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	MCO Name	Section #	Issue/Concern	Proposed Solution or Language Change
1.		8.1.31 (UMCC), 8.1.3.4 (SK) Tele Access	1. Can you verify that pharmacy and telepharmacy consultations are current services? • If so, which codes are covered?	1. Verify telepharmacy and pharmacy consultation CPT codes, supply a list of covered codes.
			2. Telepharmacy can't be billed through the pharmacy benefit because the pharmacy industry doesn't support this capability. These services would have to be billed through the medical benefit.	2. Allow telepharmacy to be billed through the medical benefit. • Add language in the contracts, or remove telepharmacy from this section.
2.		8.1.5.3 Member Handbook	1. Language: "If HHSC notifies the MCO that the change in Covered Services is *significant*, the MCO must notify existing Members…"	1. Recommend defining "significant" in the contracts, and defining parameters around what HHSC considers "significant"
			2. Notifying members of ALL changes is too broad and would inundate members with MCO communications. • There can be minor updates, such as the addition of a new DME product. • Rider 27 of the General Appropriations Act directs HHSC to implement initiatives that "minimize beneficiary and provider	2. Do not require MCOs to notify members of minor changes. 2. Allow MCOs to post updates to their member websites/portals. 2. Allow MCOs to text members (in addition to email) if the member consents.

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			abrasion or reduce unnecessary administrative and operational costs..." ● Rider 27 also directs HHSC to… "Authorize Medicaid and CHIP MCOs to communicate with enrolled members via text messages with member consent."	
			3. Concern with cost around sending out frequent member mailings/communications, especially since this update is not needed. ● Rider 27 of the General Appropriations Act guides HHSC to implement initiatives that "minimize beneficiary and provider abrasion or reduce unnecessary administrative and operational costs..." ● Rider 27 also directs HSHC to… "Authorize Medicaid and CHIP MCOs to communicate with enrolled members via text messages with member consent."	3. Allow MCOs to post updates to their member websites/portals. 3. Allow MCOs to text members (in addition to email) if the member consents. 3. If HHSC is requiring an increase in mailed member communications, the plans request justification from HHSC as to: ● Why this update is necessary for appropriate member communication, and ● how this request isn't too costly to require of the plans.
3.		8.1.9 (SK), 8.1.8 (UMCC) Utilization Management	1. Language: "the MCO must make prior authorization or service authorization coverage determinations according to the following timelines:"	1. Do not include service authorizations, as this typically refers to authorizations driven off assessments (such as PAS) which have different turnaround times for review. ● Proposed language: "The MCO must make prior authorization coverage determinations according to the following timelines…"

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			2. Parts of the Texas Insurance Code Chapter 4201 do not apply to Medicaid/CHIP.	2. Narrow applicability to what the Insurance Code says is applicable to Medicaid. See Sec. 4201.053. ● Proposed language: "The MCO must comply with the requirements of… as well as applicable requirements of the Texas Insurance Code Chapter 4201, as outlined in Section 4201.053…"
			3. Language: "UMCM 3.2: Requires MCOs to send Provider/Member notices no later than *one Business Day* from the MCO making a UM determination." ● UMCM 3.2 states: "The MCO must send both Member and Provider a written notice of final determination no later than *the next Business Day* after a determination is made on a prior authorization request."	3. Align language with the UMCM. ● Proposed language: "UMCM 3.2: Requires MCOs to send Provider/Member notices no later than *the next Business Day* from the MCO making a UM determination."

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4.		8.1.19.2 (UMCC), 8.1.21.2 (SK) General requests for and access to data, records, and other information	1. Concerns around the MCO providing "complete and unredacted" originals or copies of all records or information requested by the OIG, HHSC, its authorized agents, or other units of state government. ● This is an overreach. For example, there are multiple members on some remittances, and not all may be a part of the OIG's case. Information on other members would need to be redacted to protect those members' privacy. See CFR 438.100 (a)(b)(ii). ● Other information that may need to be redacted to protect privacy include: proprietary information, information on other Lines of Business, from other states, etc.	1. Do not make this change. Allow MCOs to supply redacted records, with justification as to why the record was redacted. ● This will ensure that Member and MCO privacy is protected, and streamline OIG/state reviews as the reviewer would be able to more directly locate and reference applicable information in submitted records.

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			2. The document history log states the purpose of this update is "to ensure OIG has access to complete, unredacted information when that information is used or relied upon by an MCO to support a position" ● This amendment is written very broadly; it seems to encompass all MCO records requested by any governmental body for any purpose.	2. Clarify the intent of this amendment. ● MCOs already supply information that they use or rely upon to support their position. ● If an MCO didn't use certain information to make a decision and therefore redacted or omitted that information, then why would the OIG need that information, or assume that information is needed? 2. If HHSC refuses to remove the "complete, unredacted" requirement, then we request that HHSC narrows the scope of the language to supply "complete, unredacted" records to the OIG only, to align with the stated purpose of the amendment.
5.		8.1.19.3 (UMCC), 8.1.21.3 (SK) Claims Data Submission Requirements	1. Concern around the request for "complete, unredacted" records. This is an overreach.	1. Allow MCOs to submit redacted records, with a justification as to why records were redacted. ● This will protect Member and MCO privacy, and will streamline the state's review of impacted records.

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6.			1. Language: addition of "Ad hoc reports as requested by HHSC."	1. Set parameters around what HHSC considers an ad hoc report. Such as frequency/duration of reports. ● For example, a report is not considered an ad hoc report if it requires multiple submissions over an extended timeframe.
		8.1.22 (SK), 8.1.20 (UMCC) Reporting Requirements	2. Language: "All information must be provided in accordance with the timelines, definitions, formats, and instructions as specified by HHSC. Where practicable, HHSC may consult with the MCO to establish timelines and formats reasonably acceptable to both Parties." ● As-is, MCOs aren't always given the time they need to consolidate data needed for HHSC-requested ad hoc reports. They may need to coordinate with several areas, outreach to providers or members, etc. ● HHSC should consult with MCOs on what all is needed to compile data for reports to inform the due date, and ensure it's feasible.	2. Revise language to: ~~Where practicable,~~ HHSC ~~may~~ must consult with the MCO to establish timelines and formats reasonably acceptable to both Parties. 2. The MCOs should not face penalty if reports aren't submitted within an HHSC-delineated timeframe if they've requested more time, and provide justification as to why more time was needed. ● This will ensure MCOs aren't forced to rush completion of reports, and have the time they need to compile and check data to ensure accurate submissions.

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7.		8.1.24.1 (SK), 8.2.2.1 (UMCC) Emergency Services	1. The omission of the terms "medically necessary" and "stabilization," implies that all services that are Urgent/Emergent are not able to be reviewed for medical necessity. • This would mean that all Behavioral Health admissions are not subject to Utilization Review and that any physical health admission would only be reviewed after the member has stabilized from the initial admitting issue.	1. Proposed language: The MCO must pay for the professional, facility, and ancillary services provided for Emergency Services ~~for any~~ that are Medically Necessary to perform the medical screening examination and stabilization of a Member presenting with an Emergency Medical Condition or an Emergency Behavioral Health Condition ~~to the Hospital emergency department, 24 hours a day, 7 Days a week,~~ whether rendered by ~~either the MCO's~~ Network or Out-of-Network Providers.
			2. Language: "For Members between the ages of 21 and 64, inpatient services for acute psychiatric conditions in an institute for mental disease (IMD) may be provided as described in UMCM Chapter 16."	2. Remove IMD language from the STAR Kids contract; the age range does not apply to this population. 2. Explain how this is not a parity concern.
8.		8.1.21 (UMCC) UMCC, and 8.1.17 (SK)	1. Language: "The MCO and its Subcontractor must disclose to HHSC and pharmacy providers the reimbursement rates and payment methodology used to develop the rates specific to the pharmacy provider during the contract negotiation between the PBM and pharmacy provider." • This is an overreach as the pharmacy and PBM share the contract and have agreed upon rates.	1. Do not add "and pharmacy providers" to this section.

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			• There is also a process for pharmacies to appeal reimbursement rates. This should be reviewed by the PBM stakeholders for impact.	
9.		8.1.38.8 (SK) ISP Requirements	1. Language: The MCO must update each Member's ISP… following a change in previously identified need(s) or newly identified need(s) that the member is anticipated to access during the ISP year; • Concern around the term "anticipated". "Anticipated" services do not adhere to current authorization/approval/review standards. • Services that a state/MCO may furnish are outlined in 42 CFR § 438.210. "Anticipated" services do not appear to be covered, and may contradict with what CFR defines as allowable.	1. Do not add "anticipated". This will help avoid ambiguity as to whether items/services not yet determined to be needed and/or desired (by the member/family) should be placed on the service plan.
10.		LD Matrix (UMCC and SK)	1. Concern: IG-7 is modified to ensure OIG has access to complete, unredacted information when that information is used or relied upon by an MCO to support a position	1. The MCOs should not face penalty if ad hoc reports aren't submitted within an HHSC-delineated timeframe if they've requested more time, and provide justification as to why more time was needed. • This will ensure MCOs aren't forced to rush completion of reports, and have the time they need to compile and check data to ensure accurate submissions.

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			2. PH-6: The MCO must maintain a minimum 95% compliance rate utilization of preferred drugs in with the preferred drug PDL requirements for each therapeutic class on the PDL.	2. Remove this item from the LD Matrix, as per discussions between VDP and health plans.
11.				