician, Certified Nurse Midwife (CNM), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), and physician assistant in a licensed birthing center;
5. Birthing services provided by a physician and CNM in a licensed birthing center;
6. Birthing services provided by a licensed birthing center;
7. Cancer screening, diagnostic, and treatment service;
8. Chiropractic services;
9. CFC services, including:
    a. PAS;
    b. Habilitation;
    c. Emergency response services; and
    d. Support consultation;
10. Day Activity and Health Services (DAHS);
11. Dialysis;
12. DME and supplies;
13. Emergency Services;
14. Family planning services;
15. Home health care services provided in accordance with 42 C.F.R. § 440.70, and as directed by HHSC;
16. Hospital services, inpatient, and outpatient;
17. Laboratory;
18. Mastectomy, breast reconstruction, and related follow-up procedures, including:
    a. 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:
        i. All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
        ii. Surgery and reconstruction on the other breast to produce symmetrical appearance;
        iii. Treatment of physical complications from the mastectomy and treatment of lymphedemas;
        iv. Prophylactic mastectomy to prevent the development of breast cancer; and

v. External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed;

19. Medical checkups and CCP services for Members under 21 years of age through the THSteps Program;
20. NEMT Services, including:
    a. Demand response transportation services, including NMT prearranged rides, shared rides, and public transportation services;
    b. Mass transit;
    c. Individual Transportation Participant (ITP) mileage reimbursement;
    d. Meals;
    e. Lodging;
    f. Advanced funds; and
    g. Commercial airline transportation services, including out of state travel;
21. NF Services;
22. Oral evaluation and fluoride varnish in the Medical Home in conjunction with THSteps medical checkup for Members under 21 years of age;
23. Outpatient drugs and biologicals, including pharmacy-dispensed and provider-administered outpatient drugs and biologicals, and drugs and biologicals provided in an inpatient setting;
24. PAS (State plan);
25. PCS for Members under 21 years of age;
26. Podiatry;
27. Prenatal care;
28. PPECC services for Members under 21 years of age;
29. Preventive services including an annual adult well check for patients 21 years of age and over;
30. Primary care services;
31. PDN services for Members under 21 years of age;
32. Radiology, imaging, and X-rays;
33. Specialty physician services;
34. Specialty Therapies – physical, occupational and speech therapies;
35. Transplantation of organs and tissues;
36. Vision services, including optometry and glasses. (Contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.);
37. Telemedicine;
38. Telemonitoring, to the extent covered by Tex. Gov't Code § 531.0216; and
39. Telehealth.

Adult Members receive three enhanced benefits compared to FFS coverage:

1. Waiver of the three-prescription per month limit, for Members not covered by Medicare;
2. Waiver of the $200,000 individual annual limit on inpatient services; and
3. The 30-day spell of illness limitation for hospital inpatient services described in the State plan does not apply to STAR+PLUS Members with SPMI.

The MCO should refer to **Exhibit F** for a more inclusive listing of limitations and exclusions that apply to each Medicaid benefit category.

The MCO also must provide, in addition to the above, the following Medically Necessary and Functionally Necessary Covered Services to Members who qualify for STAR+PLUS HCBS:

1. STAR+PLUS HCBS PAS;
2. Nursing services (in-home);
3. Emergency response services (emergency call button);
4. Home delivered meals;
5. Dental services;
6. Respite care, including in-home or out-of-home respite;
7. Minor Home Modifications;
8. Adaptive Aids and medical supplies;
9. Specialty Therapies;
10. Adult foster care;
11. Assisted living;
12. Transition Assistance Services (TAS);
13. Cognitive rehabilitation therapy;
14. FMS;
15. Support consultation;
16. Employment assistance;
    a. Members receiving similar services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act may not receive Employment Assistance through STAR+PLUS HCBS.
17. Supported employment;

The MCO must provide full coverage for Covered Services to all Members beginning on the Member's Effective Date of Coverage without regard to the Member's:

1. Previous health coverage, if any, or the reason for termination of previous coverage;
2. Health status;
3. Pre-existing conditions;
4. Insurability;
5. Confinement in a healthcare facility; or
6. Any other reason.

The MCO is responsible for authorization and management of the inpatient Hospital stay until the time of Discharge, or until such time as there is a loss of Medicaid eligibility. The MCO is responsible for professional charges during every month for which the MCO receives a full capitation for a Member, as required by "span of coverage" requirements in **Section 2.4.4.**

The MCO may not prior authorize Emergency Services.

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.

The MCO is responsible for providing Members all Covered Services equal to the amount, duration, and scope as is available through FFS as reflected in the following sources:

1. Texas Medicaid state plan under Title XIX of the Social Security Act State plans for medical assistance, 42 U.S.C. § 1396a;
2. 42 C.F.R. 438.210, with the exception of Non-Capitated Services described in **Section 2.6.63.20**;
3. 42 C.F.R § 440.230 for Members 21 and older;
4. 42 C.F.R pt. 441, subpt. B for Members under the age of 21; and
5. Exhibit F, TMPPM and any updates thereto.

The MCO must not arbitrarily deny or reduce the amount, duration, or scope of Covered Services solely because of the diagnosis, type of illness, or condition of the Member.

Covered Services are subject to change due to changes in federal and State laws, rules, or regulations, state plan or waivers, Medicaid policy; and medical practice, clinical protocols, or technology.

The MCO must have a process in place to monitor a Member's claims history for Acute Care and LTSS that receive a PA and for services/items documented on the ISP to ensure that these services are delivered.

On an ongoing basis, the MCO must monitor claims data for all approved PAs and for services/items documented on the ISP for delivery of services. The MCO must research and resolve any services not received as a result of lack of claims data. At the request of HHSC, the MCO must be able to demonstrate that Members' services requiring PAs were delivered.

The MCO must provide the Covered Services in **Sections 2.6.36 through 2.6.63** as part of the Capitated Payment it receives under this Contract.

2.6.36 ACCESS TO CARE

The MCO must ensure all Covered Services are available to Members on a timely basis, in accordance with the Contract's requirements and medically appropriate guidelines, and consistent with generally accepted practice parameters. The MCO must ensure all Members have access to a choice of Providers for all Covered Services. If the MCO is unable to meet this standard, the MCO must request an exception from HHSC as discussed in **Section 2.6.36.3**.

The MCO must comply with the access requirements as established by TDI in 28 Tex. Admin. Code pt. 1, ch. 3, subch. KK, § 3.9208 and ch. 11, subch. Q, § 11.1607, for all MCOs doing business in Texas, except as otherwise required by the Contract. Where conflicts exist between TDI access requirements and the Contract, the shortest mileage and timeframe requirements apply.

The MCO must ensure that Providers offer business hours to Members that are at least equal to those offered to the MCO's commercial lines of business, or FFS participants, if

the Provider accepts only Medicaid Members. The MCO must ensure all clinic-based Network Providers' locations are physically accessible to Members.

Upon the request of a Network Provider or Member, the MCO must provide a referral to an OON provider if Covered Services are not available through Network Providers, within the timeframes noted in **Section 2.6.52.3**. The MCO must fully reimburse the OON provider in accordance with the OON methodology for Medicaid as defined by HHSC.

The MCO must comply with Texas Medicaid State Plan Section 2.7 and 42 C.F.R § 435.403 when authorizing and monitoring Covered Services provided to Members out-of-state

The MCO must not require the Member to pay for any Medically Necessary or Functionally Necessary Covered Services provided by Providers except:

1. HHSC-specified copayments for Members, where applicable; and
2. Members who enter a NF, Assisted Living Facility (ALF), or Adult Foster Care (AFC) are required to pay the provider room and board costs, as well as any income in excess of the personal needs allowance, as established by HHSC. The MCO is not required to pay the provider room and board costs or any income in excess of the personal needs allowance for these Members. The MCO must notify HHSC when it becomes aware that a Member is not paying the provider. Neither the MCO nor the Member are required to pay the provider room and board costs for a Member receiving adult foster care in his or her home.

2.6.36.1 APPOINTMENT ACCESSIBILITY AND SERVICE INITIATION

The MCO must meet the specific standards for appointment accessibility and service initiation through its Provider Network composition and management in accordance with this section and **Chapter 5** of **Exhibit C**. The following standards are measured from the date of presentation or request, whichever occurs first, unless another date is noted. For the purposes of the time standards below, a request from a Member's LAR or Service Coordinator is treated as though the request came from the Member.

1. Emergency Services must be provided upon Member presentation at the service delivery site, including OON and out-of-area facilities;
2. Services to address an Urgent Condition, including urgent specialty care and BH Services, must be provided within 24 hours. Treatment for BH Services may be provided by a licensed BH clinician;
3. Primary Routine Care must be provided within 14 Days;
4. Specialty Routine Care must be provided within 21 Days;
5. Specialty Therapy evaluations must be provided within 21 Days of the submission of a signed referral. If an additional evaluation or assessment is required (e.g. audiology testing) as a condition of authorizing a therapy evaluation, the additional required evaluation or assessment must be scheduled to allow the Specialty Therapy evaluation to occur within 21 Days from the date of submission of a signed referral;
6. Initial outpatient BH Service visits must be provided within 14 Days;

7. Community-based LTSS must be initiated by the start date on the ISP or Service Plan; or in the case of a Change of Condition within seven Days of the ISP or Service Plan effective date, unless otherwise stated and documented by the referring Provider, Member, or as otherwise indicated in **Exhibit E** or in **Exhibit C;**
8. Prenatal care must be provided within 14 Days of the Member requesting an appointment for initial appointments, except for new Members and Members in the third trimester, for whom an initial appointment must be offered within five Days of the Member requesting an appointment, or immediately, if an emergency exists. Appointments for ongoing care must be available in accordance to the treatment plan as developed by the Provider;
9. Preventive services including annual adult well checks for Members 21 years of age and older must be offered within 90 Days;
10. Preventive health services for Members ages 18 through age 20 must be provided within 60 Days. Medicaid Members should receive preventive care in accordance with the THSteps periodicity schedule. MCOs must encourage new Members 20 years of age or younger to receive a THSteps checkup within 90 Days of enrollment. For purposes of this requirement, the term "New Member" is defined in **Chapter 12 of Exhibit C**.
11. HHSC plans to create a new chapter of **Exhibit C** establishing timelines for DME. Once published, MCOs must follow those timelines.
12. Case Management for Children and Pregnant Women services must be provided to Medicaid Members within 14 Days.

2.6.36.2 ACCESS TO PROVIDERS

This section does not apply to NEMT Services providers.

The MCO's Network must include all of the provider types listed below and in **Chapter 5 of Exhibit C** to provide timely access to all Covered Services in accordance with the service accessibility standards in **Section 2.6.36.1** and **Chapter 5 of Exhibit C.** The MCO's PCP Network must provide timely access to regular and preventive care to all Members, and THSteps services to all Members under age 21.

The MCO must allow each Member to choose his or her 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 1 Tex. Admin. Code pt. 15, ch. 353 subch. E, § 353.411.

For each provider type, the MCO must provide access to a choice of Providers that are not closed to new Members for at least 90% of Members within the prescribed distance or travel time standard. Counties will be designated as "Metro," "Micro," or "Rural," as defined in Exhibit I, Access Standard Map. The county designation is based on population and density parameters is available in Exhibit I. Members' residences identified in Enrollment Files will be used to assess distance and travel times. The MCO must comply with the requirements set forth in Chapter 5 of Exhibit C. HHSC will track MCO compliance with provider network adequacy standards. HHSC will use the MCO Provider

Files to run the geo-mapping reports that will measure provider choice, distance, and travel time. HHSC will compile the reports based on each MCO's Network. HHSC will share identified Network deficiencies with the MCO. Emergency Services Access

The MCO must provide coverage for Emergency Services to Members 24 hours a Day and seven Days a week, without regard to PA or the Emergency Service provider's contractual relationship with the MCO. The MCO's policy and procedures, Covered Services, claims adjudication methodology, and reimbursement performance for Emergency Services must comply with all applicable State and federal laws and regulations, regardless of whether the provider is in the MCO's Network or OON.

An MCO is not responsible for payment for unauthorized non-emergency services provided to a Member by OON providers, except when that provider is an IHCP enrolled as a FQHC, as provided in **Section 2.6.38.5**.

The MCO must also have a BH Services hotline that meets all requirements described in **Sections 2.6.18.4 of this SOW**.

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 2.6.63.1**. The MCO may arrange Emergency Services and crisis BH Services through mobile crisis teams.

2.6.36.2.1 PRIMARY CARE PROVIDER ACCESS

The MCO must ensure all Members have access to appropriate PCPs in accordance with **Chapter 5.28 of Exhibit C**. For purposes of assessing compliance with this section, a pediatrician is not considered an age-appropriate choice for a Member age 18 and older, unless a specific condition warrants it.

2.6.36.2.2 OBSTETRICS/GYNECOLOGY ACCESS

At a minimum, the MCO must ensure that all female Members have access to Obstetrics/Gynecology (OB/GYN) Providers with an Open Panel in accordance with **Chapter 5.28 of Exhibit C**.

If the OB/GYN is acting as the Member's PCP, the MCO must follow the access requirements for the PCP in **Section 2.6.36.2.1**. A female Member who has selected an OB/GYN must be allowed direct access to the OB/GYN's Covered Services without a referral from the Member's PCP or a PA.

2.6.36.2.3 PRENATAL

The MCO must ensure Members who are pregnant have access to Providers for prenatal care with an Open Panel in accordance with **Chapter 5.28 of Exhibit C**.

The MCO must allow a pregnant Member who is 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, OON.

2.6.36.2.4 MENTAL HEALTH - OUTPATIENT

At a minimum, the MCO must ensure that all Members have access to covered outpatient mental health service Providers with an Open Panel in accordance with **Chapter 5.28 of Exhibit C**.

The MCO must follow Network requirements for outpatient mental health as set forth in **Section 2.6.38.16**.

2.6.36.2.5 OUTPATIENT SUBSTANCE USE DISORDER TREATMENT

At a minimum, the MCO must ensure that all Members have access to CDTFs, and opioid treatment Providers accepting new patients in the Network in accordance with **Chapter 5.28 of Exhibit C**.

The MCO must follow network requirements for outpatient SUD service providers as set forth in **Section 2.6.38.19**.

2.6.36.2.6 MENTAL HEALTH TARGETED CASE MANAGEMENT AND MENTAL HEALTH REHABILITATIVE SERVICES

At a minimum, the MCO must ensure that all Members have access to Mental Health TCM/MHR Providers with an Open Panel in accordance with **Chapter 5.28 of Exhibit C**.

2.6.36.2.7 SPECIALIST PROVIDER ACCESS

The MCO must ensure that all Members have access to Network specialist Providers for all Covered Services in accordance with **Chapter 5.28 of Exhibit C,** including:

1. Audiologist;
2. Cardiology/cardiovascular disease;
3. Otolaryngology;
4. General surgeon;
5. Ophthalmologist;
6. Orthopedic/orthopedic surgeon;
7. Pediatric sub-specialty;
8. Psychiatrist;
9. Urologist; and
10. All other specialists not listed above.

The MCO must ensure PCPs make referrals for specialty Providers on a timely basis, based on the urgency of the Member's medical condition, but no later than five Days after the PCP identifies the need for the specialty care.

In addition, all Members must be allowed to select a Network ophthalmologist or therapeutic optometrist to provide eye Health Care Services, other than surgery and 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.

2.6.36.2.8 LONG TERM SERVICES & SUPPORT (LTSS) PROVIDERS

The MCO must ensure all Members have access to LTSS providers for all Covered LTSS in accordance with **Chapter 5.28 of Exhibit C.**

2.6.36.2.9 THERAPIES -- OCCUPATIONAL, PHYSICAL, AND SPEECH THERAPY PROVIDED IN AN OUTPATIENT CLINIC OR FACILITY ACCESS

The MCO must ensure the Member has access to Providers for Specialty Therapies and in-home therapies with an Open Panel in accordance with **Chapter 5.28 of Exhibit C**.

2.6.36.2.10 ACUTE CARE HOSPITAL

The MCO must ensure that Members have access to Acute Care Hospitals in accordance with **Chapter 5.28 of Exhibit C.**

2.6.36.2.11 NURSING FACILITY

The MCO must ensure that Members have access to NF Service Providers in accordance with **Chapter 5.28 of Exhibit C.**

2.6.36.2.12 PHARMACY

The MCO must ensure that all Members have Pharmacy access. The MCO must ensure that access is consistent with UMCM Chapter 5.28.1, Access to Network Providers Performance Standards and Specifications.

2.6.36.2.13 COMMUNITY ATTENDANT CARE SERVICES

MCOs must ensure that a minimum of 90% of Members who are authorized to receive community attendant care services, e.g., PAS, have timely access to such services. For purposes of this paragraph, timely access is within seven Days from the authorization of the services as stated in **Section 2.6.36.1**.

The STAR+PLUS MCO must have workforce development capacity to work with agencies contracted to provide community attendant care services to improve recruitment and retention of provider agency community attendant staff.

2.6.36.2.14 ASSISTED LIVING FACILITIES

MCOs must ensure that 90% of Members in every county have access to at least two Assisted Living Facilities (ALF) within distance or travel time requirements described in **Section 2.6.36.2.** For purposes of access to ALFs the county classification is based on Medicare Advantage designations developed by CMS.

2.6.36.2.15 ACCESS TO ALL OTHER COVERED SERVICES

The MCO must ensure that all Members have access to a Network Provider for all other Covered Services in accordance with **Chapter 5.28 of Exhibit C**. This access requirement includes, but is not limited to:

1. Specialists not previously referenced in **Section 2.6.36.2**;
2. Oncology including surgical and radiation;
3. Specialty Hospitals;
4. Psychiatric Hospitals,
5. Diagnostic services; and
6. Single or limited service health care physicians or Providers, as applicable to the Program.

The MCO may make arrangements with providers outside the MCO's SA for Members to receive care of a higher level of skill or specialty than the level available within the SA, including but not limited to, treatment of cancer, burns, and cardiac diseases.

2.6.36.3 EXCEPTION PROCESS

If the MCO cannot meet any of the above access requirements, the MCO must submit an exception request to HHSC. HHSC will consider requests for exceptions to the access standards for all provider types under limited circumstances.

The MCO must support each exception request with information and documentation as specified in the template provided by HHSC. HHSC may grant exceptions if the MCO has established, through utilization data, that a normal pattern for securing Covered Services within a SA does not meet these standards, or when the MCO is providing care of a higher skill level or specialty than the level available within the SA. Exceptions may be granted only for a specific amount of time at HHSC's discretion.

2.6.36.4 MONITORING ACCESS

This section does not apply to NEMT Services providers.

The MCO must verify that Covered Services furnished by Providers are available and accessible to Members in compliance with the standards described in **Sections 2.6.38 and 2.6.36**.

The MCO must develop and implement a Provider directory verification report to verify that the Provider information maintained by the MCO is correct and in alignment with the Provider information maintained by the HHSC or its designee. The MCO must complete a report annually each SFY and provide to HHSC in accordance with **Chapter 5 of Exhibit C**.

The Provider directory verification report must include the following elements:

1. Provider name;
2. Practice physical address;
3. Phone number;

4. Office hours;
5. Days of operation;
6. Practice limitations;
7. Languages spoken;
8. Provider type/specialty;
9. Length of time a Member must wait between scheduling an appointment and receiving treatment;
10. For PCPs, whether the Provider is accepting new patients;
11. For PCPs, whether the Provider is a THSteps enrolled Provider;
12. Accessibility of Provider offices, per ADA requirements as referenced in 42 U.S.C. § 12101, et seq.;
13. Whether the Provider offers Telemedicine, Telehealth, or Telemonitoring; and
14. Whether the Provider has certifications or training in EBPs or promising practices such as:
    a. TIC;
    b. TF-CBT;
    c. PCIT;
    d. TBRI; and
    e. CPP.

2.6.37 TELEMEDICINE, TELEHEALTH, TELEPHARMACY, AND TELEMONITORING ACCESS

Telemedicine, Telehealth, Telepharmacy, and Telemonitoring are Covered Services and are benefits of Texas Medicaid**.** MCOs must contract with Providers offering these services to provide better access to healthcare for its Members.

The MCO must include information about Providers with Telemedicine, Telehealth, and Telemonitoring capabilities in its hard copy and electronic provider directory.
The MCO must be able to accept and process Provider claims for Covered Services using modifier 95 when delivered by Telemedicine or Telehealth. In addition, the Medicaid MCO must be able to accept and process Provider claims for Telemonitoring and Telepharmacy.
The MCO must conduct outreach to its Providers to encourage more Providers to offer Telemedicine, Telehealth and Telemonitoring, with emphasis on rural and medically underserved areas. The MCO must also outreach to specialty Providers as that term is defined in 1 TAC § 353.7 and Behavioral Health Services Providers to assure engagement of qualified Providers offering Telemedicine, Telehealth, and Telemonitoring. During the outreach process, the MCO must offer trainings and supports to help establish Telemedicine, Telehealth, and Telemonitoring literacy and capabilities. In addition, the MCO must actively recruit additional rural providers in order to increase Member access to the services that can be delivered through Telemedicine and Telehealth.

MCOs are required to comply with Texas Government Code § 531.0216 and §§ 531.02161(a), (c) and (d).

MCOs must not deny reimbursement for a Covered Service delivered by a Network Provider via Telemedicine or Telehealth solely because the Covered Service is not

provided through an In-person consultation. MCOs must not deny reimbursement for a Covered BH Service delivered by a Network Provider via Telemedicine or Telehealth, including Audio-only Behavioral Health Services, solely because the Covered Service is not provided through In-person consultation. MCOs cannot limit, deny, or reduce reimbursement for a Covered Service or procedure delivered remotely by a Provider based upon the Provider's choice of platform, except in the event a Provider utilizes an Audio-only Platform for providing a Telemedicine or Telehealth service that HHSC has found must not be provided via Audio-only. MCOs must allow Members to receive Telemedicine or Telehealth services from providers other than the Member's PCP.

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

2.6.37.1 SCHOOL-BASED TELEMEDICINE AND TELEHEALTH SERVICES

School-based Telehealth services are a Covered Service for Members pursuant to Tex. Gov't Code § 531.02171. The MCO must reimburse an eligible distant site provider providing treatment even if the provider is not the Member's PCP. To be eligible for reimbursement, the distant site provider providing treatment must meet the service requirements outlined in Tex. Gov't Code § 531.02171(b). The MCO may not request PA for school-based Telemedicine medical services.

2.6.38 PROVIDER NETWORK

This section does not apply to NEMT Services providers.

The MCO must enter into written Provider Contracts with properly credentialed Providers. The Provider Contracts must comply with the requirements in **Section 2.6.38.2**, and include reasonable administrative and professional terms as necessary.

The MCO must maintain a Network sufficient to provide all Members with access to the full range of Covered Services required under the Contract. The MCO must ensure its Providers and Subcontractors meet all State and federal eligibility criteria, reporting requirements, and any other applicable rules or regulations. The MCO must seek to obtain participation, in its Network, of qualified providers currently serving the Medicaid Members in the MCO's SAs.

MCOs utilizing OON providers to render services to their Members must not exceed the utilization standards established in 1 Tex. Admin. Code, pt.15, ch. 353, subch. A, § 353.4. HHSC may modify this requirement for MCOs that demonstrate good cause for noncompliance in accordance with 1 Tex. Admin. Code, pt. 15, ch. 353, subch. A, § 353.4(g)(3). Each exception request must be supported by information and documentation as specified in **Chapter 5 of Exhibit C.**

The Provider Network must be responsive to the linguistic, cultural, and other unique needs of any Members who are minority, elderly, or have physical, intellectual, or cognitive disability, or other special population in the SAs served by the MCO, including the capacity to communicate with Members in languages other than English, when necessary, as well as with individuals who are blind, deaf-blind, deaf, or hearing impaired.

The MCO must seek participation in the Provider Network from the following types of entities that may serve American Indian and Alaskan Native Members:

1. Health clinics operated by a federally-recognized tribe in the SA;
2. FQHCs operated by a federally-recognized tribe in the SA; and
3. Urban Indian organizations in the SA.

2.6.38.1 ALL PROVIDERS

If licensure or certification is required to provide a Covered Service, the MCO must ensure through its Provider Contracts, the Provider is licensed or certified in the State of Texas, except as provided in **Section 2.6.39,** and that the Provider maintains such license or certification during the term of its Provider Contract.

The Provider Contract must ensure that all Providers comply with all federal and State laws governing the provision of Covered Services.

The Provider Contract must ensure all Providers have a NPI in accordance with 45 C.F.R. pt. 162, subpt. D, and are enrolled with HHSC as Medicaid Providers under that NPI.

The MCO is prohibited from employing, contracting with, or entering into a Provider Contract with Providers whose license or certification is expired or cancelled or who are excluded, suspended, under sanction, or terminated from participation in the Texas Medicaid and CHIP programs. The MCO must reconcile its list of credentialed Providers to the master Provider file as often as HHSC or its designee makes it available.

2.6.38.2 PROVIDER CONTRACT REQUIREMENTS

The MCO's contract with Providers and, as applicable, NEMT Services 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 **Chapter 8 of Exhibit C**. The Provider Contract must require the Provider to be credentialed, and the Provider and MCO must both sign the contract. The MCO must provide each Provider with the Provider's copy of this executed contract within 45 Days of execution. Credentialing requirements do not apply to NEMT Services providers.

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 Network.

The MCO must resubmit the model Provider Contracts to HHSC any time it makes modifications to such agreements. HHSC retains the right to reject or require changes to any Provider Contract that does not comply with Program requirements or the STAR+PLUS Contract.

2.6.38.3 INPATIENT HOSPITAL AND MEDICAL SERVICES

The MCO must ensure, through Provider Contracts, that Acute Care Hospitals and Specialty Hospitals are available and accessible 24 hours per Day, seven Days per week,

within the MCO's Network to provide Covered Services to Members throughout the SA. The MCO must enter into a Provider Contract with any willing state Hospital and Hospitals receiving funds as a DSH that meet the MCO's Credentialing requirements and agree to the MCO's contract rates and terms.

2.6.38.4 SIGNIFICANT TRADITIONAL PROVIDERS

Upon HHSC's request, the MCO must offer STPs the opportunity to participate in its Network for at least three years from the start of HHSC's request to include STPs. However, the STP 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 on Accreditation of Health Care Organizations 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.

If the MCO has so terminated an STP for cause within the past 12 months, the MCO does not have to extend a contracting opportunity.

The MCO must ensure these requirements are applicable to Case Management for Children and Pregnant Women Providers statewide until the expiration date of September 1, 2025.

2.6.38.5 INDIAN HEALTH CARE PROVIDERS

The MCO must demonstrate a sufficient number of IHCP are participating in its 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 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 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 Provider.

The MCO must pay for Covered Services provided by an IHCP to an Indian Member, regardless of whether the IHCP is part of the MCO's Network.

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 FFS. If an IHCP is enrolled in Medicaid as an FQHC, the IHCP must be reimbursed as described in **Section 2.6.12.8**.

2.6.38.6 TRAUMA CENTER SERVICES

The MCO must ensure Member access to Texas Department of State Health Services (DSHS) designated Level I and Level II trauma centers within the State of Texas or Hospitals meeting the equivalent level of trauma care in the MCO's SA, or in close proximity to such SA. The MCO must enter a written reimbursement arrangement with OON DSHS-designated Level I and Level II trauma centers or Hospitals meeting equivalent levels of trauma care, if the MCO does not include such a trauma center in its Network.

2.6.38.7 TRANSPLANT CENTER SERVICES

The MCO must ensure Member access to HHSC-designated transplant centers or centers meeting equivalent levels of care. The HHSC utilizes the CMS list for the HHSC-designated transplant centers list which may be found on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/transplantcenters. The MCO must enter a written reimbursement arrangement with an OON designated transplant center or a center meeting equivalent levels of care in proximity to the Member's residence, if the MCO does not include such a center in its Network.

2.6.38.8 HEMOPHILIA CENTER SERVICES

The MCO must ensure Member access to hemophilia centers supported by the Centers for Disease Control and Prevention (CDC), which include pharmacy services provided by the centers. A list of these hemophilia centers is maintained by the CDC at https://dbdgateway.cdc.gov/HTCDirSearch.aspx. The MCO must make written reimbursement arrangements with an OON CDC-supported hemophilia center, if the MCO does not include such a center in its Network.

2.6.38.9 PHYSICIAN SERVICES

The MCO must contract with a sufficient number of participating physicians and specialists within each SA for which the MCO has contracted to comply with the access requirements throughout **Section 2.6.36** and meet the Members' needs for all Covered Services.

The MCO must ensure that an adequate number of physicians have admitting privileges at one or more participating Acute Care Hospitals in its Network to ensure that necessary admissions are made.

The MCO must ensure that an adequate number of Network specialty physicians have admitting privileges at one or more participating Hospitals in its Network to ensure 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.

2.6.38.10 URGENT CARE CLINIC SERVICES

The MCO must ensure that urgent care clinics, including multi-specialty clinics serving in this capacity, are included within its Network.

2.6.38.11 PHARMACY PROVIDER SERVICES

The MCO must ensure, through Provider Contracts, that all pharmacy Providers meet the requirements under 1 Tex. Admin. Code § 353.909. 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 (https://www.txvendordrug.com/) in accordance with 1 Tex. Admin. Code § 354.1853 with one or more pharmacy Provider. These arrangements must comply with Tex. Gov't Code § 533.005(a)(23)(G) and 1 Tex. Admin. Code §§ 353.905 and 353.911.

MCOs may have only retail pharmacy Networks and specialty pharmacy Networks. Except for selective arrangements for drugs on the HHSC Specialty Drug List (located at https://www.txvendordrug.com/formulary/information/specialty-drugs), MCOs may not have preferred pharmacy or selective pharmacy networks. MCOs must allow pharmacies in the retail pharmacy Network to dispense any drug listed on the VDP formulary, with the exception of drugs listed on the HHSC Specialty Drug List. MCOs may limit the dispensing of drugs on the HHSC Specialty Drug List to pharmacies enrolled in the MCOs specialty pharmacy Network.

The MCO and MCO Subcontractors must not require Medicaid/CHIP pharmacy providers to enroll in other lines of business as a condition for Medicaid/CHIP enrollment.

2.6.38.12 DIAGNOSTIC IMAGING SERVICES

The MCO must ensure that diagnostic imaging services are available and accessible to all Members in each SA which MCO serves under the Contract in accordance with the access standards throughout **Section 2.6.36** The MCO must ensure 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.

2.6.38.13 HOME HEALTH SERVICES AND DURABLE MEDICAL EQUIPMENT AND SUPPLIES

The MCO must have a sufficient number of contracts with home health Providers to ensure all Members have access to a choice of Providers for home health Covered Services. The

MCO must ensure delivery of DME and supplies occur within the time appropriate to the circumstances relating to the delivery of the services and the condition of the Member.

2.6.38.14 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. Geriatrician;
5. OB/GYN (including OB/GYNs who also qualify as a PCP);
6. APRNs and physician assistants when APRNs and physician assistants are practicing under the supervision of a physician;
7. FQHCs, RHCs, and similar community clinics; and
8. Physicians serving Members residing in NFs.

In addition, if applicable, the MCO's Network must include a sufficient number of IHCPs to ensure that eligible Members enrolled in the MCO have timely access to services.

The MCO must treat APRNs and physician assistants 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 Network; and
3. Inclusion as a PCP in any Provider directory maintained by the MCO.

A pediatrician is not considered an age-appropriate choice for a Member age 18 and over.

The PCP for a Member may be a specialist physician who agrees to provide PCP services to the Member. The MCO Provider Contract must ensure that the specialist physician agrees to perform all PCP duties required in the Contract, and PCP duties must be within the scope of the specialist's license. The MCO Provider Contract must ensure that any interested Member may initiate the request, through the MCO, for a specialist to serve as the Member's PCP. The MCO must handle these requests in accordance with 28 Tex. Admin. Code § 11.900.

If the PCP for a female Member is not a women's health specialist, the MCO must provide the Member with direct access to a women's health specialist within the Network to provide covered routine and preventive women's health care services.

The MCO must require PCPs, through contract provisions, to provide Members with preventive services and to assess the medical needs of Members for referral to specialty care providers and provide referrals as needed. The MCO must make best efforts to ensure that PCPs assess Members' needs for referrals and make such referrals. Best efforts must include but are not limited to Provider education activities and review of Provider referral patterns. The MCO Provider Contract must ensure that PCPs coordinate such Members' care with specialty care providers after referral.

The MCO Provider Contract must ensure that PCPs either have admitting privileges at a Network Hospital or make referral arrangements with a Provider who has admitting

privileges at a Network Hospital. In no case, may there be less than one Network PCP with admitting privileges available and accessible 24 hours per Day, seven Days per week, for each Acute Care Hospital in the Network.

The MCO must require, through contract provisions, that PCPs are accessible to Members 24 hours a Day, seven Days a week. The MCO is encouraged to 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 non-business hours coverage includes all of the following:

1. The office telephone is answered during non-business hours by an answering service, which meets the language requirements of each of the Prevalent Languages and can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes;
2. The office telephone is answered during non-business hours by a recording in the language of each of the Prevalent Languages, 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
3. The office telephone is transferred during non-business hours to another location where someone will answer the telephone and be able to contact the PCP or another Provider, who can return the call within 30 minutes.

Unacceptable non-business hours coverage includes but is not limited to:

1. The office telephone is only answered during office hours;
2. The office telephone is answered during non-business hours by a recording that tells Members to leave a message;
3. The office telephone is answered during non-business hours by a recording that directs Members to go to an Emergency Room for any services needed; and
4. Returning non-business hours calls outside of 30 minutes.

2.6.38.15 PRIMARY CARE PROVIDER NOTIFICATIONS

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 File from the HHSC EB each month. The MCO may offer and provide such enrollment information in alternative formats when such format is acceptable to the PCP.

2.6.38.16 OUTPATIENT MENTAL HEALTH SERVICES PROVIDERS

The MCO must ensure that all Members have access to outpatient mental health treatment service Providers in the Network, including masters and doctorate-level trained practitioners practicing independently or at clinics/group practices, or at outpatient Hospital departments as detailed in **Chapter 5 of Exhibit C**. The outpatient mental health service Provider should be the appropriate Provider type to meet each individual Member's needs: Licensed Clinical Social Workers (LCSWs); Licensed Marriage and Family

Therapists (LMFTs); Licensed Professional Counselors (LPCs); licensed psychologists; and providers that employ peer specialists for mental health and SUD.

2.6.38.17 Mental Health Rehabilitative Services

The MCO must ensure Members have access to MHR and Mental Health TCM services provided by Comprehensive Provider Agencies, including LMHAs and non-LMHA Providers.

2.6.38.18 Local Mental Health Authority, Local Behavioral Health Authority, and Local Intellectual and Development Disability Authorities

The MCO must enter into a Provider Contract with any willing LMHA, Local BH Authority or Local IDD Authority that meets the MCO's Credentialing requirements and agrees to the MCO's contract rates and terms.

2.6.38.19 Outpatient Substance Use Disorder Service Providers

The MCO must make reasonable effort to contract with outpatient SUD service providers. The MCO's Network for outpatient SUD service Providers must include CDTFs. The Network must also include the following for MAT:

1. Licensed narcotic (opioid) treatment programs;
2. CDTFs licensed by HHSC; and
3. Appropriately trained physicians and other qualified prescribers as specified in **Exhibit F**.

The MCO must include STPs of this benefit in its Network and provide such STPs with expedited Credentialing. The MCO must enter into Provider Contracts with any willing STP of these benefits that meets the Medicaid enrollment and 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 the SA, and unlike other STP requirements are not limited to the first three years of operation.

2.6.38.20 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 CDTFs licensed by HHSC to provide residential services. 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. MCOs must enter into Provider Contracts with any willing STP

of these benefits that meets the Medicaid enrollment and 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.

2.6.38.21 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

2.6.38.22 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 access requirements.

The MCO must ensure, through Provider Contracts, that reference laboratory specimen procurement services facilitate the provision of clinical diagnostic services for Providers and Members through the use of convenient reference satellite labs in each SA, strategically located specimen collection areas in each SA, and the use of a courier system under the management of the reference lab. The MCO must follow the THSteps Medical Checkup Laboratory Requirements for Testing/Analysis for Members 18 through 20 years of age. The MCO must refer Providers to the THSteps Online Provider Training Modules referencing specimen collection on the THSteps website and to **Exhibit F** for the most current information and updates.

2.6.38.23 Long-Term Services and Supports Services

The MCO must ensure that all Members living within the SA have access to a choice of Providers of Medically Necessary and Functionally Necessary LTSS.

2.6.38.24 Nursing Facility Services

The MCO must ensure that all Members living within the SA have access to NF Services. PCPs associated with a NF must either have admitting privileges at a Hospital that is part of the MCO's Provider Network or make referral arrangements with a Provider who has admitting privileges to a Network Hospital.

The MCO must enter into a Provider Contract with any willing NF Services Provider that is licensed, certified, and has a Medicaid contract with HHSC; meets the NF Credentialing standards and minimum performance standards in **Chapter 8 of Exhibit C;** and agrees to

the MCO's contract rates and terms. The MCO must comply with the rate requirements set forth in **Section 2.6.43.3.4**. A STAR+PLUS MCO is prohibited from contracting with a NF provider if it does not meet Credentialing standards. The MCO may refuse to contract with a NF provider if it does not meet the minimum performance standards in **Chapter 8 of Exhibit C.** As required in 1 Tex. Admin. Code, Chapter 380the Nursing Facility is responsible for providing transportation to medical services outside the facility. NEMT Services are available to Members in a Nursing Facility for transportation to dialysis treatment centers.

2.6.38.25 AMBULANCE PROVIDER SERVICES

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.

2.6.38.26 FINANCIAL MANAGEMENT SERVICE AGENCIES

The MCO's Provider Network must include FMSAs.

2.6.39 CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN

The MCO must make a reasonable effort to contract with Case Management for Children and Pregnant Women providers within its Service Area. The MCO must ensure all Members have access to Case Management for Children and Pregnant Women Services.

2.6.40 OUT-OF-STATE PROVIDERS

The MCO may enroll out-of-state providers in its Medicaid Networks, in accordance with 1 Tex. Admin. Code § 352.17 and pharmacy providers in accordance with 1 Tex. Admin. Code § 353.909. The MCO may enroll out-of-state diagnostic laboratories in its Medicaid Networks under the circumstances described in Tex. Gov't Code § 531.066.

The MCO must ensure that the out of state providers it chooses to enroll in its Network are enrolled as a Medicaid provider with HHSC.

This subsection does not limit the MCO's ability or responsibility to provide NEMT Services to a Member and his or her NEMT Attendant for out-of-state travel.

2.6.41 VALUE-ADDED SERVICES

The MCO may offer additional services for coverage which are VAS. Best practice approaches to delivering Covered Services are not considered VAS.

If the MCO offers any VAS, then the MCO must offer VAS to all Members within a SA but may distinguish among Population Risk Groups. VAS do not need to be consistent across more than one SA.

Any VAS that the MCO elects to provide must be provided at no additional cost to HHSC. The MCO must not report the costs of VAS as allowable costs on the FSR for either

medical or administrative expenses and are not factored into the rate-setting process. The MCO must not pass on the cost of the VAS to Members or providers. HHSC may collect data on VAS costs for informational purposes.

The MCO may offer discounts on non-Covered Services to Members as VAS, provided that the MCO complies with applicable Texas Insurance Code provisions. The MCO must ensure that Providers do not charge Members for any other cost-sharing for a VAS, including copayments or deductibles.

The MCO must specify the conditions and parameters regarding the delivery of each VAS and must clearly describe any limitations or conditions specific to each VAS 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 will be given the opportunity to add, enhance, delete, or reduce VAS once per SFY. HHSC may, but is not required to, allow additional modifications to VAS if Covered Services are amended by HHSC during a SFY. The MCO must submit requests to add, enhance, delete, or reduce a VAS to HHSC by April 1 of each SFY to be effective September 1 of that SFY. The MCO must use HHSC's template for submitting proposed VAS found in **Chapter 4 of Exhibit C**.

Once requests are approved, the MCO cannot reduce or delete any VAS until September 1 of the following SFY. When the MCO requests deletion or reduction of a VAS, the MCO must include information regarding the processes by which the MCO will notify Members and revise Member Materials and Marketing Materials in accordance with **Chapter 4 of Exhibit C**.

The MCO must not include a VAS in any Member Materials until the MCO obtains HHSC's approval. The Member Materials approval process is outlined in **Section 2.6.17.1**.

2.6.42 CASE-BY-CASE SERVICES

The MCO may offer additional benefits that are outside the Capitation Rate and SOW to individual Members on a case-by-case basis, based on Medical or Functional Necessity, cost-effectiveness, the wishes of the Member or Member's LAR, and the potential for the improved health status of the Member. 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. The MCO must maintain documentation of each authorized Case-by-case Service provided to each Member. Case-by-case Services authorized by the MCO are not considered in the rate-setting process; are provided by the MCO at no cost to HHSC, the Member, or provider; and must be appropriately reported in the MCO's FSR as may be provided by HHSC, but not within medical expenses or administrative expenses.

2.6.43 COVERED LONG-TERM SERVICES AND SUPPORTS

LTSS refers to both institutional care and Community-based LTSS. The MCO must identify Members needing LTSS and identify, assess for, authorize, and deliver these services within HHSC-specified timeframes. MCOs must authorize LTSS in a manner that reflects the Member's ongoing need for services and supports. The MCO must ensure that

Providers of LTSS are appropriately licensed, certified, or recognized as qualified by HHSC to deliver the service they provide.

STAR+PLUS HCBS services must be provided in a manner consistent with CMS home and community-based settings requirements. See 42 C.F.R. § 441.301(c)(4).

The MCO must provide Community-based LTSS when necessary for preventive reasons to avoid more expensive hospitalizations, ER visits, or institutionalizations. The MCO must make Community-based LTSS services available to an extent that Members maintain the highest level of function in the least restrictive setting. The MCO must consider the Member's need for Community-based LTSS that assists with the activities of daily living as important as needs related to a medical condition.

2.6.43.1 State Plan Community-Based Long-Term Services and Supports Available to All Members

The MCO must contract with Providers of State plan PAS and DAHS to make them available to all Members as Functionally Necessary. These Providers must meet all of the following state licensure and certification requirements for providing the services under the Contract. For PAS, the Provider must be licensed by HHSC as a HCSSA. The level of licensure required depends on the type of service delivered and the Provider may have only the PAS level of licensure. For DAHS, the Provider must be licensed by HHSC regulatory services and to deliver DAHS, the Provider must provide the range of services required for DAHS.

2.6.43.2 Community First Choice Services

CFC provides Community-based LTSS as an alternative to living in an institution to eligible Members with physical or cognitive Disabilities, SPMI, or SED. The MCO must make the array of services allowable under CFC available to Members who meet eligibility requirements. The MCO must provide CFC services in accordance with 1 Tex. Admin. Code pt. 15, ch. 354, subch. A, div 27.

To be eligible for CFC 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 an institutional LOC for a NF, an Intermediate Care Facility (ICF), or an Institution for Mental Disease (IMD). The MCO must use the assessment and reassessment process, and assessment instruments outlined in **Section 2.6.59.1**, and **Exhibit E.**

The MCO must notify Members of the eligibility determination. If the Member is eligible for CFC services, the MCO will notify the Member of the effective date of eligibility. If the Member is not eligible for CFC services, the MCO will provide the Member information on the right to appeal the determination, including access to HHSC's State Fair Hearing process as described in **Section 2.6.34**. The MCO must prepare any requested documentation regarding its assessments and Service Plans and attend the State Fair Hearing as referenced in 42 C.F.R. pt. 431, subpt. E, Fair Hearings for Applicants and Beneficiaries.

As part of any CFC service assessment, the MCO must inform the Member about service delivery options, as outlined in **Section 2.6.46**.

The MCO must contract with Providers of CFC services and ensure access to these services for all qualified Members. The MCO must ensure CFC services are provided in a manner consistent with CMS home and community-based services settings requirements. See 42 C.F.R. § 441.301(c)(4). Providers of CFC must meet all of the requirements for providing the following services:

Provider Qualifications to Deliver CFC in STAR+PLUS	
Service	Licensure and Certification Requirements
CFC Services - with the exception of Emergency Response Service - CFC	The Provider must be licensed as HCSSA or certified as a Home and Community-Based Services (HCS) or TxHmL agency. The level of licensure required depends on the type of service delivered. For Members using the CDS option, providers include individuals hired by the Member or LAR who meets provider qualifications and qualified FMSAs. For PAS - CFC: the agency may have only the PAS level of licensure.
Emergency Response Service - CFC	The Provider must meet HHSC's qualifications described in 26 Tex. Admin. Code § 279.51.

2.6.43.3 NURSING FACILITIES

The MCO must provide access to NF Services for all qualified Members. The MCOs must ensure that NF Services Providers meet all of the state licensure, certification, and contracting requirements for providing the services in **Chapter 8 of Exhibit C.**

The MCO must use HHSC established Credentialing criteria and minimum performance standards for NFs seeking to participate in STAR+PLUS in accordance with Tex. Gov't Code § 533.00251(e). The MCO may refuse to contract with a NF that does not meet the minimum performance standards established by HHSC. 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. Credentialing documentation must be submitted to HHSC upon request.

2.6.43.3.1 PREADMISSION SCREENING AND RESIDENT REVIEW

The MCO must coordinate with the LMHA or IDD authority, NF, Member, and interdisciplinary team to develop the Member's Service Plan. The MCO must ensure Preadmission Screening and Resident Review (PASRR) specialized services are provided in compliance with the Member's Service Plan.

2.6.43.3.2 PARTICIPATING IN TEXAS PROMOTING INDEPENDENCE INITIATIVE

The MCO must participate in the Texas Promoting Independence (PI) initiative, which is the State of Texas' response to *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999), that requires the provision of home and community-based services for persons with Disabilities who would otherwise be entitled to institutional services.

The Service Coordinator must review the CMS "minimum data set – version 3.0" section Q responses and must verbally ask the Member if they want to return to the community during the quarterly face-to-face visits, including informing the Member of TAS and community services available to them. The MCO must designate a point of contact, if not the Service Coordinator, to receive referrals for NF Members who want to return to the community through the use of STAR+PLUS HCBS services. The Service Coordinator must assess the individual to determine service and transition need, including mental health and SUD services. The MCO must follow the timeframes prescribed in **Exhibit E.**

The Service Coordinator or designated point of contact regarding transition services must assess the Member to determine if the Member can be safely served in the community with available resources. If determined eligible, the MCO must assess for service and transition needs within timeframes prescribed in **Exhibit E.** The Service Coordinator or point of contact must work with the Member and his or her family, the Member's PCP, the NF Discharge planner, and other community partners, as needed, to ensure timely and coordinated access to an array of providers and other non-capitated services as necessary and appropriate, including referrals to community organizations. If needed, the MCO must coordinate TAS as part of the STAR+PLUS HCBS and must refer for additional community resources including 811 Project Rental Assistance (PRA). The MCO must distribute supplemental funds, using non-Medicaid funds or other resources, as one-time financial assistance for essential household or transition expenses not covered by TAS, as defined in **Section 2.6.35**, for all Members with an identified need.

If the initial review does not support a return to the community, the Service Coordinator must conduct a second assessment 90 Days after the initial assessment, and quarterly thereafter, to evaluate if the Member's condition or circumstances changed and support a return to the community. If a return to the community is possible and appropriate, the Service Coordinator must develop and implement transition planning with the Member and his or her supports.

Prior to Discharge date the MCO must ensure all necessary services, including TAS items, as well as, mental health or SUD treatment, are in place on the Discharge date. The Service Coordinator or point of contact must be present at the relocation site on the day and time

of the Member's transition. Following Discharge, the MCO must maintain contact with Members relocated from NFs in the time intervals prescribed in **Exhibit E.**

The MCO must maintain documentation of the assessments completed as part of this initiative and make them available for HHSC review at any time.

2.6.43.3.3 NURSING FACILITIES TRAINING

In addition to **Section 2.6.8.3**, the MCO must train all NF Services Providers regarding the requirements of the Contract and special needs of 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 the services. The MCO must place special emphasis on NF Services and STAR+PLUS Program requirements, policies, and procedures that vary from Medicaid FFS and commercial coverage rules, including payment policies and procedures;
2. The assistance provided by the MCO, including provider billing practices for these services and who to contact at the MCO for assistance with this process;
3. Relevant requirements of the Contract, including the role of the Service Coordinator;
4. Processes for making referrals and coordinating Non-capitated Services;
5. The MCO's QAPI program and the Provider's role in these programs; and
6. The MCO's STAR+PLUS Program policies and procedures, including those relating to Network and Out of Network referrals.

2.6.43.3.4 NURSING FACILITY CLAIMS ADJUDICATION, PAYMENT, AND FILE PROCESSING

The MCO must process claims in accordance with **Chapter 2 of Exhibit C.** The MCO must pay clean claims no later than 10 Days after submission of the clean claim. The MCO must use the initial and daily Service Authorization System (SAS), Provider, and rate data in the adjudication of NF claims for Unit Rate and Medicare coinsurance. For purposes of this section only, clean claim is defined in Tex. Gov't Code § 533.00251(a)(2).

The MCO must ensure that NF Providers are paid NF Unit Rates at or above the minimum rates established by HHSC for the dates of service. HHSC will post NF Unit Rates at https://pfd.hhs.texas.gov/long-term-services-supports/nursing-facility-nf. If HHSC makes a retroactive rate adjustment to a NF Unit Rate, the MCO must retroactively auto-adjust payment to a NF, no later than 30 Days after receipt of HHSC notification and meet the auto-adjustment Benchmark outlined in **Chapter 2 of Exhibit C.** Further, the MCO must provide a list of NF Providers upon HHSC's request and must withhold payments to a NF in accordance with 1 Tex. Admin. Code part 15, ch. 355, subch. A.

The MCO must ensure that all enrollment and eligibility files in the JIP are loaded into the claims adjudication system before the first Day of the month following receipt of such files.

2.6.44 COMPREHENSIVE CARE PROGRAM COMMUNITY-BASED SERVICES

This section is only applicable to Members age 18 through 20. The MCO must provide all benefits and services authorized through the CCP and all Community-Based Services, including but not limited to PCS, CFC services, PDN services, and PPECC services to Members age 18 through 20.

PCS must be made available to Members who require assistance with Activities of Daily Living (ADLs), 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 authorized if determined appropriate through the MN/LOC and upon receipt of a Practitioner Statement of Need (PSON). If a Member meets an institutional LOC, then the MCO must provide CFC in place of PCS. CFC includes the following additional services: Habilitation, emergency response services and support management.

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, nutritional counseling, psychosocial services, PCS, and transport to and from the PPECC 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 Members who receive PCS or CFC, PDN, PPECC, or a combination of these services, have access to appropriate Providers. For example, if the Member is receiving PCS for BH reasons, the PCS Provider should have the experience with or training on working with children and youth with BH challenges.

2.6.45 LONG-TERM SERVICES AND SUPPORTS PROVIDERS

LTSS requirements are set forth below.

2.6.45.1 LTSS TRAINING

The MCO must comply with **Section 2.6.8**, regarding Provider manual and Provider training specific to the STAR+PLUS Program. The MCO must train all LTSS Providers regarding the requirements of the Contract and special needs of 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 such services to Members and billing the MCO for such services. The MCO must place special emphasis on LTSS and Program requirements, policies, and procedures that vary from FFS and commercial coverage rules, including payment policies and procedures;

2. The transition process of up to six months for the continuation of LTSS for Members receiving those services at the time of the STAR+PLUS Program implementation, including Provider billing practices for these services and who to contact at the MCO for assistance with this process;
3. Inpatient Hospital services and the authorization and billing of such services for Members;
4. Relevant requirements of the Contract, including the role of the Service Coordinator;
5. Processes for making referrals and coordinating Non-capitated Services;
6. The MCO's QAPI program and the Provider's role in such programs; and
7. The MCO's policies and procedures, including those relating to Network and OON referrals.

2.6.45.2 LONG TERM SERVICES AND SUPPORTS PROVIDER BILLING

The MCO must make accommodations to its claims processing system for LTSS Providers to allow for a smooth transition from billing in FFS to billing in Medicaid managed care. HHSC encourages MCOs to include attendant care payments as part of the regular claims payment process.

The MCO must utilize the standardized method of LTSS billing described in **Exhibit E.**

2.6.45.3 RATE ENHANCEMENT PAYMENTS FOR AGENCIES PROVIDING ATTENDANT CARE

The MCO must allow its LTSS Providers to participate in the Attendant Care Enhancement Program (ACEP). The MCO must use the enrollment dates for ACEP prescribed by HHSC and require, through its Provider Contracts, that participating Providers submit annual cost reports to HHSC.

The MCO must implement and pay the enhanced payments in accordance with the requirements in **Chapter 2 of Exhibit C** and 1 Tex. Admin. Code § 355.112, as applicable.

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.

Upon HHSC's request, the MCO must provide HHSC with a current list of Providers of the following attendant services: DAHS, state plan PAS, PAS provided through STAR+PLUS HCBS, PCS, and PAS and habilitation provided through CFC.

2.6.45.4 NURSING FACILITY DIRECT CARE RATE ENHANCEMENT

The MCO must allow its NF Services Providers to participate in the STAR+PLUS "direct care staff rate enhancement program" in accordance with 1 Tex. Admin. Code § 355.308.

HHSC will determine direct care staff rate enhancement payments that are included in the NF Unit Rates and post information regarding the payments on the HHSC website at https://pfd.hhs.texas.gov/long-term-services-supports/nursing-facility-nf.

The MCO must submit a rate methodology to HHSC for approval. The rate methodology submitted by the MCO must result in a staff rate enhancement that is no less than the rate that would be developed under the methodology existing at HHSC on August 31, 2015.

The MCO must ensure, through its Provider Contracts, that participating NF Services Providers comply with spending and staffing requirements under the program. If HHSC determines that a participating NF Services Provider is not compliant with the spending and staffing requirements and makes a retroactive rate adjustment to the NF's Unit Rate for this reason, the MCO must retroactively auto-adjust payments to the NF Services Provider no later than 30 Days after receipt of HHSC and meet the auto-adjustment Benchmark outlined in **Chapter 2 of Exhibit C.**

2.6.45.5 COST REPORTING FOR LONG TERM SERVICES AND SUPPORTS PROVIDERS

The MCO must ensure, through Provider Contracts, that LTSS Providers submit annual cost reports and supplemental reports to HHSC in accordance with 1 Tex. Admin. Code ch. 355, subch. A and 1 Tex. Admin. Code § 355.403. If an LTSS Provider fails to comply with these requirements, HHSC will notify the MCO to hold payments to the LTSS provider until HHSC instructs the MCO to release the payments. If a hold is placed on a Provider without HHSC approval, or if HHSC requests a hold be released and the hold is not lifted within three Business Days, the MCO is subject to contractual remedies.

2.6.46 HOME AND COMMUNITY BASED SERVICES SETTINGS

The MCO must ensure that a setting in which any of the following STAR+PLUS home and community-based services are provided complies with 42 CFR § 441.301(c)(4)(i)-(v), § 441.530, and § 441.710(4)(i)-(v), as applicable:

1. Personal assistance services
2. CFC PAS
3. CFC Habilitation
4. Respite
5. Nursing
6. Physical Therapy
7. Occupational Therapy
8. Cognitive Rehabilitation Therapy
9. Speech Therapy
10. Supported Employment
11. Employment Assistance
12. Support Consultation
13. Assisted living
14. Adult Foster Care

The MCO must ensure that a setting in which Assisted Living or Adult Foster Care is provided complies with 42 CFR §441.301(c)(4)(vi).

2.6.47 SERVICE DELIVERY OPTIONS

There are three service delivery options available to STAR+PLUS Members for the delivery of certain community-based LTSS. These service delivery options are:

1. Consumer Directed Services (CDS) option;
2. Service responsibility option (SRO); and
3. Agency option

The MCO must provide information about the service delivery options in the Member handbook, and the MCO Service Coordinator must present information about the three service delivery options to Members at the following times:

1. At initial assessment;
2. At annual reassessment or annual contact with the STAR+PLUS Member; and
3. At the Member's request.

The MCO must contract with Home and Community Supports Services agencies (HCSSAs), certified Home and Community-based Services (HCS) or Texas Home Living (TxHmL) Providers, and Financial Management Services Agencies (FMSAs) to ensure availability of all service delivery options. Network Providers must meet licensure and certification requirements as indicated in Attachment B-1, Sections 8.1.33.1 and 8.1.33.2 of the Uniform Managed Care Contract.
Regardless of which service delivery option(s) the Member selects, the Service Coordinator and the Member work together to develop the Individual Service Plan.

2.6.47.1 CONSUMER DIRECTED SERVICES OPTION

In the CDS option, the Member or the Member's LAR is the employer of record and retains control over the hiring, management, and termination of employees. The Member or Member's LAR is responsible for ensuring that the employee or contracted service provider meets all applicable eligibility qualifications and requirements. The Member is required to receive Financial Management Services provided by a FMSA. The FMSA performs functions including processing payroll, withholding taxes and filing tax-related reports to the Internal Revenue Services and the Texas Workforce Commission for services delivered through the CDS option. The FMSA is also responsible for providing training to the Member or Member's LAR on being an employer, verifying provider qualifications (including criminal history and registry checks), and approving the CDS budget.

The MCO must ensure the FMSA meets necessary qualifications to provide financial management services, including completing the mandatory FMSA enrollment training provided by HHSC and meeting eligibility requirements for an HHSC FMSA contract.

The MCO must ensure that the CDS budget is calculated using HHSC rates for CDS services.

The MCO must offer the CDS option and make it available for eligible program covered services, including Medicaid state plan personal assistance services and respite.

The MCO must offer the CDS option and make it available for the following STAR+PLUS and STAR+PLUS HCBS covered services:

1. CFC Personal Assistance Services;
2. CFC Habilitation;
3. Personal Assistance Services;
4. Respite;
5. Nursing;
6. Physical Therapy;
7. Occupational Therapy;
8. Cognitive Rehabilitation Therapy; and
9. Speech Therapy.

2.6.47.2 SERVICE RESPONSIBILITY OPTION

In the service responsibility option (SRO), the Home and Community Support Services agency (HCSSA) or certified Home and Community-based Services (HCS) or Texas Home Living (TxHmL) Provider in the MCO Provider Network is the employer of record for the Provider. The Member or the Member's legal guardian is actively involved in choosing and overseeing the service provider but is not the employer of record.
The Member selects their service provider from the HCSSA or certified HCS or TxHmL Provider's employees. The Member retains the right to supervise and train the service provider, and to establish the schedule for service delivery. The Member may request a different personal attendant and the HCSSA or certified HCS or TxHmL Provider must honor the request as long as the new attendant is an employee of the agency. The HCSSA establishes the service provider's payment rate, benefits, and conducts all administrative functions. The MCO must offer SRO and make it available for the following STAR+PLUS and STAR+PLUS HCBS Covered Services:

1. CFC Personal Assistance Services
2. CFC Habilitation
3. Personal Care Services
4. Respite

2.6.47.3 AGENCY OPTION

In the agency option, the MCO contracts with a Home and Community Support Services agency (HCSSA) or a certified Home and Community-based Services (HCS) or Texas Home Living (TxHmL) Provider for the delivery of services. The HCSSA is the employer of record for the Provider. The HCSSA or certified HCS or TxHmL Provider establishes the payment rate and benefits for the service providers and conducts all administrative functions. The agency option is the default service delivery option for all community-based Long Term Services and Supports (LTSS).

The MCO must offer the agency option and make it available for all STAR+PLUS and STAR+PLUS HCBS Covered Services.

2.6.48 HEALTH HOME SERVICES

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. MCO must ensure that the Health Home provides an array of services and supports, outlined below, that extend beyond what is required of a PCP. MCO must ensure that the Health Homes operate through either a primary care practice or, if appropriate, a specialty care practice and provide a team-based approach to care that is designed to enhance ease of access, coordination between Providers, and quality of care.

MCO must ensure that Health Home services are part of a person-based approach and holistically address the needs of Members with multiple Chronic or Complex Conditions or a single serious and persistent mental or health condition.

As described in **Section 2.6.49.6,** MCO may allow an integrated Health Home to perform Service Coordination functions and serve as an identified Service Coordinator. The MCO must permit and provide for a Health Home to provide Service Coordination in Provider Contracts.

Health Home Services must include:

1. Member self-management education;
2. Provider education;
3. Member-centered and family-centered care;
4. Evidence-based models and minimum standards of care; and
5. Member 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 for Members 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 Member 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.

The Health Home Services requirements do not apply to Dual Eligible Members unless HHSC enters into a Dual Demonstration project with the CMS. Under a Dual Demonstration project, MCOs will be required to coordinate health home initiatives with their affiliated MA Dual SNPs.

2.6.48.1 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. The MCO may offer 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 Member-centered Medical Homes found in Tex. Gov't Code § 533.0029. 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.

2.6.49 SERVICE COORDINATION

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.

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. If the Member refuses Service Coordination, the MCO must document the refusal in the Member's case file.

2.6.49.1 SERVICE COORDINATION STRATEGIC PLAN REQUIREMENTS

The MCO must implement and maintain a Service Coordination strategic plan. HHSC must approve the initial strategic plan and any changes to the strategic plan. The plan must address:

1. How the MCO will conduct Service Coordinator outreach to Members and educate them about the availability of Service Coordination;
2. How the MCO will comply with conflict-free case management;
3. How the MCO will assess Members, develop the Service Plan or ISP, identify initial and ongoing Member needs, services, and supports;
4. How the MCO will identify, track, and prioritize Members who need an assessment or reassessment when changes in their health or life circumstances occur;

5. The training a Service Coordinator will receive to identify a Member's strengths, goals, needs, and preferences;
6. How the MCO will ensure that the Member receives the required number of Service Coordination contacts, either in person or by telephone per **Section 2.6.49.2**;
7. How the Service Coordination team interfaces with the Member Hotline;
8. How the Service Coordination team is structured, including roles and responsibilities of team members, and the team's strategy for delivering the Service Coordination benefit;
9. How the Service Coordinator collaborates with other case management, care coordination, or recovery management entities to arrange Non-capitated Services;
10. How the Service Coordinator collaborates with Providers, the Member, and family members on the care team to ensure timely services and an integrated approach to care;
11. How Service Coordinators use data to inform opportunities for care coordination;
12. How Service Coordinators assist Members transitioning from a facility to the community, including how the Service Coordinator or the MCO's designee assists in locating and securing affordable housing and educates Members of their option for these services;
13. How referrals generated through the HHSC LTSS screener on YourTexasBenefits website are addressed;
14. How the Service Coordinator works with a Member's other care coordinators including waiver case managers and waiver service coordinators;
15. How Service Coordination functions are tracked by the MCO; and
16. How the MCO expects the Service Coordinators to document Member contacts and changes to a Member's Service Plan or ISP;
17. Outreach and education for Members about service planning.

The Service Coordination strategic plan must include a description of Service Coordination strategies that the MCO will use for the following categories:

1. Members with a high level of service needs;
2. Members receiving STAR+PLUS HCBS, including RNs identifying and properly documenting the Member's skilled nursing needs, and collaboration with other MCO-employed or contracted RNs as necessary;
3. Members receiving CFC;
4. Members screened positive through PASRR;
5. Members receiving services under a Medicaid waiver program as defined by Tex. Gov't. Code § 534.001(11);
6. Members residing in a NF;
7. Members residing in a community-based ICF/IID;
8. Dual Eligible Members;
9. Members with SPMI or SUD;
10. Members with serious and complex medical needs;
11. Members who are pregnant;
12. Members with a diagnosis of end stage renal disease;
13. Members with high-cost catastrophic cases or high service utilization (such as a high volume of ER or hospital visits);

14. Members with mental illness and co-occurring substance use diagnosis;
15. Members who transitioned from the STAR Kids or STAR Health Medicaid managed care programs during their first six months of enrollment in STAR+PLUS, including how the STAR+PLUS Service Coordinators will work with the STAR Kids Transition Specialists; and
16. All other Members not addressed above.

The MCO must assign all Members within the same NF, ALF, adult foster care, or group home to the same Service Coordinator.

2.6.49.2 SERVICE COORDINATION STRUCTURE

At a minimum, the MCO must have three tiers of Service Coordination for all Members.

2.6.49.2.1 SERVICE COORDINATION LEVEL 1

A Level 1 Member is defined as a Member with the highest level of utilization of Covered Services. Level 1 Members must include those:

1. In STAR+PLUS HCBS;
2. Residing in a NF in the SA;
3. Who are pregnant;
4. With end stage renal disease;
5. With high-cost catastrophic cases or high service utilization (such as a high volume of ER or hospital visits);
6. With co-occurring mental health and SUD diagnoses;
7. With a SPMI diagnosis;
8. Who transitioned from STAR Kids or STAR Health and are in their first six months of STAR+PLUS enrollment; and
9. Other Members with complex medical needs.

MCOs must provide Level 1 Members with a single identified person as their assigned Service Coordinator.

2.6.49.2.1.1 NURSING FACILITY MEMBERS

All Members within a NF must have the same assigned Service Coordinator. HHSC must provide written approval for any exceptions.

The MCO must ensure that Level 1 Members residing in a NF receive quarterly face-to-face visits, including NF service planning meetings or other interdisciplinary team meetings. Required quarterly face-to-face visits must be made at least 60 Days apart, but no more than 90 Days may elapse between visits. The MCO must maintain and make available to HHSC upon request documentation verifying the occurrence of required face-to-face Service Coordination visits, which may include participation in service planning or other interdisciplinary team meetings. In accordance with requirements for services by Telecommunication located in UMCM Chapter 16, a Service Coordinator of the MCO may determine it is appropriate to offer Level 1 Members in a Nursing Facility an Audio-visual

Service Coordination visit in place of an In-Person visit. MCOs must conduct at least one Face-to-face Service Coordination visit In-Person annually. Additionally, MCOs must conduct NF discharge planning visits In-Person, including when a Member is transitioning to STAR+PLUS HCBS.

The MCO must have an internal escalation process to address when the Service Coordinator is unable to visit a NF Member on their Member caseload because the Member no longer resides at the NF. This excludes Members on a three Day (72-hour) therapeutic home visit away from the facility as defined in 26 Tex. Admin. Code § 554.2603. The MCO must track any discrepancy between its NF Member caseload and that of the NF Services Provider. The MCO must report this information upon request from HHSC.

2.6.49.2.1.2STAR+PLUS HCBS, SPMI MEMBERS, AND ALL OTHER LEVEL 1 MEMBERS

All STAR+PLUS HCBS Members or Members with SPMI, and all other level 1 Members not mentioned above must receive a minimum of two Face-to-face and four telephonic Service Coordination contacts annually. For STAR+PLUS HCBS Members, one of the two Face-to-face visits can be the annual reassessment. The other, semi-annual Face-to-face visit must occur 4-6 months after the ISP start date. For Members with SPMI without an ISP, the other semi-annual Face-to-face visit must occur 4-6 months after the Service Plan start date. It is permissible for an MCO to schedule a Face-to-face visit outside of the 4-6 month timeframe at the Member's request. This request must be documented by the MCO. In accordance with requirements for services by Telecommunication located in UMCM Chapter 16, a Service Coordinator of the STAR+PLUS MCO may determine it is appropriate to offer these Level 1 Members Audio-visual Service Coordination in place of an In-Person visit if no assessment or reassessment is being conducted. STAR+PLUS MCOs must conduct at least one Service Coordination visit In-Person annually. An initial assessment or reassessment conducted In-Person satisfies the annual In-Person Service Coordination visit requirement. The required telephonic contacts may not be made in the same month as the Face-to-face visit and must be at least two months apart.

Contacts may include the Service Coordinator’s participation in care planning or other interdisciplinary team meetings. During the contacts, the MCO Service Coordinator must confirm needed services are in place and if the Member has additional needs that require Service Coordination or changes to service planning documents. No more than six months may elapse between required bi-annual face-to-face visits within the ISP, Service Plan, or enrollment year.

2.6.49.2.2 SERVICE COORDINATION LEVEL 2

For the purposes of this section, a Level 2 Member is a Member with less intensive needs than a Level 1 Member. Level 2 Members must include Members who have not been identified as a Level 1 Member and who receive LTSS, Members in MBCC, Members with SUD or non-SPMI BH needs, and Members who receive services in an ICF/IID or who are enrolled in an IDD Waiver. MCOs must provide Level 2 Members with a single identified person as their assigned Service Coordinator.

Members receiving state plan PAS, CFC services, or DAHS must receive a minimum of one In-Person and one telephonic Service Coordination contact annually.

Members with non-SPMI BH issues and MBCC Members must receive a minimum of one In-Person and one telephonic Service Coordination contact annually. A reasonable amount of time must elapse between contacts based on the Member's needs.

Members who receive services in an ICF/IID or who are enrolled in an IDD Waiver must receive a minimum of one In-Person and one telephonic Service Coordination contact annually. Additionally, the MCO must request to be invited by the LIDDA or IDD Waiver case manager to participate in the IDD Waiver service planning meetings. If the Member and Authorized Representative approve of the MCO's attendance at their service planning team meetings, the MCO must participate in at least one service planning team meeting per year and document their attendance in the Member's case record.

Service Coordinators may provide in person assistance to MBCC Members during the MBCC six-month recertification process to fulfill the in-person Service Coordination visit requirement.

In accordance with requirements for services by Telecommunication located in UMCM Chapter 16, a Service Coordinator of the STAR+PLUS MCO may determine it is appropriate to offer Level 2 Members Audio-visual Service Coordination in place of an In-Person visit, if no assessment or reassessment is being conducted. STAR+PLUS MCOs must conduct at least one Service Coordination visit In-Person annually. An initial assessment or reassessment conducted In-Person satisfies the annual In-person Service Coordination visit requirement.

2.6.49.2.3 SERVICE COORDINATION LEVEL 3

For the purposes of this section, a Level 3 Member is a Member who does not qualify as a Level 1 or Level 2 Member. This includes Members residing in a NF receiving hospice, Members who are provisionally residing in a NF outside the MCO's SA, and Dual-Eligibles who do not meet Level 1 or 2 requirements. Level 3 Members are not required to have a named Service Coordinator; however, MCOs must offer them one. The exception is that MCOs must provide a named Service Coordinator to Level 3 Members if:

1. The Member requests one;
2. The Member is in a NF receiving hospice; or
3. The Member is provisionally residing in a NF outside the SA.

The MCO must make at least two telephonic service coordination outreach contacts yearly.

2.6.49.2.4 DISCONTINUATION OF SERVICE COORDINATION OR ASSESSMENTS USING TELECOMMUNICATIONS

HHSC may, on a case-by-case basis, require an MCO to discontinue Service Coordination or assessments using Telecommunication if HHSC determines that the discontinuation is in the best interest of the Member.

2.6.49.2.5 INTENTIONALLY LEFT BLANK

2.6.49.3 COMMUNICATION

Upon enrollment and periodically thereafter, MCOs must provide written notice to all STAR+PLUS Members (including Level 3 Members who do not have a named Service Coordinator) that includes the following information:

1. A description of Service Coordination;
2. The name of the Member's Service Coordinator, if applicable;
3. The direct phone number of the Member's Service Coordinator, if applicable;
4. The minimum number of contacts the Member will receive every year;
5. The types of contacts the Member will receive;
6. The MCO's Service Coordination phone number; and
7. The availability of an annual wellness exam as a covered benefit.

The MCO must honor the preferences of the Member, the Member's Authorized Representative, LAR, or guardian to receive this communication in another format.

MCOs must notify the Member if any of the above information changes. For Service Coordination phone number requirements, see **Section 2.6.18**.

2.6.49.4 CHANGE IN SERVICE COORDINATOR

Upon a Member's enrollment, or in the event of a named Service Coordinator change, the MCO must notify the Member in writing within five Business Days of the name and phone number of their new Service Coordinator. The notification may be in the manner of communication specified by the Member, the Member's Authorized Representative, LAR, or guardian. The MCO must also post the new Service Coordinator's information on the Member and Provider portals within the same timeframe in accordance with **Sections 2.6.20.2 and 2.6.20.3**.

2.6.49.5 DOCUMENTATION

When reaching out to Members to make the required contacts for each level, the MCO must document in the Member case file:

1. If Covered Services have been delivered and received, or if there has been any interruption in services since the last contact,
2. If there has been any change in the health status of the Member including:
    a. New diagnoses,
    b. New medications,
    c. Hospitalizations/visits to ER/doctor visits/institutionalization and
    d. Change in Condition.
3. If there have been any significant life stressors since the last contact including:
    a. Pending eviction,
    b. Death of spouse or other loved ones,
    c. Change in caregivers, and

d. Natural disasters.
4. If the Member requires any assistance from the MCO.

If the MCO fails to meet the Service Coordination performance standards, HHSC may impose liquidated damages.

2.6.49.6 SERVICE COORDINATION TEAMS

Service Coordination teams must be led by at least one Service Coordinator. An integrated Health Home may perform Service Coordination functions and serve as the identified Service Coordinator. Service Coordination Teams must have the following expertise or have access within the MCO to identified subject matter experts in the following areas:

1. BH, including inpatient, outpatient, and MHR;
2. SUD;
3. Local resources, including basic needs like housing, food, utility assistance;
4. LTSS;
5. DME;
6. End of life or advanced illness and advanced directives;
7. Acute care;
8. Preventative care;
9. Cultural Competency based on the federal and state standards;
10. Pharmacology;
11. Nutrition;
12. Texas PI strategies;
13. Financial management services;
14. Person-Centered planning;
15. The nursing process and assessment for skilled nursing needs and appropriate documentation;
16. Employment First practices including Employment Assistance and Supported Employment;
17. PASRR;
18. Trauma-informed care and trauma-informed practices;
19. NEMT Services;
20. Working with individuals with IDD; and
21. LTSS and medical services that may be necessary for individuals with IDD;

2.6.49.7 COORDINATION WITH OTHER ENTITIES

The MCO must ensure that each Member has a qualified PCP who is responsible for overall clinical direction and, in conjunction with the Service Coordinator, serves as a central point of integration and coordination of Covered Services, including primary, Acute Care, LTSS, and BH Services.

The MCO must ensure that the Service Coordinator works with the Member's PCP to coordinate all Covered Services and any applicable Non-capitated Services, regardless of whether the PCP is in the MCO's Network, and particularly for Dual Eligible Members. In

order to integrate the Member's care while remaining informed of the Member's needs and condition, the MCO must ensure that the Service Coordinator actively involves the Member's primary and specialty care Providers, including BH Service Providers; providers of Non-capitated Services; and traditional Medicare and Medicare Advantage health plans for qualified Dual Eligible Members.

For Members eligible for LTSS services, including NF, ALF, and adult foster care, the MCO must ensure, through Service Coordination, that a Member's mental health and SUD treatment needs are identified and services coordinated.

The MCO may subcontract with community-based organizations to assist in locating and securing affordable housing for Members transitioning from a facility to the community. When considering whether to refer a Member to a NF or other long-term care facility, the MCO must ensure the Service Coordinator considers the availability of the Programs of All-Inclusive Care for the Elderly (PACE) for that Member.

The MCO must support Members or their families in coordinating their own care, to the extent of the Member's or the family's capability and willingness to coordinate care.

2.6.49.8 SERVICE COORDINATORS

The MCO must employ, as Service Coordinators, persons experienced in meeting the needs of vulnerable populations who have Chronic or Complex Conditions. Service Coordinators are Key Personnel as described in **Section 4.02 of Exhibit A**. In addition, Service Coordinators must meet the following requirements:

1. A Service Coordinator for Level 1 Member must be a RUG-Certified RN or NP with the following exceptions:
    a. Members with SPMI or members with co-occurring mental health and SUD diagnosis may receive service coordination from a masters-level social worker or professional counselor, Licensed Bachelor of Social Work (LBSW), Provisionally Licensed Psychologist (PLP), or Licensed Psychological Associate (LPA) licensed to practice in Texas;
    b. Members in their first six months of STAR+PLUS enrollment after transitioning from STAR Kids or STAR Health, who would not otherwise qualify for Level 1 Service Coordination, may receive Service Coordination from a Service Coordinator who:
        i has an undergraduate or graduate degree in social work or a related field; or is an LVN, RN, NP, physician's assistant, or qualified IDD professional as outlined in 42 Code of Federal Regulations §483.430(a); or
        ii has a minimum of a high school diploma or General Education Diploma (GED) and direct experience with the Aged, Blind, or Disabled and Supplemental Security Income (ABD/SSI) population in three of the last five years.

2. A Service Coordinator for a Level 2 or 3 Member must have:

a. an undergraduate or graduate degree in social work or a related field; or be an LVN, RN, NP, physician's assistant, or qualified IDD professional as outlined in 42 Code of Federal; Regulations §483.430(a); or
b. have a minimum of a high school diploma or General Education Diploma (GED) and direct experience with the ABD/SSI population in three of the last five years.
c. A Service Coordinator for Members who receive ICF/IID services or who are enrolled in an IDD Waiver must have at least two years of experience working directly with people with IDD and meet one of the following: is a masters-level social worker or professional counselor; is LBSW or meets requirements for qualified IDD professionals as outlined in 42 Code of Federal Regulations §483.430(a).
The MCO must receive written approval from HHSC for any exception to this standard;

3. Service Coordinators must have experience in meeting the needs of the Member population served (for example, people with Disabilities).
4. Service Coordinators must possess knowledge of the principles of most integrated settings, including federal and State requirements like the federal home and community-based settings regulations;
5. Service Coordinators must complete no less than 32 hours of training within 6 months of being hired. MCOs must administer the training, which must include:
    a. Information related to the population served by STAR+PLUS and by the Service Coordinator;
    b. Information about the CDS option, including the benefits of the CDS option and best practices in offering and describing the option to all Members receiving LTSS, regardless of Disability;
    c. How to assess a Member's medical, BH, functional, cognitive, and social needs and concerns, including functional assessments and outcomes for Service Plan/ISP development with a focus on health and social needs;
    d. How to assess and provide information to Members on all Covered Services;
    e. Identifying and reporting Critical Events or Incidents and educating Members regarding protections;
        i For Service Coordinators working with Members receiving Community-Based LTSS, including CFC and HCBS services, this training must be provided before contact with Members served, but no later than 30 Days of the date of hire and annually thereafter;
    f. Available local and statewide resources;
    g. Respect for cultural, spiritual, racial, and ethnic beliefs of others; and
    h. Overview of the standards of documentation, licensure, and scope of practice requirements applicable to providers in the LTSS setting, consistent with the Texas Occupational Code and Texas Administrative Code;
    i. Employment First practices and policies;

j. 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;
k. American with Disabilities Act (ADA) and *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999) requirements; and
l. Person-centered planning principles, processes, and policies.

In addition, Service Coordinators must receive no less than 32 hours of ongoing Service Coordination training every two years. MCOs must administer the training, which may be a refresher from the training specified in number 4 above, and topics required below may be tailored to the Members in a Service Coordinator's caseload. Topics in the ongoing MCO-administered training must include the following, as applicable to the Service Coordinator's caseload:

1. How the Texas Administrative Code related to nursing licensure and the nursing process is applicable in the LTSS setting;
2. PASRR requirements and how to escalate issues related to a Member not receiving PASRR-authorized services;
3. How to complete the "Medical Necessity/Level of Care (MN/LOC) Assessment" (located in the **Procurement Library**) that is submitted to TMHP and designated by HHSC per form instructions;
4. How to perform a thorough investigation of third-party resources before authorizing STAR+PLUS HCBS;
5. Person-centered planning for special populations, including for Members who do not use words to communicate;
6. The nursing process and assessment for skilled nursing needs, and appropriate documentation for members with IDD;
7. Employment Assistance and Supported Employment for eligible Members;
8. Provision of Mental Health TCM for Members receiving MHR;
9. Trauma-informed care and trauma-informed practices for Members with IDD;
10. National quality of life standards for individuals with IDD,
11. Prevention and crisis response services to ensure Members with IDD are not inappropriately institutionalized;
12. HCBS settings requirements (42 C.F.R.§ 441.530);
13. Accessibility and accommodations for Members with different types of Disabilities, including IDD;
14. Independent living and recovery for Members with different types of Disabilities, including IDD;
15. The IDD Community-based waiver programs and community-based ICF/IIDs;
16. Working with Members with IDD; and
17. LTSS and Covered Services which may be necessary for Members with IDD;

The MCO must ensure that all Service Coordinators participate in all trainings required by HHSC.

The MCO must ensure that Service Coordinators working with Members receiving LTSS, including CFC, and STAR+PLUS HCBS services complete an HHSC-approved training on Person-Centered practices and Person-Centered plan facilitation to meet federal

requirements on person-centered planning for LTSS, including for Members who do not use words to communicate.

The MCO must ensure that this training is completed within two months of the Service Coordinator's hire date 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 other Service Coordinator training requirements identified in this section.

Service Coordinators assessing for facility or community based LTSS must receive, at a minimum, eight hours of training related to Person-Centered planning, the discovery process, and person-centered outcomes.

Service Coordinators must also receive an HHSC-approved or HHSC-offered Person Centered training refresher course every two years.

The MCO must ensure that the Service Coordinator for Dual-Eligible Members receives training regarding Medicare-covered benefits and the coordination of Medicare and Medicaid. The MCO must provide the Service Coordinator with ongoing, updated resources, and supports related to Medicare.

2.6.49.9 REFERRAL TO COMMUNITY ORGANIZATIONS

The MCO must ensure Service Coordinators provide information about and referral to community organizations providing Non-capitated Services that are important to the health and wellbeing of all Members, including referrals related to caregiver supports. The MCO must implement a systematic process to coordinate and track referrals to community organizations and identify service gaps for each Member.

The MCO also must make a best effort to establish relationships with State and local programs and community organizations. These organizations include, but are not limited to:

1. State and federal agencies (e.g., those agencies with jurisdiction over aging, public health, SUD, mental health, IDD, rehabilitation, income support, nutritional assistance, family support agencies, etc.);
2. Social service agencies (e.g., area agencies on aging, residential support agencies, independent living centers, supported employment agencies, etc.);
3. City and county agencies (e.g., welfare departments, housing programs, etc.);
4. Civic and religious organizations;
5. Consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning, etc.); and
6. Affordable housing programs (e.g. Section 811, local housing authorities, agencies that operate affordable housing, homeless service agencies).

2.6.49.10 DISCHARGE PLANNING

The MCO must provide Discharge planning, transition care, and other education programs to Providers regarding all available LTSS settings and options. The MCO must have a

protocol for quickly assessing the needs of Members Discharged from a Hospital, NF, ALF, or other care or treatment facility, including inpatient psychiatric facilities.

The MCO's Service Coordinator must work with the Member's PCP, the facility Discharge planner, the attending physician, the Member, and the Member's informal supports to assess and plan for the Member's Discharge prior to the Member's Discharge. When LTSS or Acute Care services, including nursing, home health, DME, or other Covered Services are needed, the MCO must ensure that the Member's Discharge plan includes arrangements and authorizations for community-based care so items, services and supports are in place in the LTSS setting upon Discharge. The MCO must ensure the Member, the Member's informal supports, and the Member's PCP are well informed of all service options available to meet the Member's needs in the community.

Upon receipt of notice of a Member's Discharge from a Hospital or an inpatient psychiatric facility, Service Coordinators must contact the Member within one Business Day. The Service Coordinator must assist the Member in locating and scheduling an appointment for outpatient BH care upon Discharge.

If the Member is in a program or waiver not operated by the MCO, the MCO must coordinate with the other program or waiver to ensure the Member's health and safety needs are met.

2.6.49.11 CENTRALIZED MEDICAL RECORD AND CONFIDENTIALITY

The Service Coordinator is responsible for maintaining a case file related to Member contacts, assessments, and service authorizations, referred to hereafter as a centralized Member record. 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.

2.6.49.11.1 SECTION 811 PROJECT RENTAL ASSISTANCE

The PRA program provides project-based rental assistance for extremely low-income persons with Disabilities linked with long term services. The program is made possible through a partnership between Texas Department of Housing and Community Affairs, HHSC, and eligible multifamily properties.

The MCO must ensure that Service Coordinators coordinate with the PRA program point of contact on an ongoing basis, as needed, in accordance with their role as the 811 Service Coordinator for Members with Disabilities exiting a NF and receiving services from the Section 811 PRA program.

2.6.49.11.2 SERVICE COORDINATION USING TELECOMMUNICATION

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

2.6.49.11.3 ICD 10 Z CODES

The MCO must request that PCPs, emergency room providers and BH providers submit claims, as appropriate, for Members that include ICD-10 Z codes regarding socioeconomic and psychosocial circumstances and their related subcategories, as described in **Chapter 16 of Exhibit C.** When the MCO receives a claim that includes one of these codes, the MCO must communicate this information to the Service Coordinators to ensure appropriate delivery of services.

2.6.50 DISEASE MANAGEMENT

The MCO must provide DM programs consistent with State and federal statutes and regulations that focus on the whole person. The MCO's DM programs must identify Members at highest risk of utilization of medical services, tailor interventions to better meet Members' needs, encourage Provider input in Service Plan and ISP development, and apply clinical evidence-based practice protocols for individualized care.

The MCO must ensure that its DM program(s) include the following components:

1. Member self-management as age appropriate, in which a Member becomes an informed and active participant in the management of physical and mental health conditions and co-morbidities;
2. Caregiver care management education;
3. Provider education;
4. Technological supports;
5. EBPs and TIC;
6. Standardized protocols and participation criteria;
7. Physician-directed or physician-supervised care;
8. A continuum of interventions to address individualized need;
9. Mechanisms to modify or change interventions that are not proven effective; and
10. Mechanisms to monitor the clinical and financial impact of the DM program over time.

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

The MCO must provide designated staff to implement and maintain DM programs and to assist participating Members in accessing DM services. The MCO must educate Members, Caregivers, and Providers about the MCO's DM programs and activities. Additional requirements related to the MCO's DM programs and activities are found in **Chapter 9 of Exhibit C.**

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 **Chapter 9 of Exhibit B**.

2.6.50.1 DISEASE MANAGEMENT FOR MEMBERS WITH COMPLEX CARE NEEDS AND HIGH COSTS

The MCO must have a specialized program for targeting, outreach, education, and intervention for MCN who have excessive utilization patterns that indicate typical DM approaches are not effective. The MCO must, at a minimum, have the following infrastructure in place to address MCNs' needs:

1. Methodology for identification of MCNs on an ongoing basis, based on cost, utilization of the emergency department, utilization of inpatient or pharmacy services, physical and BH comorbidities, or other specified basis;
2. Resources dedicated to ongoing targeting and identification of MCNs;
3. Staff resources for effective outreach and education of Providers and MCNs;
4. Specialized intervention strategies for MCNs. The interventions must include an option for in-person interactions with the Member that occur outside of a standard clinical setting. This in-person intervention may be performed by medical care providers or other non-medical Providers that are employed by the MCO or are Subcontracted with the MCO;
5. Evaluation process to determine effectiveness of the MCNs program. As part of the annual evaluation of effectiveness, the MCO should include a description or example of an intervention it found effective, e.g., a Member case study with a description of the interventions and improvements or a specific project with demonstrated effectiveness; and

Upon request, the MCO must demonstrate to HHSC its methodologies for identification and intervention strategies for this population, to include the MCO's dedicated resources to support this effort. On an ad hoc basis, the MCO must provide its documentation of management strategies to address MCNs including the criteria listed above using **Chapter 9 of Exhibit C.** HHSC will evaluate the plan and provide feedback to the MCO. Upon HHSC's approval of the plan, the MCO will be retrospectively evaluated on its execution of the written plan, as described in **Section 2.6.50.3**. The 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.

APMs for Providers of services to MCNs: The MCO is strongly encouraged to implement APMs for Providers who provide interventions for this population. Funds expended on APMs for this population will be counted toward APM targets delineated in **Section 2.6.25.5**.

2.6.50.2 DISEASE MANAGEMENT AND PARTICIPATING PROVIDERS

At a minimum, the MCO must:

1. Implement a system for Providers to request specific DM interventions;
2. Give Providers and Service Coordinators information, including differences between recommended prevention and treatment and actual care received by Members enrolled in a DM Program, and information concerning such Members' adherence to a Service Plan or ISP; and

3. Provide reports on changes in a Member's health status to their PCP, for Members enrolled in a DM Program.

2.6.50.3 HHSC Evaluation of Disease Management Program

HHSC or its EQRO will evaluate the MCO's DM program and evaluate it at a frequency determined by HHSC. The MCO must provide all information HHSC deems necessary for such evaluation.

2.6.51 Behavioral Health Services

The MCO must provide or arrange for the delivery of all Medically Necessary BH Services to Members as described in the Contract. BH Services are described in more detail in **Exhibit F.**

All BH Services must be provided in conformance with the access standards included in **Section 2.6.36**, and the BH Provider network standards in **Section 2.6.36.2**. BH Services are described in more detail in **Exhibit F.**

When assessing Members for BH Services, the MCO and its BH Service Providers must include a primary and secondary (if present) diagnosis using the most recent DSM. HHSC may require use of other assessment instruments or outcome measures in addition to the most recent DSM. The MCO must require that Providers document DSM and assessment or outcome information in the Member's medical record.

As allowed by 42 C.F.R. § 438.3(e), the MCO may provide certain HHSC-approved services in lieu of BH Services, as described in **Chapter 16 of Exhibit C**.

2.6.51.1 Behavioral Health Provider Network

The MCO must maintain a BH Services Network to ensure accessibility and availability of qualified Providers to all Members in the SA. The Provider Network must include BH Service Providers with experience serving special populations included in the STAR+PLUS Program, such as:

1. Persons with Disabilities;
2. The elderly;
3. Cultural or linguistic minorities;
4. Members identified by the MCO as having BH issues that may affect their physical health or treatment compliance, including Members with Serious and Persistent Mental Illness;
5. Members with serious ongoing illness or a Chronic or Complex Condition that is anticipated to last for a significant period and requires ongoing therapeutic or pharmacological intervention and evaluation;
6. Members with co-occurring mental illness and SUD;
7. Members with high cost catastrophic cases or high service utilization;
8. Pregnant and postpartum Members; and
9. Members who have experienced trauma.

2.6.51.2 Member Education and Self-referral for Behavioral Health Services

The MCO must maintain a Member education process to help Members know where and how to obtain BH Services and assist Members and LARs in locating Providers appropriate for or specializing in serving individuals with IDD.

The MCO must permit Members or their LARs to self-refer to any Network BH Services Provider without 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 such self-referral to BH Services. The MCO must permit Members to participate in the selection of the appropriate BH Services Providers who will serve them and must provide the Members with information on accessible Providers with relevant experience within the distance standards for BH Providers as detailed in **Chapter 5 of Exhibit C**.

2.6.51.3 Coordination between the Behavioral Health Provider and the Primary Care Provider

The MCO must ensure that the behavioral and physical health clinical Member information is shared efficiently and effectively between the PCP and BH Service Providers. If the MCO uses a BHO as a Material Subcontractor, the MCO must ensure that MCO and BHO have shared, integrated data systems to facilitate Service Coordination and the timely sharing of Member information with PCPs and BH specialists.

The MCO must require, through Provider contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or appropriate referral for, any known or suspected BH problems and disorders. The MCO must provide training to PCPs on how to screen for and identify BH disorders, the MCO's referral process for BH Services and clinical coordination requirements for such services. The MCO must include training on coordination and quality of care such as BH screening techniques for PCPs and new models of BH interventions.

The MCO must develop and disseminate policies regarding clinical coordination and the sharing of Member information between BH Service Providers and PCPs, as clinically indicated. The MCO must require that BH Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment. The MCO must require that PCPs and BH 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 BH condition. The MCO must develop a simple communication format for sharing information between BH Service Providers and PCPs and other subspecialty Providers. The MCO must consult with PCPs, psychiatrists, and other relevant BH 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 on the role of the Service Coordinator in the coordination and sharing of health information and status.

The MCO must require that BH Service Providers and PCPs send each other initial and updated summary reports of a Member's physical and BH status, as agreed to by the PCP team members.

The MCO must require PCPs to screen Members for any BH condition and may treat Members within the appropriate scope of their practice and refer Members for treatment through the Provider Network.

The MCO must use evidence-based integrated 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 seek to recruit PCPs and BH 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 BH coordination of treatment and services.

The MCO must seek to recruit providers who practice using the Medical Home Model and IPC. 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 BH problems. The MCO must regularly measure Member BH improvement using psychometrically sound instruments.

MCO training for PCPs must include the use of valid and recommended screening and assessment tools. MCO training must include the use of the THSteps Forms for Members aged 18 to 20. The MCO must train PCPs on identifying and referring all Members suspected of having a developmental delay or developmental Disability, SED, mental illness, or a SUD. 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 services.

The MCO must provide information to Providers on evidence-based interventions for BH 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 BH Services Providers to address the Member's special needs. The MCO must assist PCPs and other Providers with access by facilitating specialty consults through the use of Telemedicine technology. The MCO must provide Provider training that includes information on how to access Telemedicine or Telehealth resources.

The MCO must require BH Services Providers to refer Members with known or suspected and untreated physical health problems or disorders to their PCP, with the Member's or the Member's LAR's consent. The MCO must specify in the Provider manual that BH Services Providers may only provide physical health care services if they are licensed to do so.

The MCO must require that BH Providers send initial and quarterly, or more frequently, if clinically indicated, summary reports of a Member's BH status to the PCP, with the

Member's or the Member's LAR's or legal guardian's consent. The MCO must specify this reporting requirement in the Provider manual.

2.6.51.4 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. Prior to Discharge, the MCO must review the Member's case history and Service Plan or ISP and attempt to communicate with the Member or Member's LAR and key Providers to determine if additional Community-Based Services, such as STAR+PLUS HCBS services or CFC services, and other supports might reduce subsequent need for re-admission. If the MCO identifies additional service and support needs through this process, the MCO must work with the Member and the Member's LAR to establish the services.

The MCO must ensure that BH Service Providers contact Members, who have missed appointments, within 24 hours of the missed appointment to reschedule appointments.

The MCO must adopt additional policies to work with the Members and the LARs following an inpatient BH admission for the purpose of preventing re-admission.

2.6.51.5 MENTAL HEALTH REHABILITATIVE SERVICES AND MENTAL HEALTH TARGETED CASE MANAGEMENT SERVICES

The MCO must ensure that MHR and Mental Health TCM is available to eligible Members based on needs identified in the ANSA. The MCO must maintain a qualified Network of private and public Comprehensive Provider Agencies that provide these services.

The MCO must ensure MHR include training and services that help the Member maintain independence in the home and community, including the following:

1. **Medication training and support -** curriculum-based training and guidance that serves as an initial orientation for the Member in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community;
2. **Psychosocial rehabilitative services -** social, educational, vocational, behavioral, or cognitive interventions to improve the Member's potential for social relationships, occupational or educational achievement, and independent 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;
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; and

5. **Day program for acute needs -** short-term, intensive, site-based treatment in a group modality 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 MHR and Mental Health TCM in accordance with **Chapter 15 of Exhibit C**, including ensuring Comprehensive Provider Agencies are trained on how to use the Resiliency and Recovery Utilization Management Guidelines (RRUMG), and MHR and Mental Health TCM requirements in State rules and policy.

The MCO must also ensure that a Provider reviews a Member's plan of care for MHR in accordance with the RRUMG to determine whether a change in the Member's condition or needs warrants a reassessment or change in service. If the Member's condition warrants a change in service, the MCO must ensure the Provider submits a new plan of care to the MCO for authorization.

Additionally, the MCO must ensure that Providers of MHR Services and Mental Health TCM use and are trained and certified to use the ANSA tools for assessing a Member's needs.

The MCO must ensure, through Provider Contracts, that its Providers comply with 1 Tex. Admin. Code part 15, ch. 353, subch. P and 1 Tex. Admin. Code pt. 15, ch. 354, subch. M, div. 1.

The MCO must ensure that Service Coordinators coordinate with Providers of Mental Health TCM to ensure integration of behavioral and physical health needs of Members. The MCO must ensure that if a Member loses Medicaid eligibility, Service Coordinators refer the Member to community resources.

2.6.51.6 Local Mental Health Authority or Local Behavioral Health Authority

The MCO must coordinate with the LMHA or LBHA, other appropriate Providers, and the 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.

In addition, the MCO must notify an LMHA or LBHA upon MCO's notification, but in no event later than three Business Days, that a Member is admitted to a Hospital for inpatient psychiatric services, with or without a court order, if the LMHA or LBHA has provided Covered Services to the Member in the 12 months preceding the admission. If the Member has received Covered Services at more than one LMHA or LBHA in the 12 months preceding the admission, the MCO must notify only the LMHA or LBHA which last delivered Covered Services to the Member.

The MCO is required to comply with additional BH Services requirements relating to coordination with the LMHA or LBHA and care for special populations.

2.6.51.7 MENTAL HEALTH PARITY

The MCO must comply with all applicable provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and all related regulations, including 42 C.F.R. Part 438, Subpart K, and 45 C.F.R. §§ 146.136, 147.136, and 147.160. The MCO must work with HHSC to comply with MHPAEA, and must provide HHSC, upon request, with:

1. A non-quantitative treatment limitation assessment tool(s);
2. Surveys or CAPs s related to compliance with MHPAEA;
3. Statements of attestation stating compliance with MHPAEA; and
4. Any other information as requested by HHSC, including documentation requested for operational reviews.

The information must be provided within the timeframe included in HHSC's request.

2.6.51.8 COURT-ORDERED SERVICES

The MCO is required to pay for Covered Services ordered by a court pursuant to the statutory citations in **Sections 2.6.51.8.1 and 2.6.51.8.2**. The MCO cannot deny, reduce, or controvert the court orders for inpatient mental health Covered Services for Members ages 65 and older, provided:

1. Pursuant to a court order; or
2. As a condition of probation.

The MCO cannot deny, reduce, or controvert the court orders for inpatient mental health Covered Services for Members of any age if the court-ordered services are delivered in an Acute Care Hospital.

The MCO cannot limit SUD treatment or outpatient mental health services for Members of any age provided pursuant to:

1. A court order; or
2. A condition of probation

For court-ordered services, the MCO cannot apply its own UM criteria through PAs, concurrent reviews, or retrospective reviews for services delivered in an Acute Care Hospital, SUD treatment, or outpatient mental health 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.

MCOs are required to have a mechanism to receive court order documents from Providers at the time of an authorization request.

2.6.51.8.1 PSYCHIATRIC SERVICES

The MCO must provide all psychiatric Covered Services to Members ages 65 and older who have been ordered to receive the services:

1. By a court of competent jurisdiction including services ordered pursuant to the Tex. Health & Safety Code ch. 573, subchs. B and C; Tex. Health & Safety Code ch. 574, subchs. A-G; and Tex. Fam. Code ch. 55, subch. D; or
2. As a condition of probation.

These requirements are not applicable when the Member is considered incarcerated, as defined by **Chapter 16 of Exhibit C**.

The MCO must provide all inpatient psychiatric Covered Services to Members ages 65 and older, who have been ordered to receive the services:

1. By a court of competent jurisdiction ordered pursuant to the Tex. Health & Safety Code ch. 573, subchs. B and C, Tex. Health & Safety Code ch. 574, subchs. A-G; or
2. As a condition of probation if the Member receives those services at an Acute Care Hospital.

These requirements are not applicable when the Member is considered incarcerated, as defined by **Chapter 16 of Exhibit C**.

2.6.51.8.2 SUBSTANCE USE DISORDER TREATMENT SERVICES

MCOs must provide covered SUD treatment services, including residential treatment, required as a:

1. Court order consistent with Tex. Health & Safety Code ch. 462, subch. D; or
2. Condition of probation.

These requirements are not applicable when the Member is considered incarcerated as defined by **Chapter 16 of Exhibit C**.

2.6.51.9 SUBSTANCE USE DISORDER BENEFIT

The following sections outline the requirements for SUD benefits.

2.6.51.9.1 SUBSTANCE USE DISORDER AND DEPENDENCY TREATMENT SERVICES

The MCO must comply with 28 Tex. Admin. Code pt.1, ch. 3, subch. HH regarding UM and SUD treatment.

2.6.51.9.2 PROVIDERS AND REFERRALS

MCOs must follow provider requirements at **Sections 2.6.38.16, 2.6.38.19, and 2.6.36.2.5** for SUD outpatient and residential services, respectively.

MCOs must maintain a provider education process to inform SUD treatment Providers in the MCO's Network on how to refer Members for treatment.

2.6.51.9.3 REQUIREMENTS FOR MEDICATION ASSISTED TREATMENT

The MCO must comply with Tex. Hum. Res. Code § 32.03115 when reimbursing Providers for MAT for opioid use disorder or SUD.

2.6.51.9.4 MEMBER EDUCATION AND SELF-REFERRAL FOR SUBSTANCE USE DISORDER TREATMENT SERVICES

The MCO must maintain a Member education process, including hotlines, manuals, policies, and other Member Materials, to inform Members of the availability of and access to SUD treatment services, including information on self-referral.

2.6.52 CONTINUITY OF CARE AND OUT-OF-NETWORK PROVIDERS

For newly enrolled Members, the MCO must ensure that care is not disrupted or interrupted, particularly for Members whose health or BH condition has been treated by specialty care providers, or whose health could be placed in jeopardy if Covered Services are not provided. For Members transferring from another MCO, the receiving MCO must request and honor information such as the Member's needs, current Medical Necessity determinations, authorized care, and existing Service Plans or ISPs from the relinquishing MCO until such time that a Service Coordinator is able to contact the Member and assess needed services. The MCO must respond to requests from other MCOs for information, including but not limited to, information regarding the Member's needs, current Medical Necessity determinations, authorized care, Service Plans or ISPs or other documents pertinent to the health and well-being of the Member.

Upon notification from a Member, Provider, or relinquishing MCO of the existence of a PA, the new MCO must ensure Members receiving services through that PA from either another MCO or FFS, receive continued authorization of those services in the same amount, duration, and scope for the shortest period of one of the following:

1. 90 Days after the transition to a new MCO;
2. Until the end of the current authorization period, or
3. Until the MCO has evaluated and assessed the Member and issued or denied a new authorization. See **Section 2.6.50** for specific requirements for new Members transferring to the MCO's DM Program.

For instances in which a newly enrolled Member transitioning from FFS to managed care was receiving a service that did not require a PA 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 for Acute Care and 6 months for LTSS 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.

2.6.52.1 SINGLE CASE AGREEMENTS

If a Member wishes to stay with their current Provider who is Out-Of-Network with the MCO, the MCO may seek to obtain a single-case-agreement, Out-Of-Network authorization or similar arrangement with the Provider to ensure continuity of care. The MCO may use single case agreements with Out-Of-Network providers for other reasons, including for obtaining a second opinion.

2.6.52.2 AGE-OUT TRANSITIONS

For Members transitioning from STAR Kids or STAR Health to STAR+PLUS, at least 90 Days prior to enrollment or upon notification of the Member's STAR+PLUS MCO selection, the MCO must coordinate with the STAR Kids or STAR Health MCO to obtain current and active Service Plans, authorizations, and relevant case files.

2.6.52.3 OUT OF NETWORK PROVIDERS

The MCO must pay a Member's existing OON providers for Covered Services until the Member's records, clinical information, and care can be transferred to a Provider, or until such time as the Member is no longer enrolled in STAR+PLUS, whichever is shorter. The MCO must apply the same payment standards and rates as described in 1 Tex. Admin. Code pt. 15, ch. 353, subch. A, § 353.4 and subch. J, § 353.913 to OON services provided pursuant to this section.

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 OON. If a Member wants to change her OB/GYN to one who is in the Network, she must be allowed to do so if the Provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

The MCO's obligation to reimburse the Member's existing OON provider for services provided to a pregnant Member past the 24th week of pregnancy extends through delivery or miscarriage of the child, immediate postpartum care, and the follow-up checkup within the first 6 weeks of delivery or miscarriage.

With the exception of pregnant Members who are past the 24th week of pregnancy, this section does not extend the obligation of the MCO to reimburse the Member's existing OON providers for on-going care for:

1. More than 90 Days after a Member enrolls in the MCO, for Acute Care
2. More than six months after a Member enrolls in the MCO, for LTSS, or
3. For more than nine months in the case of a Member who, at the time of enrollment in the MCO, has been diagnosed with and is receiving treatment for a terminal illness and remains enrolled with the MCO.

The MCO must provide or pay OON providers who provide Covered Services to Members who move out of the SA through the end of the period for which capitation has been paid for the Member. If a Member transitions from a facility to the community in another SA, it is the responsibility of the MCO to make single-case agreements and other contractual

relationships necessary to ensure the health and safety of the Member until an enrollment change takes effect.

If Covered Services are not available within the MCO's Network, the MCO must provide Members with timely and adequate access to OON providers of Covered Services for as long as those services are necessary and are not available within the Network, in accordance with 42 C.F.R. § 438.206(b)(4). The MCO is not obligated to provide a Member with access to OON providers of Covered Services if such services become available and are within acceptable appointment availability timeframes described in the contract from a Provider.

The MCO must ensure that each Member has access to a second opinion regarding any Medically Necessary Covered Service. A Member must be allowed access to a second opinion from a Network Provider or OON provider if a Network Provider is not available, at no cost to the Member, in accordance with 42 C.F.R. § 438.206(b)(3). The MCO may use single case agreements with Out-of-Network providers for obtaining a second opinion. The MCO is not required to include Members seeking a second opinion as part of its Out-of-Network Utilization Reporting requirements under UMCM Chapter 5.

2.6.52.4 Residential and Home and Community Based Services Long-Term Services and Supports Continuity of Care

If a Member resides in a NF, an ALF, an adult foster care home, or receives supported employment or employment assistance, and the Provider's Contract is terminated or the Provider otherwise leaves the MCO Network:

1. The MCO must notify the Member of the upcoming change within ten Days of receiving final termination notice from the Provider or ten Days prior to the MCO's 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, OON 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, OON 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's Contract 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.

If a Member resides in a NF or an ALF, and the provider undergoes a change of ownership, the MCO must ensure Continuity of Care such that the care of its enrolled Members residing in the NF or ALF that underwent a change of ownership is not disrupted or interrupted, and its Members continue to receive services authorized prior to the change of

ownership. The MCO must ensure Members receiving services through a PA receive continued authorization of those services for the same amount, duration, and scope until the end of the current authorization period, or until the MCO has evaluated and assessed the Member and issued or denied a new authorization.

This section only pertains to disenrollment caused by terminations of Provider Contracts for residential and employment Providers; therefore, these requirements differ from those under **Section 2.6.15** of the Contract.

2.6.52.5 TRANSITION PROCESS AND PLANNING

The MCO must develop and maintain a transition process and plan to address events such as new population carve-ins and movement of Members between health plans, including Members who turned age 21 and are transitioning to STAR+PLUS from STAR Kids or STAR Health. The plan will describe the strategies and processes the MCO will use to accommodate Members who are entering or leaving the MCO.

The MCO must receive approval from HHSC of the transition process and plan prior to implementation. The MCO must receive approval from HHSC for any changes to the MCO's transition process and plan prior to implementing the changes.

HHSC will provide the receiving MCO with the transitioning Member's information at the time of enrollment in the MCO. If a Member transferred from another MCO, the former MCO must provide the new MCO with Acute Care and LTSS information, including but not limited to, service authorizations, Service Plans, and names of current providers. The transition process and plan must cover the period between the Member's Enrollment Effective Date and the end of the Continuity of Care period as described in **Section 2.6.52**. The MCO must ensure that the Member's current providers are paid for Medically Necessary and Functionally Necessary Covered Services that are delivered in accordance with the Member's existing Service Plan after the Member is enrolled in the MCO and until the transition period is complete.

Transition activities must include the following:

1. Review of existing Service Plans and service authorizations;
2. Execution of a transition process that ensures continuous care under the Member's existing Service Plan while the MCO conducts appropriate assessments and develops a new Service Plan, if needed;
3. If DME or supplies were ordered prior to enrollment but not received by the time of enrollment, coordination, and follow-through to ensure that the Member receives the necessary DME and supplies without undue delay; and
4. Payment to LTSS Providers of services under the existing service authorizations for up to six months for LTSS or 90 Days for Acute Care, or until the MCO completes appropriate assessments, develops a new Service Plan, and issues new service authorizations.

During such a transition, the Members' existing Service Plan or ISP must remain in place until the MCO contacts the Member or the Member's authorized representative and coordinates modifications to the Members' current plan, subject to the deadlines above.

2.6.52.6 RESPONSIBILITIES IN THE EVENT OF A FEDERAL EMERGENCY MANAGEMENT AGENCY DISASTER, 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 (COMCER) plan, particularly the care of Members whose health or BH 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 **Chapter 16 of Exhibit C.**

Additionally, the MCO must have a COMCER plan based on a risk assessment using an "all hazards" approach to respond as a business to a local disaster. As part of the plan, the MCO must describe the method to ensure that Members with a permanent address in FEMA or Governor-declared disaster areas or areas in which internal, man-made, or natural disasters have occurred, are able to access OON providers if they are unable to access Covered Services from Providers.

As described in **Chapter 16 of Exhibit C,** the COMCER plan must also describe the method it will use to ensure that PAs 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 a disaster 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 BCP 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 to the MCO and its facilities within the scope of this Contract, man-made, or natural. The BCP must address the MCO's emergency financial needs, essential functions for Member Services, critical personnel, and the return to normal operations as quickly as possible.

During a FEMA or State of Texas Governor-declared disaster or other emergency including, but not limited to, internal to the MCO and its facilities within the scope of this Contract, 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 Tex. Health & Safety Code § 483.047(b-1) as a justification for rejecting a claim, provided the pharmacy or pharmacist meets the requirements of Tex. Health & Safety Code § 483.047(b-1).

2.6.53 PHARMACY SERVICES

The MCO must provide pharmacy-dispensed and compounded prescriptions as a Covered Service. The MCO must ensure that such coverage meets the standards provided for by 42 U.S.C. § 1396r-8 and 42 C.F.R. § 438.3(s).

The MCO must submit pharmacy clinical guidelines and PA policies to HHSC for review and approval prior to making 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 and Medicaid-enrolled provider regardless of Network participation and must encourage Network pharmacies to also become Medicaid-enrolled DME providers. The MCO must ensure through its pharmacy 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. The MCO must ensure that, as an aggregate, rates comply with 42 C.F.R. pt. 50, subpt. E, regarding upper payment limits.

MCOs or MCO Subcontractors must disclose the reimbursement rates and/or payment methodology used to develop the rates specific to the pharmacy provider during contract negotiations. The disclosure must be specific to Medicaid/CHIP and not include rates or methodologies for the MCO's or MCO Subcontractor's other lines of business. MCO or MCO Subcontractors must not prohibit pharmacy providers from disclosing to HHSC: any price or quality information, including the allowed amount, negotiated rates or discounts, any fees for services, or any other claim-related financial obligations included in the provider's contract with the MCO; or any MCO with which the pharmacy contracts.

The MCO's or MCO Subcontractor's processes for Medicaid and CHIP pharmacy provider reimbursement must be documented separately from other lines of business. This includes provider notification, payments, overpayments, adjustments, recoupments, contract effective rate agreements, network negotiations, claims processing and claims data storage.

The MCO must comply with all applicable provisions of 42 C.F.R. pt. 438, subpt. K, which implements MHPAEA of 2008 for pharmacy services. The MCO must ensure compliance with Tex. Ins. Code ch. 1369, subch. J.

HHSC will provide the MCO with pharmacy data on the MCO's Members on a weekly basis through the VDP or, should these services be outsourced, through the PBM.

2.6.53.1 FORMULARY AND PREFERRED DRUG LIST

The MCO must demonstrate compliance for all covered outpatient drugs on the Medicaid formulary including those provided under a non-risk based payment mode or otherwise

carved-out of managed care. The MCO must demonstrate compliance with any FFS edits or other prescription drug limitations applicable to the MCO or related to the HHSC's PDL and any other State-mandated PA or clinical edit.

The MCO must provide access to covered outpatient drugs and biological products, certain LHHS, and vitamins and minerals through formularies and the PDL developed by HHSC. HHSC will maintain separate Medicaid and CHIP formularies, and a Medicaid PDL.

The MCO must educate Providers about how to access HHSC's formularies and the Medicaid PDL on HHSC's website. The MCO must allow Providers access to the formularies and Medicaid PDL through a free, point-of-care, web-based application accessible on smart phones, tablets, or similar technology. The application must also identify preferred and non-preferred drugs, Clinical PAs, and any preferred drugs that can be substituted for non-preferred drugs. The MCO must update this information at least weekly.

The MCO must feature HHSC's formularies on the MCO's website. The MCO must also inform Members that the formulary is available in paper form without charge and provide it upon request within five Business Days.

In accordance with Tex. Ins. Code ch. 1369, subch. 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 complies with Tex. Ins. 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 healthcare 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

2.6.53.2 PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS AND 72-HOUR EMERGENCY SUPPLIES

HHSC's Medicaid PDL PA, Clinical PA, and other drug policies for the VDP are available on HHSC's VDP website.

HHSC will identify both required and optional Clinical PAs on the VDP website, www.txvendordrug.com. The MCO must ensure Clinical PAs are processed correctly. If the information about a Member's medical condition meets the PA criteria, the claim or PA request may be approved automatically without action from the prescribing Provider or dispensing pharmacy. If a Member's medical condition does not meet the PA criteria, the claim or PA request may be denied and require the prescribing Provider to request a PA. The MCO is responsible for managing PA denials through its appeal process.

The MCO must submit any proposed clinical criteria not listed on the VDP website to HHSC for review and approval following the process outlined in **Chapter 3 of Exhibit C**. 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 adhere to VDP's PDLs for Medicaid drugs. The MCO must Adjudicate preferred drugs 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.

HHSC's website, https://www.txvendordrug.com/, also includes exception criteria for each drug class included on HHSC's Medicaid PDL. These exception criteria describe the circumstances under which a non-preferred drug may be dispensed without a PDL PA. If HHSC modifies the policies described above on the VDP website, HHSC will notify the MCO.

The MCO must submit new Clinical PA proposals to HHSC for DUR board review and approval. The MCO may also submit any proposed revisions to existing Clinical PAs to HHSC for DUR board review and approval. The MCO must submit all Clinical PA proposals in compliance with the required information outlined in **Chapter 3 of Exhibit C**. 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 VDP's Clinical PAs, the MCO can reference VDP's Texas Medicaid formulary on Epocrates. The MCO may choose to implement additional Clinical PAs once the criteria are approved by the DUR board or by HHSC.

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 pharmacy Provider may fill consecutive 72-hour supplies if the prescriber's office remains unavailable. The MCO must reimburse the pharmacy Provider for dispensing the temporary supply of medication.

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 of the request. If the MCO cannot make a timely PA determination, the MCO must allow the Member to receive at least a 72-hour supply of the medication pending resolution of the PA request.

The MCO must have an automated process that may be used to assess a Member's medical and drug claim history to determine whether the Member's medical condition satisfies the applicable criteria for dispensing a drug without an additional PA request. See Tex. Gov't

Code § 531.073(h). This process must automatically evaluate whether a submitted pharmacy claim meets PA criteria for both PDL and Clinical PAs. See **Chapter 2 of Exhibit C,** for the definition of an Automated PA Request.

The MCO's PA system must accept PA requests from prescribers that are sent electronically, by phone, fax, or mail. The MCO may not charge pharmacies for PA transaction, Software, or related costs for processing PA requests.

If the MCO or its PBM operates a separate call center for PA requests, the PA call center must meet the Provider Hotline performance standards set forth in **Section 2.6.10**. 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 must 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 and Services Administration (HRSA) 340B discount drug program, the MCO may only impose Clinical PA requirements. The MCO must exempt these drugs from all PDL PA requirements.

A Provider may appeal PA denials on a Member's behalf, in accordance with **Section 2.6.34**.

If a Member changes to another MCO, the MCO must provide the new MCO 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 48-hours of the new MCO's request.

2.6.53.3 COVERAGE EXCLUSIONS

In accordance with 42 U.S.C. § 1396r-8, the MCO must exclude coverage for any drug marketed by a drug company or labeler that does not participate in the federal drug rebate program. The MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product. A list of participating drug companies can be found on the CMS website under contact information.

The MCO may restrict some compounded medications available through the pharmacy benefit. The MCO's coverage of compounded medications must follow the same requirements as outlined in this section and must be listed on the Texas Medicaid formulary. The MCO may not reimburse pharmacies for compounding powders since these are not included on the Texas Medicaid formulary.

2.6.53.4 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; and
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 pt. 15, ch. 354, subch. F, div. 7, § 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 in place to allow a prescriber or pharmacy to dispute a rejected claim for a compounded medication.

The MCO may pend a claim for compounded medications $200.00 or more for further review to determine if the product is safe and effective.

For auditing purposes, an MCO may request prescription compounding logs from a pharmacy to verify National Drug Codes (NDCs), quantities, and calculations.

2.6.53.5 PHARMACY REBATE PROGRAM

Under the provisions 42 U.S.C. § 1396r-8, drug companies that wish to have their products covered through the Texas Medicaid program must sign an agreement with the federal government to provide the pharmacy claims information that is necessary to return federal rebates to the State.

Under Tex. Gov't Code § 533.005(a)(23)(D)(i), the MCO may not negotiate rebates with drug companies for pharmaceutical products. HHSC 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 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 support HHSC's Medicaid rebate dispute resolution processes in a timely manner. The MCO must:

1. Allow HHSC or its designee to contact pharmacy Providers to verify information submitted on claims, and upon HHSC's request, assist with this process; and
2. Establish a single point of contact with the MCO where HHSC 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.

For purposes of this section, the term rebates is intended to include all Revenues, proceeds, reimbursements, funds, discounts, monies and payments generated from or in any way related to pharmaceutical products, whether or not such Revenues, proceeds, reimbursements, funds, discounts, monies and/or payments are described as 'rebates' by and between any such pharmaceutical manufacturers, their Affiliates, agents, assigns, or other parties and PBM or PBM's agents.

2.6.53.6 DRUG UTILIZATION REVIEW PROGRAM

The MCO must have a DUR program process in place to conduct prospective and retrospective Utilization Review of prescriptions. The MCO's DUR program must comply with 42 U.S.C. § 1396r-8, 42 C.F.R. pt. 456, subpt. K. The MCO must submit an annual report to VDP that provides a detailed description of its DUR program activities, as provided for under 42 C.F.R. § 438.3(s).

The MCO must implement a prospective review in the pharmacy claims processing systems at Point of Sale (POS). The prospective review at the POS must include screening to identify potential drug therapy problems such as drug-disease contraindication, therapeutic duplication, adverse drug-drug interaction, incorrect drug dosage, incorrect duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse.

The MCO's retrospective review must monitor prescribers and contracted pharmacies for outlier activities as outlined in 42 U.S.C. § 1396r-8 and 42 C.F.R. § 456.709. MCO's retrospective reviews must also determine whether services were delivered as prescribed and consistent with the MCO's payment policies and procedures. The MCO must provide the requested data as described in **Chapter 2 of Exhibit C**.

2.6.53.7 PHARMACY BENEFITS MANAGER

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 the MCO or by the MCO's parent company, 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.

The MCO must provide a plan documenting how it will monitor any PBM providing services as a part of this Contract and allow HHSC 30 Days to comment on the plan before MCO executes the PBM contract.

The MCO must ensure its PBM Subcontractor follows all pharmacy-related Contract, **Exhibit C,** state, and federal law requirements related to the provision of pharmacy services.

Any Material Subcontract, PBM agreement or contract cannot include language that permits:

1. Pharmacy provider rate reductions without HHSC notification of approval as required in UMCC Section 8.1.4.8
2. Reconciliation methodologies that include Medicaid/CHIP claims
3. Mechanisms that facilitate "spread pricing"
4. Contracting language that is more restrictive than HHSC requirements for Medicaid/CHIP participation
5. Provider reimbursement clawbacks and/or discounts.

Further, the MCO's reimbursement methodology for the PBM Subcontractor must be developed as a pass-through pricing model based on the actual amount paid by the PBM Subcontractor to a pharmacy Provider for dispensing and ingredient costs. All monies related to services provided by the PBM for the MCO are passed through to the MCO, including but not limited to, dispensing fees and ingredient costs paid to pharmacies, and all Revenue received, including but not limited to pricing discounts eligible to be paid to the PBM, rebates, inflationary payments, and supplemental rebates. All payment streams, including any financial benefits such as rebates, as defined in **Section 2.6.53.5**, discounts, credits, claw backs, fees, grants, chargebacks, reimbursements, or other payments that the PBM receives related to services provided for the MCO must be fully disclosed to the MCO, and provided to HHSC upon request. However, this prohibition on the industry practice commonly 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 **Chapter 6 of Exhibit C**. The payment model for the PBM's administrative and transactional fees will be made available to HHSC. If concerns are identified regarding the administrative fee, HHSC reserves the right to request any changes be made to the payment model.

Unless directed by HHSC, the MCO and MCO's PBM are prohibited from implementing a reconciliation process after the point-of-sale transaction, such that the final cost of drugs for payors is changed or the price paid to pharmacy providers is changed. This includes reconciliation processes for additional fees, contracted effective rate agreements, payments, payment adjustments, and the recoupments of funds based on financial performance measures.

The MCO must submit all PBM agreements or contracts between the PBM/Pharmacy Provider, including referenced addendums and attachments to HHSC for review and/or approval 90 Days prior to implementation.

2.6.53.7.1 PHARMACY BENEFITS MANAGER AGREEMENT

The MCO must include the following provisions in any agreement between the MCO and its PBM:

1. The term of the PBM Subcontract will not exceed two years.
2. The PBM will 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.
3. At least annually, the PBM will hire an independent third party to complete a SOC 1 audit over the PBM's services and activities. This report will be provided to the MCO, and information from this audit will be made available to HHSC upon request.
4. In addition to the SOC 1 audits, the PBM and the MCO will cooperate with and grant full access to any independent audit entity retained by HHSC to perform periodic compliance audits of the PBM. These compliance audits would measure the PBM's compliance with any contractual obligations as well as with federal and State requirements. The PBM will agree to correct any noncompliance issues discovered during these audits.
5. The PBM will not steer or require any providers or Members to use a specific pharmacy or mail order pharmacy service in which the PBM or MCO has an ownership interest or that has an ownership interest in the PBM, if for the primary purpose of reducing competition or financially benefitting the PBM's associated businesses. Arrangements between MCO and PBMs to promote value-based reimbursement and payment or enhancing health outcomes are permitted.
6. Whether the MCO or its designee has ownership or control interest with the PBM or not, the MCO and HHSC have the right to audit and review contracts or agreements between the PBM and their pharmacies at least annually to ensure correct pricing has been applied. This includes, but is not limited to, prescription drug claim data, billing records, and other records to ensure the PBM's compliance with the terms and conditions of their agreement.
7. PBM will not sell any pharmacy data related to services provided for the MCO.
8. A clause that allows the MCO to terminate the agreement for cause, including conduct that is likely to mislead, deceive, or defraud the public, as well as unfair or deceptive business practices.
9. PBM will assign to HHSC all of PBM's State and federal antitrust claims and causes of action that relate to all goods, services, or Deliverables provided for or related to this Contract.

2.6.53.8 FINANCIAL DISCLOSURES FOR PHARMACY SERVICES

The MCO must disclose all contracts and 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 distributor or labeler,

including formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, rebates, and any other fees. **Article 8 of Exhibit A** provides HHSC with the right to audit such information at any time. HHSC agrees to maintain the confidentiality of information disclosed by the MCO pursuant to this section, to the extent that such information is confidential under State or federal law.

2.6.53.9 LIMITATIONS REGARDING REGISTERED SEX OFFENDERS

The MCO must comply with the requirements of Tex. Gov't Code § 531.089 prohibiting the provision of sexual performance enhancing medication to persons required to register as sex offenders under Tex. Crim. Proc. Code ch. 62.

2.6.53.10 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 pt. 15, ch. 353, subch. J, § 353.905 and ch.354, subch. F, div. 3, § 354.1853 and include processes for notifying Network pharmacy Providers.

2.6.53.11 MAXIMUM ALLOWABLE COST REQUIREMENTS

The MCO must develop MAC prices and lists that comply with State and federal laws, including Tex. Gov't 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 FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the *Orange Book*, or 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. MCOs must not use B-rated drugs in MAC pricing calculation. MCOs and PBMs can include B-rated drugs in the same market basket, but those B-rated drugs must be assigned the same price as the A-rated drugs.

The MCO must not set a MAC on a drug that is both preferred on HHSC's PDL and a brand name drug.

The MCO must provide a pharmacy Provider the sources used to determine the MAC pricing at contract execution, renewal, and upon request. MCOs may not use provider and/or provider network performance standards and/or effective rate agreements as a pricing source.

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 SA. The MCO is prohibited from implementing MAC price adjustments based on drug/claim reconciliations made after the point-of-sale.

The MCO must provide HHSC a quarterly report regarding MAC price review and updates upon request in the manner and format specified by HHSC in **Chapter 5 of Exhibit C,** no later than 30 Days after the MCO receives the request.

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 **Chapter 5 of Exhibit C.**

The MCOs or PBMs, as applicable, must provide a process for each of its pharmacy Providers to readily access the MAC list specific to that pharmacy Provider directly from the MCO or PBM, even if the pharmacy is contracted with a PSAO. At a minimum, MCOs and PBMs must allow a pharmacy Provider to download a searchable file of the MAC list specific to that pharmacy Provider from the MCO or PBM website. Alternatively, MCOs or PBMs may allow a pharmacy Provider to view and search the MAC list specific to that pharmacy on the MCO's or PBM's website. The MCO must ensure that the list it or the PBM provides on their respective website must be searchable by drug name. The MCO must provide HHSC with access to MAC lists upon request as outlined in **Article 8 of Exhibit A** no later than ten Days after the MCO receives the request. The MCO must submit the process for HHSC's review and approval prior to implementation and at least 30 Days prior to any modification. As described in Tex. Gov't Code § 533.005(a-2), a MAC price list that is specific to a pharmacy Provider is confidential for all other purposes.

The MCO must notify HHSC no later than 21 Days after implementing a MAC price list for drugs dispensed at retail pharmacies; but not by mail.

2.6.53.12 MAIL ORDER AND DELIVERY

The MCO may include mail-order pharmacies in its pharmacy Network; but must not require Members to use a mail-order pharmacy except in its specialty pharmacy network when a drug is available only from a mail-order pharmacy.

The MCO must not charge a Member who opts to use a mail order pharmacy Provider any fees for using this service, including postage or handling for standard or expedited

deliveries. The MCO must implement a process to ensure that Members receive free outpatient pharmaceutical deliveries from community retail pharmacies in their SAs, or through other methods approved of by HHSC. The MCO must not substitute mail order delivery for delivery from a qualified community retail pharmacy Provider unless requested by the Member. The MCO's process must be submitted to HHSC for review using HHSC's provided template and include all qualified community retail pharmacies identified by HHSC. The MCO must obtain HHSC approval before implementing the process.

2.6.53.13 HEALTH RESOURCES AND SERVICES ADMINISTRATION 340B DISCOUNT DRUG PROGRAM

The MCO must use a shared-savings approach for reimbursing Providers that participate in the federal 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, 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 must not require a Provider to submit its Actual Acquisition Cost (AAC) on outpatient drugs and biological products purchased through the HRSA's 340B program, consistent with **Chapter 2 of Exhibit C**. In addition, the MCO must not impose PA requirements based on non-preferred status, sometimes referred to as PDL PAs, for these drugs and products.

The MCO must process claims in accordance with Tex. Ins. Code § 843.339 and **Chapter 2 of Exhibit C**. This law requires the MCO to pay Clean Claims that are submitted electronically no later than 18 Days after adjudication, and no later than 21 Days after adjudication if the claim is not submitted electronically. In addition, the MCO must comply with **Section 2.5.5**, regarding payment of OON pharmacy claims.

HHSC will provide the MCO or its designee with pharmacy interface files, including formulary, HHSC's PDL, TPL, master provider, drug exception files, and other relevant files required to administer the Program. Due to the POS nature of outpatient pharmacy benefits, the MCO must ensure all applicable MIS, including pharmacy claims adjudication systems, are updated to include the data provided in the pharmacy interface files. The MCO must update within two Business Days of the files becoming available through HHSC's file transfer process, unless clarification is needed, or data file exceptions are identified. If clarification is needed, the MCO must notify HHSC prior to the conclusion of the two Business Day deadline. Additionally, the MCO must be able to perform off-cycle formulary and PDL updates at HHSC's request and within the deadlines stated in such requests.

The MCO must ensure that all daily Enrollment Files in the JIPs are loaded into the pharmacy claims adjudication system within two Days of receipt.

2.6.53.14 PHARMACY CLAIMS AND FILE PROCESSING

The MCO must process claims in accordance with Tex. Ins. Code § 843.339 and **Chapter 2 of Exhibit C**. This law requires the MCO to pay Clean Claims that are submitted electronically no later than 18 Days after adjudication, and no later than 21 Days after adjudication if the claim is not submitted electronically. In addition, the MCO must comply with **Section 2.6.52**, regarding payment of OON pharmacy claims.

HHSC will provide the MCO or its designee with pharmacy interface files, including formulary, HHSC's PDL, TPL, master provider, drug exception files, and other relevant files required to administer the Program. Due to the POS nature of outpatient pharmacy benefits, the MCO must ensure all applicable MIS, including pharmacy claims adjudication systems, are updated to include the data provided in the pharmacy interface files. The MCO must update MIS systems within two Business Days of the pharmacy interface files becoming available through HHSC's file transfer process, unless clarification is needed, or data file exceptions are identified. The MCO must notify HHSC within the same two Business Days if clarification or data/file exceptions are needed. Additionally, the MCO must be able to perform off-cycle formulary and PDL updates at HHSC's request.

The MCO must ensure that all Enrollment Files in the JIP are loaded into the pharmacy claims adjudication system within two Days of receipt.

2.6.53.15 PHARMACY AUDITS

The MCO and its PBM are prohibited from using extrapolation in pharmacy audits.

2.6.53.16 E-PRESCRIBING

The MCO must provide the appropriate data to the national e-prescribing network, which must support: eligibility confirmation; HHSC's PDL benefit confirmation; identification of preferred drugs that can be used in place of non-preferred drugs, also referred to as alternative drugs; medication history; and prescription routing.

2.6.53.17 CANCELLATION OF PRODUCT ORDERS

If a Provider offers delivery services for covered products, such as DME, home health supplies, outpatient drugs or biological products, the Provider Contract must require the Provider to reduce, cancel, or stop delivery at the written or oral request of the Member, LAR. The Provider Contract must require the Provider to maintain records documenting the request.

2.6.53.18 AUTOMATED REFILLS

For automated refill orders for covered products, the 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 pt. 15, ch. 291, subch. B, § 291.34. The MCO must ensure that the Member has the option to withdraw from an automated refill delivery program at any time.

2.6.53.19 CLINICIAN ADMINISTERED DRUGS

Consistent with the regulations at 42 CFR § 438.210 and 42 CFR § 457.1230(d), prior authorization criteria for clinician-administered drugs cannot be more restrictive than those implemented by VDP.

2.6.53.20 AUTOMATED REFILLS

For automated refill orders for covered products, the 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 pt. 15, ch. 291, subch. B, § 291.34. The MCO must ensure that the Member has the option to withdraw from an automated refill delivery program at any time.

2.6.54 PREADMISSION SCREENING AND RESIDENT REVIEW REFERRING ENTITY REQUIREMENTS

The MCO must follow any PASRR requirements when acting as a referring entity for Members as required by 26 Tex. Admin. Code §§ 303.101 and 303.301.

2.6.55 ACUTE CARE SERVICES FOR RECIPIENTS OF ICF-IID PROGRAM AND IDD WAIVER SERVICES

Members with IDD who do not qualify for Medicare and who receive services through the Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF-IID) Program or an IDD Waiver are eligible for Acute Care services through STAR+PLUS. These Members will not be eligible for the STAR+PLUS HCBS while enrolled in the ICF-IID Program or an IDD Waiver. The MCO must follow the procedures outlined in **Exhibit E** regarding coordination with other programs.

Refer to **Section 2.6.48** for MCO requirements related to Service Coordination for these Members.

2.6.56 STAR+PLUS HCBS PROGRAM SERVICES AVAILABLE TO QUALIFIED MEMBERS

The MCO must offer STAR+PLUS HCBS to eligible Members as a cost-effective alternative to living in a NF. STAR+PLUS HCBS services must be provided in home and community-based settings and comply with the federal home and community-based settings rule at 42 C.F.R. § 441.301(c)(4). The MCO must make the full array of STAR+PLUS HCBS services available to Members who meet STAR+PLUS HCBS

eligibility requirements as described in **Section 2.6.61**, and 1 Tex. Admin. Code § 353.1153. See **Exhibit E** for a list of the services.

The MCO must adhere to the requirements relating to the delivery of services located in **Exhibit E.**

Provider Requirements for LTSS in the STAR+PLUS HCBS Program	
Service	Licensure, Certification, and Other Minimum Qualification Requirements
PAS	The Provider must be licensed by the State as a HCSSA. The level of licensure required depends on the type of service delivered. An agency may have only the PAS level of licensure. If the Member uses the CDS option, the Provider must meet the requirements outlined in the 1115 demonstration project.
Employment Assistance	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 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.
Supported Employment	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

Provider Requirements for LTSS in the STAR+PLUS HCBS Program	
Service	Licensure, Certification, and Other Minimum Qualification 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.
Assisted Living Services	The Provider must be licensed by HHSC's Long Term Care Regulatory Division in accordance with 26 Tex. Admin. Code ch. 553. The type of licensure determines what services may be provided.
Nursing Services	The Provider must be a licensed RN by the Texas Board of Nursing under 22 Tex. Admin. Code ch. 217.
Cognitive Rehabilitation Therapy	Psychologist must be licensed under Tex. Occ. Code ch. 501. Speech and language pathologists must be licensed under Tex. Occ. Code ch. 401. Occupational therapist must be licensed under Tex. Occ. Code ch. 454.
Adult Foster Care	Adult Foster Care (AFC) homes must meet the standards described in **Exhibit E**. AFC homes including the Member's home must either have been determined qualified based on the standards or licensed by HHSC under 26 Tex. Admin. Code ch. 553, for homes serving four or more residents. The MCO must demonstrate the ability to recruit, train, and certify AFC Providers based on standards referenced above either in-house or through an AFC-agency Provider.

Provider Requirements for LTSS in the STAR+PLUS HCBS Program	
Service	Licensure, Certification, and Other Minimum Qualification Requirements
Support Consultation	The Provider must complete HHSC required training and receive a certificate of completion from HHSC.
Dental	The Provider must be licensed by the Texas State Board of Dental Examiners as a Dentist under 22 Tex. Admin. Code ch. 101.
Respite Care	The Provider must be licensed by HHSC as a HCSSA under 26 Tex. Admin. Code ch. 558; licensed as a NF Provider under 26 Tex. Admin. Code ch. 554; licensed by HHSC as an Assisted Living provider under 26 Tex. Admin. Code ch. 553; or AFC provider licensed by HHSC under 26 Tex. Admin. Code ch. 553. Unlicensed AFC providers must meet the qualifications described in **Exhibit E.** AFC homes serving four or more participants must be licensed by HHSC under 26 Tex. Admin. Code ch. 553.
Home Delivered Meals	The Provider must comply with requirements for providing home delivered meal services in accordance with 40 Tex. Admin. Code ch. 55.
Physical Therapy Services	The Provider must be a licensed physical therapist through the Texas Board of Physical Therapy Examiners, Tex. Occ. Code ch. 453.
Occupational Therapy Services	The Provider must be a licensed occupational therapist through the Texas Board of Occupational Therapy Examiners, Tex. Occ. Code ch. 454.
Speech, Hearing, and Language Therapy Services	The Provider must be a licensed speech therapist through the Texas Department of Licensing and Regulation under 16 Tex. Admin. Code Part 4 Chapter 111.
Financial Management Services	The Provider must complete initial and ongoing HHSC-required training and receive a certificate of completion of training. FMSAs must be eligible to contract with HHSC to contract with an MCO.

Provider Requirements for LTSS in the STAR+PLUS HCBS Program	
Service	Licensure, Certification, and Other Minimum Qualification Requirements
Transition Assistance Services	The Provider must comply with the requirements for delivery of TAS. TAS Providers must demonstrate knowledge of, and experience in, successfully serving Members who require home and Community-Based Services.
Minor Home Modifications	There are no licensure or certification requirements.
Adaptive Aids and Medical Equipment/Supplies	There are no licensure or certification requirements.

2.6.57 SERVICE PLANNING FOR MEMBERS

All STAR+PLUS Members are considered MSHCN.

The MCO must conduct appropriate assessments and work in collaboration with each Member to develop a Person-Centered Service Plan that meets the requirements of 42 C.F.R. § 438.208(c)(3) and is understandable to the Member and the Member's authorized representatives. The Service Plan is informed by the health needs screening of the Member and any subsequent assessments. For STAR+PLUS HCBS Members, the ISP fulfills this requirement. The components of the ISP are determined by HHSC and located in **Exhibit E,** STAR+PLUS Handbook.

The MCO must include the following information in the Service Plan and collect such information if it is already documented in the Member's case file as described in **Exhibit E**:

1. The Member's medical and social history;
2. The Member's service delivery preferences;
3. Short and long-term needs, personal preferences, and outcomes for the Member;
4. The Member's informal supports, including caregiver supports;
5. Any training or resource needs of the caregivers that could assist them in caring for the Member as outlined in **Exhibit E,** STAR+PLUS Handbook.
6. A summary of the Member's current medical and social needs and concerns including:
    a. BH needs;

b. Physical, occupational, speech, or other specialized therapy service needs;
c. DME and medical supplies needs;
d. Needed nursing services, including but not limited to, home health skilled nursing and PDN;
e. Prescription drugs, including psychotropic medication needs
f. Pregnancy and associated needs, including high risk pregnancy due to preeclampsia, high blood pressure, diabetes, mental health or SUDs, previous pre-term birth, or other conditions;
g. High-cost catastrophic conditions or high service utilization, such as a high volume of ER or hospital visits;
h. Needs associated with a serious ongoing illnesses or Chronic Complex Conditions anticipated to last for a significant period requiring ongoing therapeutic intervention and evaluation (such as COPD, cancer, chronic asthma, cystic fibrosis, diabetes, heart disease, kidney disease, sickle cell disease, HIV, AIDS);
i. Transportation needs; and
j. Social needs including housing insecurity, substandard housing, social isolation/loneliness, food insecurity, and financial insecurity.

7. A list of Covered Services required, and their frequency, including any existing referrals and PAs;
8. A description of who will provide the Covered Services; and
9. A list of non-Covered Services, community supports, and other resources that the Member already receives or that would be beneficial to the Member. This shall include information on any needed assistance in accessing affordable, integrated housing, and other services from which the Member could benefit or if the Member requests such information.
10. The minimum number of Service Coordination contacts a Member will receive per year and the process for Members to request more or fewer contacts;
11. How Service Coordination will be provided: either in person or by telephone contact;
12. How a Member or Provider can reach a Service Coordinator.

The MCO must ensure that Members have access to comprehensive treatment by a multidisciplinary team of both physician and non-physician Providers when the Member's PCP determines the treatment is Medically Necessary, or to avoid separate and fragmented evaluations and Service Plans and include that treatment in the Member's Service Plan. The multidisciplinary team must:

1. Participate in Hospital Discharge planning;
2. Participate in pre-admission Hospital planning for non-emergency hospitalizations;
3. Develop nursing, specialty care, and support service recommendations to be incorporated into the SP; and
4. Provide information to the Member, the Member's authorized representatives concerning nursing and specialty care recommendations.

The MCO must share the Service Plan with the Member and the Member's authorized representatives and Providers.

The MCO must update the Service Plan annually, upon a Change in Condition, and at the request of the Member or Member's authorized representatives.

2.6.58 SERVICE PLAN AND THE USE OF TELECOMMUNICATIONS

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

2.6.59 STAR+PLUS ASSESSMENTS

The MCO must use an evidence-based screening tool for health-related social needs. Results from the screening may indicate the need for additional assessments, including functional needs assessments and referrals to community organizations for community-based resources. MCOs must track these referrals as part of the systematic process to coordinate and track referrals to community organizations required in Section 2.6.45.9. MCOs must provide to their Network Providers social needs resources, such as education on the screening tool and community-based resources, to address Members' needs. The MCO must assess a Member's caregiver supports as part of the initial health needs screening and annual reassessment and provide resources and training to caregivers as needed. The MCO must update the Service Plan or ISP if a change in caregiver supports impacts the Member's service needs.

The MCO must have and use functional assessment instruments approved or provided by HHSC to identify the needs of Members with significant health problems, Members with immediate health care needs, and Members who are at risk of needing facility-based LTSS. The MCO, a Subcontractor, a local IDD authority, or a Provider may complete assessment instruments, but the MCO remains responsible for the data recorded.

The MCO must complete HHSC's prescribed assessment forms as detailed in **Exhibit E** including any applicable addendums, to assess and reassess a Member's need for or change in Functionally Necessary Covered Services or the needs of informal caregivers that may have an effect on Member's care, as described in **Exhibit E**. The MCO may adapt the forms to reflect the MCO's name or distribution instructions, but the elements must be the same and instructions for completion must be followed without amendment. The MCO may not add, delete, or modify questions from the form or change the questions in any way.

The MCO must assess for preexisting and new needs during the Member's initial health needs screening, at the Member's annual reassessment, if the Member requests services, upon a Change in Condition, and when the MCO determines the Member requires a change in services.

Upon notice of a Change in Condition by a Member, the Member's Authorized Representative, caregiver, Provider, or Service Coordinator, the MCO must reassess and authorize necessary services no later than 14 Days following the notification of a Change in Condition that jeopardizes the Member's ability to remain safely in the community; and for all other changes in condition no later than 21 Days following notification.

If the Change in Condition relates to the Member's functional ability, the MCO must complete the appropriate functional assessments specified by HHSC as indicated in **Exhibit E**. If the Change in Condition relates to a Member's caregiver supports and results in a change to the Service Plan or ISP, but does not impact results of the most recent assessment, the MCO must authorize appropriate services, including needed resources for the informal caregivers, note the change in the Member's case file and Service Plan and, for STAR+PLUS HCBS Members, update the ISP in the Member's case file. The MCO must notify the Member and the Provider delivering the impacted service(s) within two Business Days of any determination, including a change in service(s) or denial of service(s) following the reassessment.

The MCO must attempt to locate the Member for an assessment as indicated in Exhibit E. For Members requiring NF Unit Rate Services, the MCO's Provider Contracts must require that the NF use the state and federally required assessment instrument, as amended or modified, to assess Members and to supply current medical information for medical necessity determinations. The MCO's Provider Contract must require the NF to supply these assessments to the MCO.

2.6.59.1 COMMUNITY FIRST CHOICE ASSESSMENTS

CFC is a service array offering home and community-based services to eligible Members as an alternative to living in an institution. For more information on CFC see **Section 2.6.43.2**. Members seeking or needing services provided through CFC must be tested for eligibility before those services are provided.

2.6.59.1.1 CFC FOR INDIVIDUALS WITH PHYSICAL DISABILITIES

Members with a physical Disability or who are elderly must meet the MN/LOC requirements (found at TMHP.com) for NF care to be eligible for CFC services. The MCO must complete the MN/LOC assessment form, as amended or modified, and submit the form to HHSC or its designee. The MCO must also complete the CFC assessment documentation (located under Forms in **Exhibit E**) identifying the needed CFC services, as well as any additional services from which the Member might benefit and include that information in the Member's Service Plan or ISP.

After the initial Service Plan is established, Service Plans must be completed on an annual basis. Assessments related to a Member's institutional LOC must be completed annually at reassessment. The MCO is responsible for tracking assessment expiration dates to ensure all Member reassessment activities have been completed and posted on the long-term care online portal no later than 45 Days prior to the expiration date of institutional LOC. For the annual reassessment, the MCO must not initiate or submit the community MN/LOC assessment instrument earlier than 90 Days prior to the end date of the previous assessment. The annual reassessment will expire 90 Days from the MN/LOC assessment date, if the MN/LOC is not approved by HHSC or its designee and CFC services have not been authorized. The MCO must complete assessment activities within the timeframes specified by HHSC in **Exhibit E**.

2.6.59.1.2 CFC FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

Members with IDD must meet institutional LOC criteria for an ICF-IID or related conditions to be eligible for CFC services. The MCO must review and consider the assessment and CFC Service Plan completed by the Local Intellectual and Developmental Disability Authority (LIDDA) within seven Business Days of receipt when determining eligibility for CFC services and finalizing the Member's Service Plan or ISP.

After the initial Service Plan is established, the Member must be reassessed and the Service Plan must be completed on an annual basis. The MCO is responsible for tracking the renewal dates to ensure all Member reassessment activities for Members with IDD have been completed prior to the end of the 12th month after the previous assessment was completed. The MCO must complete these activities within the timeframe specified by HHSC in **Exhibit E**.

2.6.59.1.3 CFC FOR INDIVIDUALS WITH SEVERE AND PERSISTENT MENTAL ILLNESS

Members under age 21 and those age 65 or older with a SPMI must meet an IMD LOC, which is determined by receiving an ANSA with a LOC 4, to be eligible for CFC services.

The MCO must coordinate with a provider of MHR Services and Mental Health TCM to determine whether a Member meets an IMD LOC. The MCO must complete the CFC assessment documentation identifying the needed CFC services, as well as any additional services from which the Member might benefit and include that information in the Member's Service Plan or ISP.

After the initial Service Plan is established, it must be completed on an annual basis. The IMD LOC assessment and Service Plan must be completed at least annually at reassessment. The MCO must complete these activities within the timeframe specified by HHSC in **Exhibit E**.

2.6.59.2 STAR+PLUS HCBS PROGRAM ASSESSMENTS

For Members and applicants seeking or needing STAR+PLUS HCBS services, the MCO must use the MN/LOC assessment, as amended or modified, to provide a comprehensive nursing assessment of applicants and Members and to supply current medical information for medical necessity determinations and individual service planning. See **Procurement Library** for the assessment and instructions on "Medical Necessity and Level of Care Assessment Item by Item Guide."

The MCO must also complete the ISP and all prescribed forms and addendums, for each Member no later than 30 Days prior to ISP start date. The ISP is established for a one-year period. After the initial ISP is established, the ISP must be reviewed on an annual basis A Member must receive a STAR+PLUS HCBS service no less than once per quarter to remain eligible for STAR+PLUS HCBS.

No later than four weeks after the ISP start date, or the ISP effective date for a Change in Condition, the Service Coordinator or a member of the Service Coordination team must contact the Member to determine whether medically and functionally necessary services

identified in the assessment process are in place and maintain documentation of the contact and result. At the time of that contact, if services that should be in place are not, the Service Coordination team must help arrange care for the Member and document the result. If, during the contact with the Member, the Member requests assistance that may only be performed by an RN, the Service Coordinator must address the Member's needs. Within three months of the ISP start date, the MCO must verify through direct Member contact or through claims data that all services on the ISP are being rendered to the Member. No less than twice per year, a Service Coordinator must review the Member's ISP to determine if updates are required.

Required assessments and forms as located in **Exhibit E** must be completed annually at reassessment. The MCO is responsible for tracking the end dates of the ISP to ensure all Member reassessment activities have been completed and posted on the long-term care online portal 30 Days prior to the expiration date of the ISP.

An initial MN/LOC assessment determination will expire 120 Days from the assessment date if the assessment is not approved by HHSC, and as a result HHSC does not authorize STAR+PLUS HCBS.

For the annual reassessment, the MCO must not initiate or submit the MN/LOC assessment earlier than 90 Days prior to the expiration date of the current ISP. The annual reassessment expires 90 Days from the assessment date if the assessment is not approved by HHSC and STAR+PLUS HCBS services have not been authorized.

If a Member experiences a Change in Condition, the MCO must follow prescribed timelines in **Section 2.6.61.3.1**, and update the ISP in the Member's case file, if any services change as a result of the reassessment.

2.6.60 REQUIREMENTS REGARDING MEDICARE DUAL ELIGIBLE MEMBERS

Requirements for Dual Eligible Members are set forth below.

2.6.60.1 COORDINATION OF SERVICES FOR DUAL ELIGIBLE MEMBERS

The MCO must coordinate Medicare and Medicaid services for Dual Eligibles. This includes original Medicare and Medicare Advantage.

MA Dual SNPs are Medicare Advantage plans that provide Medicare services and coordination of Medicaid STAR+PLUS services for Dual Eligibles with a chronic health condition. MA Dual SNPs also cover their Members' Medicare cost sharing obligations, which include Medicare Parts A and B deductibles, coinsurance, and co-payments for Dual Eligibles in STAR+PLUS, including Qualified Medicare Beneficiaries (QMBs) with full Medicaid and Specified Low-Income Medicare Beneficiaries (SLMBs) with full Medicaid. Texas MA Dual SNPs are considered "zero-dollar cost sharing" plans because Members receiving the Medicaid types mentioned above are not liable for paying cost sharing obligations.

Effective January, 2025, the MCO must have a contract with CMS as a zero-dollar cost-sharing MA Dual SNP with a Medicare service area(s) that aligns with their entire awarded

STAR+PLUS Medicaid Service Area(s), to provide Medicare benefits to Dual Eligibles for all counties in their awarded STAR+PLUS Medicaid Service Area(s). An MCO with an existing MA Dual SNP contract must apply to CMS for a Medicare service area expansion by a CMS-specified deadline, as necessary to ensure the MA Dual SNP's Medicare service area aligns with the MCO's STAR+PLUS Medicaid Service Area. An MCO without an existing HHSC-contracted MA Dual SNP must submit to CMS, by a CMS-specified deadline, a non-binding Notice of Intent to Apply (NOIA) for a MA Dual SNP contract to be effective January 2025, and to follow the subsequent timelines and contract submission requirements specified by CMS.

In addition to the MA Dual SNP contracting requirements, MCOs that are contracted with HHSC as a Dual Demonstration Medicare-Medicaid Plan (MMP) in their awarded STAR+PLUS Medicaid Service Area(s) must continue to contract as an MMP in those Dual Demonstration counties through the duration of the Dual Demonstration; and MCOs contracted with HHSC as a Dual Demonstration MMP outside of their awarded STAR+PLUS Medicaid Service Area(s) must continue to contract as an MMP in those Dual Demonstration counties through December 31, 2024

The MCO must maintain its contracts with CMS for MA Dual SNP and MMP services as applicable in their awarded STAR+PLUS Medicaid Service Areas. The Texas MA Dual SNP agreements and MMP contracts, as amended or modified, will be incorporated by reference into the Contract.

The MCO must maintain a separate capitation agreement with HHSC whereby the MCO's MA Dual SNP plan reimburses Medicare providers for the cost sharing obligations that HHSC would otherwise be required to pay on behalf of qualified STAR+PLUS Dual Eligibles.

2.6.60.2 MEDICAID WRAP-AROUND SERVICES

This section applies to Dual-Eligibles who are not enrolled in a Dual Demonstration MMP. The MCO must supplement Medicare coverage for STAR+PLUS Dual Eligible Members by covering Medicaid Wrap-Around Services, which include services as described below The MCO must cover:

1. Medicaid Wrap-Around Services for outpatient drugs and biological products as described in **Section 2.6.60.2.1**;
2. Nursing Facility Medicare Coinsurance for Members in a Nursing Facility as described in **Section 2.6.60.2.2**; and
3. Other capitated long-term care and Community-Based Long-Term Services and Supports as described in **Section 2.6.60.2.3**.

When an authorization request for a Medicaid Wrap-Around Service that is not covered by Medicare is submitted to an MCO, the MCO must not require a Provider to submit a Medicare denial or explanation of benefits. Refer to UMCM Chapter 2, Uniform Managed Care Claims Manual, for additional information regarding the claims processing requirements for these Medicaid Wrap-Around Services.

MCOs must inform Providers and Members that all other Medicaid Wrap-Around Services than described herein are adjudicated and reimbursed by HHSC's claims administrator and provide information about that process.

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.

2.6.60.2.1 MEDICAID WRAP-AROUND SERVICES FOR OUTPATIENT DRUGS AND BIOLOGICAL PRODUCTS

The MCO must provide Medicaid Wrap-Around Services for outpatient drugs, biological products, certain limited home health supplies, and vitamins and minerals as identified on the HHSC drug exception file to Members under a non-risk, cost settlement basis, as described in **Section 2.8.15**. The MCO must adhere to requirements regarding the claims processing for these Medicaid Wrap-Around Services as described in **Chapter 2 of Exhibit C**.

2.6.60.2.2 NURSING FACILITY COINSURANCE

The MCO must pay HHSC's Medicare coinsurance obligation for a qualified Dual Eligible Member's Medicare-covered stay in a NF. The MCO is not responsible for HHSC's Medicare cost-sharing obligation for a Dual Eligible Member's Medicare-covered NF add-on Services, which are Adjudicated by either HHSC's FFS claims administrator or the Dual Eligible Member's Medicare plan, as applicable to the Member.

2.6.60.2.3 LONG TERM CARE AND LONG TERM SERVICES AND SUPPORTS

The MCO must provide capitated long-term care not covered by Medicare as Medicaid Wrap-Around Services, including:

1. Nursing Facility Unit Rate Services; and
2. Nursing Facility Add-on Services, as described in UMCM Chapter 2,

and UMCM 3.31, MMC Nursing Facility Provider Manual, Attachment A. However, the MCO is not responsible for covering physical therapy, speech therapy, and occupational therapy Nursing Facility add-on services for Dual Eligible Members.

The STAR+PLUS MCO must provide capitated Community-based LTSS not covered by Medicare as Medicaid Wrap-Around Services. These services are described further in **Exhibit E,** STAR+PLUS Handbook, and include:

1. Community First Choice (CFC) services for qualified members, as specified in Section 2.6.40.2, Community First Choice Services;
2. STAR+PLUS Home and Community Based Services (HCBS);
3. Personal Assistance Services (PAS); and
4. Day Activity and Health Services (DAHS).

2.6.61 STAR+PLUS HCBS ELIGIBILITY

To be eligible for STAR+PLUS HCBS services, an individual must meet MN/LOC requirements for NF care.

The cost of the services provided to a STAR+PLUS HCBS Member cannot exceed 202% of the cost of care if the Member were served in a NF. The Member must have a plan of care at initial determination of eligibility, at annual reassessment, and for assessments related to Change in Condition, in which the MCO's annualized cost is equal to or less than 202% of the annualized cost of care if the Member were to enter a NF. If the MCO determines the Member's cost of care will exceed the 202% limit, the MCO must submit the required documents specified in **Exhibit E** to HHSC Utilization Review (UR) no later than 60 Days prior to the proposed start date of care. HHSC UR may conduct a clinical review of the case to consider the use of the State general revenue funds (GR) to cover costs over the 202% allowance, in accordance with HHSC's policy and procedures or authorize the MCO to exceed the cost limit under HHSC's medically fragile policy. If HHSC approves the use of GR, or an exception to exceed the cost limit under HHSC's medically fragile policy, the MCO will be allowed to provide STAR+PLUS HCBS in excess of the 202% allowance.

The MCO must be able to demonstrate the Member has a minimum of one unmet need for at least one STAR+PLUS HCBS service and must receive one HCBS service at least quarterly to remain eligible. If the only service named on the Member's ISP is a State plan service, the MCO must provide the Member that service through STAR+PLUS State plan options. Non-HCBS services are not Medicaid Allowable Expenses and MCO must not report them as such on the FSRs.

2.6.61.1 MEMBERS ELIGIBLE FOR STAR+PLUS HCBS

Members may request to be assessed for eligibility for STAR+PLUS HCBS. The MCO may also initiate STAR+PLUS HCBS eligibility assessments if the MCO determines that the Member would benefit from the services.

The MCO must complete the MN/LOC assessment for LOC determination and submit the form to HHSC or its designee. The MCO is also responsible for completing the assessment documentation and all required forms and addenda identified in **Section 2.6.59.2**. The MCO must complete these activities within 45 Days of the identified need for or request for STAR+PLUS HCBS. The MCO must authorize all STAR+PLUS HCBS services by the start date of the ISP.

HHSC will notify the Member and the MCO of the eligibility determination, which is based on results of the assessments and the information provided by the MCO and Member. If the STAR+PLUS Member is eligible for STAR+PLUS HCBS, HHSC will notify the Member of the effective date of their eligibility. If the Member is not eligible for STAR+PLUS HCBS, HHSC will provide the Member information on their right to appeal the eligibility determination, including the right to a State Fair Hearing. Regardless of the eligibility determination, HHSC will provide a copy of the Member notice to the MCO.

The MCO must prepare any requested documentation regarding its assessments and Service Plans, and if requested by HHSC, attend the State Fair Hearing.

2.6.61.2 NON-MEMBER APPLICANTS ELIGIBLE FOR STAR+PLUS HCBS

Non-Members who are not eligible for Medicaid in the community may apply for participation in the STAR+PLUS HCBS under the financial and functional eligibility requirements of the 217-Like Group described in the Texas Healthcare Transformation and Quality Improvement Program 1115 demonstration project. HHSC will provide the applicant's selected MCO an authorization form to initiate pre-enrollment assessment services required under the STAR+PLUS HCBS. The MCO's initial home visit with the applicant must occur within 14 Days of the receipt of the referral from HHSC.

To be eligible for STAR+PLUS HCBS, the applicant must meet financial eligibility and eligibility criteria set forth in **Section 2.6.61**. The MCO must complete the MN/LOC assessment for LOC determination, and submit the form to HHSC or its designee. The MCO must complete the assessment documentation and all required forms and addendums prescribed by HHSC. The MCO must complete these activities within 45 Days of receiving the HHSC's authorization form for eligibility testing. The MCO must authorize all STAR+PLUS HCBS services by the start date of the ISP.

HHSC will notify the applicant and the MCO of the results of its eligibility determination. If the applicant is eligible, HHSC will notify the applicant and the MCO of the effective date of their eligibility.

If the applicant is not eligible for STAR+PLUS HCBS, HHSC will provide the applicant information on right to appeal the determination, including the right to a State Fair Hearing. Regardless of the eligibility determination, HHSC will provide a copy of the applicant notice to the MCO. The MCO must prepare any requested documentation regarding its assessments and Service Plans, and if requested by HHSC, attend the Fair Hearing.

2.6.61.3 ANNUAL REASSESSMENT

Every year, no later than 30 Days before the end date of the ISP, the MCO must complete the activities detailed in **Section 2.6.59.2** by conducting a reassessment to determine and validate each Members' continued eligibility for STAR+PLUS HCBS and submit the Member's ISP to HHSC. If the previous ISP was approved to exceed the cost limit under HHSC's medically fragile policy or through the use of GR, the MCO must follow the procedures listed in **Exhibit E** and submit the required documents at least 45 Days before the end date of the Member's ISP. As part of the assessment, the MCO must inform the Member of the available service delivery options and SRO. The MCO is not required to obtain a physician's signature for LOC reassessments. MCOs are bound by **Section 2.6.61.3.1** for authorizations related to reassessments.

2.6.61.3.1 REASSESSMENT FOLLOWING A CHANGE IN CONDITION

Upon notice by a Member, the Member's authorized representative, caregiver, Provider, Service Coordinator, or other entity of a Change in Condition, the MCO must reassess the

Member and authorize appropriate services as soon as possible but no later than 14 Days from notification of the Change in Condition. The MCO must document the date, time, and source of notification and any action taken. Following the reassessment and determination, the MCO must then notify the Member and the Provider delivering the impacted service(s) within two Business Days of any determination, including any change in service(s) or denial of service(s). 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 five Days following notification of the Change in Condition. The MCO must document the date, time, and source of notification and any action taken. The MCO must then notify the Member and the Provider delivering the impacted service(s) within two 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 MN/LOC assessment and functional assessments specified in **Exhibit E.** If the Change in Condition relates to the Member's functional ability, the MCO must complete the appropriate functional assessments specified in **Exhibit E.** 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, including needed resources for the informal caregivers.

Following any Change in Condition, the MCO must 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 two Business Days following the reassessment and determination.

2.6.61.4 HHSC UTILIZATION REVIEWS

HHSC will conduct URs, in accordance with Tex. Gov't Code § 533.00281. The reviews will include an investigation of the MCO's procedures for determining STAR+PLUS HCBS eligibility. If HHSC recoups money from the MCO as a result of an UR conducted under this section, the MCO must not hold a Provider liable for the good faith provision of services based on the MCO's authorization.

2.6.61.5 TEXAS HEALTH STEPS

The following sections outline requirements for THSteps. The MCO must provide all THSteps services, except the Non-capitated services referenced in **Section 2.6.63.20**, to Members age 18 through 20 years.

2.6.61.5.1 TEXAS HEALTH STEPS MEDICAL CHECKUPS

The MCO must develop effective methods to ensure that young adults age 18 through 20 years receive THSteps medical checkup services when due and according to the recommendations established by the THSteps periodicity schedule as described in **Exhibit F.**

The MCO must arrange for timely THSteps medical checkups 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.

For purposes of timely THSteps medical checkups, the terms new Member and existing Member are defined in **Chapter 12 of Exhibit C.**

For new Members age 18 through 20 years, any overdue or upcoming THSteps medical checkups should be offered as soon as practicable, but no later than 90 Days from the date of the Member's enrollment.

A THSteps medical checkup for an existing Member is due annually beginning on the Member's birthday and is considered timely if it occurs no later than 364 Days after the Member's birthday.

2.6.61.5.2 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 THSteps Providers when performed on the same day as the THSteps medical checkup. The MCO must educate Providers about the importance of OEFV documentation for inclusion in the Member's medical record, and the necessity of documentation to support a qualification for reimbursement for appropriate provision of OEFV to eligible Members. The Provider education must include information about how to assist a Member with referral to a dentist to establish a Dental Home.

2.6.61.5.3 LAB

The MCO must educate Providers about THSteps requirements for submitting laboratory tests to DSHS. The MCO must ensure that all laboratory specimens collected as a required component of a THSteps checkup are submitted to the DSHS or to a laboratory approved by the DSHS under Tex. Health & Safety Code § 33.016 for analysis unless otherwise provided by **Exhibit F**.

2.6.61.5.4 EDUCATION AND OUTREACH

The MCO must ensure Members are provided information and educational materials about THSteps services, including:

1. How and when Members should obtain the preventive THSteps medical checkups, along with diagnostic and treatment services, and dental services, including Texas Health Steps Comprehensive Care Program services;

2. How Members can access NEMT Services; and
3. How the Member can request advocacy and assistance from the MCO.

The MCO must use required language, describing THSteps services, including medical, dental, and case management services, as provided in **Chapter 2 of Exhibit C**. Any additions to or deviations from the required language must be reviewed and approved by HHSC prior to publication and distribution to Members

The MCO must provide outreach to Members to ensure Members are effectively informed about available THSteps services, and to ensure the Member has access to prompt services. Each month, the MCO must retrieve from the HHSC EB Bulletin Board System a list of Members who are due and overdue THSteps services. Using these lists and its own internally generated list, the MCO must contact such Members to encourage scheduling the service as soon as possible. The MCO outreach staff must coordinate with the THSteps Outreach and Informing Unit and other agencies to ensure Member access to timely THSteps services.

The MCO must make an effort to coordinate and cooperate with existing community and school-based health and education programs that offer services to Members 18 through 20 in a location that is both familiar and convenient to the Members.

2.6.61.5.5 TRAINING

The MCO must provide appropriate training to all Providers and Provider staff regarding the scope of THSteps services. Training must include:

1. THSteps benefits (preventive care, diagnostic services, and treatment), as outlined in **Exhibit F**;
2. The periodicity schedule for THSteps medical checkups and immunizations as outlined in **Exhibit F**;
3. The required components of THSteps 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;
4. Providing or arranging for all required lab screening tests, the importance of complete documentation for THSteps medical checkups, and medically necessary services available to Members through age 20;
5. CCP services available under the THSteps program to Members age 18 through 20 years;
6. NEMT Services available to Members;
7. Importance of updating contact information to ensure accurate Provider directories and the Medicaid online Provider lookup;
8. The process to submit missed appointment referrals to either THSteps Outreach and Informing Unit or the MCO and the assistance provided by the MCO for these referrals;
9. Scope of DME and other items commonly found in a pharmacy that are available for Members through age 20; and

10. Education and training to treat each THSteps visit as an opportunity for a comprehensive assessment of the Member.

2.6.61.5.6 DATA VALIDATION

The MCO must require all Providers delivering THSteps services to submit claims for services paid on the NSF 837 claim form or CMS 1500 claim form and use the HIPAA compliant code set required by HHSC.

Encounter Data will be validated by chart review of a random sample of THSteps 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 or Providers being investigated for potential FWA without notice to the MCO or the Provider.

2.6.61.5.7 TEXAS HEALTH STEPS – COMPREHENSIVE HEALTH CARE PROGRAM

The MCO must provide all medically necessary Covered Services listed in Section 1905(a) of the Social Security Act to Members aged 20 and younger through the Texas Health Steps Comprehensive Care Program in accordance with Section 1905(r) of the Social Security Act and the Omnibus Budget Reconciliation Act of 1989. The MCO must provide Texas Health Steps Comprehensive Care Program services in accordance with prior authorization requirements and service limitations specified in the Texas Medicaid Provider Procedures Manual, Children's Services Handbook, Chapter 2.

Services required by EPSDT, including Texas Health Steps Comprehensive Care Program services, are not considered Case-by-case Services or Value-added Services.

2.6.62 IMMUNIZATIONS

The MCO must educate Providers on the immunization standard requirements set forth in Tex. Health & Safety Code ch. 161; the standards in the Advisory Committee on Immunization Practices (ACIP) Immunization Schedule; and the ACIP Immunization Schedule for Medicaid Members. The MCO must educate Providers that Medicaid Members age 18 through age 20 years must be immunized during the THSteps checkup according to the ACIP routine immunization schedule. The MCO must also educate Providers that the screening Provider, or the Provider's appropriate designee is responsible for administration of the immunization and should not refer children to Local Health Departments or other entities to receive immunizations.

The MCO must educate Providers about the importance of including documentation for immunizations in the Member's medical record, and the necessity of the Provider's documentation to support a qualification for reimbursement for appropriate provision of immunizations to eligible Members.

The MCO must educate Providers about and require Providers to comply with the requirements of Tex. Health & Safety Code ch. 161, relating to the statewide Texas Immunization Registry (ImmTrac2).

The MCO must notify Providers that they may enroll, as applicable, as Texas Vaccines for Children Providers. The MCO must work with HHSC and health care providers to improve the immunization rate of STAR+PLUS Members and the reporting of immunization information for inclusion in the ImmTrac2 registry.

2.6.63 PROVISIONS RELATED TO COVERED SERVICES FOR MEMBERS

The following sections provide additional service requirements.

2.6.63.1 NEMT SERVICES

The MCO must assess, approve, arrange, coordinate, and ensure delivery of NEMT Services in accordance with the Contract and Chapter 16 of Exhibit C, UMCM. NEMT Services include the following:

1. Demand response transportation services, including Nonmedical Transportation (NMT) Services, and public transportation services;
2. Mass transit;
3. Individual transportation participant (ITP) mileage reimbursement;
4. Meals;
5. Lodging;
6. Advanced funds; and

Commercial airline transportation services.

NEMT Services must be delivered using the most cost-effective and cost-efficient method of delivery that allows the Member to meet his or her health care needs, including delivering NMT Services through a Transportation Network Company (TNC) or other transportation vendor if available and medically appropriate.

The MCO must coordinate NEMT Services that enable Members to obtain Medicaid-covered dental benefits in the Dental Program.

The MCO must require NEMT Services within the Member's Service Area to be requested at least two Business Days in advance of the date of the requested trip. The MCO must require a request for a trip outside of the Member's Service Area (i.e., a "long distance trip") to be received at least five Business Days in advance of the trip. The MCO must make an exception to either of these requirements for transportation to access treatment for an Urgent Condition, transportation after hospital discharge, and transportation to a pharmacy to pick-up a prescription or obtain Health Care Services provided by a pharmacy, such as DME items. These trips may be requested with less than 48 hours' notice. Additional exceptions to these timeframe requirements may be granted at the MCO's discretion. The MCO is not required to approve requests for NEMT Services made with less than three hours' notice. The MCO must document actions taken in attempt to arrange the requested transportation.

2.6.63.2 NEMT SERVICES DATABASE

The MCO must develop and maintain data related to the administration and tracking of NEMT services. The data must be capable of interfacing with HHSC systems.

At a minimum, the MCO must:

1. Establish and maintain a computer system that complies with federal and state laws, rules, and regulations, including HIPAA;
2. Maintain hardware, software, internet and communication equipment to support automated services necessary to carry out the requirements of the Contract using industry standard products;
3. Maintain a reservation system capable of conducting NEMT Services reservations and confirmation of transactions;
4. Track NEMT Services received by Members, and accurately and fully maintain those service records as HIPAA-complaint Encounter transactions;
5. Maintain a history of changes and adjustments and audit trails for current and retroactive data;
6. Maintain a vehicle management platform capable of monitoring vehicle status including mileage, condition, and inspections routinely, including identification data for the vehicles including owner, plate number, and vehicle identification number;
7. Maintain a driver management platform capable of monitoring driver status including trainings, driver's license, criminal history checks, sex offender registry checks, motor vehicle reports from DPS, drug testing, and federal and state screening requirements;
8. Maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure; and
9. Maintain and provide electronic records or media records in a format compatible with HHSC systems. Acceptable electronic/media records formats may include but are not limited to:
    a. Formats identified in the MT88 Managed Care Organization (MCO) Companion Guide.
    b. Formats identified 837P Managed Care Organizations (MCOs) Transportation Encounter Companion Guide.
    c. Deliverables as specified in the Uniform Managed Care Manual or other contract documents.
    d. Reporting requests with specific formats provided to MCOs via TexConnect or other notification systems.
    e. Ad hoc requests for data for the purposes of contract monitoring/oversight, audits, or other reviews.
    f. Ad hoc requests for review/reconciliation of NEMT services expenditures purpose for HHSC Actuarial Analysis and external contractors hired to support the rate setting process.

2.6.63.3 APPROVAL OF NEMT SERVICES

All NEMT Services provided to Members must be approved by the MCO. The MCO must have a process in place for modifying a Member's approved, scheduled trip to add a stop,

such as to the pharmacy, clinic, or other health care facility as reasonable or ordered by an attending physician. The MCO must use an automated scheduling system to record, approve, and coordinate NEMT Services. This system must be capable of accommodating reservations for future trips as well as requests for same day trips and urgent trips. At minimum, for any delivered NEMT Services, the MCO must be able to provide documentation of the following upon request:

1. The name and Medicaid number of the Member using the service;
2. The pickup and destination addresses, including a telephone number for the trip destination;
3. Evidence that the NEMT Service was for an allowable purpose and in conjunction with a covered Health- Care Service;
4. Evidence that the Member had no other means of transportation (this may be met through self-attestation);
5. Information on any special transportation needs, such as use of a wheelchair; and
6. If applicable, the justification for providing NEMT Services outside of the Service Area.

Each MCO may determine the means by which this information is collected, including whether the information is collected prior to each NEMT service occurrence.

To avoid risk to Member health and safety, the MCO must determine the appropriateness of using a TNC while authorizing the transportation.

Separate from, and in addition to the automated scheduling system, the MCO must provide an online reservation system for Members or Providers to request NEMT Services.

2.6.63.4 OUT OF STATE TRAVEL REQUESTS

The MCO must permit and provide out-of-state NEMT Services to Members for approved out-of-state Health Care Services. If a Member must travel to another state to receive Health Care Services, the MCO must not levy additional fees against the Member or HHSC.

2.6.63.5 MEALS AND LODGING

The MCO must provide the cost of meals and lodging for a Member, birth through age 20, if the costs are either:

1. Directly associated with a long-distance trip to obtain Health Care Services, or
2. Necessary because a Member who is already outside his or her county of residence experiences an unplanned or urgent healthcare event that requires the Member to remain in the area overnight for treatment before the Member can return home.

Meals and lodging may be provided while en route to and from or while receiving a Health Care Service. The MCO may approve meals or lodging or both. If the Member requires an NEMT Attendant, the cost of meals and lodging for the NEMT Attendant must also be covered, except if the NEMT Attendant is a service animal.

The MCO is responsible for making the appropriate arrangements, reservations, and otherwise coordinating the stay with the lodging facility.

Meal Per Diem: The per diem rate for meals is $25 per day per person. The MCO must approve meals for an additional NEMT Attendant when a health care provider documents the need for the Attendant.

Lodging: The MCO must approve expenses to cover the Member's lodging for the night before a Health Care Service if travel cannot be reasonably accomplished on the day of the appointment, or if a health care provider's statement of need or equivalent documents the necessity to travel the night before a Health Care Service. The MCO must approve expenses for lodging services the night after a Health Care Service if:

1. Travel to the Member's residence reasonably requires an additional day due to length or circumstances beyond the Members control; or
2. A health care provider's statement of need or equivalent documents the necessity for additional lodging.

Lodging services are limited to the overnight stay and do not include any amenities or incidentals used during the Member's stay, such as phone calls, room service, or laundry service. The Member may use amenities offered by charitable organizations, such as the Ronald McDonald House, at no cost to the Member or HHSC. The MCO must approve lodging for an additional NEMT Attendant when a health care provider documents the need, such as for both parents to receive training on the use of medical equipment or delivery of complex care or to allow both parents to accompany a child not expected to survive the trip.

2.6.63.6 INDIVIDUAL TRANSPORTATION PARTICIPANTS (ITPS)

ITP services reimburse a Member or his or her family member, friend, or neighbor for the mileage, as calculated by the MCO, incurred when driving the Member to a Health Care Service. ITP services are available to Members of any age.

2.6.63.7 ADVANCED FUNDS

For Members age 20 and younger, the MCO must authorize advanced funds to be used to purchase gas, meals, or lodging prior to the trip if the Member requires these funds in advance to access necessary Health Care Services. All other ITP requirements apply in these circumstances.

2.6.63.8 NONMEDICAL TRANSPORTATION SERVICES

The MCO must only approve a TNC to provide NMT Services. If a TNC does not operate in the area where the Member or the Health Care Service is located, the MCO may not approve the use of NMT. Instead, the MCO must provide the requested transportation using another NEMT Service for the Member, including demand response transportation services (DRTS) with less than 48-hours' notice, if the trip is to access treatment for an Urgent Condition, transportation after hospital discharge, or transportation to a pharmacy.

2.6.63.9 NEMT ATTENDANT REQUIREMENTS

Members who need assistance while being transported may request an NEMT Attendant. The MCO may approve an NEMT Attendant for nonmedical reasons, such as to provide communication assistance to the Member, without a written statement from a healthcare provider. A written statement from the Member's primary healthcare provider is necessary for the MCO to approve an NEMT Attendant for medical reasons. Member parents and guardians are considered NEMT Attendants and do not need to be approved by the MCO as a NEMT Attendant.

The NEMT Attendant must accompany the Member from the point of origin to the approved destination and on the return trip, including add-on trips. Except for parents or guardians, the MCO must document the need for the NEMT Attendant. If documentation states an NEMT Attendant is necessary, the trip may not proceed without an NEMT Attendant. If an NEMT Attendant is necessary but not present when the driver arrives to pick up the Member, the NEMT Service must be recorded as a Member "no-show" and rescheduled. The NEMT Attendant must remain at the location where Health Care Services are being provided but may remain in the waiting room during the Member's appointment. The NEMT Services provider must not require reimbursement from the NEMT Attendant.

Before the trip may commence, the NEMT Attendant must provide and install any necessary child safety seats if not provided by the NEMT Service.

2.6.63.10 APPROVAL OF MASS TRANSIT NEMT SERVICES

The MCO must not authorize mass transit if the Member's health care provider has documented that the Member:

1. Has a high-risk pregnancy;
2. Is in the eighth month of pregnancy or later;
3. Has high-risk cardiac conditions;
4. Has severe breathing problems; or
5. Requires life sustaining medical care.

The NEMT Service must provide alternate transportation means instead of mass transit for members with these health issues. NEMT Services must be scheduled for Members with these health issues to minimize wait times and riding times.

2.6.63.11 NEMT SERVICES PROVIDERS

2.6.63.11.1 TRANSPORTATION NETWORK

The MCO will establish and maintain a transportation network that meets NEMT Services needs for Members within the Service Area. In establishing its network, the MCO must consider the following factors: Member characteristics; historical service utilization data; geographic location of heath care providers and Members, including distance, travel time, and available modes of transportation; and health care provider hours of operation that may be outside regular business hours, such as dialysis centers. The MCO's transportation

network must include a sufficient and reliable fleet of vehicles, and various modes of transportation, including buses, sedans, vans, wheelchair accessible vehicles, and the personal cars of drivers who that are part of a TNC's network.

The MCO must ensure vehicles in its transportation network comply with all applicable state and federal laws, rules, and regulations, including Federal Motor Vehicle Safety Standards (49 C.F.R. Part 571) and Texas Transportation Code, Title 7, Chapter 547. MCOs must also ensure there are sufficient vehicles in their networks that comply with the ADA Accessibility Guidelines for Transportation Vehicles (36 C.F.R. Part 1192) in order to meet the needs of Members with special needs.

2.6.63.11.2 NEMT Services Provider Enrollment

The MCO must:

1. Comply with the provider selection requirements in 42 C.F.R. § 438.214 and the prohibitions against provider discrimination in 42 C.F.R. § 438.12, as applicable;
2. Ensure that NEMT Services providers are properly enrolled through the HHSC's Claims Administrator and appear on PEMS or other system applications designated by HHSC in order to be eligible for inclusion in the MT88 MCO Network File prior to providing NEMT Services;
3. Enroll NEMT Services providers that will be part of the MT88 MCO Network File through the MCO enrollment process and enter into a written agreements with each of those providers of NEMT Services. An executed copy of the written agreement must be provided to HHSC no later than 10 Business Days after execution; and
4. Enter into a Data Use Agreement (DUA) with the NEMT Services provider and maintain a signed copy of that DUA.

NEMT Services providers may have an Atypical Provider Identifier (API) or NPI.

2.6.63.12 NEMT Services Call Center Requirements

The MCO must ensure Members are able to request NEMT Services by phone. This requirement may be met through augmenting the existing MCO Member Hotline staff, creating a dedicated NEMT Services call center, contracting with an entity to arrange NEMT Services requested by telephone, or another HHSC approved model. In any arrangement, the NEMT Services call center must be staffed between the normal business hours of 8:00 a.m. to 5:00 p.m. local time for the Service Area, Monday through Friday, excluding state-approved holidays. The NEMT Services call center must be staffed sufficiently to answer calls regarding NEMT Services, including providing approval of services, scheduling and tracking rides, and answering Member questions related to ride status. If a dedicated NEMT Services call center or contracted entity is used, those staff are responsible for ensuring a warm transfer to the MCO's standard call center for questions related to program benefits that are received during MCO call center operating hours to ensure consistent and comprehensive support is provided to Members.

The NEMT Services call center must have the staffing capacity to handle all telephone calls at all times during the required hours of operation and have the ability to upgrade for

handling additional call volume as needed. Calls cannot be answered by an answering service between the normal business hours of 8:00 a.m. to 5:00 p.m. local time and recording devices cannot be used as the final point of destination for callers during these business hours.

The MCO must have a separate "Where's My Ride" line and/or phone prompt, for Members to call for their rides home and/or check on the status of their scheduled rides. The MCO must ensure the Member's calls are answered by live operators 5:00 a.m. through 7:00 p.m. local time Monday through Saturday. The MCO must ensure that Members can reach this line and/or phone prompt and NEMT Services providers during observed holidays in which NEMT Services must be provided.

The MCO must properly train NEMT Services call center staff on NEMT Services policies, including the following:

1. Handling difficult callers;
2. Reporting Fraud, Waste, and Abuse;
3. Overview of managed care and NEMT Services;
4. Scheduling and coordination of NEMT Services;
5. Civil rights;
6. Cultural diversity training; and
7. Customer service.

The MCO must ensure a desk or training manual for NEMT Services call center staff is developed that includes all processes, policies, and procedures used in scheduling trips, authorization of services, and management of transportation services.

At the time of trip scheduling, NEMT Services call center staff must advise NEMT attendants or any person accompanying children that car safety seats are required and that the persons accompanying children are responsible for installing the child safety seat if not provided by the NEMT Services.

NEMT Services call centers, including the "Where's my Ride" line, are subject to all Member Hotline performance standards and reporting.

In addition to Member Hotline reporting requirements found in Section 8.1.5.6, and to comply with directives from Frew v. Young, the MCO will provide HHSC with "trunk reports." "Trunk" refers to telephone lines that are routed through a carrier network. Trunk reports are only required for the following counties: Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, and Walker.

The MCO will make trunk reports available to HHSC upon request for all trunks used to answer Member calls about NEMT Services. The MCO must require the trunk vendor to provide and report, at a minimum, the following information:

1. Number of trunks available;
2. Number of call attempts;
3. Number of blocked or overflow call attempts; and
4. Number of trunks out of service.

The MCO must back up all data reports from the trunk vendor. It is the responsibility of the MCO to ensure its reporting system and trunks are configured in a manner that will enable the MCO to track the performance measures specified by HHSC. The MCO must ensure receipt and backup of all trunk reports data provided by the vendor. This backup will occur before any data is purged.

2.6.63.13 NEMT Services Encounter Data Submission

The MCO must provide complete and accurate Encounter Data for all applicable NEMT Services provided to Members. Encounter Data must follow the format and data elements as described in the 837P Companion Guides, Encounter Submission Guidelines, MT88 MCO Companion Guide, or comparable format as determined by HHSC. HHSC will specify the method of transmission. The MCO must submit to HHSC 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 no later than the 30th Day after the last Day of the month in which each claim was Adjudicated. The MCO must make original records available to HHSC upon request. Encounter Data that does not meet quality standards must be corrected and returned within a time period specified by HHSC.

For reporting claims processed by the MCO and submitted on the prescribed Encounter 837P format or comparable format as determined by HHSC, the MCO must use the HCPCS, provider identifiers, and other codes as directed by HHSC. Any exceptions will be considered on a case-by-case basis after HHSC receives written notice from the MCO requesting an exception.

The MCO must:

1. Implement and maintain policies and procedures to support Encounter Data reporting and submission;
2. Establish quality control procedures and edits to allow for the detection and correction of errors prior to submission of Encounter Data to HHSC or its designee;
3. Ensure the paid amount on Encounter Data is the amount paid to the provider of the NEMT Services;
4. Have a system in place for verifying and ensuring that only approved NEMT Services are rendered and, as applicable, paid to NEMT Services providers;
5. Review its quality control procedures at least on a quarterly basis to mitigate issues with the submission of Encounter Data; and
6. Have a computer processing and reporting system that is capable of following or tracing the Encounter record within its system using the unique authorization number assigned to each of the NEMT Services.

2.6.63.14 Emergency Services

The MCO's policies and procedures, provision of Covered Services, claims adjudication methodology, and reimbursement performance for Emergency Services and Post-Stabilization Care Services must comply with all applicable state and federal laws, rules,

and regulations, including 42 C.F.R. § 438.114 and 1 Tex. Admin. Code pt. 15, ch. 353, whether the Provider is in the MCO's Network or OON. 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 BH Condition and Post-Stabilization Care Services to the Hospital emergency department, 24 hours a Day, seven Days a week, rendered by either the MCO's Network or OON providers.

The MCO must not require PA or a PA number as a condition for payment for an Emergency Medical Condition, an Emergency BH Condition, including Emergency Detentions as defined in Tex. Health & Safety Code ch. 573, subch. A and ch. 462, subch. C, or labor and delivery. The MCO must not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. In accordance with 42 C.F.R. § 438.114, the MCO must not 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 10 Days of presentation for Emergency Services.

The MCO must not hold the Member who has an Emergency Medical Condition or an Emergency BH Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or Stabilize the Member. The MCO must accept the emergency 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. §§ 438.114(b) and (c), 489.20, and 489.24. 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 services and the Hospital's Emergency Services, including the emergency room and its ancillary services.

When the medical screening examination determines that an Emergency Medical Condition or Emergency BH Condition exists, the MCO must pay for Emergency Services performed to Stabilize the Member (Post-stabilization Care Services). The MCO must reimburse for both the physician and Hospital's emergency stabilization services including the ER 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) and (e) and 42 C.F.R. § 422.113(c)(2). The MCO is financially responsible for Post-Stabilization Care Services provided by Network or OON providers 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 PA within one hour of receipt of the request;
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 Provider is not available for consultation.

In this situation, the MCO must give the treating physician the opportunity to consult with a Provider and the treating physician may continue with care of the Member until a Provider is reached. The MCO's financial responsibility ends as follows:

1. The Provider with privileges at the treating Hospital assumes responsibility for the Member's care;
2. The Provider assumes responsibility for the Member's care through Transfer;
3. The MCO representative and the treating physician reach an agreement concerning the Member's care; or
4. The Member is Discharged.

The requirements in this section regarding access to and payment of OON providers apply only to OON providers who are enrolled Texas Medicaid providers.

2.6.63.15 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 the Provider Network or OON. 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 Covered Services available under Texas Medicaid program for family planning services. The MCO must reimburse family planning agencies the Medicaid FFS amounts for family planning services, including Medically Necessary medications, contraceptives, and supplies not covered by the VDP and must reimburse OON family planning providers in accordance with 1 Tex. Admin. Code § 353.4. The MCO must not require a PA for family planning services whether rendered by a Network or OON provider.

The MCO must provide medically approved methods of contraception to Members, provided that the methods of contraception are Covered Services. Contraceptive methods must be accompanied by verbal and written instructions on their correct use. The MCO must establish mechanisms to ensure all medically approved methods of contraception are made available to the Member, either directly or by referral to a Subcontractor.

The MCO must develop, implement, monitor, and maintain standards, policies, and procedures for providing information regarding family planning to Providers and Members, specifically regarding state and federal laws governing Member confidentiality, including minors. Providers and family planning agencies must not 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 the Member's confidentiality for family planning services.

2.6.63.16 PERINATAL SERVICES

The MCO's perinatal Covered Services must ensure appropriate care is provided to Members and infant Members from the preconception period through the infant's first year of life. The MCO's perinatal health care system must comply with the requirements of the Tex. Health & Safety Code ch. 32 and administrative rules codified at 25 Tex. Admin. Code, pt. 1, ch. 37, subch. M.

The MCO must have a perinatal health care system in place that provides the following services:

1. Pregnancy planning and perinatal health promotion and education for reproductive-age women;
2. Perinatal risk assessment of non-pregnant women, pregnant, and postpartum women;
3. Access to appropriate levels of care based on risk assessment, including Emergency Services;
4. Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary;
5. Availability and accessibility of OB/GYN Providers, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems;
6. Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems; and
7. Education and care coordination for Members who are at high-risk for preterm labor, including education on the availability of medication regimens to prevent preterm birth, such as hydroxyprogesterone caproate.

The MCO must also educate Providers on the PA processes for these benefits and Covered 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, education, Service Coordination, and Member referrals to Providers, to assess the need for the use of hydroxyprogesterone caproate, sometimes referred to as 17P, to identified Members as described in this section to prevent additional preterm births. The MCO must report on use of the data file as specified in **Chapter 5 of Exhibit C**.

In accordance with the appointment access standard in **Section 2.6.36.1**, the MCO must have a process to expedite an obstetrical exam for a pregnant Member. Specifically, a

pregnant Member must have an obstetrical exam no later than five Days after the Member is diagnosed as pregnant or five Days after the Member's Effective Date of Coverage, whichever is later.

The MCO must have procedures in place to contact and assist a pregnant Member or a Member who has recently given birth in selecting a PCP for her baby either before the birth or soon after the baby is born.

The MCO must provide Covered Services relating to the labor and delivery for its pregnant and delivering Members, including inpatient care and professional services for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated caesarian delivery. The MCO must provide all Medically Necessary neonatal care to the newborn Member and may not place limits on the duration of such care.

The MCO must notify Providers involved in the care of newborns and pregnant or delivering women, including OON providers and Hospitals, of the MCO's PA requirements. The MCO must not require a PA as a condition for payment for Covered Services provided to a pregnant or delivering Member for a medical condition that requires Emergency Services, regardless of when the Emergency Medical Condition arises.

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 HHSC-issued Medicaid ID number for a newborn Member. The MCO must accept provider claims for newborn services based on mother's name or Medicaid ID number, with accommodations for multiple births, as specified by the MCO. The MCO can specify whether the mother's name, Medicaid ID number, or both must be used when the newborn's Medicaid ID number is not yet available, and the MCO must specify how multiple births are distinguished.

2.6.63.17 Sexually Transmitted Infections and Human Immunodeficiency Virus

The MCO must provide Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV) Covered Services that include STI and HIV prevention, screening, counseling, diagnosis, and treatment. The MCO must ensure that Members have prompt access to appropriate services for STIs and HIV. The MCO must allow Members access to STI services and HIV diagnosis services without PA or referral by a PCP.

The MCO must provide all Covered Services required to form the basis for a diagnosis by the Provider, as well as the STI and HIV treatment plan. The MCO must make education available to Providers and Members on the prevention, detection, and effective treatment of STIs and HIV.

The MCO must inform and require its Providers who provide STI and HIV services to comply with all State laws relating to communicable disease reporting requirements. The MCO must require Providers to report all confirmed cases of STIs and HIV, to the local or regional health authority in accordance with 25 Tex. Admin. Code pt. 1, ch. 97, subch. F,

§§ 97.131–134, using the required forms and procedures for reporting STIs and HIV. The MCO must require the Providers to coordinate with the DSHS regional health authority to ensure that Members with confirmed cases of syphilis, cancroid, gonorrhea, chlamydia, neonatal herpes, and HIV receive risk reduction and partner elicitation, and 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 Providers to have procedures in place to protect the confidentiality of Members who receive STI and 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 implement policies and procedures to monitor Provider compliance with confidentiality requirements. The MCO must have policies and procedures in place regarding obtaining informed consent and counseling Members provided STI and HIV services.

2.6.63.18 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 2.6.63.20**, 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. For purposes of this section, 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, the CDC, and DSHS policies and standards.

The MCO must implement policies and procedures requiring Providers to report all confirmed or suspected cases of TB to the local TB control program within one Business Day of identification, using the most recent DSHS forms and procedures for reporting TB. 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 Provider Contracts, that Providers report to DSHS or the local TB control program any Member who is non-compliant, who is 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 Tex. Health & Safety Code ch. 81.

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.

2.6.63.19 Objection to Providing 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.

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 Covered Services 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.

HHSC may make downward adjustments to Capitation Rates for the MCO if it objects to providing certain Covered Services based on moral or religious grounds.

The MCO must notify 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 HHSC.

2.6.63.20 Non-capitated Services

The following Texas Medicaid programs, services, or benefits have been excluded from MCO Covered Services. Members are eligible to receive these Non-capitated Services on another basis, such as a FFS basis or through a dental MCO, for most dental services. The MCO should refer to relevant chapters in **Exhibit F,** for more information:

1. THSteps dental, including orthodontia;
2. THSteps Environmental Lead Investigation (ELI);
3. Texas School Health and Related Services (SHARS);
4. TB services provided by DSHS-approved providers, including DOT and contact investigation;
5. Medicaid hospice services;
6. PASRR screenings, evaluations, and specialized services for Members;

7. For Members who are enrolled in STAR+PLUS during an Inpatient Stay under one of the scenarios identified in **Section 2.4.4.2,** Hospital facility charges associated with the Inpatient Stay are Non-capitated Services; and
8. MHR and Mental Health TCM for Dual Eligible Members, and
9. SUD treatment in a CDTF for Dual Eligible Members.

The MCO must educate Members regarding the availability of Non-capitated Services and provide appropriate referrals for Members to obtain or access these services. The MCO is responsible for educating Providers that bills for all Non-capitated Services must be submitted to HHSC or its designee for reimbursement.

2.6.63.21 MEMBER RIGHTS AND RESPONSIBILITIES

In accordance with 42 C.F.R. § 438.100, the MCO must maintain written policies and procedures for informing Members of their rights and responsibilities, including rights and responsibilities that apply specifically to utilization of NEMT Services outlined in UMCM Section 3.4. Attachment FF, and must notify all Members of their right to request a copy of these rights and responsibilities, and their right to a State Fair Hearing separate from the appeals process for all Members. The MCO must ensure the Member handbook includes notification of Member rights and responsibilities, as set forth in **Chapter 3 of Exhibit C.**

The use of seclusion is not permitted for Members in STAR+PLUS. Seclusion is the involuntary placement of an individual alone in an area from which the individual is prevented from leaving. STAR+PLUS MCOs are required to report the use of seclusion of its Members to HHSC as a Critical Event or Incident through the process outlined in UMCM Chapter 5. MCOs must also report seclusion to the Department of Family and Protective Services.

2.6.63.22 COORDINATION WITH PUBLIC HEALTH ENTITIES

The MCO must identify MCO staff who will be available to assist Public Health Entity Providers and PCPs in efficiently referring Members to the Public Health Entity Providers, specialists, and health-related service providers, either within or outside of the MCO's Network.

The MCO must also inform Members in writing that confidential healthcare information will be provided to the PCP and educate Members on how to better utilize their PCPs, Public Health Entity Providers, ERs, specialists, and health-related service Providers.

2.6.63.22.1 REIMBURSED ARRANGEMENTS WITH PUBLIC HEALTH ENTITIES

The MCO must make a good faith effort to enter into a Subcontract 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. STI services;
2. Confidential HIV testing;
3. Immunizations;

4. TB care;
5. Family planning services;
6. THSteps medical checkups, and
7. Prenatal services.

These Provider Contracts must be available for review by HHSC on the same basis as all other MCO Provider Contracts. If the MCO is unable to enter into a Provider Contract with Public Health Entities, the MCO must document efforts to contract with Public Health Entities and make such documentation available to HHSC upon request.

The MCO's Provider Contracts with Public Health Entities must specify the scope of responsibilities of each party, 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.

2.6.63.22.2 Non-Reimbursed Arrangements with Local Public Health Entities

The MCO must coordinate with Public Health Entities in each SA regarding the provision of essential Covered Services. The MCO must:

1. Report to local 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 of communicable disease outbreaks, as defined by State law, involving Members;
3. Educate Members and Providers regarding WIC services available to Members;
4. Ensure through Provider Contracts that Providers coordinate with local Public Health Entities that have a child lead program, or with the DSHS Texas Childhood Lead Poisoning Prevention Program when the local Public Health Entity does not have a child lead program, when following up on suspected or confirmed cases of childhood lead exposure; and
5. Make a good faith effort to establish and maintain an effective working relationship with all State and local Public Health Entities in its SAs to identify issues and promote initiatives addressing public health concerns.

2.6.63.23 Coordination with Other State Health and Human Services Programs

The MCO must coordinate with other State HHSC programs in each SA for which the MCO has a Contract regarding the provision of essential Covered Services. The MCO must:

1. Require Providers to use the DSHS laboratories for specimens obtained as part of a THSteps medical checkup, as indicated in **Section 2.6.38.22**;
2. Notify Providers of the availability of vaccines through the Texas Vaccines for Children Program;
3. Work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac2;
4. Participate, to the extent practicable, in the community-based coalitions with the Medicaid-funded case management programs; and
5. Cooperate with activities required of State and local public health authorities necessary to conduct the annual population and community-based needs assessment.
6. Coordinate with THSteps Outreach and Informing Unit for Members age 18 to 20;
7. Coordinate care protocols for working with dental contractors, as well as protocols for reciprocal referral and communication of data and clinical information regarding the Member's Medically Necessary dental Covered Services and any related NEMT Services for Members age 18 to 20; and
8. Develop a coordination plan to share with local entities regarding clients identified as requiring special needs or assistance during a disaster.

2.6.63.24 Case Management for Children and Pregnant Women

The MCO must provide Case Management for Children and Pregnant Women Services. MCO efforts to provide these services include, but are not limited to, Member education, outreach, Service Coordination, and case collaboration with and referrals to and from Case Management for Children and Pregnant Women Providers. The MCO is required to follow referral procedures as outlined in UMCM Chapter 16.

The MCO must reimburse Out-of-Network Case Management for Children and Pregnant Women providers in accordance with HHSC's administrative rules regarding OON payment at 1 Tex. Admin. Code § 353.4.

The MCO must ensure Case Management for Children and Pregnant Women Providers have completed HHSC-approved training as required by Title 25, Part 1, Chapter 27, Subchapter C of the Texas Administrative Code.

The MCO must educate its Providers, including PCPs, Pediatric, and OB/GYN Providers, on the availability of Case Management for Children and Pregnant Women Services and how to provide referrals to Case Management for Children and Pregnant Women Providers.

The MCO must require its Service Coordination staff to annually complete the THSteps online training module titled "Case Management Services in Texas," and must maintain proof of completion of such training.

2.6.63.25 ADVANCE DIRECTIVES

The MCO must maintain written policies and procedures for informing all Members 18 years of age and older, in writing. about their rights to refuse, withhold, or withdraw medical treatment and mental health treatment through advance directives in accordance with 42 U.S.C. §§ 1396a(a)(57) and 1396b(m)(1)(A).

The MCO's Member handbooks must inform the Member how to exercise an advance directive. The MCO's policies and procedures must include written notification to Members 18 years of age and older and comply with the provisions of 42 C.F.R. § 422.128 and 42 C.F.R. pt. 489, subpt. I, regarding advance directives for all Hospitals, critical access Hospitals, skilled nursing facilities, home health agencies, Providers of home health care, Providers of PCS, PAS, and hospice, as well as the following State laws and rules:

1. A Member's right to self-determination in making healthcare decisions;
2. The Advance Directives Act, Tex. Health & Safety Code ch. 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, Tex. Civ. Prac. & Rem. Code § 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 must not require a Member to execute or issue an advance directive as a condition of receiving health care services. The MCO must not discriminate against a Member based on whether or not the Member has executed or issued an advance directive.

The MCO must document in the Member's medical record whether or not the Member has executed 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.

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.

2.6.63.26 ABUSE, NEGLECT, OR EXPLOITATION

The MCO must protect against ANE.

2.6.63.26.1 MEMBER EDUCATION ON ABUSE, NEGLECT, OR EXPLOITATION

At the time of assessment, but no later than when the Member is approved for LTSS, the MCO must ensure that the Member and any individuals residing in the same residence as the Member are informed orally and in the Member handbook of the processes for reporting allegations of ANE. The MCO must provide the toll-free numbers for HHSC Regulatory Services Division and DFPS in the event that the Member needs to report ANE.

2.6.63.26.2 ABUSE, NEGLECT, OR EXPLOITATION EMAIL NOTIFICATIONS

The MCO must provide HHSC with an email address at which the MCO will receive and respond to APS ANE notifications. The MCO must respond to emails received through this email address and provide the information requested by APS within 24 hours of delivery of the notification, seven Days a week.

2.6.63.26.3 MANAGED CARE ORGANIZATION TRAINING ON ABUSE, NEGLECT, OR EXPLOITATION AND UNEXPLAINED DEATH

MCOs must provide ANE and Unexplained Death training to all MCO staff who have direct contact with a Member. Direct contact includes in-person and telephone contact. MCOs must use the approved training materials provided by HHSC as set forth in the **Chapter 16 of Exhibit C,** regarding policy guidance.

The MCO must ensure that all newly hired staff who have direct contact with a Member must be trained no later than 30 Days from the date of hire. The MCO must also ensure all employees that receive the required training must sign, upon completion of the training, an acknowledgement of their understanding of their duty to report ANE.

The MCOs must retain records of the ANE training, including copies of all training materials and the employee's signed acknowledgment, during the employment of the staff member and for 10 years thereafter.

For Service Coordinators working with Members receiving Community-Based LTSS, this training must be provided before contact with Members served, no later than 30 Days from the date of hire and annually thereafter.

2.7 TURNOVER PHASE SCOPE

This section presents the SOW for the Turnover Phase of the Contract. The MCO is required to perform all required activities prior to, upon, and following termination, expiration, merger, assignment, or acquisition of the Contract in accordance with its HHSC-approved Turnover Plan. HHSC reserves the right to update the Turnover requirements and related reporting requirements at any time during the Contract. HHSC will not enforce any Capitation Rate change during the period of time between the receipt of the notice of intent to terminate or to allow the Contract to expire and the end of the Turnover Phase.

The MCO, in the instance of termination, expiration, merger, assignment, or acquisition of the Contract, is responsible for all Turnover Phase costs, including HHSC's costs for modifying its business rules, systems identifiers, communications materials, web page, and all other costs as a result of the termination, expiration, merger, assignment, or acquisition. If the MCO terminates the Contract, the MCO will be responsible for HHSC's reprocurement costs.

2.7.1 TURNOVER PLAN

No later than twelve months after the start of the Contract Term, the MCO must provide a Turnover Plan covering the turnover of the records and information maintained to either HHSC or a subsequent Contractor. Thereafter, the MCO must update the Turnover Plan annually and submit to HHSC for approval.

Twelve months prior to the end of the Contract Term, or earlier with enough lead time to complete turnover, the MCO must update its Turnover Plan and submit it to HHSC for approval.

If HHSC terminates the Contract prior to the expiration of the Contract Term, HHSC requires the MCO to propose the Turnover Plan immediately. In such cases, HHSC's notice of termination will include the date the Turnover Plan is due.

If the MCO terminates the Contract, MCO will provide a Turnover Plan with the notice of termination compliant with this section. The MCO will also provide an updated Turnover Plan six months before the Contract Term is to expire or concurrently with the MCO's notice of intent to allow Contract to expire, whichever is earlier.

Until the Turnover Plan is complete to HHSC satisfaction, MCO will not be relieved of responsibilities and obligations under the Contract except as expressly set forth in the approved Turnover Plan.

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, at a minimum, describe the MCO's policies and procedures that will assure:

1. The least disruption in the delivery of Covered Services to Members who are enrolled with the MCO during the transition to a subsequent Contractor;
2. The least disruption in authorization and payment to Providers contracted with the MCO during transition to a subsequent Contractor;
3. Cooperation with HHSC and the subsequent Contractor in notifying Members and Providers of the transition, as requested and in the form required or approved by HHSC; and
4. Cooperation with HHSC and the subsequent Contractor in transferring information to the subsequent Contractor, as requested and in the form required or approved by HHSC.

The Turnover Plan must be approved by HHSC and, at a minimum, include:

1. The MCO's approach and schedule for the transfer of data and information, as described above;
2. The Quality Assurance process the MCO must 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; and
4. The MCO's staffing plan to ensure sufficient staffing resources to execute the Turnover Plan throughout the turnover period and for six months after turnover.
5. Information about Custom Software, MCO Proprietary Software, Third-Party Software (collectively "STAR+PLUS Software") used by the MCO in the performance of duties under the Contract, including the manner in which the STAR+PLUS Software is used and terms of any STAR+PLUS Software license agreements, so that HHSC can determine if the STAR+PLUS Software is needed to transition operations.

The MCO must provide additional information or modify its Turnover Plan as requested by HHSC.

2.7.2 TRANSFER OF DATA AND INFORMATION

For the purposes of this section, "Data and Information" means all operations, technical, and user manuals used in conjunction with the STAR+PLUS 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 Data and Information in the formats in which it exists at the expiration or termination of the Contract. To the extent the Data and Information requires proprietary or MCO-owned viewers, translators, or other manipulation programs, MCO must likewise provide such viewers, translators, or other manipulation programs. HHSC reserves the right to request Data and Information in additional or differing formats.

The MCO must transfer to HHSC or a subsequent Contractor, identified by HHSC, all Data and Information necessary to transition operations, including but not limited to:

1. Source code;
2. Data dictionaries

3. Data and reference tables;
4. Data entry interfaces;
5. License agreements for Third-Party Software;
6. License rights for MCO Proprietary Software;
7. Ownership rights for Custom Software;
8. Documentation relating to STAR+PLUS Software and interfaces;
9. Functional business process flows;
10. Operational information, including correspondence, documentation of ongoing or outstanding issues;
11. Operations support documentation;
12. Operational information regarding Subcontractors;
13. Any data, information, and services necessary and sufficient to enable HHSC to map all managed care program data from the MCO's systems to the replacement systems of HHSC or its designee; and
14. STAR+PLUS Program hardware.

The MCO must provide all of the data, information and services:

1. According to the schedule approved by HHSC in the Turnover Plan; and
2. At no additional cost to HHSC.

The MCO must ensure all relevant Data and Information is received and accepted by HHSC or its designee. If HHSC determines that Data and Information are not accurate or complete, HHSC may hire an independent contractor to assist HHSC in obtaining and transferring all the required Data and Information. The MCO must bear all of the costs of providing these services

2.7.3 POST TURNOVER SERVICES

Within 30 Days following turnover of operations, the MCO must provide HHSC with a turnover results report documenting the completion and results of each step of its Turnover Plan. Turnover will not be considered complete until this document is approved by HHSC. HHSC may withhold up to 20 percent (20%) of the final month's Capitation Payment until the turnover activities are complete and the turnover results report is approved by HHSC.

2.8 TERMS AND CONDITIONS OF PAYMENT

2.8.1 CALCULATION OF MONTHLY CAPITATION PAYMENT

This is a Risk-based contract. The MCO will provide Health Care Services and NEMT 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 the Contract.

MCO will be required to provide timely financial and statistical information necessary in the Capitation Rate determination process. Encounter Data provided by MCO must conform to all HHSC requirements (see **Section 2.6.30.2)**. Encounter Data containing non-compliant information, including inaccurate client or Member identification numbers, inaccurate provider identification numbers, or diagnosis or procedures codes insufficient to adequately describe the diagnosis or medical procedure performed, will not be considered in the MCO's experience for rate-setting purposes.

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.

The fixed monthly Capitation Rate consists of the following components:

1. An amount for Health Care Services and NEMT Services performed during the month;
2. An amount for state premium taxes;
3. An amount for administering the Program; and
4. 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.

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.

2.8.2 TIME AND MANNER OF PAYMENT

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.

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

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 10 of Exhibit A**. MCO will be responsible for providing all Covered Services as mandated by this Contract even if there is a reduction in Capitation Payment to account for an unpaid Experience Rebate.

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 7 of Exhibit A**, or
2. Terminate the Contract in accordance with **Article 10 of Exhibit A**.

2.8.3 CERTIFICATION OF CAPITATION RATES

HHSC will employ or retain a qualified actuary to certify the actuarial soundness of the Capitation Rates as required in 42 C.F.R. § 438.4 and contained in this Contract. HHSC will also employ or retain a qualified actuary to certify all revisions or modifications to the Capitation Rates.

2.8.4 MODIFICATION OF CAPITATION RATES

The Parties understand and agree that the Capitation Rates are subject to modification in accordance with **Article 7 of Exhibit A** 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 10 of Exhibit A**.

2.8.5 CAPITATION RATE STRUCTURE

Capitation Rates are defined on a per Member per month basis by Rate Cells. The Rate Cells are based on client category as follows:

1. Medicaid Only Standard Rate;
2. Medicaid Only STAR+PLUS HCBS or Rate – Above Floor;
3. Medicaid Only STAR+PLU`S HCBS or Rate – Below Floor;
4. Dual Eligible Standard Rate;
5. Dual Eligible STAR+PLUS HCBS or Rate – Above Floor;
6. Dual Eligible STAR+PLUS HCBS Rate – Below Floor;
7. NF – Medicaid only;
8. NF – Dual Eligible; and
9. Individuals with Developmental Disabilities (IDD) – age 21 and older
10. Medicaid for Breast and Cervical Cancer Program (MBCCP)

These Rate Cells are subject to change.

HHSC will establish the Rate Period 1 Capitation Rates by SA based on managed care experience in the counties included in the SA.

HHSC may evaluate and implement an acuity adjustment methodology, or alternative reasonable methodology, that appropriately reimburses the MCO for acuity and cost differences that deviate from that of the community average, if HHSC in its sole discretion determines that such a methodology is reasonable and appropriate. The community average is a uniform rate for all MCOs in a SA is determined by combining all the experience for all MCOs in a SA to get an average rate for the SA.

VAS will not be included in the rate-setting process.

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

All SPW recipients will be registered into Service Authorization System Online (SASO). The Premium Payment System (PPS) will process data from the SASO system in establishing a Member's correct Capitation Payment.

Once a current MCO Member has been certified to receive SPW services, there is a two-month delay before the MCO will begin receiving the higher Capitation Payment.

Non-Waiver Members who qualify for STAR+PLUS based on eligibility for SPW services and Waiver recipients who transfer from another region will not be subject to this two-month delay in the increased Capitation Payment.

2.8.6 MCO INPUT DURING RATE SETTING PROCESS

MCO must provide certified Encounter Data and financial data as described in **Chapters 5 and 6 of Exhibit C** or as otherwise requested by HHSC. The required information may include claims lag information, capitation expenses, and stop loss reinsurance expenses. The MCO must provide written explanation to an HHSC request for clarification or provide additional financial information to HHSC upon request. HHSC will notify the MCO of the deadline for submitting a response, which will include a reasonable amount of time for response.

HHSC will allow the MCO to review and comment on data used by HHSC to determine Capitation Rates. HHSC will notify the MCO of the deadline for submitting comments, which will include a reasonable amount of time for response. HHSC will not consider in its rate analysis comments received after the deadline.

During the rate setting process, HHSC will conduct a minimum of 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 written comments, which will include a reasonable amount of time to review and comment on the proposed Capitation Rates and rate setting process. After reviewing any comments and making any necessary changes due to those comments, HHSC will conduct a second meeting to discuss the final Capitation Rates and any changes.

2.8.7 ADJUSTMENTS TO CAPITATION PAYMENTS.

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.

The MCO may appeal the adjustment of Capitation Payments in the above circumstances using the HHSC dispute resolution process set forth in **Section 10.13 of Exhibit A**.

2.8.8 EXPERIENCE REBATE

2.8.8.1 MCO'S DUTY TO PAY

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 2.8.8.2**. 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 Administrative Expense Cap ("Admin Cap"), or the reinsurance cap

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 SAs, with the exception of the Dual Demonstration and Medicaid Dental.

2.8.8.2 GRADUATED EXPERIENCE REBATE SHARING METHOD

The graduated Experience Rebate sharing method is:

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

HHSC and the MCO will share the consolidated Net Income Before Taxes for its HHSC programs as follows unless HHSC provides the MCO an Experience Rebate in accordance with **Section 2.6.25.6**, and **Chapter 6 of Exhibit C**:

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.

2.8.8.3 NET INCOME BEFORE TAXES

The MCO must compute the Net Income Before Taxes in accordance with **Chapters 5 and 6 of Exhibit C**. 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 **Chapters 5 and 6 of Exhibit C** in accordance with **Section 7.05 of Exhibit A**.

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

1. The payment of an Experience Rebate;
2. Any interest expense associated with late or underpayment of the Experience Rebate;
3. Financial incentives;
4. Financial disincentives, including without limitation, the liquidated damages as described in **Exhibit D**. See **Chapter 6 of Exhibit C**.

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.

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 must not be included as reported expenses and shall 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.

2.8.8.4 CARRY FORWARD OF PRIOR FSR REPORTING PERIOD LOSSES

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

In the case of a loss in a given FSR Reporting Period being carried forward and applied against profits in either or both of the next two FSR Reporting Periods, the loss must first be applied against the first subsequent FSR Reporting Period such that the profit in the first subsequent FSR Reporting Period is reduced to a zero Net Income Before Taxes; 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 2.8.8.7.6**

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 contract and current Contract.

2.8.8.4.1 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.

2.8.8.5 SETTLEMENTS FOR PAYMENT

There may be one or more MCO payment(s) of the Experience Rebate on income generated for a given FSR Reporting Period under the STAR+PLUS Program. The first scheduled payment (the Primary Settlement) will equal 100 percent (100%) 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 section, refers strictly to what should be paid with the 90-day FSR and does not refer to the first instance in which an MCO may tender a payment. For example, an MCO may submit a 90-day FSR indicating no Experience Rebate is due but then submit a 334-day FSR with a higher income and a corresponding Experience Rebate payment. In this case, this initial payment would be subsequent to the Primary Settlement.

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 2.8.8.6** 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 2.8.8.6**. 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)."

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:

1. The date of the management representation letter resulting from the audit; or
2. 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 2.8.8.6**.

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 **Chapters 6 and 5 of Exhibit C**. HHSC has final authority in auditing and determining the amount of the Experience Rebate.

2.8.8.6 INTEREST ON EXPERIENCE REBATE

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 2.8.8.5**. 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.

If an audit or adjustment determines a downward revision of income after an interest payment has previously been required for the same SFY, then HHSC will recalculate the interest and, if necessary, issue a full or partial refund or credit to the MCO.

Any interest obligations that are incurred that are not timely paid will be subject to daily compounding and accumulation of interest as well, at the same rate as applicable to the underlying Experience Rebate.

All interest assessed 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 in this section will continue 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.

If the MCO incurs an interest obligation under this section for an Experience Rebate payment, HHSC will assess such interest at 12 percent (12%) per annum, compounded daily. If the interest rate stipulated in this section is found by a court of competent jurisdiction to be outside 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.

Any such interest expense incurred under this section is not an Allowable Expense for reporting purposes on the FSR.

2.8.8.7 ADMINISTRATIVE EXPENSE CAP

2.8.8.7.1 GENERAL REQUIREMENT

The calculation methodology of Experience Rebates described in **Section 2.8.8** will be adjusted by an Admin Cap. 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 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 the Contract will be subject to limitations on total deductible administrative expenses. The limitations will be calculated as set forth below.

2.8.8.7.2 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 (i.e., 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 Capitation Rates are changed during the FSR Reporting Period, this same methodology of multiplying the Capitation 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.

2.8.8.7.3 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 and 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;
    a. The percentage rate to apply against the total premiums paid (the "percentage of premium" within the administrative expenses);
    b. The dollar rate per Member Month (the "fixed amount" within the administrative expenses); and
    c. The portion incorporated into the pharmacy (prescription expense) rate that pertains to prescription administrative expenses.

These will be taken from the supporting details associated with the official notification of final Capitation Rates, as supplied by HHSC. This notification is sent to the MCO during the annual rate setting process via 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 at https://pfd.hhs.texas.gov/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."

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.

2.8.8.7.4 EXAMPLE OF CALCULATION

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

1. Multiply the predetermined administrative expense rate structure "fixed amount," or dollar rate per Member Month (for example, $8.00), by the actual number of

Member Months for the Program during the FSR Reporting Period (for example, 70,000):
   a. $8.00 x 70,000 = $560,000.
2. Multiply the predetermined percent of premiums in the administrative expense rate structure (for example, 5.25 percent), by the actual aggregate premiums earned by the MCO during the FSR Reporting Period (for example, $6 million).
   a. 5.25% 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):
   a. $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:
   a. ($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.

2.8.8.7.5 CONSOLIDATION AND OFFSETS

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

2.8.8.7.6 IMPACT OF LOSS CARRY-FORWARD

For Experience Rebate calculation purposes, the calculation of any loss carry-forward, as described in **Sections 2.8.8.4**, will be based on the allowable pre-tax loss as determined under the Admin Cap.

2.8.8.7.7 MCOS ENTERING A SERVICE DELIVERY AREA OR PROGRAM

If an MCO enters a SA or offers a HHSC Program that it was not participating in previously, HHSC may, at its discretion, exempt the MCO from the Admin Cap, or revise its application, for a period of time to be determined by HHSC, up through the first FSR Reporting Period or portion thereof.

2.8.8.8 REINSURANCE CAP

Reinsurance is reported by the MCO on HHSC's FSR 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 percent (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 **Chapter 6 of Exhibit C.**

2.8.9 -PAYMENT BY MEMBERS

The MCO and its Providers are prohibited from billing or collecting any amount from a Member for Health Care Services covered by this Contract. The MCO must inform Members of costs for non-covered services, and must require its 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.

MCOs must work with Members or their LAR or guardian to help NFs collect applied income where applicable.

2.8.10 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.

2.8.11 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.

2.8.12 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 the Contract, including salaries, benefits, employment taxes, workers compensation benefits, unemployment insurance and benefits, and other insurance or fringe benefits for staff.

2.8.13 NO ADDITIONAL CONSIDERATION.

MCO is not entitled to, nor will it 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.

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 Contract.

The 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.

2.8.14 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, including recouping this money by deducting or withholding Capitation Payments to MCO. 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.

2.8.15 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+PLUS Members. HHSC will make supplemental payments to the MCO for these Medicaid Wrap-Around Services, based on Encounter Data received by HHSC or its designee 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 or its designee 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 S (Field 281) on the 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.

2.8.16 NON-RISK PAYMENTS FOR CERTAIN DRUGS

The Capitation Rates do not include the costs of certain clinician-administered and pharmacy drugs as identified in **Chapter 2 of Exhibit C**. For providing these drugs to Members, HHSC will make non-risk payments to the MCO based on Encounter Data received by HHSC or its designee 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 formulary through the end of that State fiscal quarter. Thereafter, non-risk payments will cover quarterly encounter reporting periods. HHSC will make non-risk payments within a reasonable amount of time after the Encounter reporting period, but no later than 95 Days after HHSC or its designee has processed the Encounter Data. Non-risk payments will be limited to the actual amounts the MCO paid to pharmacy Providers for these drugs as represented in "Net Amount Due" field (Field 281) on the NCPDP Encounter transaction up to the FFS reimbursement amount. To be eligible for reimbursement, pharmacy encounters must contain a Financial Arrangement Code "14" in the "Line of Business" field (Field 270) on the NCPDP Encounter transaction.

For clinician-administered drugs, the first non-risk payment will cover medical Encounter Data received from the effective date of the drugs specified on the CAD_Formulary_NRP file, as defined in Chapter 2 of the UMCM, through the end of that State Fiscal Quarter. Thereafter, non-risk payments will cover 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 or its designee has processed the medical Encounter Data. Non-risk payments will be limited to the actual amounts paid to medical Providers for the ingredient cost of these drugs up to the FFS reimbursement amount. To be eligible for reimbursement, medical encounters must contain a Financial Arrangement Code "20" in segment NTE02 on the encounter transaction.

2.8.17 NON-RISK PAYMENTS FOR CERTAIN AUTISM SERVICES

Capitation Rates do not include the costs of delivering applied behavior analysis (ABA) services to Medicaid Members age 20 and under or the costs of interdisciplinary team meetings to identify needed services and formulate individualized treatment plans for these eligible Medicaid Members, as described in the **Exhibit F**.

For providing these services to eligible Medicaid 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. HHSC will reimburse for services provided to eligible Medicaid Members as documented in both the invoice and Encounter Data on a non-risk basis subject to the non-risk upper payment limit in 42 CFR § 447.362.

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 for these services require MCO adherence to all applicable requirements, including those specified in the **Exhibit F**.

Non-risk payments will be limited to the actual amounts MCOs paid to providers for these services up to the Fee-for-Service reimbursement amount. The non-risk payments will cover only the cost of the covered ABA services and interdisciplinary team meetings to identify needed services and formulate individualized treatment plans for these eligible Medicaid Members.

Deliverables/Liquidated Damages Matrix

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
Operations Readiness (OR)					
OR-1	SOW § 2.5 Transition Phase Scope SOW §2.6 Operations Phase Scope	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 to be operational based on the requirements in §§ 2.5 and 2.6 of the SOW.	Operational Start Date	Each Day of noncompliance, per MCO's Service Area.	HHSC may assess up to $10,000 per Day of noncompliance, for each Day beyond the Operational Start Date that the MCO is not operational until the Day that the MCO is operational, including all systems.

[1] Derived from the SOW (Exhibit B), Exhibit A, or Exhibit C.

[2] Standard specified in the SOW. Note: Where the due date states 30 days, the MCO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the MCO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

[3] Period during which HHSC will evaluate service for purposes of tailored remedies.

[4] Measure against which HHSC will apply remedies.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
OR-2	SOW § 2.5.3.6 Systems Readiness and Transfer of Data	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 Management Plan; 4. Joint Interface Plan; 5. Risk Management Plan; 6. Systems Quality Assurance Plan. 7. Change Management 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.
OR-3	SOW § 2.5.3.7 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 for each Day the directory, and per MCO's Service Area is not submitted or is late, inaccurate, or incomplete.
General/ Administrative (GA)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
GA-1	General Requirement: Failure to Perform an Administrative Service Exhibit A Managed Care UTCs SOW §§ 2.5, 2.6, and 2.7	The MCO fails to timely perform an MCO Administrative Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, such failure either: (1) results in actual harm to a Member or places a Member at risk of imminent harm, or (2) materially affects HHSC's ability to administer the Program.	Ongoing	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 Exhibit A Managed Care UTCs SOW §§ 2.5, 2.6, and 2.7	The MCO fails to timely provide an MCO Covered Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, such failure results in actual harm to a Member or places a Member at risk of imminent harm.	Ongoing	Each Day of noncompliance, per MCO's Service Area per each incident of noncompliance.	HHSC may assess up to $7,500 per Day of noncompliance and per MCO's Service Area for each incident of noncompliance.
GA-3	SOW §§ 2.5, 2.6, and 2.7 Exhibit C Uniform Managed Care Manual (UMCM)	All reports and Deliverables as specified in §§ 2.5, 2.6, and 2.7 of the SOW 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
GA-4	SOW §§ 2.5, 2.6, and 2.7 Exhibit C - UMCM	All reports as specified in §§ 2.5, 2.6, and 2.7 of the SOW 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	Exhibit A Managed Care UTCs § 6.05 HIPAA and Article 9 Disclosure & Confidentiality of Information	The MCO must meet all privacy standards under applicable State or federal law, rule, regulation and Contract's 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 privacy standards in the Contract.
PS-2	Exhibit A Managed Care UTCs, § 6.05 HIPAA and Article 9 Disclosure & Confidentiality of Information	The MCO must meet all security standards under applicable state or federal law, rule, regulation and Contract's 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 security standards in the Contract.
PS-3	Exhibit A Managed Care UTCs, § 6.05 HIPAA and Article 9 Disclosure & Confidentiality of Information	The MCO must meet all confidentiality standards under applicable State or federal law, rule, regulation and the Contract's requirement.	Transition Phase and Quarterly during Operations Phase	Per quarterly reporting period, per privacy/security incident.	HHSC may assess up to $5,000 per quarterly reporting period for each breach by MCO scenario as required by HHSC.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PS-4	Exhibit A Managed Care UTCs, § 6.05 HIPAA and Article 9 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 the Contract's 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	Exhibit A Managed Care UTCs, § 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 non-compliance.	HHSC may assess up to $5,000 per Day of noncompliance.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
MS-2	Exhibit A Managed Care UTCs, § 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 non-compliance.	HHSC may assess up to $5,000 per Day of noncompliance.
MS-3	Exhibit A Managed Care UTCs, § 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 non-compliance.	HHSC may assess up to $5,000 per Day of non-compliance.
MS-4	Exhibit A Managed Care UTCs, § 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 non-compliance.	HHSC may assess up to $5,000 per Day of non-compliance.
Claims (CL)					
CL-1	SOW § 2.6.29.1 General Reporting Requirements Exhibit C - UMCM Chapter 5	Claims Summary Report: The MCO must submit monthly Claims Summary Reports to HHSC by the last Day of each month following the reporting period.	Operations Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CL-2	SOW § 2.6.33.1 Provider Appeal of Managed Care Organization Claims Determinations Exhibit C - 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	SOW § 2.6.12.1 Claims Project Exhibit C - UMCM Chapters 2 and 5	The MCO must complete all claims projects within 60 Days of the claims project's start date unless the MCO enters into a written agreement with the Provider before the initial expiration of the 60 Days to establish the claims project's agreed upon timeframe. MCOs may not include nursing facility daily/unit rate claims as part of the claims project.	Operations Phase	Per incident of noncompliance.	HHSC may assess up to $5,000 per incident of noncompliance. A claim's project incident of noncompliance is considered any claims project not completed within 60 Days of the claims project's start date or any claims project that includes Nursing Facility Daily/Unit Rate claims.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CL-4	SOW § 2.6.30.3 Claims Processing Requirements Exhibit C - 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	SOW § 2.6.30.3 Claims Processing Requirements Exhibit C – UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in SOW § 2.6.30.3 and in Exhibit C Chapter 2. The MCO must pay or deny 98% of Clean Claims within 30 Days of the claim being submitted to the MCO.	Operations Phase	Per month, per claim type.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month and per claim type that an MCO's monthly claims performance percentages fall below the performance standards.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CL-6	SOW § 2.6.30.3 Claims Processing Requirements Exhibit C – UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in SOW § 2.6.30.3 and in Exhibit C Chapter 2. The MCO must pay or deny 99% of 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	SOW § 2.6.30.3 Claims Processing Requirements SOW § 2.6.53.14 Pharmacy Claims and File Processing Exhibit C – UMCM Chapter 2	For a Clean Claim for outpatient pharmacy benefits not adjudicated within (1) 18 Days after receipt by the MCO if submitted electronically or (2) 21 Days after receipt by the MCO if submitted non-electronically, the MCO must pay the provider interest at 18% per annum, calculated daily for the full period in which the Clean Claim remains unadjudicated beyond the 18-Day or 21-Day claims processing deadline. Interest owed to the provider must be paid on the same date as the claim.	Operations Phase	Per month, per claim.	HHSC may assess up to $1,000 per month and per claim if the MCO fails to pay interest timely.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CL-8	SOW § 2.6.30.3 Claims Processing Requirements SOW § 2.6.53.14 Pharmacy Claims and File Processing Exhibit C – UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in SOW §§ 2.6.30.3, 2.6.53.14, and in Exhibit C Chapter 2. The MCO must pay or deny 98% of electronic pharmacy Clean Claims within 18 Days of the claim being submitted to the MCO.	Operations Phase	Per month.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month that an MCO's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month that an MCO's monthly claims performance percentages fall below the performance standards.
CL-9	SOW § 2.6.30.3 Claims Processing Requirements SOW § 2.6.53.14 Pharmacy Claims and File Processing Exhibit C – UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in SOW §§ 2.6.30.3, 2.6.53.14, and in Exhibit C Chapter 2. The MCO must pay or deny 98% of non-electronic pharmacy Clean Claims within 21 Days of the claim being submitted to the MCO.	Operations Phase	Per month.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month that an MCO's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month that an MCO's monthly claims performance percentages fall below the performance standards.

CL-10	SOW § 2.6.30.3 Claims Processing Requirements SOW § 2.6.53.14 Pharmacy Claims and File Processing Exhibit C – UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in SOW § 2.6.30.3 and § 2.6.53.14 and Exhibit C - UMCM Chapter 2. The MCO must ensure all applicable MIS systems (including pharmacy claims adjudication systems) are updated with data provided in the pharmacy interface files within two Business Days of the receipt from HHSC unless the MCO requests clarification or data or file exceptions from HHSC within the same Business Days.	Ongoing	Per Day, per incident of noncompliance.	HHSC may assess up to $500 per Day, per each incident of noncompliance.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
SPCL-1	SOW § 2.6.30.3 Claims Processing Requirements SOW § 2.6.43.3.4 Nursing Facility Claims Adjudication, Payment, and File Processing Exhibit C – 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, per claim if the MCO fails to pay interest timely.
SPCL-2	SOW § 2.6.30.3 Claims Processing Requirements Exhibit C - UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in SOW § 2.6.30.3 and in Exhibit C 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.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month that an MCO's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month that an MCO's monthly claims performance percentages fall below the performance standards.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
SPCL-3	SOW § 2.6.30.3 Claims Processing Requirements Exhibit C – UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in SOW § 2.6.30.3 and in Exhibit C 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.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month that an MCO's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month that an MCO's monthly claims performance percentages fall below the performance standards.
SPCL-4	SOW § 2.6.30.3 Claims Processing Requirements SOW § 2.6.43.3.4 Nursing Facility Claims Adjudication, Payment, and File Processing Exhibit C **–** UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in SOW § 2.6.30.3 and § 2.6.43.4. and in Exhibit C 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.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month that an MCO's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month that an MCO's monthly claims performance percentages fall below the performance standards.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
SPCL-5	SOW § 2.6.30.3 Claims Processing Requirements SOW § 2.6.43.3.4 Nursing Facility Claims Adjudication, Payment, and File Processing Exhibit C – UMCM Chapter 2	The MCO must comply with the claims processing requirements and standards as described in SOW § 2.6.30.3 and § 2.6.43.3.4 and in Exhibit C 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.	For the first occurrence of noncompliance: HHSC may assess up to $1,750 per month that an MCO's monthly claims performance percentages fall below the performance standards. For each subsequent occurrence of noncompliance: HHSC may assess up to $8,500 per month that an MCO's monthly claims performance percentages fall below the performance standards.
Encounter Data (ED)					
ED-1	SOW § 2.6.30.2 Encounter Data	The MCO must submit complete and accurate non-pharmacy Encounter Data transmissions in accordance with SOW § 2.6.30.2.	Measured Quarterly during the 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
ED-2	SOW § 2.6.30.2 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	SOW § 2.6.30.2 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.	For the initial quarter: HHSC may assess up to $2,500 per month and per incident of noncompliance if the MCO fails to submit monthly non-pharmacy Encounter Data in a quarter. For each subsequent quarter: HHSC may assess up to $5,000 per month and per incident of noncompliance , and per MCO's Service Area for each month in any subsequent quarter that the MCO fails to submit monthly non-pharmacy Encounter Data.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
ED-4	SOW § 2.6.30.2 Encounter Data	The MCO must submit complete and accurate pharmacy Encounter Data transmissions in accordance with SOW § 2.6.30.2.	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	SOW § 2.6.30.2 Encounter Data	The MCO will be subject to liquidated damages if the Quarterly Encounter Reconciliation Report (which reconciles the year-to-date paid claims reported in the Financial Statistical Report (FSR) to the appropriate paid dollars reported in the Vision 21 Data Warehouse) includes more than a 2% variance for pharmacy Encounter Data.	Operations Phase	Per quarter, per incident of noncompliance	HHSC may assess up to $2,500 per quarter and per incident of noncompliance that the MCO is not within the 2% variance for pharmacy Encounter Data. HHSC may assess up to $5,000 per quarter and per incident of noncompliance for each additional quarter that the MCO is not within the 2% variance for pharmacy Encounter Data.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
ED-6	SOW § 2.6.30.2 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 the initial quarter. For each subsequent quarter: HHSC may assess up to $15,000 per quarter and per incident of noncompliance that the MCO fails to submit pharmacy Encounter Data in a timely manner.
SPED-1	SOW § 2.6.45.2 Long Term Services and Supports Provider Billing Exhibit E - STAR+PLUS Handbook	All STAR+PLUS MCOs are required to utilize the standardized method as found in the STAR+PLUS 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+PLUS Handbook, Appendix XVI, Long Term Services and Supports Codes and Modifiers.
Hotlines (HL)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
HL-1	SOW § 2.6.18.1 Member Hotline SOW § 2.6.10 Provider Hotline SOW § 2.6.63.12 NEMT Services Call Center Requirements	The MCO must operate toll-free Member and Provider hotlines from 8 AM – 5 PM local time for each MCO's Service Area, all areas of the State, 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.
HL-2	SOW § 2.6.18 Requirements Common to All Member-Facing Hotlines	Call hold rate: At least 80% of calls must be answered by hotline staff within 30 seconds.	Operations Phase and Turnover Phase	Per each percentage point below the standard, per hotline, per monthly reporting period.	HHSC may assess up to $100 for each percentage point below the standard and per hotline that the MCO fails to meet the requirements for a monthly reporting period for any MCO operated hotlines.
HL-3	SOW § 2.6.18 Requirements Common to All Member-Facing Hotlines SOW § 2.6.10 Provider Hotline SOW § 2.6.63.12 NEMT Services Call Center Requirements	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 must assess up to $100 for each percentage point above the standard and per hotline that the MCO fails to meet the requirements for a monthly reporting period for any MCO operated hotlines.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
HL-4	SOW § 2.6.18 Requirements Common to All Member-Facing Hotlines SOW § 2.6.10 Provider Hotline SOW § 2.6.63.12 NEMT Services Call Center Requirements	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	SOW § 2.6.18 Requirements Common to All Member-Facing Hotlines SOW § 2.6.18.4 Behavioral Health Services Hotline	The MCO must have a Behavioral Health Services Hotline, answered by a live voice, available 24 hours per Day, 7 Days a week, toll-free throughout the MCO's Service Area(s) which addresses routine and crisis behavioral health calls.	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	SOW § 2.6.18.4 Behavioral Health Services Hotline	Behavioral Health 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.

#	Service/ Component [1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
SPHL-1	SOW § 2.6.63.12 NEMT Services Call Center Requirements	The MCO must have a "Where's My Ride" line and/or phone prompt that ensures the Members' calls are answered by live operators 5:00 a.m. through 7:00 p.m. local time Monday through Saturday.	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.
SPHL-2	SOW § 2.6.18.2 Nurse Hotline	The MCO must operate a toll-free Nurse Hotline that Providers and Members may call 24 hours a Day, 7 Days a week, including State-approved holidays.	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	SOW § 2.6.34 Member Complaint and Appeal System SOW § 2.6.34.1 Managed Care Organization Internal Appeal Process for Members	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	SOW § 2.6.33 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. .

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
CA-3	SOW § 2.6.34 Member Complaint and Appeal System SOW § 2.6.34.1 Managed Care Organization Internal Appeal Process for Members SOW § 2.6.34.2 Expedited Managed Care Organization 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	SOW § 2.6.34 Member Complaint and Appeal System SOW § 2.6.33 Provider Complaints Exhibit C – UMCM Chapter 3	The MCO must resolve Member and Provider Complaints received by HHSC and referred to the MCO 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.).	Measured Quarterly	Per Day, per each incident of noncompliance, per MCO's Service Area.	HHSC may assess up to $250 per Day and per each incident of noncompliance, and per MCO's Service Area for each Day beyond the due date specified within the MCO notification correspondence.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
SPCA -1	SOW § 2.6.34.3 Access to State Fair Hearing and External Medical Review 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 and 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	SOW § 2.6.36 Access to Care SOW §2.6.36.1 Appointment Accessibility and Service Initiation SOW § 2.6.36.2 Access to Providers SOW § 2.6.36.4 Monitoring Access	The MCO must comply with the Contract's mileage and/or time standards and benchmarks for Member access.	Quarterly	Per quarter, per incident of noncompliance, per plan code, per county, and per Provider type.	HHSC may assess up to $1,000 per quarter, per incident of noncompliance, per plan code, per county, and per Provider type.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PN-2	SOW § 2.6.25.5 Alternative Payment Models with Providers and Value Based Payments with Providers Exhibit C – UMCM Chapter 8	The MCO must meet minimum APM ratios as follows: • Measurement Year 1: o Minimum Overall APM Ratio: >=25% o Minimum Risk Based APM Ratio: >=10% • Measurement Year 2: o Minimum Overall APM Ratio: Year 1 Overall APM Ratio +25% o Minimum Risk-Based APM Ratio: Year 1 Risk-Based APM Ratio +25% • Measurement Year 3: o Minimum Overall APM Ratio: Year 2 Overall APM Ratio +25% o Minimum Risk-Based APM Ratio: Year 2 Risk-Based APM Ratio +25% • Measurement 4 5,and 6: o Minimum Overall APM Ratio: >=50% o Minimum Risk Based APM Ratio: >=25%	Measured on September 1 of each calendar year for the previous calendar period.	Per Member per month (PMPM), per period of measurement.	Failure to meet calendar year target for overall APM, and not eligible for exception, based on HHSC's exception criteria: up to $0.10 per Member per month (PMPM) for period of measurement. Failure to meet target for Risk Based APM, and not eligible for exception: up to $0.10 per Member per month (PMPM) for period of measurement.

PN-3	SOW § 2.6.38 Provider Network Exhibit C – UMCM Chapter 5	No more than 20% of total dollars billed to the 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	SOW § 2.6.38 Provider Network Exhibit C – UMCM Chapter 5	No more than 15% of the MCO's total hospital admissions may occur in Out-of-Network facilities.	Quarterly	Per quarter.	HHSC may assess up to $25,000 per quarter.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PN-5	SOW § 2.6.38 Provider Network Exhibit C – UMCM Chapter 5	No more than 20% of the MCO's total emergency room visits may occur in Out-of-Network facilities.	Quarterly	Per quarter.	HHSC may assess up to $25,000 per quarter.
PN-6	SOW § 2.6.38 Provider Network Exhibit C – UMCM Chapter 5	No more than 20% of total dollars billed to the 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	SOW § 2.6.24 Marketing and Prohibited Practices Exhibit C – UMCM Chapter 4	The MCO must meet all Marketing and Member Materials policy requirements and may not engage in prohibited marketing practices.	Transition Phase, Measured quarterly during the Operations Phase	Per quarter, per incident of noncompliance.	HHSC may assess up to $1,000 per quarter per incident of noncompliance.
MM-2	SOW § 2.6.24 Marketing and Prohibited Practices Exhibit C – 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
MM-3	SOW § 2.6.17.1 Member Materials	No later than the fifth 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 Case Head or account name for each new Member. When a Case Head or account name Caregiver represents two or more new Members, the MCO is required to send only 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 Case Head or account name for each new Member.
Management Information Systems (MI)					
MI-1	SOW § 2.6.30 Management Information System Requirements	The MCO's Management Information System (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	SOW § 2.6.30.1 System-Wide Functions	The MCO's MIS system must meet all requirements in SOW § 2.6.30.1	Quarterly during 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)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
FR-1	SOW § 2.6.29.3.2 Financial Reporting Requirements Exhibit C – UMCM Chapter 5.	Financial Statistical Reports (FSR**)**: The MCO must file quarterly and annual FSRs. Quarterly reports are due no later than 30 Days after the conclusion of each State Fiscal Quarter (SFQ). The first annual SFY FSR report is due no later than 120 Days after the end of the Contract Year, and subsequent annual reports are due no later than 365 Days after the end of each Contract Year.	Quarterly during the Operations 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 FSR is not submitted or is late, inaccurate, or incomplete.
FR-2	SOW § 2.6.29.3.2 Financial Reporting Requirements Exhibit C – 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	SOW § 2.6.29.3.2 Financial Reporting Requirements Exhibit C - 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 Exhibit C. The "as-occurs" update is due within 30 Days of the event triggering the change.	Operations Phase and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
FR-4	SOW § 2.6.29.3.2 Financial Reporting Requirements Exhibit C - UMCM Chapter 5	Report of Legal and Other Proceedings and Related Events: The MCO must comply with Exhibit C 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	SOW § 2.6.29.3.2 Financial Reporting Requirements Exhibit C - UMCM Chapter 5.	Third Party Liability and Recovery (TPL/TPR) Reports: The MCO must submit TPL/TPR reports quarterly by the MCO Program and plan code as described in Exhibit C Chapter 5.	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	SOW § 2.6.29.3.2 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
FR-7	SOW § 2.6.29.3.2 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	SOW § 2.6.29.3.2 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	SOW § 2.6.29.3.2 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	SOW § 2.6.29.3.2 Financial Reporting Requirements Exhibit C - UMCM Chapter 5	Audit Reports: The MCO must comply with Exhibit C 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
FR-11	SOW § 2.6.29.3.2 Financial Reporting Requirements	Employee Bonus and/or Incentive Payment Plan must be submitted no later than 30 Days after the Effective Date of the Contract.	Operations Phase	Per Day of noncompliance.	HHSC may assess up to $500 per Day of noncompliance the report is not submitted or is late, inaccurate, or incomplete.
FR-12	SOW § 2.6.29.3.2 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.
SPFR-1	RESERVED				
Office of the Inspector General (IG)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
IG-1	SOW § 2.5.3.7 Operations Readiness SOW § 2.6.31 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	SOW § 2.6.31 Fraud, Waste, and Abuse	The MCO must perform pre-payment review for identified providers as directed by the HHSC OIG within ten Business Days after notification.	Transition Phase, Operations Phase, and Turnover Phase	Per Day, per each incident of noncompliance.	HHSC may assess up to $1,000 per Day and per each incident of noncompliance.
IG-3	SOW § 2.6.31.2 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	SOW § 2.6.31.2 General Requests for and Access to Data, Records, and Other Information Exhibit C - UMCM Chapter 5	The MCO must submit a Fraudulent Practices Referral to the HHSC OIG within 30 Business Days of receiving a report of possible Fraud, Waste, or Abuse from the MCO's Special Investigative Unit (SIU).	Transition Phase, Operations Phase, and Turnover Phase	Per Day of noncompliance.	HHSC may assess up to $1,000 per Day of noncompliance that the referral is not submitted or is late, inaccurate, or incomplete. This amount will increase to $5,000 per Day of noncompliance for the fourth and each subsequent occurrence within a 12-month period.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
IG-5	SOW § 2.6.31.4 Payment Holds and Settlements Exhibit C – 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	SOW § 2.6.31.4 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 Exhibit C Chapter 5.5 and the amount received by the HHSC OIG.
IG-7	SOW § 2.6.31.2 General Requests for and Access to Data, Records, and Other Information	The MCO fails to submit complete, unredacted, and accurate claims data as prescribed by 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	SOW § 2.6.31.4 Payment Holds and Settlements	The MCO must impose payment suspensions or lift payment holds as directed by 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
Frew (FW)					
SPFW -1	SOW § 2.6.29.1 General Reporting Requirements SOW § 2.6.25.8 Frew Incentives and Disincentives Exhibit C – UMCM Chapter 12	Frew Quarterly Monitoring Report – The MCO must submit the report as described in Exhibit C Chapter 12.	Quarterly	Per Day of noncompliance, per MCO.	HHSC may assess up to $1,000 per Day of noncompliance and per MCO if the report is not submitted or is late, inaccurate, or incomplete.
SPFW -2	SOW § 2.6.29.1 General Reporting Requirements SOW § 2.6.25.8 Frew Incentives and Disincentives Exhibit C – 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 Exhibit C Chapter 12.	Annually	Per Day of noncompliance.	HHSC may assess up $1,000 per Day of noncompliance the reports are not submitted or are late, inaccurate, or incomplete.
Turnover (TO)					
TO-1	SOW § 2.7.3 Post Turnover Services	The MCO must provide HHSC with a Turnover Results Report documenting the completion and results of each step of the Turnover Plan 30 Days after the turnover of operations.	Measured 30 Days after the turnover of operations	Per Day of noncompliance, and per MCO's Service Area.	HHSC may assess up to $250 per Day of noncompliance that the report is not submitted or is late, inaccurate, or incomplete.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
TO-2	SOW § 2.7.3 Post 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 HHSC or a successor MCO. If HHSC terminates the Contract prior to the expiration of the initial Contract Period or Contract Period, then HHSC may require the MCO to propose or update the Turnover Plan sooner.	Measured at twelve months prior to the end of the Contract Period, or any extension thereof, and ongoing until satisfactorily completed	Each Day of noncompliance, and per MCO's Service Area.	HHSC may assess up to $1,000 per Day of noncompliance that the Turnover Plan is not submitted or is late, inaccurate, or incomplete.
TO-3	SOW § 2.7.2 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 that the data is not submitted, is not provided in the required format, or is late, inaccurate, or incomplete.
Pharmacy (PH)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PH-1	SOW § 2.6.53.1 Formulary and Preferred Drug List SOW § 2.6.53.2 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 Prior Authorizations (Clinical PAs), and any preferred drugs that can be substituted for non-preferred drugs, updated at least weekly. If the MCO has Clinical PAs that are identical to HHSC VDP's Clinical PAs, then the MCO can reference VDP's Texas Medicaid formulary on Epocrates.	Ongoing	Per incident of noncompliance.	HHSC may assess up to $10,000 for an incident of noncompliance if the web-based application is not operational, does not identify preferred/non-preferred drugs, or Clinical PAs, and any preferred drugs that can be substituted for non-preferred drugs, is not updated at least weekly.
PH-2	SOW § 2.6.53.1 Formulary and Preferred Drug List SOW § 2.6.53.10 Specialty Drugs	The MCO must adhere to HHSC's formularies and the Specialty Drug List (SDL) for drugs provided through selective specialty pharmacy contracts.	Ongoing, Quarterly during Operations Phase	Per incident of noncompliance.	For the initial quarter of noncompliance, HHSC may assess up to $5,000 per incident of noncompliance. For each subsequent quarter of noncompliance, HHSC may assess up to $10,000 per incident of noncompliance.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PH-3	SOW § 2.6.53.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies	The MCO must allow and reimburse a pharmacy for dispensing a 72-hour supply of a prescription if the MCO cannot make a prior authorization determination within 24 hours and the dispensing pharmacist determines it is an emergency situation as outlined in this section.	Ongoing	Per incident of noncompliance.	HHSC may assess up to $5,000 per incident of noncompliance.
PH-4	RESERVED				
PH-5	SOW § 2.6.53.5 Pharmacy Rebate Program Exhibit C – UMCM Chapter 2	The MCO must include rebatable National Drug Codes (NDCs) on all encounters for outpatient drugs and biological products, including clinician-administered drugs. Encounters containing clinician-administered drugs must include, in addition to a CMS-rebate-eligible NDC, the correctly matched HCPCS code and billing units per the applicable date of service according to HHSC NDC-to-HCPCS Crosswalk.	Ongoing	Per month, per incident of noncompliance.	HHSC may assess up to $500 per month for each incident of noncompliance.

PH-6	SOW § 2.6.53.1 Formulary and Preferred Drug List	The MCO must maintain a minimum 95% compliance rate with the PDL requirements for 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PH-7	RESERVED				
PH-8	SOW § 2.6.53.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies	The MCO must ensure at least 98% of PA requests received from prescriber calls to the MCO's PA call center are approved or denied immediately at the time of the call when all 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	SOW § 2.6.53.2 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.	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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
PH-10	SOW § 2.6.53.11 Maximum Allowable Cost Requirements	The MCO must ensure at least 98% of MAC challenge requests are resolved by the 15th Day after the MCO receives the request.	Ongoing, Quarterly during Operations Phase	Per incident of noncompliance below the percentage rate.	HHSC may assess up to $1,000 per incident of noncompliance below the percentage rate each quarter.
PH-11	RESERVED				
Medical Necessity and Level of Care (MN)					

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
SPMN-1	SOW § 2.6.59 STAR+PLUS Assessments SOW § 2.6.59.2 STAR+PLUS HCBS Program Assessments SOW § 2.6.61.3 Annual Reassessment	The Community Medical Necessity and Level of Care (MNLOC) Assessment Instrument must be completed and electronically submitted via the TMHP portal in the specified format. Forms and addendums, as identified in Section 2.6.59.2 HCBS STAR+PLUS Waiver and STAR+PLUS handbook for general revenue and medically fragile must be completed and applicable forms submitted to HHSC: 1) within 45 Days from the date of referral for HCBS STAR+PLUS Waiver services for 217-Like Group applicants; 2) within 45 Days from the date of the Member's request for HCBS STAR+PLUS Waiver services for current Members requesting an upgrade; 3) within 45 Days from the date the MCO determines the Member would benefit from the HCBS STAR+PLUS Waiver; or 4) at least 30 Days prior to the annual ISP expiration date for all Members receiving STAR+PLUS HCBS STAR+PLUS services as specified in Section 2.6.59.2. 5) at least 45 days prior to the annual ISP expiration date for all HCBS Members approved for	Operations Phase and Turnover Phase	Per Day of noncompliance, per Member, per MCO's Service Area	HHSC may assess up to $500 per Day of noncompliance, per Member, and per MCO's Service Area for each Day required documentation is not submitted or is late, inaccurate, or incomplete.

		General Revenue funding as specified in Section 2.6.61.3; or 6) at least 45 days prior to the annual ISP expiration date for all HCBS Members approved to use the medically fragile policy as specified in Section 2.6.61.3.			

DOCUMENT HISTORY LOG

Document Status	Document Revision Number	Effective Date	Description of Revision
Baseline	N/A		Initial version of Exhibit Q, Document History Log.
Amendment	1	March 1, 2024	**Section 2.1 of Signature Document revised.** **Exhibit B, Amended and Restated STAR+PLUS Scope of Work amended and modify the following sections:** a. 1.2 Terms; b. 2.5.3.3 Employee Incentive Payment Plan; c. **2**.5.6 Texas Department of Insurance Licensure, Certification or Approval; d. **2**.6.25.5 Alternative Payment Models with Providers; e. 2.6.28.2 Third Party Liability, Recovery, and Coordination of Benefits; f. 2.6.38.13 Home Health Services and Durable Medical Equipment and Supplies; g. 2.6.49.2.1 Service Coordination Level 1; h. 2.6.49.2.2 Service Coordination Level 2 i. 2.6.49.8 Service Coordinators; j. 2.6.59 STAR+PLUS Assessments; k. 2.6.59.2 STAR+PLUS HCBS Program Assessments; **l.** 2.6.60.1 Coordination of Services for Dual Eligible Members; and m. 2.8.16 Non-Risk Payment For Certain Drugs. **Exhibit B, Amended and Restated STAR+PLUS Scope of Work amended and modify and withdraw the following section:** a. 2.6.49.2.5 Service Coordination for Members in ICF-IID or IDD Waiver. **Exhibit D, Amended and Restated STAR+PLUS Deliverables/Liquidated Damages Matrix to modify the following sections:** a. OR-1 Operations Readiness (OR) b. OR-2 Operations Readiness (OR) c. OR-3 Operations Readiness (OR) d. GA-1 General/ Administrative (GA)

Document Status	Document Revision Number	Effective Date	Description of Revision
			e. GA-3 General/ Administrative (GA) f. GA-4 General/ Administrative (GA) g. PS-1 Privacy/ Security (PS) h. PS-2 Privacy/ Security (PS) i. PS-3 Privacy/ Security (PS) j. PS-4 Privacy/ Security (PS) k. CL-1 Claims (CL) l. CL-5 Claims (CL) m. CL-10 Claims (CL) n. SPCL-4 Claims (CL) o. SPCL-5 Claims (CL) p. ED-1 Encounter Data (ED) q. ED-2 Encounter Data (ED) r. ED-3 Encounter Data (ED) s. HL-1 Hotlines (HL) t. HL-3 Hotlines (HL) u. HL-5 Hotlines (HL) v. CA-4 Complaints/ Appeals (CA) w. PN-1 Provider Networks (PN) x. PN-2 Provider Networks (PN) y. MM-3 Marketing and Member Materials (MM) z. MI-1 Management Information Systems (MI) aa. MI-2 Management Information Systems (MI) bb. FR-1 Financial Reporting (FR) cc. FR-6 Financial Reporting (FR) dd. IG-1 Office of the Inspector General (IG) ee. IG-7 Office of the Inspector General (IG) ff. IG-8 Office of the Inspector General (IG) gg. SPFW-1 Frew (FW) hh. TO-1 Turnover (TO) ii. TO-2 Turnover (TO) jj. TO-3 Turnover (TO) kk. PH-3 Pharmacy (PH) ll. PH-4 Pharmacy (PH) mm. PH-6 Pharmacy (PH) nn. PH-7 Pharmacy (PH) oo. PH-8 Pharmacy (PH) pp. PH-9 Pharmacy (PH) qq. PH-11 Pharmacy (PH) rr. SPMN-1 Medical Necessity and Level of Care (MN) **Exhibit D, Amended and Restated STAR+PLUS Deliverables/Liquidated Damages Matrix to modify and**

Document Status	Document Revision Number	Effective Date	Description of Revision
			withdraw the following sections: a. HL-7 Hotlines (HL) b. CA-5 Complaints/ Appeals (CA) c. SPFR-1 Financial Reporting (FR) **Exhibit D, Amended and Restated STAR+PLUS Deliverables/Liquidated Damages Matrix** **Added the following sections:** a. SPHL-2 Hotlines (HL) b. SPCA-1 Complaints/ Appeals (CA) c. SPFR-2 Financial Reporting (FR) d. SPFW-2 Few (FW) **Exhibit Q, Document History Log is added.**