Texas Health & Human Services Commission

Uniform Managed Care Terms & Conditions

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	September 1, 2011	Initial version of the Attachment A, "Medicaid and CHIP Uniform Managed Care Contract Terms & Conditions."
Revision	2.1	March 1, 2012	Definition "1915(c) Nursing Facility Waiver" is modified to correct a cross-reference. Definition for Medically Necessary is modified for clarification. The State has determined that all acute care behavioral health and non-behavioral health services for Medicaid children fall within the scope of Texas Health Steps. Note that for LTSS, such as PCS (PAS) services for children in STAR+PLUS, the functional necessity standard for LTSS also applies (see Attachment B-1, Section 8.3.3). Definition for Rate Period 1 is modified. Section 4.04 is modified to clarify the requirements for Medical Director designees, and to clarify that the provision does not apply to prior authorization determinations made by Texas licensed pharmacists. New Section 4.11 "Prohibition Against Performance Outside of the United States" added. Section 5.02(b) is modified to clarify that MCOs may not sell or transfer their Member base. Section 5.06(a)(2) is modified to clarify the exceptions to enrollment in an MCO during an Inpatient Stay. Section 5.06(a)(3) and (4) are modified to clarify that Members cannot move from FFS to an MCO or from one MCO to another during residential treatment or residential detoxification. References to the PCCM program are removed. In addition, Section 5.06(a)(8) is modified to clarify movement requirements for SSI Members in the MRSA. Section 5.08 is modified to clarify the default methodology. Section 7.02 is modified to clarify applicability to pharmacy.

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			Section 7.08(b) is modified to correct 2 cross-references. Section 10.05 is modified to include the Medicaid Only rate cell for the MRSA. Section 10.06(b) is modified to remove the Perinate Newborn 0% - 185% rate cell. Section 10.10 is modified to consolidate STAR+PLUS with STAR and CHIP for the Experience Rebate calculation. Section 10.10.1 is deleted in its entirety. Section 10.10.2 is modified to consolidate STAR+PLUS into STAR and CHIP for the Experience Rebate calculation.
Revision	2.2	June 1, 2012	Definition for Consolidated FSR Report or Consolidated Basis is added. Definition for Financial Statistical Report is added. Definitions for FSR Reporting Period, FSR Reporting Period 12/13, and FSR Reporting Period 14 are added. Definition for Material Subcontract is modified. Definition for Net Income Before Taxes is modified. Definition for Pre-tax Income is modified. Definition for Program is added. Definition for Rate Period 1 and Rate Period 2 are modified. Section 10.10 is modified to consolidate the Experience Rebate across all contracts and all programs. Section 10.10.2 is modified to consolidate the Administrative Expense Cap across all contracts and all programs.
Revision	2.3	September 1, 2012	Definition for Case Management for Children and Pregnant Women is modified to remove the acronym “CPW”. Definition for Community-based Long Term Services and Supports is modified to replace

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			references to "1915(c) Nursing Facility Waiver" with "HCBS STAR+PLUS Waiver". Definition for "1915(c) Nursing Facility Waiver" is modified to change the name to "HCBS STAR+PLUS Waiver" and to update references to "Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver" and "HCBS STAR+PLUS Waiver". Definition for "HHSC MCO Programs or MCO Programs" is modified. Definition for "Medically Necessary" is modified. Definition for "Provider Materials" is added. Section 5.06(a)(4) is modified to clarify responsibility for payment. Section 5.11 is deleted in its entirety. Section 7.02 is modified to clarify that only applicable provisions of the listed laws apply to the contract. Section 10.05 is modified to replace references to "1915(c) Nursing Facility Waiver" with "HCBS STAR+PLUS Waiver".
Revision	2.4	March 1, 2013	All references to the previous Executive Commissioner Suehs are changed to his successor, Executive Commissioner Janek. Section 5.02(e), Subsections (4) and (5) are modified. Section 10.16 is added to address supplemental payments to MCOs for wrap-around services for outpatient drugs and biological products for STAR-PLUS Members.
Revision	2.5	June 1, 2013	Contract amendment did not revise Attachment A, "Uniform Managed Care Contract Terms and Conditions."
Revision	2.6	September 1, 2013	Definition for CAHPS is modified to correct the name to which the acronym refers. Definition for "Community Health Worker" is added.

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			Definition for “Court-Ordered Commitment” is modified. Definition for Default Enrollment is modified to add T.A.C. reference. Definition for “DSM” is modified. Definition for “ECI” is modified. Definition for HEDIS is modified to correct the name to which the acronym refers. Definition for Primary Care Physician is modified to remove the list of provider types as being redundant. Definition for Rate Period is modified to include a third sub-period. Section 5.02(e) is modified to remove the language regarding disenrollment for ESRD and ventilator dependency. Section 5.08 is renamed “Modified Default Enrollment Process” and revised to include a process for all Programs. Section 5.09 is deleted and replaced with Section 5.08. Section 5.10 is deleted and replaced with Section 5.08. Section 7.04 is deleted in its entirety and updated within Section 7.02 Section 9.02 is modified for clarification that records must be provided “at no cost.” Section 9.04 is modified for clarification that records must be provided “at no cost.” Section 10.05(a) is modified to comply with the new STAR Risk Groups. Section 10.10.3 is modified to clarify that the Reinsurance Cap impacts only the Experience Rebate calculation. Section 11.01(c) is modified to add the missing word “may.”

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			Section 13.01 is modified to clarify the required certifications. Section 14.08 is modified to delete outdated language.
Revision	2.7	September 1, 2013	Section 10.17 “Pass-through Payments for Provider Rate Increases” is added.
Revision	2.8	January 1, 2014	Definition for Expansion Children is removed. Definition for Federal Poverty Level is updated. Definition for Former Foster Care Child (FFCC) Member is added. Section 5.02 is modified to add requirement for default assignment methodologies. Section 5.04 is modified to clarify that HHSC or the ASC will enroll or disenroll Members. Section 5.05 is modified to clarify that HHSC or the ASC will transmit new Member information, to remove the FPL limits, to remove the default assignment language, and to clarify the enrollment process when CHIP Perinate coverage expires. Section 5.06 “Span of Coverage” is modified to add requirements regarding movement from a STAR Health MCO to a STAR MCO. Section 10.06(b) is modified to clarify the eligibility thresholds. Section 10.09 is modified to clarify the eligibility thresholds. Section 11.01(a) is modified to correct an administrative error. Section 12.03 is modified to delete subsection (b)(8) “Termination for Insolvency” and all following subsections are renumbered.
Revision	2.9	February 1, 2014	Definition for Capitation Payment is modified to include associated Administrative Services. Definition for Child (or Children) with Special Health Care Needs (CSHCN) is clarified.

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			Definition for Clean Claim is clarified to include Nursing Facility Services. Definition for Cognitive Rehabilitation Therapy is added. Definition for Community Services Specialist (CSSP) is added. Definition for "Electronic Visit Verification System" is added. Definition for Employment Assistance is added. Definition for Family Partner is added. Definition for Fee-for-Service (FFS) is clarified that payment is made after the service is provided. Definition for ICF-IID Program is added. Definition for IDD Waiver is added. Definition for Licensed Medical Personnel is added. Definition for Licensed Practitioner of the Healing Arts is added. Definition for Local IDD Authority is added. Definition for Local Mental Health Authority is modified to reference the legal citation. Definition for Material Subcontract is modified to clarify excluded subcontractors. Definition for MCO Administrative Services is modified to include all required deliverables outside of the Covered Services. Definition for "Medical Home" is modified to have the meaning assigned in Gov't Code 533.0029. Definition for Member with Special Health Care Needs (MSHCN) is modified. Definition for Mental Health Rehabilitative Services is added. Definition for Nursing Facility is added. Definition for PASRR is added. Definition for PASRR Level I Screening is added. Definition for PASRR Level II Evaluation is added.

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			Definition for PASRR Specialized Services is added. Definition for Peer Provider is added. Definition for Population Risk Group or Risk Group is modified to add defined criteria. Definition for SED is modified to remove the reference to LMHAs. Definition for SPMI is modified to remove the reference to LMHAs. Definition for Supported Employment is added. Definition for Targeted Case Management is added. Definition for Texas Medicaid Bulletin is removed. Definition for Texas Medicaid Provider Procedures Manual is modified to remove the reference to the Texas Medicaid Bulletin. Section 4.08 is renamed “Subcontractors and Agreements with Third Parties” and is modified to include language from Section 4.10 “Agreements with Third Parties.” Section 4.10 “MCO Agreements with Third Parties” is deleted in its entirety. Section 5.06 “Span of Coverage” is modified to update the requirements effective through August 31, 2014 and to add requirements effective September 1, 2014. Section 10.01 is modified to clarify the calculation of the monthly Capitation Payment. Section 10.02 is modified to include Liquidated Damages due and unpaid including any associated interest. Section 10.08 is modified to clarify the requirements for adjustments. Section 10.10 is modified to include Liquidated Damages assessment. Section 10.10.2 is modified to clarify the data sources and to update the calculation example.

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			Section 13.02 is modified to include an obligation to comply with 41 U.S.C. § 423.
Revision	2.10	April 1, 2014	Contract amendment did not revise Attachment A, "Uniform Managed Care Contract Terms and Conditions."
Revision	2.11	September 1, 2014	Definition for "Community Health Worker" is modified to conform to formatting of other definitions. Definition for "FSR Reporting Period 15" is added. Definition for "ICF-MR" is deleted. Definition for "Legally Authorized Representative (LAR)" is added. Definition for Major Systems Change is added. Definition for "Medical Assistance Only" is revised. Definition for "Nursing Facility Cost Ceiling" is modified to change TILE to RUG. Definition for "Nursing Facility Unit Rate" is added. Definition for "Rate Period 3" is added. The definition of "Supported Employment" is revised to correct an error. Definition for "Telehealth" is added. Definition for "Telemedicine" is added. Definition for "Telemonitoring" is added. Definition for "Texas Women's Health Program" is added. Section 3.01 is modified to add the STAR+PLUS Handbook to the order of documents. Section 4.04.1 is modified to reflect current terminology. Section 5.02 is revised to clarify the MCO's right to request disenrollment. Section 5.05(c) is deleted in its entirety to maintain consistency with updated policy and rule. Section 5.06 Span of coverage (Effective through August 31, 2014) is deleted in its entirety and

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			Section 5.06 Span of Coverage (Effective Beginning September 3, 2014) has the parentheses removed. In addition, Section (a) (7) is modified to add movement between STAR MCOs or between STAR+PLUS MCOs during a CDTF stay. Section 7.07 is modified to clarify the requirement for MCOs to notify HHSC of all breaches or potential breaches of unsecured PHI. Section 7.09 "Compliance with Fraud, Waste, and Abuse requirements" is added. Section 10.05(b) is modified to add rate cells for IDD Members. Section17.01 is amended to exempt Nursing Facilities from the professional liability coverage requirements.
Revision	2.12	October 1, 2014	Section 10.18 "Supplemental Payments for Second Generation Direct Acting Antivirals for Hepatitis C" is added.
Revision	2.13	March 1, 2015	After the first appearance of the term, "Uniform Managed Care Manual" is changed to "UMCM.' Definition for Abuse or Neglect (CPS) is added. Definition for Abuse, Neglect, or Exploitation (APS) is added. Definition for Child with Special Health Care Needs is deleted. Definition for Cognitive Rehabilitation Therapy is modified to remove an extraneous word. Definition for Competent Interpreter is added. Definition for Critical Event or Incident is added. Definition for Dual Eligibles Medicare-Medicaid Plan (MMP) is added. Definition for Member(s) with Special Health Care Needs is modified. Definition for Targeted Case Management is changed to Mental Health Targeted Case Management.

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			Definition for Service management is modified to remove the reference to STAR and CHIP. Definition for Texas Dual Eligibles Integrated Care Demonstration (Dual Demonstration) Project is added. Section 4.11 is modified to clarify subsections (a)(2)(B) and (c)(1). Section 5.02 is modified to add retroactive restoration of eligibility. Section 5.06 is modified to add Dual Demonstration. Section 7.02 is modified to delete the references to OMB and replace it with 2 C.F.R. Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. Section 10.05(a) is modified to remove the SSI rate cell for MRSA. Section 10.10(c)(2)(iii) is modified to remove the reference to the Quality Challenge Award. Section 17.01(c)(1)(iv) is added to except DME providers from professional liability coverage.
Revision	2.14	May 1, 2015	Section 10.19 ““Payment/Adjustment to Capitation in Consideration of the ACA Section 9010 Health Insurance Providers Fee” is added.
Revision	2.15	June 1, 2015	Definition for Community First Choice (CFC) is added.
Revision	2.16	September 1, 2015	Section 1.04 is modified to remove one extraneous word and to replace another. Article 2 is modified to remove an extraneous word. Definition for Abuse or Neglect (CPS) is deleted. Definition for Abuse, Neglect, or Exploitation is modified to update the citations. Confidential Information is modified to change “client” to “Member” in part (1). Definition for Consolidated FSR Report or Consolidated Basis is modified to exclude the Dual Demonstration.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Definition for Critical Event or Incident is modified to remove “Abuse or Neglect (CPS)” from the list. Definition for Dental Contractor is added. Definition for “Texas Dual Eligibles Integrated Care Demonstration (Dual Demonstration) Project” is changed to “Dual Demonstration” Definition for Mental Health Targeted Case Management is modified. Definition for Severe and Persistent Mental Illness (SPMI) is better defined. Definition for Severe Emotional Disturbance (SED) is better defined. Section 3.03 is modified to clarify the language. Section 3.07 is modified to require prior approval from HHSC. Section 3.08 is modified to clarify the language. Section 4.03 is modified to clarify the language. Section 4.04.1 is modified to add subsection (e) regarding Service Coordination through an integrated Health Home. Section 4.12 “E-Verify System” is added. Section 5.06 is modified to remove a past-effective date and to add Enrollment Changes with Custom DME Prior Authorizations and Enrollment Changes with Home Modifications for Medicaid MCOs. Section 7.02 is modified to clarify the language. Section 10.10 is modified to carve-out the Dual Demonstration from the "Consolidated Basis" with respect to the Experience Rebate and to remove the reference to the Experience Rebate Reward. Section 10.10.2 is modified to carve-out the Dual Demonstration from the "Consolidated Basis" with respect to the Admin Cap. Section 11.01 is modified to clarify part (h).

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Revision	2.17	March 1, 2016	All references to the previous Executive Commissioner Janek are changed to his successor, Executive Commissioner Traylor. Definition for Abuse, Neglect, or Exploitation is modified to update the citations. Definition for Clinical Edit is modified to change the listing to Clinical Prior Authorization or Clinical PA and the definition is clarified. Definition for Self-employed Direct Provider is added. Definition for Texas Medicaid Provider Procedures Manual is modified to remove the publication frequency. Section 4.12 “E-Verify System” is renamed “Employment Verification” and the requirements updated. Section 10.09 is modified to correct a UMCM cross reference. Section 10.18 “Non-Risk Payments for Second Generation Direct Acting Antivirals for Hepatitis C” is renamed “Non-Risk Payments for Certain Drugs” and the language is clarified.
Revision	2.18	June 1, 2016	Contract amendment did not revise Attachment A, “Uniform Managed Care Contract Terms and Conditions.”
Revision	2.19	September 1, 2016	All references to the previous Executive Commissioner Traylor are changed to his successor, Executive Commissioner Smith. Definition for Breach is added. Definition for Change in Condition is added. Definition for Discovery/Discovered is added. Definition for Individual Service Plan (ISP) is added. Definition for Nursing Facility Unit Rate is modified to conform to language changes in the rule. Definition for Prescribed Pediatric Extended Care Center (PPECC) is added.

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			Section 7.02 is modified to add item (a)(17) to require MCOs to report all Member health care information upon HHSC's request and subsequent items are renumbered. Item (a)(19) is deleted as redundant. Section 9.03 is modified to add an explanation of "reasonable notice." Section 11.09 MCO's Breach Notice, Reporting and Correction Requirements is added.
Revision	2.20	December 1, 2016	Contract amendment did not revise Attachment A, “Uniform Managed Care Contract Terms and Conditions.”
Revision	2.21	February 1, 2017	Contract amendment did not revise Attachment A, “Uniform Managed Care Contract Terms and Conditions.”
Revision	2.22	March 1, 2017	Definition for "Court-Ordered Commitment" is modified to add a reference to the Texas Code of Criminal Procedure, Chapters 46B. Definition for “Texas Women's Health Program” is changed to “Healthy Texas Women Program” and the citation is updated. Definition for “National CLAS Standards” is added. Section 4.02 (c) is modified to specify notification must be in writing. Section 5.06 is modified to clarify items (a)(2) and (a)(3). Section 7.02 is modified to add a reference to C.F.R. Part 4.8 in (a)(4), to remove reference (a)(9) regarding Alberto N, and to add item (d) regarding the precedence of the C.F.R. All subsequent subsections are re-lettered. Section 7.05 is modified to add new language to comply with new CMS managed Care Rules. See C.F.R. 438.3(d) and (f) Section 9.02 (b) is modified to add item 4 Inspection and subsequent items are renumbered.

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Revision	2.23	June 1, 2017	Contract amendment did not revise Attachment A, "Uniform Managed Care Contract Terms and Conditions."
Revision	2.24	September 1, 2017	Attachment A, Article 2 Definitions is modified to comply with 42 C.F.R. §438.10(c)(4) Definition for "Adoption Assistance (AA) Member" is added. Definition for "Appeal" is modified to comply with 42 C.F.R. §438.400. Definition for "Complaint and Internal MCO Appeal System" is added as a result of changes to 42 C.F.R. §438.400. Definition for "Farmworker Child(ren) (FWC)" is modified to change the age limit to 17. Definition for "Indian Health Care Provider" is added to comply with 42 C.F.R. §438.14. Definition for "Individual Service Plan (ISP)" is modified for person-centeredness. Definition for "Inquiry" is added to reflect the HHS Circular C-052. Definition for "Local Behavioral Health Authority" is added to comply with Texas Health and Safety Code §533.0356 Definition for "Limited English Proficient (LEP)" is added. Definition for "Medicaid for Breast and Cervical Cancer (MBCC) Member" is added. Definition for "Permanency Care Assistance (PCA) Member" is added. Definition for "Person-Centered" is added. Definition for "Post-Stabilization Care Services" is modified to comply with 42 C.F.R. §438.114. Definition for "Prevalent Language" is added. Definition for "Readily Accessible" is added. Definition for "Service Plan (SP)" is modified for person-centeredness.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Definition for "Fair Hearing" is renamed "State Fair Hearing" to comply with 42 C.F.R. §438.400 Article 5 is modified to change the title from "Member Eligibility & Enrollment" to "Member Eligibility, Enrollment, and Disenrollment". Section 5.01 is modified to change the title from "Eligibility Determination" to "Eligibility Determination and Disenrollment" and to add requirements to comply with 42 C.F.R. §438.3(c). Section 7.03 "TDI licensure/ANHC certification and solvency" is deleted in its entirety. Article 9 is modified to add "and Litigation Hold" to the title. Section 9.01 is modified to extend the retention period to ten years to comply with 42 C.F.R. §438.230 and to add language requiring MCOs to maintain documents subject to litigation hold beyond regular retention schedules. Section 11.09 is deleted in its entirety and replaced with modified language. Section 14.04 is modified to comply with 42 C.F.R. § 438.116.
Revision	2.25	March 1, 2018	The following changes were made throughout the attachment: All references to Dental Contractor have been removed. Updates to citations. Removal of hyperlinks. Change “patient” to “Member”. Change “day(s)” and “calendar day(s)” to “Day”. Remove numeric number for those numbers under 10. Capitalized defined terms. Changed order of terms Fraud, Waste and/or Abuse to consistent use of phrase.

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			Changed “Fair Hearing System” to “State Fair Hearing System”. Definition for “Action” is modified to align with C.F.R. Definition for “Auxiliary Aids” is modified to comply with 28 C.F.R. § 36.303, 1115 Waiver and the MDCP 1915(c) Waiver. Definition for “Breach” is modified to harmonize obligations for the MCO and to add clarification. Definition for “Complaint (CHIP Program only)” is removed. Definition for “Complaint” is added. Definition for “Complaint and Internal MCO Appeal System” is modified and renamed “MCO Internal Appeal and Complaint System”. Definition for “Encounter Data” is modified to clarify MCO expectations. Definition for “Expedited Appeal” is modified to “Expedited MCO Internal Appeal”. Definition for “Internal MCO or Dental Contractor Appeal (Medicaid only)” is removed. Definition for “MCO Internal Appeal” for Medicaid and CHIP is added. Definitions for “Network Provider Agreement or Provider Agreement” and “Provider Agreement or Network Provider Agreement” are removed and replaced by a definition for “Provider Contract.” Definition for “Prevalent Language” is modified to elaborate on significant number of percentage and properly cite the C.F.R. Definition for “Provider Contract” is added in replacement of “Network Provider Agreement” and “Provider Agreement. Definition for “Retaliation” is added. Definition for “T.A.C.” is removed. Section 4.02 is modified to harmonize obligations for the MCO and to add clarification.

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			Section 4.08 is modified to comply with 42 C.F.R. § 438.230 and clarifies subcontractor requirements. Section 5.04 is modified to change the title from "eligibility and enrollment" to "eligibility enrollment and disenrollment" and to add requirements to comply with 42 C.F.R. §438.3(c). Sections 10.05 and 10.06 are modified to comply with 42 C.F.R. 438.3(e). Section 10.09 is modified to change the reporting period from 210 Days to 300 Days to keep consistent with the UMCM. Section 10.18 is modified to add two drugs to non-risk based category and add language for encounter transaction fee for service. Sections 11.02, 11.09, 11.09.1, and 11.09.2 are modified to harmonize obligations for the MCO and to add clarification.
Revision	2.25.1	July 1, 2018	Contract amendment did not revise Attachment A, "Uniform Managed Care Contract Terms and Conditions."
Revision	2.26	September 1, 2018	Definition for "Agency Sensitive Information" is added. Definition for "Assisted Living Facility (ALF)" is added. Definition for "Case-by-case Services" is added. Definition for "Community Services Specialist Provider" (CSSP) is modified to clarify who can be a CSSP. Definition for "Confidential Information" is modified to comply with Tex. Admin. Code Rule §202.1. Definition for "Financial Management Services Agency (FMSA)" is added. Definition for "Habilitation" is added. Definition for "Information Resources" is added. Definition for "Qualified Mental Health Professional for Community Services" (QMHP-CS) is added.

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			Section 4.12 is modified to address corrective action requested by CMS audit. Section 7.02 is modified to provide reference to applicable laws and codes for EVV, including section 12006 of the 21st Century Cures Act (Public Law 114-255) and 1 Tex. Admin. Code § 354.1177(d). Section 11.08 is modified to include all state and federal regulations for vendors who create, receive, maintain, use, disclose, or have access to HHS Information Resources or data. Section 11.09.1 is modified to comply with Tex. Admin. Code Rule § 202.1.
Revision	2.27	January 1, 2019	Definition for “Emergency Behavioral Health Condition” is modified. Definition for “Emergency Behavioral Health Condition” is modified.
Revision	2.28	March 1, 2019	
Revision	2.29	September 1, 2019	Substance abuse is changed to substance use disorder to align with the language in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Definition for “Action” is renamed “Adverse Benefit Determination.” Definition for “Adverse Determination” is deleted. Global change for the phrase, “substance abuse” to “substance use disorder.” Global change for the phrase, “substance abuser” to a “person with a substance use disorder.” Definition for “Change in Condition” is modified to ensure the requirement in STAR+PLUS for changes in a Member’s informal support. Definition for “Clean Claim” is modified to add the term “Unit Rate.”

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			Definition for “Community First Choice” is modified to add the word “habilitation” Definition for “Complaint” is modified to align with MCO Appeal standards. Definition for “HHSC Office of the Inspector General” is added. Definition for “Initial Contract Complaint” is added. Definition for “Nursing Facility Medicare Coinsurance” is added. Definition for “Nursing Facility Services” is added. Definition for “Nursing Facility Add-On Services” is added. Definition for “Nursing Facility Unit Rate” is modified to clarify Unit Rates is modified. Definition for “Specialty Therapy” is added. Definition for “Unexplained Death” is added. Definition for “Waste” is modified to align with statute and Tex. Admin. Code. Section 4.02 is modified to add SIU to the list. Section 5.06 is modified to clarify payment responsibility for inpatient hospital stays with transfers, streamline explanation of payment responsibility, align all managed care contracts, and remove outdated information. Section 9.01 is modified to add a requirement to retain certain documents for review by the OAG.
Revision	2.30	March 1, 2020	Definition for “Telepharmacy” is added.
Revision	2.31	September 1, 2020	Definition for “External Medical Review (EMR)” is added Definition for “Independent Review Organization (IRO)” is added. Definition for “Overpayment” is added Definition for “Subcontractor” is modified to clarify that providers of Medicaid and CHIP services are

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			not considered subcontractors, which aligns with federal rule. Definition for "Texas Health Steps Outreach and Informing Unit" is added. Definition for "Transition Phase" is modified to provide clarity and expectations when contracts are terminated merged or acquired. Definition for "Transition Plan" is added. Definition for "Turnover Phase" is modified to provide clarity and expectations when contracts are terminated merged or acquired. Definition for "Turnover Plan" is modified to provide clarity and expectations when contracts are terminated merged or acquired. Definition for "Readiness Review is modified to provide clarity and expectations when contracts are terminated, merged, or acquired. Definition for "URAC/American Accreditation Health Care Commission is modified to be consistent across all contracts. Section 5.01 is modified to comply with 42 C.F.R. § 438.3(c) and extend the timeframe to notify HHSC a Member is no longer Medicaid-eligible. Section 10.07 is modified to update UMCM chapter reference. Article 12 is modified to be consistent with newly awarded STAR PLUS contract. Section 12.03 is modified to clarify compliance with requirements of 42 CFR 438.710(b). Section 12.15 is deleted. Section 17.02 is modified to comply with TX Insurance Code. Section 17.03 is modified to comply with TDI Fidelity Bond.
Revision	2.32	March 1, 2021	Section 1.07 is added language required by CMS letter issued on September 4, 2020 to all State Medicaid Directors.

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			Section 4.11 is modified to remove the option for the MCO to receive authorization or approval for performance of any work or maintenance of any information outside of the United States. As the language reads now, the MCO is forbidden from performing any work or maintaining any information related to or obtained pursuant to the Agreement to occur outside of the United States. Section 11.08 is modified to remove the option for the MCO to allow a contractor to obtain express prior written permission from HHSC and comply with HHSC conditions for safeguarding offshore HHSC information. As the language reads now, the MCO's information and security and privacy program must prohibit the performance of any work or the maintenance of any information relating or obtained pursuant to this Agreement to occur outside of the United States.
Revision	2.33	June 1, 2021	Global Changes for NEMT Carve-in: House Bill (H.B.) 1576, 86th Legislature, Regular Session, 2019, makes the following changes to the delivery of nonemergency medical transportation (NEMT) services: • Increases opportunities for Transportation Network Companies (TNCs) to deliver NEMT Services. • Requires MCOs to provide NMT Services. • Moves the responsibility to provide NEMT Services from managed transportation organizations (MTOs) to managed care organizations (MCOs) for Members. This amendment implements changes to the following sections: **Definitions**: Covered Services is modified; Health Care Services is modified; Material Subcontract is modified; NEMT Attendant is added;

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			Network or Provider Network is modified; Network Provider or Provider is modified; Nonemergency Medical Transportation (NEMT) Service is added; Nonmedical Transportation Service is added; Provider or Network Provider is modified; Provider Contract is modified; Provider Network or Network is modified; Transportation Network Company (TNC) is added; and Section 10.01 Calculation of monthly Capitation Payment is modified.
Revision	2.34	September 1, 2021	Global change is modified to update UMCM chapter reference. Definition for Peer-to-Peer is added. Definition for Public Health Entity is modified to add language to strengthen coordination between programs. Section 5.02(d) is modified to change the frequency the MCOs and DMOs upload Enrollment files. Section 5.03(a) is modified to change the frequency the MCOs and DMOs upload Enrollment files. Section 5.03(b) is modified to change the frequency the MCOs and DMOs upload Enrollment files. Section 10.10 (b) is modified to add Experience Rebate for SFY 2022 only. Section 10.20 is added for clarification of payment for new autism services. Section 17.02(c) is modified to specify timeline for retiring Performance Bonds after an audit is completed

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	2.35	March 1, 2022	Contract amendment did not revise Attachment A, "Uniform Managed Care Contract Terms and Conditions."
Revision	2.36	September 1, 2022	Definition "Adult Foster Care (AFC)" is added Definition "Assisted Living Facility (ALF)" is modified to comply with the regulations at 42 CFR §441.301(c)(4), §441.530, and §441.710(4)(i). The Centers for Medicare & Medicaid Services (CMS) Definition "Audio-only" is added Definition " Audio-visual" is added Definition "Behavioral Health" is added to align with the TAC §353.2 Definition "Behavioral Health Services" is modified" to align with the TAC §353.2 Definition "Certified Community Behavioral Health Clinic (CCBHC)" is added to align with the Tex. Admin, Code § 353.1320. Definition" Collaborative Care Model (CoCM)" is added to align with the TAC §353.2. Definition "Critical Incident Management System (CIMS)" is added. " to align with the TAC §353.2 definition. Definition "ECI" is modified due to TAC rules for the ECI program having been moved to new section. Definition "Electronic Visit Verification (EVV)" is modified with a detailed definition to be consistent across contracts. Definition "Face-to-face" is added Definition "In-Person" is added Definition "Platform" is added Definition "Service Coordination" is modified due to recommendation for change Definition "Service Coordinator" is modified due to recommendation for change Definition "Service Management" is deleted

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Definition ”Substance Use Disorder” is added to align with the TAC §353.2 Definition “Telecommunication” is added Section 7.02(a) is modified to strengthen existing language. Section 10.10(b) is modified to updated fiscal year. Section 17.01(c)(1)(i) is modified to strengthen existing language.
Revision	2.37	March 1, 2023	Contract amendment did not revise Attachment A, “Uniform Managed Care Contract Terms and Conditions.”
Revision	2.38	September 1, 2023	Definition “Certified Community Behavioral Health Clinic (CCBHC)” is modified to align with the definition in a new TAC rule outlining Texas Certified Community Behavioral Health Clinic (CCBHC); definition is deleted, renamed to “Texas Certified Community Behavioral Health Clinic (T-CCBHC)”, and moved to follow alphabetical order. Definition “Telepharmacy” is deleted Section 4.05 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 Section 4.08 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 Section 9.01 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 Section 9.02 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 Section 9.03 is modified to ensure OIG has access to complete, unredacted information when that

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			information is used or relied upon by an MCO to support a position Section 9.05 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
Revision	2.39	March 1, 2024	Section 10.18 is modified to align the language in the clinician-administered drugs section with the level of detail provided in the pharmacy section by specifying where the data for non-risk payments comes from as well as which FAC code to use on non-risk encounters
Revision	2.40	September 1, 2024	Section 4.08 is modified to add contract language to require contracting officers for the Contractor and all subcontractors to allow their employees to report suspected FWA, and to provide HHSC the right to examine Subcontracts and contracts with Subcontractors.

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

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Article 1. Introduction

Section 1.01 *Purpose.*

The purpose of this Contract is to set forth the terms and conditions for the MCO's participation as a managed care organization in one (1) or more of the MCO Programs administered by HHSC. Under the terms of this Contract, MCO will provide comprehensive health care services to qualified Program recipients through a managed care delivery system.

Section 1.02 *Risk-based contract.*

This is a Risk-based contract.

Section 1.03 *Inducements.*

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

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

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

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

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

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

Accordingly, on the basis of the terms and conditions of this Contract, HHSC desires to engage MCO to perform the Services and provide the Deliverables described in this Contract under the terms and conditions set forth in this Contract.

Section 1.04 *Construction of the Contract.*

(a) Scope of Introductory Article.

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

(b) References to the "State."

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

(c) Severability.

If any provision of this Contract is construed to be illegal or invalid, such interpretation will not affect the legality or validity of any of its other provisions. The illegal or invalid provision will be deemed stricken and deleted to the same extent and effect as if never incorporated in this Contract, but all other provisions will remain in full force and effect.

(d) Survival of terms.

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

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

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

(e) Headings.

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

(f) Global drafting conventions.

(1) The terms "include," "includes," and "including" are terms of inclusion, and where used in this Contract, are deemed to be followed by the words "without limitation."

(2) Any references to "sections," "appendices," "exhibits" or "attachments" are deemed to be

references to sections, appendices, exhibits or attachments to this Contract.

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

Section 1.05 ***No implied authority.***

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

(1) make public policy;

(2) promulgate, amend or disregard administrative regulations or program policy decisions made by State and federal agencies responsible for administration of HHSC Programs; or

(3) unilaterally communicate or negotiate with any federal or state agency or the Texas Legislature on behalf of HHSC regarding the HHSC Programs.

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

Section 1.06 ***Legal Authority.***

(a) HHSC is authorized to enter into this Contract under Chapters 531 and 533, Texas Government Code; Section 2155.144, Texas Government Code; and/or Chapter 62, Texas Health & Safety Code. MCO is authorized to enter into this Contract pursuant to the authorization of its governing board or controlling owner or officer.

(b) The person or persons signing and executing this Contract on behalf of the Parties, or representing themselves as signing and executing this Contract on behalf of the Parties, warrant and guarantee that he, she, or they have been duly authorized to execute this Contract and to validly and legally bind the Parties to all of its terms, performances, and provisions.

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

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

Article 2. Definitions

As used in this Contract, the following terms and conditions have the meanings assigned below:

AAP means the American Academy of Pediatrics.

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

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

Account Name means the name of the individual who lives with the child(ren) and who applies for the Children's Health Insurance Program coverage on behalf of the child(ren).

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

Acute Care Hospital means a Hospital that provides Acute Care Services.

Adjudicate means to deny or pay a Clean Claim.

Administrative Services see MCO Administrative Services.

Administrative Services Contractor see HHSC Administrative Services Contractor.

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

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 services, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

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

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

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

(5) the failure of an MCO to act within the timeframes set forth 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 Medicaid Members' request to obtain services outside of the Network; or

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

Affiliate means any individual or entity that meets *any* of the following criteria:

(1) owns or holds more than a five percent interest in the MCO (either directly, or through one or more intermediaries);

(2) in which the MCO owns or holds more than a five percent interest (either directly, or through one or more intermediaries);

(3) any parent entity or subsidiary entity of the MCO, regardless of the organizational structure of the entity;

(4) any entity that has a common parent with the MCO (either directly, or through one (1) or more intermediaries);

(5) any entity that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the MCO; or

(6) any entity that would be considered to be an affiliate by any Securities and Exchange Commission (SEC) or Internal Revenue Service (IRS) regulation, Federal Acquisition Regulations (FAR), or by another applicable regulatory body.

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

Agreement or Contract means this formal, written, and legally enforceable contract and amendments thereto between the Parties.

Allowable Expenses means all expenses related to the Contract between HHSC and the MCO that are incurred during the Contract Period, are not reimbursable or recovered from another source, and that conform with the Uniform Managed Care Manual's "Cost Principles for Expenses."

Appeal (CHIP and CHIP Perinatal Program only) means the formal process by which a Utilization Review agent addresses adverse determinations.

Approved Non-Profit Health Corporation (ANHC) means an organization formed in compliance with Chapter 844 of the Texas Insurance Code and licensed by TDI. See also **MCO**.

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

Audio-only means interactive, two-way audio communication that uses only sound and that meets the requirements of the Health Insurance Portability and Accountability Act. Audio-only includes the use of telephonic communication. Audio-only does not include Audio-visual, In-Person, or Face-to-face communication.

Audio-visual means interactive, two-way audio and video communication that conforms to privacy requirements under the Health Insurance Portability and Accountability Act. Audio-visual does not include Audio-only or In-Person communication.

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

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

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

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

Auxiliary Aids and Services are not adaptive aids described in the STAR+PLUS HCBS program under the 1115 waiver.

Batch Processing is a billing technique that uses a single program loading to process many individual jobs, tasks, or requests for service. In managed care, batch billing is a technique that allows providers to send billing information all at once in a "batch" rather than in separate individual transactions.

Behavioral Health means mental, emotional, or Substance Use Disorders, or a combination thereof.

Behavioral Health Services means Covered Services for the treatment of mental, emotional, or Substance Use Disorders.

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

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

Business Continuity Plan or BCP means a plan that provides for a quick and smooth restoration of MIS operations after a disruptive event. BCP includes business impact analysis, BCP development, testing, awareness, training, and maintenance. This is a day-to-day plan.

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

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

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

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

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

Case-by-case Services means additional services for coverage beyond those specified in Attachments B-2, B-2.1, and B-2.2; however, services required by EPSDT are not considered Case-by-case Services.

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

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

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

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

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

Children's Health Insurance Program or **CHIP** means the health insurance program authorized and funded pursuant to Title XXI, Social Security Act (42 U.S.C. §§ 1397aa-1397jj) and administered by HHSC. The CHIP Perinatal Program is a subprogram of CHIP.

CHIP MCO Program, or CHIP Program, means the State of Texas program in which HHSC contracts with MCOs to provide, arrange for, and coordinate Covered Services for enrolled CHIP Members.

CHIP MCOs means MCOs participating in the CHIP MCO Program.

CHIP Perinatal MCOs means MCOs participating in the CHIP Perinatal Program, a subprogram of CHIP.

CHIP Perinatal Program means the State of Texas program in which HHSC contracts with MCOs to provide, arrange for, and coordinate Covered Services for enrolled CHIP Perinate and CHIP Perinate Newborn Members. Although the CHIP Perinatal Program is part of the CHIP Program, for Contract administration purposes it is sometimes identified independently in this Contract.

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 (refer to Section 5.04.1 for information concerning eligibility).

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

Clean Claim means a claim submitted by a physician or provider for health care services rendered to a Member, with the data necessary for the MCO or subcontracted claims processor to adjudicate and accurately report the claim. A Clean Claim other than a Nursing Facility Unit Rate Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate claim type encounter guides as follows:

(1) 837 Professional Combined Implementation Guide;

(2) 837 Institutional Combined Implementation Guide;

(3) 837 Professional Companion Guide;

(4) 837 Institutional Companion Guide; or

(5) National Council for Prescription Drug Programs (NCPDP) Companion Guide.

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

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

Cognitive Rehabilitation Therapy means an HCBS STAR+PLUS Waiver 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. Cognitive rehabilitation therapy may be provided when an appropriate professional assesses the Member and determines it is medically necessary. Cognitive rehabilitation therapy is provided in accordance with the plan of care developed by the assessor and includes reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.

COLA means the Cost of Living Adjustment.

Collaborative Care Model (CoCM) means a systematic approach to the treatment of Behavioral Health conditions for persons of all ages in primary care settings. The model integrates the services of a Behavioral Health care manager (BHCM) and a consulting psychiatrist with primary care provider oversight to proactively manage Behavioral Health conditions as chronic diseases, rather than treating acute symptoms. CoCM services include outreach and engagement, completion of an initial assessment, development of an individualized and person-centered plan of care, monitoring and tracking a person's progress using a registry, providing brief interventions and other focused treatments, and conducting weekly caseload reviews with the psychiatric consultant.

Community-based Long Term Services and Supports means services provided to STAR+PLUS 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 STAR+PLUS Members as well as those services available only to STAR+PLUS Members who qualify for HCBS STAR+PLUS Waiver services.

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

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

Community Resource Coordination Groups (CRCGs) means a statewide system of local interagency groups, including both public and private providers, which coordinate services for "multi-need" children and 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 who has documented full-time experience in the provision of Mental Health Targeted Case Management and Mental Health Rehabilitative Services prior to August 31, 2004. The provider who meets the following minimum requirements: (1) high school diploma or high school equivalency, and (2) three continuous years of documented full-time experience in the provisions of Mental Health Rehabilitative Services and demonstrated competency in the provision and documentation of Mental Health Rehabilitative Services.

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

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

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

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

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

Comprehensive Care Program: see definition for Texas Health Steps.

Confidential Information means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to MCO or that MCO may create, receive, maintain, use, disclose or have access to on behalf of HHS that consists of or includes any or all of the following:

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

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

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

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

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

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

(7) All privileged work product;

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

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

Consumer-Directed Services means the Member, or his legal guardian, is the employer of and retains control over the hiring, management, and termination of an individual providing personal assistance or respite.

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

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

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

Contractor or **MCO** means the MCO that is a party to this Contract and is an insurer licensed or approved by TDI as an HMO, ANHC formed in compliance with Chapter 844 of the Texas Insurance Code, or an EPO with an Exclusive Provider Benefit Plan approved by TDI in accordance with 28 Tex. Admin. Code § 3.9201-3.9212.

Copayment (CHIP only) means the amount that a Member is required to pay when utilizing certain CHIP Covered Services. Once the copayment is made, further payment is not required by the Member.

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

Covered Services means Health Care Services and NEMT Services the MCO must arrange to provide to Members, including all services required by the Contract and state and federal law, and all Value-added Services negotiated by the Parties (see **Attachments B-2, B-2.1, B-2.2 and B-3** of the **HHSC Managed Care Contract** relating to "Covered Services" and "Value-added Services").

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

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

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

Critical Incident Management System (CIMS) is an online reporting system to report and track Incidents of abuse, neglect, and exploitation (ANE) allegations and Critical Events or Incidents.

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

DADS means the Texas Department of Aging and Disability Services or its successor agency (formerly Department of Human Services).

Date of Disenrollment means the last day of the last month for which MCO receives payment for a Member.

Day means a calendar day unless specified otherwise.

Default Enrollment means the processes established by HHSC to assign an enrollee who has not selected an MCO to an MCO. See 1 Tex. Admin. Code § 353.403 for Medicaid default enrollment processes, and 1 Tex. Admin. Code § 370.303 for CHIP default enrollment processes.

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

Delivery Supplemental Payment means a one-time per pregnancy supplemental payment for STAR, CHIP and CHIP Perinatal MCOs.

Designated Provider means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that are determined by the State and approved by the U.S. Secretary of Health and Human Services to be qualified to be a Health Home for Members with chronic conditions on the basis of documentation that the physician practice or clinic (A) has the systems and infrastructure in place to provide Health Home services and (B) satisfies the qualification standards established by the U.S. Secretary of Health and Human Services.

Diagnostic means assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a provider to diagnose existing conditions.

Disabled Person or Person with Disability means a person under 65 years of age, including a child, who qualifies for Medicaid services because of a disability.

Disability means a physical or mental impairment that substantially limits one (1) or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

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

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

Discharge means a formal release of a Member from an Inpatient Hospital stay when the need for continued care at an inpatient level has concluded. Movement or Transfer from one (1) Acute Care Hospital or Long Term Care Hospital /facility and readmission to another within 24 hours for continued treatment is not a discharge under this Contract.

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

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

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

DSHS means the Texas Department of State Health Services or its successor agency (formerly Texas Department of Health and Texas Department of Mental Health and Mental Retardation).

DSM means the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders,* which is the American Psychiatric Association's official classification of Behavioral Health disorders, or its replacement.

Dual Demonstration means the Texas Dual Eligibles Integrated Care Demonstration Project, which uses a service delivery model for Dual Eligibles that combines Medicare and Medicaid services under the same health plan.

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

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

ECI means Early Childhood Intervention, a federally mandated program for infants and toddlers under the age of three with developmental delays or disabilities. See 34 C.F.R. § 303.1 *et seq*. and 26 Tex. Admin. Code § 350.101 et seq. for further clarification.

EDI means electronic data interchange.

Effective Date means the effective date of this Contract, as specified in the HHSC Managed Care Contract document.

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

Electronic Visit Verification (EVV) is a computer-based system that electronically documents and verifies service delivery information, such as the date, time, service type and location for certain Medicaid service visits.

Eligibles means individuals residing in one (1) of the Service Areas and eligible to enroll in a STAR, STAR+PLUS, CHIP, or CHIP Perinatal MCO, as applicable.

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

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

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

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

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

(1) placing the Member's health in serious jeopardy;

(2) serious impairment to bodily functions;

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

(4) serious disfigurement; or

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

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

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

1. identifying an individual'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 Assistance is not available to Members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. For any Member receiving one of those waiver services, the MCO must document that the Employment Assistance service is not available to the Member in the Member's record.

Encounter means a Covered Service or group of Covered Services delivered by a Provider to a Member during a visit between the Member and Provider. This also includes Value-added Services.

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

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

EPSDT means the federally mandated Early and Periodic Screening, Diagnosis and Treatment program contained at 42 U.S.C. § 1396d(r). The name has been changed to Texas Health Steps in the State of Texas.

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

Expansion Area means a county or Service Area that has not previously provided healthcare to HHSC's MCO Program Members utilizing a managed care model.

Expansion Service Areas are the Hidalgo and Medicaid Rural Service Areas for the STAR Program; and the El Paso, Hidalgo, and Lubbock Service Areas for the STAR+PLUS Program.

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

Experience Rebate means the portion of the MCO's Net Income Before Taxes that is returned to the State in accordance with Section 10.10 for the STAR, CHIP and CHIP Perinatal Programs and 10.10.1 for the STAR+PLUS Program ("Experience Rebate").

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

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

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

Face-to-face means In-Person or Audio-visual communication that meets the requirements of the Health Insurance Portability and Accountability Act. Face-to-face does not include Audio-only communication.

Family Partner means a Mental Health Rehabilitative Service provider who meets the following minimum requirements: (1) high school diploma or high school equivalency, and (2) one cumulative year of participating in mental health services as the parent or legally authorized representative of a child receiving mental health services.

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

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

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

Financial Management Services Agency (FMSA) means an entity that contracts with HHSC or an MCO to provide financial management services as

described in 40 Tex. Admin Code § 41.309(a) to an employer or designated representative.

Financial Statistical Report (see FSR below).

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

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

FQHC means a Federally Qualified Health Center, certified by CMS to meet the requirements of §1861(aa)(3) of the Social Security Act as a federally qualified health center, that is enrolled as a provider in the Texas Medicaid program.

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

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

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

FSR Reporting Period 12/13 means the 18-month period beginning on March 1, 2012 and ending on August 31, 2013. This is the first FSR Reporting Period under this Contract.

FSR Reporting Period 14 means the 12-month period beginning on September 1, 2013 and ending on August 31, 2014.

FSR Reporting Period 15 means the twelve month period beginning on September 1, 2014 and ending on August 31, 2015.

Functionally Necessary Covered Services means Community-based Long Term Services and Supports services provided to assist STAR+PLUS 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 STAR+PLUS Member to remain independent or in the most integrated setting

Habilitation has the same meaning as found in 1 Tex. Admin. Code § 353.2.

Habilitative and Rehabilitative Services means Health Care Services described in **Attachment B-2** that may be required by children who fail to reach (habilitative) or have lost (rehabilitative) age appropriate developmental milestones.

HCBS STAR+PLUS Waiver 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 HCBS STAR+PLUS Waiver are eligible to receive the home and community based services component of the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver as described in Attachment B-2 "STAR+PLUS Covered Services," under the heading "HCBS STAR+PLUS Waiver services for those Members who qualify for such services."

Health and Human Services Commission or **HHSC** means the administrative agency within the executive department of Texas state government established under Chapter 531, Texas Government Code, or its designee, including, but not limited to, the HHS Agencies.

Health Care Services means the Acute Care, Behavioral Health Care, and health-related services that an enrolled population might reasonably require in order to be maintained in good health. Health Care Services do not include NEMT Services.

Health Home means a Designated Provider, including a provider that operates in coordination with a team of health care professionals, or a Heath Team selected by a Member with chronic conditions to provide Health Home Services.

Health Home Services means comprehensive and timely high-quality services that are provided by a Designated Provider, a Team of Health Care 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.

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

Health Team means such term as described in Section 3502 of the Patient Protection and Affordable Care Act, P.L. 111-148 (March 23, 2010), as amended or modified.

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

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

HHS Agency means the Texas health and human service agencies subject to HHSC's oversight under Chapter 531, Texas Government Code, and their successor agencies.

HHSC Administrative Services Contractor (ASC) means an entity performing MCO administrative services functions, including Member enrollment functions, for the STAR, STAR+PLUS, CHIP, or CHIP Perinatal MCO Programs under contract with HHSC.

HHSC MCO Programs or MCO Programs mean the STAR, STAR+PLUS, and CHIP MCO Programs.

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

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

Home and Community Support Services Agency or HCSSA means an entity licensed to provide home health, hospice, or personal assistance services provided to individuals in their own home or independent living environment as prescribed by a physician or individualized service plan. Each HCSS must provide clients with a plan of care that includes specific services the agency agrees to perform. The agencies are licensed and monitored by DADS or its successor.

Hospital means a licensed public or private institution as defined by Chapter 241, Texas Health and Safety Code, or in Subtitle C, Title 7, Texas Health and Safety Code.

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.

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 Waiver program (TxHmL).

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

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

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

Individual Service Plan (ISP) means an 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.

Information Resources means the procedures, equipment, and software that are employed,

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

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

Initial Contract Period means the Effective Date of the Contract through August 31, 2015.

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

In-Person or In Person means within the physical presence of another person. In-Person or In Person does not include Audio-visual or Audio-only communication.

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

JCAHO means Joint Commission on Accreditation of Health Care Organizations.

Joint Interface Plan (JIP) means a document used to communicate basic system interface information. This information includes: file structure, data elements, frequency, media, type of file, receiver and sender of the file, and file I.D. The JIP must include each of the MCO's interfaces required to conduct business under this Contract. The JIP must address the coordination with each of the MCO's interface partners to ensure the development and maintenance of the interface; and the timely transfer of required data elements between contractors and partners.

Key MCO Personnel means the critical management and technical positions identified by the MCO in accordance with **Article 4**.

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

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

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

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

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

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

Local Health Department means a local health department established pursuant to Health and Safety Code, Title 2, Local Public Health Reorganization Act §121.031.

Local IDD Authority has the meaning assigned in Health and Safety Code § 531.002(11).

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

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

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

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

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

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

(1) enroll with the MCO; or

(2) not enroll in, or to disenroll from, another MCO.

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

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

- the other entity is an Affiliate of the MCO;
- the Subcontract is considered by HHSC to be for a key type of service or function, including
  - Administrative Services (including but not limited to third party administrator, Network administration, and claims processing);
  - delegated Networks (including but not limited to Behavioral Health, dental, pharmacy, and vision);
  - management services (including management agreements with parent)
  - reinsurance;
  - Disease Management;
  - pharmacy benefit management (PBM) or pharmacy administrative services; or
  - call lines (including nurse and medical consultation); or
  - delegated transportation networks; or
- any other Subcontract that exceeds, or is reasonably expected to exceed, the lesser of a) $500,000 per year, or b) 1% of the MCO's annual Revenues under this Contract. Any Subcontracts between the MCO and a single entity that are split into separate agreements by time period, Program, or SDA, etc., will be consolidated for the purpose of this definition.

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

Material Subcontractor or **Major Subcontractor** means any entity with a Material Subcontract with the MCO. For the purposes of this Agreement, Material Subcontractors do not include providers in the MCO's Provider Network. Material Subcontractors may include, without limitation, Affiliates, subsidiaries, and affiliated and unaffiliated third parties.

MCO means managed care organization.

MCO or **Contractor** means the MCO that is a party to this Contract and is an insurer licensed or approved by TDI as an HMO, ANHC formed in compliance with Chapter 844 of the Texas Insurance Code, or an EPO with an Exclusive Provider Benefit Plan approved by TDI in accordance with 28 Tex. Admin. Code § 3.9201-3.9212.

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

MCO Internal Appeal

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

For CHIP: means the formal process by which the MCO or a Utilization Review agent addresses the MCO's Adverse Benefit Determination.

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

MCO's Service Area means all the counties included in any HHSC-defined Service Area, as applicable to each MCO Program and within which the MCO has been selected to provide MCO services.

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

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 6 months.

Medicaid MCOs means contracted MCOs participating in STAR, STAR+PLUS, or STAR Health.

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

Medical Home has the meaning assigned to a patient-centered Medical Home in Texas Gov't Code § 533.0029(a).

Medically Necessary has the meaning defined in 1 Tex. Admin. Code §353.2 for Medicaid and 1 Tex. Admin. Code § 370.4 for CHIP.

Member means a person who:

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

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

participant in the STAR or STAR+PLUS Program, and is enrolled in the STAR or STAR+PLUS Program and the MCO's STAR or STAR+PLUS MCO;

(3) has met CHIP eligibility criteria and is enrolled in the MCO's CHIP MCO; or

(4) has met CHIP Perinatal Program eligibility criteria and is enrolled in the MCO's CHIP Perinatal Program.

Member Materials means all written materials produced or authorized by the MCO and distributed to Members or potential Members containing information concerning the MCO Program(s). Member Materials include, but are not limited to, Member ID cards, Member handbooks, Provider directories, and Marketing Materials.

Member Month means one (1) Member enrolled with the MCO during any given month. The total Member Months for each month of a year comprise the annual Member Months.

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

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

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

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

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

Migrant Farm Worker means a migratory agricultural worker, generally defined as an individual:

(1) whose principal employment is in agriculture on a seasonal basis;

(2) who has been so employed within the last twenty-four months;

(3) who performs any activity directly related to the production or processing of crops, dairy products, poultry, or livestock for initial commercial sale or as a principal means of personal subsistence; and

(4) who establishes for the purposes of such employment a temporary abode.

MIS means Management Information System.

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

National Committee for Quality Assurance (NCQA) means the independent organization that accredits MCOs, managed Behavioral Health organizations, and accredits and certifies disease management programs. HEDIS and the Quality Compass are registered trademarks of NCQA.

NEMT Attendant means

1. for a Member under age 18, the Member's parent, guardian, or another adult authorized in writing by the parent or guardian to accompany the Member;
2. an adult that accompanies a Member to provide necessary mobility, personal or language assistance to the Member during the time that transportation services are provided, including an adult serving as a personal attendant;
3. a service animal that accompanies a Member to provide necessary mobility or personal assistance to the Member during the time that transportation services are provided and who occupies a seat that would otherwise be filled with another Member; or
4. an adult that accompanies a Member because a health care provider has stated in writing that the Member requires an attendant.

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

Network or **Provider Network** means all Providers that have entered into Provider Contracts.

Network Provider or **Provider** means an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a Provider Contract for the delivery of Health Care Services to the MCO's Members.

Non-capitated Services means those Medicaid services identified in **Attachment B-1**, Section 8.2.2.8.

Nonemergency Medical Transportation (NEMT) Services means non-emergency transportation-related services available under the Medicaid state plan, including Nonmedical Transportation (NMT) Services.

Nonmedical Transportation (NMT) Services has the meaning assigned by Tex. Gov't Code § 533.00258(a)(1).

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

Non-Urban County or **Rural County** means any county with fewer than 50,000 residents as reported by the Texas Association of Counties on the Texas Association of Counties website.

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

Nursing 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 wheel chairs, 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. This level of care and associated resource allocation is referred to as the Resource Utilization Group or the RUG. The per diem cost is annualized to achieve the nursing facility ceiling.

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 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 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.

OB/GYN means obstetrician-gynecologist.

Open Panel means PCPs who are accepting new Members for the MCO Program(s) served.

Operational Start Date means the first day on which an MCO is responsible for providing Covered Services to MCO Program Members and all related Contract functions in a Service Area. The Operational Start Date may vary per MCO Program and Service Area. The Operational Start Date(s) applicable to this Contract are set forth in the **HHSC Managed Care Contract** document.

Operations Phase means the period of time when MCO is responsible for providing the Covered Services and all related Contract functions for a Service Area. The Operations Phase begins on the Operational Start Date and may vary by MCO Program and Service Area.

Out-of-Network (OON) means an appropriately licensed individual, facility, agency, institution, organization or other entity that has not entered into a contract with the MCO for the delivery of Covered Services to the MCO's Members.

Outpatient Hospital Services means diagnostic, therapeutic, and rehabilitative services that are provided to Members in an organized medical facility, for less than a 24-hour period, by or under the direction of a physician.

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

Parties means HHSC and MCO, collectively.

Party means either HHSC or MCO, individually.

PASRR means the Preadmission Screening and Resident Review, 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: (1) be evaluated for mental illness, intellectual disability, or both; (2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and (3) receive the services they need in those settings.

PASRR Level I Screening has the meaning assigned in 26 Tex. Admin. Code § 303.102(48).

PASRR Level II Evaluation has the meaning assigned in 26 Tex. Admin. Code § 303.102(48).

PASRR Specialized Services has the meaning assigned in 26 Tex. Admin. Code § 303.102(60).

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

Peer-to-Peer means the discussion held between the physician requesting, ordering, or intending to provide a service for which prior authorization is required and an MCO's Medical Director, or his or her physician designee regarding the medical necessity, appropriateness, or the experimental or investigational nature of a healthcare service. (This section does not apply to CHIP Members.)

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

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

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

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

Platform has the meaning set forth in Texas Government Code §531.001(4-d).

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

Post-stabilization Care Services has the meaning assigned to it in 42 C.F.R. § 438.114. Accordingly, the phrase means Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, for a Medicaid Member, under the circumstances described in 42 C.F.R. § 438.114(e) and 42 C.F.R. § 422.113(c)(2) to improve or resolve the Medicaid Member's condition.

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

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

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

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

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

Program means a managed care program operated by HHSC. Depending on the context, the term may include one or more of the following: STAR, STAR+PLUS, STAR Health, CHIP, Children's Medicaid Dental Services or CHIP Dental Services.

Proposal means the proposal submitted by the MCO in response to the RFP.

Provider or Network Provider means an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors that has a Provider Contract for the delivery of Health Care Services to the MCO's Members.

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

Provider Materials means all written materials produced or authorized by the MCO or its Administrative Services Subcontractors concerning the MCO Program(s) that are distributed to Network Providers. Provider Materials include the MCO's Provider Manual, training materials regarding MCO Program requirements, and mass communications directed to all or a large group of Network Providers (e-mail or fax "blasts"). Provider Materials do not include written correspondence between the MCO or its Administrative Services Subcontractors and a provider regarding individual business matters.

Provider Network or Network means all Providers that have entered into Provider Contracts.

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

Public Health Entity means a DSHS health service regional office in a Public Health Region administered by a regional director under Section 121.007, Health and Safety Code and acting in the capacity of a local public health entity; a Local Health Department established under Subchapter D, Chapter 121, Health and Safety Code; a Public Health District established under Subchapter E, Chapter 121 Health and Safety Code; a Local Health Unit described by Section 121.004, Health and Safety Code; or a Hospital District providing Covered Services to Medicaid Members.

Public Information means information that:

(1) Is collected, assembled, or maintained under a law or ordinance or in connection with the transaction of official business by a governmental body or for a governmental body; and

(2) The governmental body owns or has a right of access to.

Qualified and Disabled Working Individual (QDWI) means an individual whose only Medicaid benefit is payment of the Medicare Part A premium.

Qualified Medicare Beneficiary (QMB) means a Medicare beneficiary whose only Medicaid benefits are payment of Medicare premiums, deductibles, and coinsurance for individuals who are entitled to Medicare Part A, whose income does not exceed 100% of the federal poverty level, and whose resources do not exceed twice the resource limit of the SSI program.

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

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

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

Rate Period 1 means the 18-month period beginning on March 1, 2012 and ending on August 31, 2013. For purposes of rate setting only, Rate Period 1 will be divided into three sub-periods: March 1, 2012 through August 31, 2012, September 1, 2012 to May 31, 2013, and June 1, 2013 to August 31, 2013.

Rate Period 2 means the 12-month period beginning on September 1, 2013 and ending on August 31, 2014.

Rate Period 3 means the 12-month period beginning on September 1, 2014 and ending on August 31, 2015.

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

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

Real-Time Captioning (also known as CART, Communication Access Real-Time Translation) means a process by which a trained individual uses a

shorthand machine, a computer, and real-time translation software to type and simultaneously translate spoken language into text on a computer screen. Real Time Captioning is provided for individuals who are deaf, have hearing impairments, or have unintelligible speech. It is usually used to interpret spoken English into text English but may be used to translate other spoken languages into text.

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

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

Revenue means all revenue received by the MCO pursuant to this Contract, including retroactive adjustments made by HHSC. Revenue includes any funds earned on Medicaid or CHIP managed care funds such as investment income and earned interest. Revenue excludes any reinsurance recoveries, which shall be shown as a contra-cost, or reported offset to reinsurance expense. Revenues are reported at gross and are not netted for any reinsurance premiums paid. See also the Uniform Managed Care Manual's "Cost Principles for Expenses."

Risk means the potential for loss as a result of expenses and costs of the MCO exceeding payments made by HHSC under the Contract.

Routine Care means health care for covered preventive and medically necessary Health Care Services that are non-emergent or non-urgent.

Rural County or **Non-Urban County** means any county with fewer than 50,000 residents as reported by the Texas Association of Counties on the Texas Association of Counties website.

Rural Health Clinic (RHC) means an entity that meets all of the requirements for designation as a rural health clinic under § 1861(aa)(1) of the Social Security Act and approved for participation in the Texas Medicaid Program.

Scope of Work means the description of Services and Deliverables specified in this Contract, the RFP, the MCO's Proposal, and any attachments and modifications to these documents.

SDX means State Data Exchange.

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

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

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

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

Service Coordinator means the person with primary responsibility for providing Service Coordination and care management to Members.

Service Plan (SP) means an individualized and person-centered plan in which an individual, with assistance as needed, identifies and documents his or her preferences, strengths, and needs in order to develop short-term objectives and action steps to ensure personal outcomes are achieved within the most integrated setting by using identified supports and services. The Service Plan which is described in 8.1.12.4 supported by the results of the Member's program-specific assessment.

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

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

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

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

Significant Traditional Provider or **STP** means primary care providers, long term services and supports providers, and pharmacy providers identified by HHSC as having provided a significant level of

care to Medicaid or CHIP clients. Disproportionate Share Hospitals (DSH) are also Medicaid STPs.

Skilled Nursing Facility Services (CHIP only) Services provided in a facility that provides nursing or rehabilitation services and Medical supplies and use of appliances and equipment furnished by the facility.

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

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

Specialty Therapy means physical therapy, speech therapy, or occupational therapy.

Specified Low-Income Medicare Beneficiary (SLMB) means a Medicare beneficiary whose only Medicaid benefit is payment of the Medicare Part B premium.

SSA means the Social Security Administration.

Stabilize means to provide such medical care as to assure within reasonable medical probability that no deterioration of the condition is likely to result from, or occur from, or occur during discharge, transfer, or admission of the Member.

STAR+PLUS or STAR+PLUS Program means the State of Texas Medicaid managed care program in which HHSC contracts with MCOs to provide, arrange, and coordinate preventive, primary, acute and Long-term Services and Supports Covered Services to adult persons with disabilities and elderly persons age 65 and over who qualify for Medicaid through the SSI program or the MAO program. Children birth through age 20 who qualify for Medicaid through the SSI program, may voluntarily participate in the STAR+PLUS program.

STAR+PLUS MCOs means contracted MCOs participating in the STAR+PLUS Program.

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

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

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

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

Subsidiary means an Affiliate controlled by such person or entity directly or indirectly through one (1) or more intermediaries.

Substance Use Disorder means the use of one or more drugs or substances, including alcohol, which significantly and negatively impacts one or more major areas of life functioning and which meets the criteria for Substance Use Disorders as described in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance Use Disorders.

Supplemental Security Income (SSI) means a Federal income supplement program funded by general tax revenues (not Social Security taxes) designed to help aged, blind and disabled people with little or no income by providing cash to meet basic needs for food, clothing and shelter.

Supported Employment means assistance provided as an HCBS STAR+PLUS Waiver service, in order to sustain competitive employment, to a Member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which Members without disabilities are employed. Supported Employment includes employment adaptations, supervision, and training related to a Member's assessed needs. Individuals receiving supported employment earn at least minimum wage (if not self-employed).

Supported Employment is not available to Members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. For any Member receiving one of those waiver services, the MCO must document that the Employment Assistance service is not available to the Member in the Member's record.

TDD means Telecommunication device for the deaf. It is interchangeable with the term Teletype machine or TTY.

TDI means the Texas Department of Insurance.

Team of Health Care Professionals means physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, Behavioral Health professional, or any professionals deemed appropriate by HHSC and approved by CMS. The team may be free-standing, virtual, or based at a Hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by HHSC and approved by CMS.

Telecommunication means an exchange of information by electronic and electrical means.

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

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

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

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Temporary Assistance to Needy Families (TANF) means the federally funded program that provides assistance to single parent families with children who meet the categorical requirements for aid. This program was formerly known as the Aid to Families with Dependent Children (AFDC) program.

Texas Certified Community Behavioral Health Clinic (T-CCBHC) means a clinic certified by the HHSC in accordance with the criteria set forth in 26 Tex. Admin. Code Chapter 306, Subchapter C.

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

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

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

Texas Public Information Act refers to the provisions of Chapter 552 of the Texas Government Code.

Third Party Liability (TPL) means the legal responsibility of another individual or entity to pay for all or part of the services provided to Members under the Contract (see 1 Tex. Admin. Code §§ 354.2301 *et seq*., relating to Third Party Resources).

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

Transfer means the movement of the Member from one (1) Acute Care Hospital or Long Term Care Hospital/facility and readmission to another Acute Care Hospital or Long Term Care Hospital or facility within 24 hours for continued treatment.

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

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

Transportation Network Company (TNC) has the meaning assigned by Tex. Occ. Code § 2402.001.

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

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

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

Uniform Managed Care Manual (UMCM) means the manual published by or on behalf of HHSC that contains policies and procedures required of all MCOs participating in the HHSC Programs. The UMCM, as amended or modified, is incorporated by reference into the Contract.

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

Urban County means any county with 50,000 or more residents as reported by the Texas Association of Counties on the Texas Association of Counties website: http://www.county.org/.

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

Urgent Condition means a health condition including an Urgent Behavioral Health Situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

Utilization Review means the system for retrospective, concurrent, or prospective review of the Medical Necessity and appropriateness of Health

Care Services provided, being provided, or proposed to be provided to a Member. The term does not include elective requests for clarification of coverage.

Value-added Services means additional services for coverage beyond those specified in **Attachments B-2, B-2.1,** and **B-2.2**. Value-added Services may be actual Health Care Services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improve health outcomes among Members. Value-added Services that promote healthy lifestyles should target specific weight loss, smoking cessation, or other programs approved by HHSC. Temporary phones, cell phones, additional transportation benefits, and extra home health services may be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.

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

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

(1) when the Dual Eligible Member has exceeded the Medicare coverage limit; or

(2) that are not covered by Medicare.

Article 3. General Terms & Conditions

Section 3.01 *Contract elements.*

(a) Contract documentation.

The Contract between the Parties will consist of the HHSC Managed Care Contract document and all attachments and amendments.

(b) Order of documents.

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

(1) The final executed **HHSC Managed Care Contract** document, and all amendments;

(2) HHSC Managed Care Contract **Attachment A** – "Uniform Managed Care Contract Terms and Conditions," and all amendments;

(3) HHSC Managed Care Contract **Attachment B** – "Scope of Work/Performance Measures," and all amendments;

(4) for STAR+PLUS MCOs only, the **STAR+PLUS Handbook** and all amendments;

(5) The **Uniform Managed Care Manual (UMCM)**, and all amendments; and

(6) HHSC Managed Care Contract **Attachment C –** "MCO's Proposal."

Section 3.02 *Term of the Contract.*

The term of the Contract will begin on the Effective Date and will conclude on the Expiration Date. The Parties may renew the Contract for an additional period or periods, but the Contract Term may not exceed a total of eight (8) operational years. All reserved contract extensions beyond the Expiration Date will be subject to good faith negotiations between the Parties and mutual agreement to the extension(s).

Section 3.03 *Funding.*

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

Section 3.04 *Delegation of authority.*

Whenever, by any provision of this Contract, any right, power, or duty is imposed or conferred on HHSC, the right, power, or duty so imposed or conferred is possessed and exercised by the Executive Commissioner unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of HHSC. The Commissioner will reduce any such delegation of authority to writing and provide a copy to MCO on request.

Section 3.05 *No waiver of sovereign immunity.*

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

Section 3.06 *Force Majeure.*

Neither Party will be liable for any failure or delay in performing its obligations under the Contract if such failure or delay is due to a Force Majeure Event. The existence of such causes of delay or failure will extend the period of performance in the exercise of reasonable diligence until after the causes of delay or

failure have been removed. Each Party must inform the other in writing with proof of receipt within five (5) Business Days of the existence of a Force Majeure Event.

Section 3.07 ***Publicity.***

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

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

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

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

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

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

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

(3) Member Materials (the MCO must comply with the UMCM's provisions regarding the review and approval of Member Materials).

Section 3.08 ***Assignment.***

(a) Assignment by MCO.

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

(b) Assignment by HHSC.

MCO understands and agrees HHSC may in one (1) or more transactions assign, pledge, transfer, or hypothecate the Contract. This assignment will only be made to another State agency or a non-State agency that is contracted to perform agency support.

(c) Assumption.

Each party to whom an assignment is made (an "Assignee") must assume all of the assigned interests in and responsibilities under the Contract and any documents executed with respect to the Contract

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

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

Section 3.10 ***Renegotiation and reprocurement rights.***

(a) Renegotiation of Contract terms.

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

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

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

(c) Termination rights upon reprocurement.

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

Section 3.11 ***RFP errors and omissions.***

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

Section 3.12 ***Enforcement Costs.***

In the event of any litigation, appeal, or other legal action to enforce any provision of the Contract, MCO

agrees to pay all reasonable expenses of such action, if HHSC is the prevailing Party.

Section 3.13 ***Preferences under service contracts.***

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

Section 3.14 ***Time of the essence.***

In consideration of the need to ensure uninterrupted and continuous MCO Program performance, time is of the essence in the performance of the Scope of Work under the Contract.

Section 3.15 ***Notice***

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

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

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

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

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

(c) All notices must be sent to the Project Manager identified in the **HHSC Managed Care Contract** document. In addition, legal notices must be sent to the Legal Contact identified in the **HHSC Managed Care Contract** document.

(d) Routine communications that are administrative in nature will be provided in a manner agreed to by the Parties.

Article 4. Contract Administration & Management

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

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

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

(a) Designation of Key Personnel.

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

(1) Member Services;

(2) Management Information Systems;

(3) Claims Processing,

(4) Provider Network Development and Management;

(5) Benefit Administration and Utilization and Care Management;

(6) Quality Improvement;

(7) Behavioral Health Services;

(8) Financial Functions;

(9) Reporting;

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

(11) Executive Director(s) for applicable HHSC MCO Program(s) as defined in **Section 4.03**, "Executive Director";

(12) Medical Director(s) for applicable HHSC MCO Program(s) as defined in Section **4.04**, "Medical Director"; and

(13) Management positions for STAR+PLUS Service Coordinators for STAR+PLUS MCOs as defined in **Section 4.04.1**, "STAR+PLUS Service Coordinator."

(14) Special Investigative Unit (SIU).

(b) Support and Replacement of Key Personnel.

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

(c) Notification of replacement of Key Personnel.

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

Section 4.03 ***Executive Director.***

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

(b) The Executive Director must be authorized and empowered to represent the MCO regarding all matters pertaining to the Contract prior to such representation. The Executive Director must act as liaison between the MCO and the HHSC and must have responsibilities that include, but are not limited to, the following:

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

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

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

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

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

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

(7) meeting with HHSC at the time and place requested by HHSC, if HHSC determines that the MCO is not in compliance with the requirements of the Contract.

Section 4.04 ***Medical Director.***

(a) The MCO must have a qualified individual to serve as the Medical Director for its HHSC MCO Program(s). The Medical Director must be currently licensed in Texas under the Texas Medical Board as an M.D. or D.O. with no restrictions or other licensure limitations. The Medical Director must comply with the requirements of 28 Tex. Admin. Code § 11.1606 and all applicable federal and state statutes and regulations.

(b) The Medical Director, or his or her designee, must be available by telephone 24 hours a Day, seven Days a week, for Utilization Review decisions. The Medical Director, and his/her designee, must either possess expertise with Behavioral Health Services, or ready access to such expertise to ensure timely and appropriate medical decisions for Members, including after regular business hours.

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

(d) For purposes of this section, the Medical Director's designee must be:

(1) a physician that meets the qualifications for a Medical Director, as described in subparts (a) through (c), above; or

(2) for prior authorization determinations for outpatient pharmacy benefits, a Texas-licensed pharmacist working under the direction of the Medical Director, provided such delegation is included in the MCO's TDI-approved utilization review plan.

(e) The Medical Director, or his or her physician designee, must make determinations regarding Utilization Review appeals, including appeals of prior authorization denials for outpatient pharmacy benefits.

Section 4.04.1 STAR+PLUS Service Coordinator

(a) STAR+PLUS MCOs must employ as Service Coordinators persons experienced in meeting the needs of people with disabilities, old and young, and vulnerable populations who have Chronic or Complex

Conditions. A Service Coordinator must have an undergraduate and/or graduate degree in social work or a related field, or be a Registered Nurse, Licensed Vocational Nurse, Advanced Nurse Practitioner, or a Physician Assistant.

(b) The STAR+PLUS MCO must monitor the Service Coordinator's workload and performance to ensure that he or she is able to perform all necessary Service Coordination functions for the STAR+PLUS Members in a timely manner.

(c) The Service Coordinator must be responsible for working with the Member or his or her representative, the PCP and other Providers to develop a seamless package of care in which primary, Acute Care, and Long-term Services and Supports service needs are met through a single, understandable, rational plan. Each Member's Service Plan must also be well coordinated with the Member's family and community support systems, including Independent Living Centers, Area Agencies on Aging, Local IDD Authorities, and LMHAs. The Service Plan should be agreed to and signed by the Member or the Member's representative to indicate agreement with the plan. The plan should promote consumer direction and self-determination and may include information for services outside the scope of Covered Services such as how to access affordable, integrated housing. For Dual Eligible Members, the STAR+PLUS MCO is responsible for meeting the Member's Community Long- term Services and Supports needs.

(d) The STAR+PLUS MCO must empower its Service Coordinators to authorize the provision and delivery of Covered Services, including Community Long-term Services and Supports Covered Services.

(e) The MCO may allow a Member to receive Service Coordination through an integrated Health Home if the individual providing Service Coordination and the Service Coordination structure meet STAR+PLUS program requirements. The MCO must reimburse a Health Home that provides Service Coordination to its Members through an enhanced rate structure, a per-member-per-month fee, or other reasonable methodology agreed to between the MCO and Health Home.

Section 4.05 ***Responsibility for MCO personnel and Subcontractors.***

(a) MCO employees and Subcontractor employees will not in any sense be considered employees of HHSC or the State of Texas but will be considered for all purposes as the MCO's employees or its Subcontractor's employees, as applicable.

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

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

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

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

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

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

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

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

Section 4.06 ***Cooperation with HHSC and state administrative agencies.***

(a) Cooperation with Other MCOs.

MCO agrees to reasonably cooperate with and work with the other MCOs in the MCO Programs, Subcontractors, and third-party representatives as

requested by HHSC. To the extent permitted by HHSC's financial and personnel resources, HHSC agrees to reasonably cooperate with MCO and to use its best efforts to ensure that other HHSC contractors reasonably cooperate with the MCO.

(b) Cooperation with state and federal administrative agencies.

MCO must ensure that MCO personnel will cooperate with HHSC or other state or federal administrative agency personnel at no charge to HHSC for purposes relating to the administration of MCO Programs including, but not limited to the following purposes:

(1) The investigation and prosecution of Fraud, Waste, and Abuse in the HHSC programs;

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

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

Section 4.07 ***Conduct of MCO personnel and Subcontractors.***

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

(1) Comply with applicable state rules and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations; and

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

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

(1) Removing the employee or Subcontractor from the project;

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

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

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

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

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

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

(a) MCO remains fully responsible for the obligations, services, and functions performed by its Subcontractors to the same extent as if such obligations, services, and functions were performed by MCO's employees, and for purposes of this Contract such work will be deemed work performed by MCO. The MCO must ensure its contracts with Subcontractors comply with all of the requirements of 42 C.F.R. 438.230. HHSC reserves the right to require the replacement of any Subcontractor found by HHSC to be unacceptable and unable to meet the requirements of the Contract, and to object to the selection of a Subcontractor.

(b) MCO must:

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

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

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

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

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

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

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

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

the MCO has shown good cause for a shorter notice period.

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

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

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

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

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

(5) an existing Material Subcontractor changes one (1) or more of its MIS subsystems, claims processing or operational functions; or

(6) a Readiness Review is requested by HHSC.

The MCO must submit information required by HHSC for each proposed Material Subcontractor as indicated in **Section 7**, "Transition Phase Requirements." Refer to **Sections 8.1.1.2**, "Additional Readiness Reviews and Monitoring Efforts," and **8.1.18**, "Management Information System Requirements" for additional information regarding MCO Readiness Reviews during the Contract Period.

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

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

(f) Except as provided herein, all Subcontracts must be in writing and must provide HHSC the right to examine the Subcontract and complete and unredacted originals or copies of all Subcontractor records and information relating to the Contract and the Subcontract. This requirement does not apply to agreements with non-Affiliate utility or mail service providers.

If the MCO intends to report compensation or any other payments paid to any third party (including without limitation an Affiliate) as an Allowable Expense under this Contract, and the amounts paid to the third party exceed $200,000, or are reasonably anticipated to exceed $200,000, in a State Fiscal Year (or in any contiguous twelve-month period), then the MCO's agreement with the third party must be in writing. The agreement must provide HHSC the right to examine the agreement and complete and unredacted originals or copies of all records and information relating to the agreement.

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

(g) A Subcontract or any other agreement in which the MCO receives rebates, recoupments, discounts, payments, incentives, fees, free goods, bundling arrangements, retrocession payments (as described in UMCM Chapter 6) or any other consideration from a Subcontractor or any other third party (including without limitation Affiliates) as related to this Contract must be in writing and the MCO must allow HHSC and the Office of the Attorney General to examine the Subcontract or agreement and complete and unredacted originals or copies of all related records and information.

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

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

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

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

barriers for HHSC in monitoring compliance with this Contract.

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

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

(n) The MCO and its Subcontractors must provide all records and information required under Section 4.08 to HHSC, or to the Office of the Attorney General, if requested, at no cost.

(o) The MCO must include in any Subcontract, including existing Subcontracts, a requirement that:

(1) notwithstanding any confidentiality, non-disclosure, or similar agreements or provisions, Subcontractor must require its employees who have a reasonable cause to believe that fraud, waste, or abuse has occurred to report the questioned activity to the HHSC Office of Inspector General;

(2) notwithstanding any confidentiality, non-disclosure, or similar agreements or provisions, Subcontractor must provide HHSC the right to examine the Subcontract and complete and unredacted originals or copies of all Subcontractor records and information relating to the Contract and the Subcontract;

(3) notwithstanding any confidentiality , non-disclosure, or similar agreements or provisions, an individual or entity that enters a contract or agreement with a Subcontractor that relates directly or indirectly to the performance of the MCO's obligations under this Contract with HHSC must provide HHSC the right to examine such contract or agreement and must provide complete and unredacted originals or copies of all records and information relating to such contract or agreement; and

(4) notwithstanding any confidentiality, non-disclosure, or similar agreements or provisions, an individual or entity that enters a contract or agreement with an individual or entity described in paragraph (3) above that relates directly or indirectly to the performance of the MCO's obligations under this Contract with HHSC must provide HHSC the right to examine such contract or agreement and must provide complete and unredacted originals or copies of all records and information relating to such contract or agreement.

(p) The MCO must have a Subcontract with all Material Subcontractors. The MCO must have a Subcontract with all PBMs.

Section 4.09 ***HHSC's ability to contract with Subcontractors.***

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

Section 4.10 ***This Section Intentionally Left Blank***

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

(a) Findings.

(1) HHSC finds the following:

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

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

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

(D) Some of the software used or developed by HHSC may also be subject to statutory restrictions on the export of technology to foreign nations, including but not limited to the Export Administration Regulations, 15 C.F.R. Parts 730-774.

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

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

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

3) Further, HHSC forbids the performance of any work or the maintenance of any information relating or obtained pursuant to this Agreement to occur outside of the United States.

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

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

(2) Conversely, the phrase "outside the United States" means any location that is not within the territorial boundaries comprising the republic of the United States of America, including of any of the 48 coterminous states in North America, the states of Alaska and Hawaii, and the District of Columbia.

(c) Maintenance of Confidential Information.

(1) MCO and all subcontractors, vendors, agents, and service providers of or for MCO must not allow any Confidential Information that MCO receives from or on behalf of HHSC to be moved outside the United States by any means (physical or electronic) at any time, for any period of time, for any reason.

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

(d) Performance of Work under Agreement.

(1) Subject to the exceptions specified in paragraph (e) of this Section 4.11, MCO and all subcontractors, vendors, agents, and service providers of or for MCO must perform all services under the Agreement, including all tasks, functions, and responsibilities assigned and delegated to MCO under this Agreement, within the United States.

(A) This obligation includes, but is not limited to, all Services, including but not limited to information technology services, processing, transmission, storage, archiving, data center services, disaster recovery sites and services, customer support), medical, dental, laboratory and clinical services.

(B) All custom software prepared for performance of this Agreement, and all modifications of custom, third party, or vendor proprietary software, must be performed within the United States.

(2) Subject to the exceptions specified in paragraph (e) of this Section 4.11, MCO and all subcontractors, vendors, agents, and service providers of or for MCO must not permit any person to perform work under this Agreement from a location outside the United States.

(e) Exceptions.

(1) COTS Software. The foregoing requirements will not preclude the acquisition or use of commercial off-the-shelf software that is developed outside the United States or hardware that is generically configured outside the United States.

(2) Foreign-made Products and Supplies. The foregoing requirements will not preclude MCO from acquiring, using, or reimbursing products or supplies that are manufactured outside the United States, provided such products or supplies are commercially available within the United States for acquisition or reimbursement by HHSC.

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(f) Disclosure.

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

(g) Remedy.

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

liquidated damages in accordance with this Agreement.

(2) HHSC may terminate the Agreement with notice to MCO at least one Day before the effective date of such termination.

Section 4.12 ***Employment Verification***

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

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

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

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

A relationship as described in this section is as follows:

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

(2) A subcontractor of the MCO as governed by 42 CFR §438.230.

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

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

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

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

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

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

(4) National Plan & Provider Enumeration System.

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

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

Article 5. Member Eligibility, Enrollment, and Disenrollment

Section 5.01 ***Eligibility Determination and Disenrollment***

HHSC or its designee will make eligibility determinations for each of the HHSC MCO Programs. Should a Member become ineligible for Medicaid, HHSC will disenroll the Member from the managed care plan. If an MCO becomes aware that a Member has moved outside of the MCO's Service Area or that a Member is no longer Medicaid-eligible, for example the Member has moved outside of the state or is deceased, the MCO must inform HHSC within 10 Business Days.

Section 5.02 ***Member Enrollment & Disenrollment.***

(a) HHSC or the HHSC Administrative Services Contractor will enroll and disenroll eligible individuals in the MCO Program. The HHSC Administrative Services Contractor will use HHSC's default assignment methodologies, as described in 1 Tex. Admin. Code § 353.403 and § 370.303, to enroll individuals who do not select an MCO or PCP. To enroll in an MCO, the Member's permanent residence must be located within the MCO's Service Area. The MCO is not allowed to induce or accept disenrollment from a Member. The MCO must refer the Member to the HHSC Administrative Services Contractor.

(b) 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 such enrolling Members 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.

(c) The HHSC Administrative Services Contractor will electronically transmit to the MCO new Member information and change information applicable to active Members.

(d) In cases where a Member loses Medicaid eligibility, if Medicaid eligibility is re-instated or re-

established within six months from the date of loss, HHSC will retroactively restore a Member's managed care enrollment to avoid a gap in coverage. In these cases, the HHSC Administrator Services Contractor will retroactively enroll the Member into the same MCO the Member was in before losing coverage. The retro-enrolled Members will be sent on a daily file to the MCO and the MCO must upload the daily Enrollment File into its system within 24 hours of receipt.

(e) As described in the following Sections, depending on the MCO Program, special conditions may also apply to enrollment and span of coverage for the MCO.

(f) A Medicaid MCO has a limited right to request a Member be disenrolled from MCO without the Member's consent. HHSC must approve any MCO request for disenrollment of a Member for cause. MCO must take reasonable 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 may permit disenrollment of a Member 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 MCO's or Provider's ability to provide services to either the Member or other Members, and Member's behavior is not related to a developmental, intellectual, or physical disability or Behavioral Health condition.

(3) Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow MCO to treat the underlying medical condition).

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

(h) If the Member disagrees with the decision to disenroll the Member from MCO, HHSC must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's State Fair Hearing process.

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

(j) Members taken into conservatorship by the Department of Family and Protective Services (DFPS) will be disenrolled from the MCO effective the date of conservatorship and enrolled in the STAR Health Program unless otherwise determined by DFPS.

Section 5.03 ***STAR enrollment for pregnant women and infants.***

(a) The HHSC Administrative Services Contractor will retroactively enroll some pregnant Members in a Medicaid MCO based on their date of eligibility. The retro-enrolled Members will be sent on a daily file to the MCO and the MCO must upload the daily Enrollment File into its system within 24 hours of receipt.

(b) The HHSC Administrative Services Contractor will enroll newborns born to Medicaid eligible mothers who are enrolled in a STAR MCO in the same MCO for at least 90 Days following the date of birth, unless the mother requests a plan change as a special exception. The HHSC Administrative Service Contractor will consider such requests on a case-by-case basis. The HHSC Administrative Services Contractor will retroactively, to date of birth, enroll newborns in the applicable STAR MCO. The retro-enrolled Members will be sent on a daily file to the MCO and the MCO must upload the daily Enrollment File into its system within 24 hours of receipt.

Section 5.03.1 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, the HHSC Administrative Service Contractor will enroll the newborn into that MCO's STAR MCO product, if one (1) exists. All rules related to STAR newborn enrollment will apply to the newborn. 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 Fee-for-Service Medicaid and given the opportunity to select a STAR MCO.

Section 5.04 ***CHIP eligibility, enrollment, and disenrollment.***

(a) Term of coverage.

HHSC or the HHSC Administrative Services Contractor, on HHSC's behalf, determines CHIP eligibility. HHSC or the HHSC Administrative Services Contractor will enroll and disenroll eligible individuals into and out of CHIP. Should a Member become ineligible for CHIP, HHSC will disenroll the Member from the managed care plan. If an MCO becomes aware that a Member is no longer CHIP-eligible, for example the Member has moved outside of the state or is deceased, or that Member has moved outside of the MCOs Service Area, the MCO must inform HHSC within five Business Days.

(b) Pregnant Members and Infants.

(1) HHSC or the HHSC Administrative Contractor will refer pregnant CHIP Members, with the exception of Legal Permanent Residents and other legally qualified aliens barred from Medicaid due to federal eligibility restrictions, to Medicaid for eligibility determinations. Those CHIP Members who are determined to be Medicaid Eligible will be disenrolled from the MCO's CHIP plan. Medicaid coverage will be coordinated to begin after CHIP eligibility ends to avoid gaps in health care coverage.

(2) In the event the MCO remains unaware of a CHIP Member's pregnancy until delivery, the facility and professional costs associated with the delivery will be covered by CHIP in accordance with Attachment B-1.1, "CHIP Covered Services." This includes the post-delivery costs for the newborn's care while in the facility, as described in Attachment B-1.1, "CHIP Covered Services.," HHSC or the HHSC Administrative Services Contractor will set a pregnant CHIP mother's eligibility expiration date at the later of (1) the end of the second month following the month of the pregnancy delivery or the pregnancy termination or (2) the Member's original eligibility expiration date.

HHSC or the Administrative Services Contractor will screen the newborn's eligibility for Medicaid, and then CHIP (if the newborn is not eligible for Medicaid). If the newborn is eligible for CHIP, the Administrative Services Contractor will enroll the newborn in the mother's CHIP plan prospectively, following standard cut-off rules. The newborn's CHIP eligibility ends when the mother's CHIP eligibility expires, as described above.

Section 5.05 ***CHIP Perinatal eligibility, enrollment, and disenrollment***

(a) HHSC or the HHSC Administrative Contractor will electronically transmit to the MCO new CHIP Perinate Member information based on the appropriate CHIP Perinate or CHIP Perinate Newborn Rate Cell. There is no waiting period for CHIP Perinatal Program Members.

(b) Once born, a CHIP Perinate who lives in a family with an income at or below the Medicaid eligibility threshold will be deemed eligible for 12 months of continuous Medicaid coverage (beginning on the date of birth). A CHIP Perinate will continue to receive coverage through the CHIP Perinatal Program as a "CHIP Perinate Newborn" after birth if the child's family income is above the Medicaid eligibility threshold. A CHIP Perinate Newborn is eligible for 12 months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal MCO.

(c) Once a CHIP Perinate Newborn Member's coverage expires, the child will be added to his or her siblings' active CHIP program case. If there is no active CHIP program case, then in the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Program Members' information.

Section 5.06 ***Span of Coverage***

(a) Medicaid MCOs.

(1) Open Enrollment.

HHSC will conduct continuous open enrollment for Medicaid Eligibles and 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 health status or any other factor.

(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 the 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, or (2) date of Transfer, or (3) loss of Medicaid eligibility.

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

(3) Enrollment Changes Due to SSI Status.

When an adult STAR Member becomes qualified for SSI, the Member will move to STAR+PLUS or the Dual Demonstration. When a child STAR Member becomes qualified for SSI, the Member will move to FFS or STAR Kids. Section 5.06(c) describes how HHSC will determine the effective date of the Member's SSI status.

(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.

(5) Responsibility for Costs Incurred After Loss of Medicaid Eligibility.

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

(6) Reenrollment 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.

(7) Enrollment Changes during a Chemical Dependency Treatment Facility (CDTF) Stay.

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

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

The responsible party will pay the CDTF charge until the earlier of: (1) date of discharge from the CDTF, or (2) loss of Medicaid eligibility. The New MCO may evaluate for medical necessity of the CDTF stay prior to the end of the authorized services period.

(8) 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.

(9) Enrollment Changes During a Nursing Facility Stay.

The following table describes payment responsibility for Medicaid enrollment changes that occur during a Nursing Facility 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

	Scenario	Nursing Facility Unit Rate and/or Medicare Coinsurance	All Other Covered Services
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

(10) Enrollment Changes with Custom DME and Augmentative Device Prior Authorization

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

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

(11) Enrollment Changes with Home Modification

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

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

(b) CHIP MCOs.

If a CHIP Program or CHIP Perinatal Program Member's Effective Date of Coverage occurs while the Member is confined in a Hospital, the MCO is responsible for the Member's costs of Covered Services beginning on the Effective Date of Coverage. If a Member is disenrolled while the Member is confined in a Hospital, the MCO's responsibility for the Member's costs of Covered Services terminates on the Date of Disenrollment.

(c) Effective Date of SSI Status.

In accordance with **Section 8.2.12**, 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 Federal SSI status by the Social Security Administration (SSA). Once HHSC has updated the 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.

Section 5.07 *Verification of Member Eligibility.*

Medicaid 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.

Section 5.08 *Modified Default Enrollment Process*

Under the circumstances described in HHSC's administrative rules at 1 Tex. Admin. Code § 353.403 and 1 Tex. Admin. Code § 370.303, HHSC may implement a modified default enrollment process to equitably assign enrollees who have not selected an MCO. To the extent possible, HHSC will make assignments based on an enrollee's prior history with and geographic proximity to a PCP. HHSC will determine the length of the modified default enrollment period by considering factors such as MCO market share, viability, and Member Choice. HHSC reserves the right to extend the modified default period or implement additional modified default periods as it determines necessary and with prior written notice to impacted MCOs.

Section 5.09 ***This Section Intentionally Left Blank***

Section 5.10 ***This Section Intentionally Left Blank***

Section 5.11 ***This Section Intentionally Left Blank***

Article 6. Service Levels & Performance Measurement

Section 6.01 *Performance measurement.*

Satisfactory performance of this Contract will be measured by:

(a) Adherence to this Contract, including all representations and warranties;

(b) Delivery of the Services and Deliverables;

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

(d) Timeliness, completeness, and accuracy of required reports; and

(e) Achievement of performance measures developed by MCO and HHSC and as modified from time to time by written agreement during the term of this Contract.

Article 7. Governing Law & Regulations

Section 7.01 *Governing law and venue.*

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

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

(a) MCO must comply, to the satisfaction of HHSC, with all provisions set forth in this Contract, all provisions of state and federal laws, rules, regulations, federal waivers, policies and guidelines, and any court-ordered consent decrees, settlement agreements, or other court orders that govern the performance of the Scope of Work including, but not limited to, all of the following:

(1) Titles XIX and XXI of the Social Security Act;

(2) Chapters 62 and 63, Texas Health and Safety Code;

(3) Chapters 531 and 533, Texas Government Code;

(4) 42 C.F.R. Parts 417, 438, 455, and 457, as applicable;

(5) 45 C.F.R. Parts 74 and 92;

(6) 48 C.F.R. Part 31 and 2 C.F.R. Part 200;

(7) 1 Tex. Admin. Code Part 15, Chapters 361, 370, 371, 391, and 392;

(8) Consent Decree and Corrective Action Orders, *Frew, et al. v. Smith, et al.*, (applies to Medicaid MCOs only);

(9) Texas Human Resources Code Chapters 32 and 36;

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

(11) 1 Tex. Admin. Code Chapter 353;

(12) 1 Tex. Admin. Code Chapter 354, Subchapters B, J, and F, with the exception of the following provisions in Subchapter F: 1 Tex. Admin. Code § 354.1865, § 354.1867, § 354.1873, and Division 6, "Pharmacy Claims; and §354.3047:

(13) 1 Tex. Admin. Code Chapter 354, Subchapters I and K, as applicable;

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

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

(16) Clinical Laboratory Improvement Amendments (CLIA, 42 C.F.R. Part 493) (for purposes of the Contract, the MCO must require its Providers to agree that the MCO and HHSC are "authorized persons");

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

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

(19) An MCO is prohibited from requiring a Network Provider who is a governmental entity to agree to indemnify the MCO if such indemnification by the governmental entity is prohibited by law.

(b) The Parties acknowledge that the federal and/or state laws, rules, regulations, policies, or guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that affect the performance of the Scope of Work may change from time to time or be added, judicially interpreted, or amended by competent authority. MCO acknowledges that the MCO Programs will be subject to continuous change during the term of the Contract and, except as provided in Section 8.02, MCO has provided for or will provide for adequate

resources, at no additional charge to HHSC, to reasonably accommodate such changes. The Parties further acknowledge that MCO was selected, in part, because of its expertise, experience, and knowledge concerning applicable Federal or state laws, regulations, policies, or guidelines that affect the performance of the Scope of Work. In keeping with HHSC's reliance on this knowledge and expertise, MCO is responsible for identifying the impact of changes in applicable Federal or state legislative enactments and regulations that affect the performance of the Scope of Work or the State's use of the Services and Deliverables. MCO must timely notify HHSC of such changes and must work with HHSC to identify the impact of such changes.

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

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

(e) MCO is responsible for any fines, penalties, or disallowances imposed on the State or MCO arising from any noncompliance with the laws and regulations relating to the delivery of the Services or Deliverables by the MCO, its Subcontractors or agents.

(f) MCO is responsible for ensuring each of its employees, agents or Subcontractors who provide Services under the Contract is properly licensed, certified, and/or has proper permits to perform any activity related to the Services.

(g) MCO warrants that the Services and Deliverables will comply with all applicable Federal, State, and County laws, regulations, codes, ordinances, guidelines, and policies. MCO will indemnify HHSC from and against any losses, liability, claims, damages, penalties, costs, fees, or expenses arising from or in connection with MCO's failure to comply with or violation of any such law, regulation, code, ordinance, or policy.

Section 7.03 ***This Section Intentionally Left Blank***

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

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

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

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

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

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

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

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

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

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

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

have meaningful access to programs, benefits, and activities.

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

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

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

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

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

Section 7.05 ***Environmental protection laws.***

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

(a) Pro-Children Act of 1994.

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

(b) National Environmental Policy Act of 1969.

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

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

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

(d) State Clean Air Implementation Plan.

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

(e) Safe Drinking Water Act of 1974.

MCO must comply with applicable provisions relating to the protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (21 U.S.C. § 349; 42 U.S.C. §§ 300f to 300j-9).

Section 7.06 ***HIPAA.***

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

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

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

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

(e) The MCO must comply with rights of individual access by a Member or a Member's Legally Authorized Representative to Member's protected health information. The MCO may permit limited disclosures of protected health information as permissible under HIPAA for a family member, other relative, or close personal friends of the Member or anyone identified in the Member's protected health information directly relevant to the Member's

involvement with the Member's healthcare or payment related to the Member's healthcare. The MCO should refer to 45 C.F.R. § 164.510(b) and related regulatory guidance for additional information.

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

(a) Definitions.

For purposes of this Section:

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

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

(b) HUB Requirements.

(1) In accordance with Attachment B-1, Section 8.1.20.2, the MCO must submit an HSP for HHSC's approval during the Transition Phase and maintain the HSP thereafter.

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

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

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

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

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

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

Article 8. Amendments & Modifications

Section 8.01 ***Mutual agreement.***

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

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

If Federal or State laws, rules, regulations, policies or guidelines are adopted, promulgated, judicially interpreted or changed, or if contracts are entered or changed, the effect of which is to alter the ability of either Party to fulfill its obligations under this Contract, the Parties will promptly negotiate in good faith appropriate modifications or alterations to the Contract. Such modifications or alterations must be in writing and signed by individuals with authority to bind the parties, equitably adjust the terms and conditions of this Contract, and must be limited to those provisions of this Contract affected by the change.

Section 8.03 ***Modifications as a remedy.***

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

Section 8.04 ***Modification Process.***

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

(b) MCO must respond to HHSC's proposed modification within the timeframe specified by HHSC, generally within 10 Business Days of receipt. Upon receipt of MCO's response to the proposed modifications, HHSC may enter into negotiations with MCO to arrive at mutually agreeable Contract amendments. In the event that HHSC determines that the Parties will be unable to reach agreement on mutually satisfactory contract modifications, then HHSC will provide written notice to MCO of its intent terminate the Contract, or not to extend the Contract beyond the current Contract Term.

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

(a) HHSC will provide MCO with at least 10 Business Days advance written notice before implementing a substantive and material change in

the UMCM, a change that materially and substantively alters the MCO's ability to fulfill its obligations under the Contract. The UMCM, and all modifications thereto made during the Contract Term, are incorporated by reference into this Contract. HHSC will provide MCO with a reasonable amount of time to comment on such changes, generally at least five Business Days. HHSC is not required to provide advance written notice of changes that are not material and substantive in nature, such as corrections of clerical errors or policy clarifications.

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

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

Section 8.06 ***CMS approval of amendments***

Amendments, modifications, and changes to the Contract are subject to the approval of the Centers for Medicare and Medicaid Services ("CMS.")

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

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

Article 9. Audit & Financial Compliance and Litigation Hold

Section 9.01 ***Record retention and audit.***

The State, CMS, the OIG, the Comptroller, the Attorney General and their designees have the right to investigate, audit, inspect, and review complete and unredacted originals or copies of all records and information related to this Contract of the MCO or to contracts between the MCO and MCO's Subcontractors for ten years from the final date of the Contract Period or from the date of any audit, whichever is later.

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

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

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

This Article survives any termination or expiration of the Contract.

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

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

(b) MCO and its Subcontractors must provide the access described in this Section upon HHSC's request. This request may be for, but is not limited to, the following purposes:

(1) examination;

(2) audit;

(3) investigation;

(4) inspection

(5) contract administration; or

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

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

(1) The United States Department of Health and Human Services or its designee;

(2) The Comptroller General of the United States or its designee;

(3) MCO Program personnel from HHSC or its designee;

(4) The Office of Inspector General;

(5) The Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;

(6) Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC;

(7) The Office of the State Auditor of Texas or its designee;

(8) A State or Federal law enforcement agency;

(9) A special or general investigating committee of the Texas Legislature or its designee; and

(10) Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

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

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

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

Section 9.03 ***Audits of Services, Deliverables and inspections.***

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

(1) service locations, facilities, or installations;

(2) complete and unredacted originals or copies of all records and information related to this Contract; and

(3) Software and Equipment.

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

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

(1) MCO's capacity to bear the risk of potential financial losses;

(2) the Services and Deliverables provided;

(3) a determination of the amounts payable under this Contract;

(4) a determination of the allowability of costs reported under this Contract;

(5) an examination of Subcontract terms and/or transactions;

(6) an assessment of financial results under this Contract;

(7) detection of Fraud, Waste, or Abuse; or

(8) other purposes HHSC deems necessary to perform its oversight function and/or enforce the provisions of this Contract.

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

(d) If, as a result of an investigation, audit, inspection, or review of payments made to the MCO, HHSC discovers a payment error or overcharge, HHSC will notify the MCO of such error or overcharge. HHSC will be entitled to recover such funds as an offset to future payments to the MCO, or to collect such funds directly from the MCO. MCO must return funds owed to HHSC within 30 Days after receiving notice of the error or overcharge, or interest will accrue on the amount due. HHSC will calculate interest at 12% per annum, compounded daily. In the event that an audit reveals that errors in reporting by the MCO have resulted in errors in payments to the MCO or errors in the calculation of the Experience

Rebate, the MCO will indemnify HHSC for any losses resulting from such errors, including the cost of the investigation, audit, inspection, or review. If the interest rate stipulated hereunder is found by a court of competent jurisdiction to be outside the range deemed legal and enforceable, then the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

Section 9.04 ***SAO Audit***

The MCO understands that acceptance of funds under this Contract acts as acceptance of the authority of the State Auditor's Office ("SAO"), or any successor agency, to conduct an investigation in connection with those funds. The MCO further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested at no cost. The MCO will ensure that this clause concerning the authority to audit funds and the requirement to cooperate is included in any Subcontract, and in any third party agreements described in **Section 4.10**, "MCO Agreements with Third Parties."

Section 9.05 ***Response/compliance with findings.***

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

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

(1) Required by Texas or Federal law, regulation, rule, court order, or other audit requirement relating to MCO's business;

(2) Performed by MCO as part of the Scope of Work; or

(3) Necessary due to MCO's noncompliance with any law, regulation, rule, court order, or audit requirement imposed on MCO.

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

Section 9.06 ***Notification of Legal and Other Proceedings, and Related Events.***

The MCO must notify HHSC of all proceedings, reports, documents, actions, and events as specified in UMCM Chapter 5.

Article 10. Terms & Conditions of Payment

Section 10.01 ***Calculation of monthly Capitation Payment.***

(a) This is a Risk-based contract. For each applicable MCO Program, HHSC will pay the MCO fixed monthly Capitation Payments based on the number of eligible enrolled Members. HHSC will calculate the monthly Capitation Payments by multiplying the number of Members in each Rate Cell category by the Capitation Rate for each Rate Cell. In consideration of the Monthly Capitation Payments, the MCO agrees to provide the Services and Deliverables described in this Contract.

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

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

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

(1) an amount for Health Care Services performed during the month;

(2) an amount for administering the MCO Program;

(3) an amount for the MCO's Risk margin, and

(4) an amount for NEMT Services provided during the month.

Capitation Rates for each MCO Program may vary by Service Area and MCO. HHSC will employ or retain qualified actuaries to perform data analysis and calculate the Capitation Rates for each Rate Period.

(e) MCO understands and expressly assumes the risks associated with the performance of the

duties and responsibilities under this Contract, including the failure, termination or suspension of funding to HHSC, delays or denials of required approvals, and cost overruns not reasonably attributable to HHSC.

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

(a) During the Contract Term and beginning after the Operational Start Date, HHSC will pay the monthly Capitation Payments by the 10th Business Day of each month.

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

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

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

(1) equitably adjust Capitation Payments for all participating MCOs, and reduce scope of service requirements as appropriate in accordance with **Article 8**, "Amendments and Modifications,"

(2) terminate the Contract in accordance with **Article 12**, "Remedies and Disputes."

Section 10.03 ***Certification of Capitation Rates.***

HHSC will employ or retain a qualified actuary to certify the actuarial soundness of the Capitation Rates, and all revisions or modifications thereto.

Section 10.04 ***Modification of Capitation Rates.***

The Parties expressly understand and agree that the agreed Capitation Rates are subject to modification in accordance with **Article 8**, "Amendments and Modifications," if changes in state or federal laws, rules, regulations, guidelines, policies, or court orders affect the rates or the actuarial soundness of the rates. HHSC will provide the MCO notice of a modification to the Capitation Rates at least 60 Days prior to the effective date of the change, unless HHSC determines that circumstances warrant a shorter notice period. If the MCO does not accept the rate change, either Party may terminate the Contract in accordance with **Article 12**, "Remedies and Disputes."

Section 10.05 ***STAR and STAR+PLUS Capitation Structure.***

(a) STAR Rate Cells.

STAR Capitation Rates are defined on a per Member per month basis by Rate Cells and Service Areas. STAR Rate Cells are:

(1) Under Age 1 Child;

(2) Age 1-5 Child;

(3) Age 6-14 Child;

(4) Age 15-18 Child;

(5) Age 19-20 Child;

(6) TANF adults; and

(7) Pregnant women.

These Rate Cells are subject to change.

(b) STAR+PLUS Rate Cells.

STAR+PLUS Capitation Rates are defined on a per Member per month basis by Rate Cells. STAR+PLUS Rate Cells are based on client category as follows:

(1) Medicaid Only Standard Rate

(2) Medicaid Only HCBS STAR+PLUS Waiver Rate – Above Floor

(3) Medicaid Only HCBS STAR+PLUS Waiver Rate – Below Floor

(4) Dual Eligible Standard Rate

(5) Dual Eligible HCBS STAR+PLUS Waiver Rate – Above Floor

(6) Dual Eligible HCBS STAR+PLUS Waiver Rate – Below Floor

(7) Nursing Facility – Medicaid only

(8) Nursing Facility - Dual Eligible

(9) Individuals with Developmental Disabilities (IDD) – under age 21

(10) Individuals with Developmental Disabilities (IDD) – age 21 and older

These Rate Cells are subject to change.

(c) STAR and STAR+PLUS Capitation Rate development:

(1) Capitation Rates for Service Areas with historical Medicaid MCO Program participation.

For Service Areas where HHSC operated a Medicaid MCO Program prior to the Effective Date of this Contract, HHSC will develop base Capitation Rates by analyzing the Medicaid MCO Program's historical Encounter Data and financial data for the Service Area (e.g., Capitation Rates for the STAR Program will be based on STAR Program historical Encounter Data and financial data for the Service Area). This analysis will apply to all MCOs in the Service Area, including MCOs that have no historical participation in the Medicaid MCO Program in Service Area. The analysis will include a review of historical enrollment and claims experience information; any

changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information. If the MCO participated in the Medicaid MCO Program in the Service Area prior to the Effective Date of this Contract, HHSC may modify the Service Area base Capitation Rates using diagnosis-based risk adjusters to yield the final Capitation Rates.

(2) Capitation Rates for Rate Periods 1 and 2 for Service Areas with no historical STAR Program participation.

For Service Areas where HHSC has not operated a Medicaid MCO Program prior to the Effective Date of this Contract, HHSC will establish base Capitation Rates for Rate Periods 1 and 2 by analyzing Fee-for-Service claims data for the Medicaid MCO Program and Service Area (e.g., Capitation Rates for the STAR Program will be based fee-for-service data in the Service Area). This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information.

(3) Capitation Rates for subsequent Rate Periods for Service Areas with no historical STAR Program participation.

For Service Areas where HHSC has not operated a Medicaid MCO Program prior to the Effective Date of this Contract, HHSC will establish base Capitation Rates for the Rate Periods following Rate Period 2 by analyzing the Medicaid MCO Program's historical Encounter Data and financial data for the Service Area. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information.

(d) Acuity adjustment.

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 Service Area and is determined by combining all the experience for all MCOs in a Service Area to get an average rate for the Service Area.

(e) Value-added Services.

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

(f) Case-by-case services.

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

(g) Delay in Increased STAR+PLUS Capitation Level for Certain Members Receiving Waiver Services Once a current STAR+PLUS MCO Member has been certified to receive STAR+PLUS Waiver (SPW) services, there is a two (2) 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 (2) month delay in the increased capitation payment.

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.

Section 10.06 ***CHIP Capitation Rates Structure.***

(a) CHIP Rate Cells.

CHIP Capitation Rates are defined on a per Member per month basis by the Rate Cells applicable to a Service Area. CHIP Rate Cells are based on the Member's age group as follows:

(1) under age 1;

(2) ages 1 through 5;

(3) ages 6 through 14; and

(4) ages 15 through 18.

(b) CHIP Perinatal Program Rate Cells.

CHIP Perinatal Capitation Rates are defined on a per Member per month basis by the Rate Cells applicable to a Service Area. CHIP Perinatal Rate Cells are based on the Member's birth status and household income as follows:

(1) CHIP Perinate at or Below Medicaid Eligibility Threshold (an unborn child who will qualify for Medicaid once born);

(2) CHIP Perinate Above Medicaid Eligibility Threshold (an unborn child who will not qualify for Medicaid once born); and

(3) CHIP Perinate Newborn Above Medicaid Eligibility Threshold (newborn that does not qualify for Medicaid).

(c) CHIP and CHIP Perinatal Program Capitation Rate development:
HHSC will establish base Capitation Rates by analyzing Encounter Data and financial data for each

Service Area. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information. HHSC may modify the Service Area base Capitation Rate using diagnosis based risk adjusters to yield the final Capitation Rates.

(d) Acuity adjustment.

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 Service Area and is determined by combining all the experience for all MCOs in a Service Area to get an average rate for the Service Area.

(e) Value-added Services.

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

(f) Case-by-case services.

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

Section 10.07 ***MCO input during rate setting process.***

(a) In Service Areas with historical STAR or STAR+PLUS Program participation, MCO must provide certified Encounter Data and financial data as prescribed in UMCM Chapter 5. Such information may include, without limitation: claims lag information by Rate Cell, capitation expenses, and stop loss reinsurance expenses. HHSC may request clarification or for additional financial information from the MCO. HHSC will notify the MCO of the deadline for submitting a response, which will include a reasonable amount of time for response.

(b) HHSC will allow the MCO to review and comment on data used by HHSC to determine base Capitation Rates. In Service Areas with no historical STAR or STAR+PLUS Program participation, this will include Fee-for-Service data for Rate Periods 1 and 2. HHSC will notify the MCO of deadline for submitting comments, which will include a reasonable amount of time for response. HHSC will not consider comments received after the deadline in its rate analysis.

(c) During the rate setting process, HHSC will conduct at least two (2) meetings with the MCOs. HHSC may conduct the meetings InPerson, via teleconference, or by another method deemed appropriate by HHSC. Prior to the first meeting, HHSC will provide the MCO with proposed Capitation Rates. During the first meeting, HHSC will describe the process used to generate the proposed Capitation Rates, discuss major changes in the rate setting process, and receive input from the MCO. HHSC will notify the MCO of the deadline for submitting comments, which will include a reasonable amount of time to review and comment on the proposed Capitation Rates and rate setting process. After reviewing such comments, HHSC will conduct a second meeting to discuss the final Capitation Rates and changes resulting from MCO comments, if any.

Section 10.08 ***Adjustments to Capitation Payments.***

(a) Adjustment.

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

(1) a Member's eligibility status or program type is changed, corrected as a result of error, or is retroactively adjusted;

(2) the Member is enrolled into the MCO in error;

(3) the Member moves outside the United States;

(4) the Member dies before the first Day of the month for which the payment was made; or

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

(b) Appeal of adjustment.

The MCO may appeal the adjustment of capitations in the above circumstances using the HHSC dispute resolution process set forth in **Section 12.13**, "Dispute Resolution."

Section 10.09 ***Delivery Supplemental Payment for CHIP, CHIP Perinatal and STAR MCOs.***

(a) The Delivery Supplemental Payment (DSP) is a function of the average delivery cost in each Service Area. Delivery costs include facility and professional charges.

(b) CHIP and STAR MCOs will receive a Delivery Supplemental Payment (DSP) from HHSC for each live or stillbirth by a Member. CHIP Perinatal MCOs will receive a DSP from HHSC for each live or stillbirth of a CHIP Perinate above the Medicaid eligibility threshold (i.e., a Perinate who does not qualify for Medicaid once born, measured at the time of enrollment in the CHIP Perinatal subprogram). CHIP Perinatal MCOs will not receive a DSP from HHSC for a live or stillbirth of a CHIP Perinate at or below the Medicaid eligibility threshold (i.e., a Perinate who qualifies for Medicaid once born). For

STAR and CHIP and CHIP Perinatal Program MCOs, the one-time DSP payment is made in the amount identified in the **HHSC Managed Care Contract** document regardless of whether there is a single birth or there are multiple births at time of delivery. A delivery is the birth of a live born infant, regardless of the duration of the pregnancy, or a stillborn (fetal death) infant of 20 weeks or more of gestation. A delivery does not include a spontaneous or induced abortion, regardless of the duration of the pregnancy.

(c) MCO must submit a monthly DSP Report in the format prescribed in UMCM Chapter 5.

(d) HHSC will pay the Delivery Supplemental Payment within 20 Business Days after receipt of a complete and accurate report from the MCO.

(e) The MCO will not be entitled to Delivery Supplemental Payments for deliveries that are not reported to HHSC within 300 Days after the date of delivery, or within 30 Days from the date of discharge from the Hospital for the stay related to the delivery, whichever is later.

(f) MCO must maintain complete claims and adjudication disposition documentation, including paid and denied amounts for each delivery. The MCO must submit the documentation to HHSC within five Business Days after receiving a request for such information from HHSC.

Section 10.10 ***Experience Rebate***

(a) MCO's duty to pay.

(1) General.

At the end of each FSR Reporting Period beginning with FSR Reporting Period 12/13, 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 set forth below. The Net Income Before Taxes and the total Revenues are as measured by the FSR, as reviewed and confirmed by HHSC. The final amount used in the calculation of the percentage may be impacted by various factors herein, including the Loss Carry Forward, the Admin Cap, and/or the Reinsurance Cap.

(2) Basis of Consolidation.

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

(b) Graduated Experience Rebate Sharing Method.

For the limited period beginning September 1, 2021, through August 31, 2023, the following Graduated Experience Rebate Sharing Method will be utilized to calculate the Experience Rebate:

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

HHSC and the MCO will share the consolidated Net Income Before Taxes for its HHSC Programs as follows:
(1) The MCO will retain all the Net Income Before Taxes that is equal to or less than 3% of the total Revenues received by the MCO;
(2) HHSC and the MCO will share that portion of the Net Income Before Taxes that is over 3% and less than or equal to 5% of the total Revenues received, with 80% to the MCO and 20% to HHSC.
(3) HHSC will be paid the entire portion of the Net Income Before Taxes that exceeds 5% of the total Revenues.

Beginning September 1, 2023, the Graduated Experience Rebate Sharing Method will revert to the following:

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

HHSC and the MCO will share the consolidated Net Income Before Taxes for its HHSC Programs as follows:

(1) The MCO will retain all the Net Income Before Taxes that is equal to or less than 3% of the total Revenues received by the MCO;

(2) HHSC and the MCO will share that portion of the Net Income Before Taxes that is over 3% and less than or equal to 5% of the total Revenues received, with 80% to the MCO and 20% to HHSC.

(3) HHSC and the MCO will share that portion of the Net Income Before Taxes that is over 5% and less than or equal to 7% of the total Revenues received, with 60% to the MCO and 40% to HHSC.

(4) HHSC and the MCO will share that portion of the Net Income Before Taxes that is over 7% and less than or equal to 9% of the total Revenues received, with 40% to the MCO and 60% to HHSC.

(5) HHSC and the MCO will share that portion of the Net Income Before Taxes that is over 9% and less than or equal to 12% of the total Revenues received, with 20% to the MCO and 80% to HHSC.

(6) HHSC will be paid the entire portion of the Net Income Before Taxes that exceeds 12% of the total Revenues.

(c) Net income Before taxes.

(1) The MCO must compute the Net Income Before Taxes in accordance with applicable federal regulations, UMCM Chapters 5 and 6, and similar such instructions for other HHSC Programs. The Net Income Before Taxes will be confirmed by HHSC or its agent for the FSR Reporting Period relating to all Revenues and Allowable Expenses incurred pursuant to the Contract. HHSC reserves the right to modify the "Cost Principles for Expenses" and "FSR Instructions for Completion" found in the UMCM in accordance with **Section 8.05**, "Modification of the Uniform Managed Care Manual."

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

(i) the payment of an Experience Rebate;

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

(iii) financial incentives, including without limitation any incentives described in **Attachment B-1**, Section 6.3.2; and

(iv) financial disincentives, including without limitation: the Performance-based Capitation Rate Program described in **Attachment B-1**, Section 6.3.2.2; and

(v) liquidated damages, and any interest expense associated, as described in **Attachment B-3**.

See UMCM Chapter 6.

(3) Financial incentives will not be reduced by potential increased Experience Rebate payments. Financial disincentives will not be offset in whole or part by potential decreases in Experience Rebate payments.

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

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

(1) General.

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. Any such prior losses may be carried forward for the next two contiguous FSR Reporting Periods.

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

Carrying forward of losses may be impacted by the Admin Cap; see Section 10.10.2 (f) below.

Losses incurred in the last or next-to-last FSR Reporting Period of a prior contiguous contract with HHSC may be carried forward up to two FSR Reporting Periods into the first or potentially second FSR Reporting Period of this Contract, if such losses meet all other requirements of both the prior and current contracts.

(2) Basis of consolidation.

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

(e) Settlements for payment.

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

The "Primary Settlement," as utilized herein, 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 such case, this initial payment would be subsequent to the Primary Settlement.

(2) The next scheduled payment will be an adjustment to the Primary Settlement, if required, and will be paid on the same Day that the 334-Day FSR Report is submitted to HHSC if the adjustment is a payment from the MCO to HHSC. Section 10.10(f) describes the interest expenses associated with any payment after the Primary Settlement.

An MCO may make non-scheduled payments at any time to reduce the accumulation of interest under Section 10.10(f). For any nonscheduled payments prior to the 334-Day FSR, the MCO is not required to submit a revised FSR, but is required to submit an Experience Rebate calculation form and an adjusted summary page of the FSR. The FSR summary page is labeled "Summary Income Statements (Dollars), All Coverage Groups Combined (FSR, Part I)."

(3) HHSC or its agent may audit or review the FSRs. If HHSC determines that corrections to the FSRs are required, based on an HHSC audit/review or other documentation acceptable to HHSC, then HHSC will make final adjustments. Any payment resulting from an audit or final adjustment will be due from the MCO within 30 Days of the earlier of:

(i) the date of the management representation letter resulting from the audit; or

(ii) the date of any invoice issued by HHSC.

Payment within this 30-Day timeframe will not relieve the MCO of any interest payment obligation that may exist under Section 10.10(f).

(4) In the event that any Experience Rebates and/or corresponding interest payments owed to the State are not paid by the required due dates, then HHSC may offset such amounts from any future Capitation Payments or collect such 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, or allowable in accordance with UMCM Chapter 6, UMCM Chapter 5, and the Federal Acquisition Regulations (FAR), or other applicable federal or state regulations. HHSC has final authority in auditing and determining the amount of the Experience Rebate.

(f) Interest on Experience Rebate.

(1) Interest on *any* Experience Rebate owed to HHSC will be charged beginning 35 Days after the due date of the Primary Settlement, as described in Section 10.10(e)(1). Thus, any Experience Rebate due or paid on or after the Primary Settlement will accrue interest starting at 35 Days after the due date for the 90-Day FSR Report. For example, any Experience Rebate payment (s) made in conjunction with the 334-Day FSR, or as a result of audit findings, will accrue interest back to 35 Days after the due-date for submission of the 90-Day FSR.

The MCO has the option of preparing an additional FSR based on 120 Days of claims run-out (a "120- Day FSR"). If a 120-Day FSR, and an Experience Rebate payment based on it, are received by HHSC before the interest commencement date above, then such a payment would be counted as part of the Primary Settlement.

(2) If an audit or adjustment determines a downward revision of income after an interest payment has previously been required for the same State Fiscal Year, then HHSC will recalculate the interest and, if necessary, issue a full or partial refund or credit to the MCO.

(3) Any interest obligations that are incurred pursuant to Section 10.10 that are not timely paid will be subject to accumulation of interest as well, at the same rate as applicable to the underlying Experience Rebate.

(4) All interest assessed pursuant to Section 10.10 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 45 Days after the start of interest, then the $75,000 will be subject to 45 Days of interest, and the $25,000 balance will continue to accrue interest until paid. The accrual of interest as defined under Section 10.10(f) will not stop during any period of dispute. If a dispute is resolved in the MCO's favor, then interest will only be assessed on the revised unpaid amount.

(5) If the MCO incurs an interest obligation pursuant to Section 10.10 for an Experience Rebate payment-HHSC will assess such interest at 12% per annum, compounded daily. If any interest rate stipulated hereunder is found by a court of competent jurisdiction to be outside the range deemed legal and enforceable, then the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

(6) Any such interest expense incurred pursuant to Section 10.10 is not an Allowable Expense for reporting purposes on the FSR.

Section 10.10.1 This Section Intentionally Left Blank

Section 10.10.2 Administrative Expense Cap.

(a) General requirement.

The calculation methodology of Experience Rebates described in Section 10.10 will be adjusted by an Administrative Expense Cap ("Admin Cap.") The Admin Cap is a calculated maximum amount of administrative expense dollars that can be deducted from Revenues for purposes of determining income subject to the Experience Rebate. While Administrative Expenses may be limited by the Admin Cap to determine Experience Rebates, all valid Allowable Expenses will continue to be reported on the Financial Statistical Reports (FSRs). Thus, the Admin Cap does not impact FSR reporting, but may impact any associated Experience Rebate calculation.

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

Such limitations will be calculated as follows:

(b) Calculation methodology.

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

If rates are changed during the FSR Reporting Period, HHSC will use this same methodology of multiplying the predetermined HHSC rates for a given month against the ultimate actual number of Member Months or Revenues that occurred during that month, such that HHSC will apply each month's actual results against the rates that were in effect for that month.

(c) Data sources.

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

(1) The total premiums paid by HHSC (received by the MCO), and corresponding Member Months, will be taken from the relevant FSR (or audit report) for the FSR Reporting Period.

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

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

(ii) the dollar rate per Member Month (the "fixed amount" within the administrative expenses); and

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

These will be taken from the supporting details associated with the official notification of final Capitation Rates, as supplied by HHSC. This notification is sent to the MCOs during the annual rate setting process via email, labeled as "the final rate exhibits for your health plan." The email has one (1) or more spreadsheet files attached, which are particular to the given MCO. The spreadsheet(s) show the fixed amount and percentage of premium components for the administrative component of the Capitation Rate.

The components of the administrative expense portion of the Capitation Rate can also be found on HHSC's Medicaid website, under "Rate Analysis for Managed Care Services." Under each Program, there is a separate Rate Setting document for each Rate Period that describes the

development of the Capitation Rates. Within each such document, there is a section entitled "Administrative Fees," where it refers to "the amount allocated for administrative expenses."

(3) In cases where the administrative expense portion of the Capitation Rate refers to "the greater of (a) [one (1) set of factors], and (b) [another set of factors]," then the Admin Cap will be calculated each way, and the larger of the two (2) results will be the Admin Cap utilized for the determination of any Experience Rebates due.

(d) Example of calculation.

By way of example only, HHSC will calculate the Admin Cap for an FSR Reporting Period 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 a given Program during the FSR Reporting Period (for example, 70,000):

- $8.00 x 70,000 = $560,000.

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

- 5.75% x $6,000,000 = $345,000.

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

- $1.80 x 70,000 = $126,000.

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

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

In this example, $1,143,000 would be the Admin Cap for a single Program for an MCO in a particular FSR Reporting Period.

(e) Consolidation and offsets.

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

(f) Impact on Loss carry-forward.

For Experience Rebate calculation purposes, the calculation of any loss carry-forward, as described in Section 10.10(d), will be based on the allowable pre-tax loss as determined under the Admin Cap.

(g) MCOs entering a Service Delivery Area or Program.

If an MCO enters a new Service Area or offers a Program that it did not offer under a previous contract, it may be exempt from the Admin Cap for those Service Areas and Programs for a period of time to be determined by HHSC, up through the first FSR Reporting Period or portion thereof.

(h) Service Delivery Areas with only one (1) MCO in a Program.

In Service Areas operating with only one (1) MCO for a Program, HHSC may, at its sole discretion, revise the Admin Cap if its application would create an undue hardship on the MCO.

(i) Unforeseen events.

If, in HHSC's sole discretion, it determines that unforeseen events have created significant hardships for one (1) or more MCOs, HHSC may revise or temporarily suspend the Admin Cap as it deems necessary.

Section 10.10.3 *Reinsurance Cap*

Beginning with FSR Reporting Period 12/13, the MCO is subject to the Reinsurance Cap.

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

The MCO will be limited to a maximum amount of net reinsurance cost PMPM for purposes of calculating the pre-tax net income that is subject to the Experience Rebate. This limitation does not impact an MCO's ability to purchase or arrange for reinsurance. It only impacts what is factored into the

Experience Rebate calculation. The maximum amount of allowed net reinsurance cost PMPM (Reinsurance Cap) varies by MCO Program and is equal to 110% of the net reinsurance cost PMPM contained in the Capitation Rates for the Program during the FSR Reporting Period.

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

Section 10.11 ***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 pursuant to this Contract. This restriction does not apply to fees the MCO pays to Subcontractors for the performance of the Scope of Work.

Section 10.12 ***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 and all such taxes, including any penalties and interest. In addition, HHSC is exempt from Federal excise taxes, and will not pay any personal property taxes or income taxes levied on MCO or any taxes levied on employee wages.

Section 10.13 ***Liability for employment-related charges and benefits.***

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

Section 10.14 ***No additional consideration.***

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

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

(c) MCO will not be 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 whatsoever.

Section 10.15 ***Federal Disallowance***

If the federal government recoups money from the state for expenses and/or costs that are deemed unallowable by the federal government, the state has the right to, in turn, recoup payments made to the MCOs for these same expenses and/or costs, even if they had not been previously disallowed by the state and were incurred by the MCO, and any such expenses and/or costs would then be deemed unallowable by the state. If the state retroactively recoups money from the MCOs due to a federal disallowance, the state will recoup the entire amount paid to the MCO for the federally disallowed expenses and/or costs, not just the federal portion.

Section 10.16 ***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, as described in Attachment B-1, Section 8.2.13.1. HHSC will make supplemental payments to the MCO for these Medicaid Wrap-Around Services, based on encounter data received by HHSC's Administrative Services Contractor during an encounter reporting period. The first supplemental payment will cover encounter data received from March 1, 2012, to February 28, 2013. Thereafter, supplemental payments will cover six-month encounter reporting periods. HHSC will make supplemental payments within a reasonable amount of time after the encounter reporting period, generally no later than 95 Days after HHSC's Administrative Services Contractor has processed the encounter data. Supplemental payments will be limited to the actual amounts paid to pharmacy providers for these Medicaid Wrap-Around Services, as represented in "Net Amount Due" field (Field 281) on the National Council for Prescription Drug Programs (NCPDP) encounter transaction. To be eligible for reimbursement, encounters must contain a Financial Arrangement Code "14" in the "Line of Business" field (Field 270) on the NCPDP encounter transaction.

Section 10.17 ***Pass-through Payments for Provider Rate Increases***

The capitation rates do not include the costs of federally-mandated provider rate increases, per

PPACA as amended by Section 1202 of the Health Care and Education Reconciliation Act. HHSC will make supplemental payments to the MCO for these rate increases, and the MCO will pass through the full amount of the supplemental payments to qualified providers no later than 30 Days after receipt of HHSC's supplemental payment report, contingent upon the receipt of HHSC's payment allocation. Additional information regarding these requirements is located in Attachment B-1, Section 8.2.16, "Supplemental Payments for Qualified Providers."

Section 10.18 ***Non-Risk Payments for Certain Drugs***

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

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

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's Administrative Services Contractor has processed the medical Encounter Data. Non-risk payments will be limited to the actual amounts MCOs paid to medical providers for the ingredient cost of these drugs up to the Fee-for-Service reimbursement amount. To be eligible for reimbursement, medical encounters must contain a Financial Arrangement Code "20" in segment NTE02 on the encounter transaction.

Section 10.19 ***Payment/Adjustment to Capitation in Consideration of the ACA Section 9010 Health Insurance Providers Fee***

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

Beginning in calendar year 2014, the PPACA requires the MCO to pay the HIP Fee no later than September 30th (as applicable to each relevant year, the "HIP Fee Year") with respect to premiums paid to the MCO in the preceding calendar year (as applicable to each relevant year, the "HIP Data Year"), and continuing similarly in each successive year. In order to satisfy the requirement for actuarial soundness set forth in 42 C.F.R. § 438.6(c) with respect to amounts paid by HHSC under this Agreement, the parties agree that HHSC will make a retroactive adjustment to capitation to the MCO for the full amount of the HIP Fee allocable to this Agreement, as follows:

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

- The amount of the HIP Fee attributable to this Agreement;
- The federal income tax liability, if any, that the MCO incurs as a result of receiving HHSC's payment for the amount of the HIP Fee attributable to this Agreement; and
- Any Texas state premium tax attributable to the capitation adjustment.

The amount of the HIP Fee will not be determinable until after HHSC establishes the regular Capitation Rates for a rate period. HHSC therefore will perform an actuarial calculation to account for the HIP Fee within actuarially sound Capitation Rates each year and apply this Capitation Rate adjustment to the regular Capitation Rates already paid to the MCO.

The MCO's federal income tax rate will not be known prior to the end of the tax year. As a result, HHSC will make a tax rate assumption for purposes of

developing the capitation adjustment. If the tax rate assumption later proves to be higher than the actual tax rate for one or more MCOs, HHSC may re-determine the capitation adjustment for those MCOs using the lower tax rate and reconcile the capitation amount paid.

Documentation Requirements: HHSC will pay the MCO after it receives sufficient documentation, as determined by HHSC, detailing the MCO's Texas Medicaid and CHIP-specific liability for the HIP Fee. The MCO will provide documentation that includes the following:

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

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

This provision will survive the termination of the Agreement.

Section 10.20 ***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 TMPPM.

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 TMPPM.

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.

Article 11. Disclosure & Confidentiality of Information

Section 11.01 ***Confidentiality.***

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

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

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

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

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

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

must provide HHSC certificates evidencing such destruction.

(g) The obligations in this Section must not restrict any disclosure by the MCO pursuant to any applicable law, or by order of any court or government agency, provided that the MCO must give prompt notice to HHSC of such order.

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

(1) Already known to the Receiving Party without restrictions at the time of its disclosure by the Furnishing Party;

(2) Independently developed by the Receiving Party without reference to the Furnishing Party's Confidential Information;

(3) Rightfully obtained by the Receiving Party without restriction from a third party after its disclosure to a third party by the Furnishing Party;

(4) Publicly available other than through the fault or negligence of the Receiving Party; or

(5) Lawfully released without restriction to anyone.

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

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

(b) MCO will require its Subcontractors, consultants, and agents to comply with the terms of this provision.

Section 11.03 ***Member Records***

(a) MCO must comply with the requirements of state and federal laws, including the HIPAA requirements set forth in **Section 7.07**, regarding the transfer of Member Records.

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

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

Section 11.04 ***Requests for public information.***

(a) When the MCO produces reports or other forms of information that the MCO believes consist of proprietary or otherwise confidential information, the MCO must clearly mark such information as confidential information or provide written notice to HHSC that it considers the information confidential.

(b) If HHSC receives a request, filed in accordance with the Texas Public Information Act ("Act,") seeking information that has been identified by the MCO as proprietary or otherwise confidential, HHSC will deliver a copy of the request for public information to MCO, in accordance with the requirements of the Act.

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

Section 11.05 ***Privileged Work Product.***

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

(b) HHSC will notify MCO of any privileged work product to which MCO has or may have access. After the MCO is notified or otherwise becomes aware that such documents, data, database, or communications

are privileged work product, only MCO personnel, for whom such access is necessary for the purposes of providing the Services, may have access to privileged work product.

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

(1) Immediately notify HHSC; and

(2) Use all reasonable efforts to resist providing such access.

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

(1) Represent MCO in such resistance;

(2) Retain counsel to represent MCO; or

(3) Reimburse MCO for reasonable attorneys' fees and expenses incurred in resisting such access.

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

Section 11.06 ***Unauthorized acts.***

Each Party agrees to:

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

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

(3) Cooperate with the other Party in any litigation and investigation against third Parties deemed necessary by such Party to protect its proprietary rights; and

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

Section 11.07 ***Legal action.***

Neither party may commence any legal action or proceeding in respect to any unauthorized possession, use, or knowledge, or attempt thereof by any person or entity of HHSC's Confidential Information or information identified by the MCO as confidential or proprietary, which action or proceeding identifies the other Party's information without such Party's consent.

Section 11.08 ***Information Security and Privacy Requirements***

(a) Compliance.
The MCO agrees to comply with all applicable state and federal security and privacy requirements governing the creation, collection, access, use, storage, maintenance, disclosure, safeguarding and destruction of Texas HHS data including Agency Sensitive Information and Confidential Information.
(b) Protection.
The MCO will implement, maintain, document, and use appropriate administrative, technical and physical security measures to protect all Texas HHS Information Resources and data, including Agency Sensitive Information and Confidential Information.
(c) Reviews.
The MCO must comply with security and privacy controls compliance assessments, updates, and monitoring by Texas HHS as required by state and federal law or by Texas HHS's' discretion. The security and privacy controls will be based on the National Institute of Standards and Technology (NIST) Special Publication 800-53 from the applicable state and federal requirements. The Texas HHS process is described in the Information Security Risk Assessment and Monitoring Procedures (IS-RAMP) that is published on the Texas HHS Internet website.
(d) Workforce.
The MCO must ensure that their workforce, including Subcontractors, who are granted specified Texas HHS authorized access to internal Texas HHS Information Resources, comply with the Texas HHS Acceptable Use Policy (AUP) and sign the Acceptable Use Agreement (AUA) prior to access, in accordance with 1 Tex. Admin. Code Chapter 202.22.
(e) Information Security and Privacy Officials.
The MCO must designate an Information Security Official and a Privacy Official who will be responsible for managing its security and privacy programs and Texas HHS requirements. The MCO will provide Texas HHS the names, phone numbers and email addresses of these officials. The Information Security Official and Privacy Official roles may be performed by the same individual.
(f) Program.
The MCO must establish an information security and privacy program and maintain information security and privacy policies and standards that are updated at least annually with respect to the management or handling of Texas HHS Information Resources or data. The program will:

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

(2) comply with Texas HHS Information Security Office's published or provided policies, standards, and controls available at Doing Business with HHS

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

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

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

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

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

(8) document system accountability with an associated Texas HHS Information owner and, if provided by the MCO, Information custodians;

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

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

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

(12) prohibit the performance of any work or the maintenance of any information relating or obtained pursuant to this Agreement to occur outside of the United States;(13) provide the workforce security and privacy training, conduct appropriate background checks, ensure individual accountability, and implement appropriate sanctions for non-compliance;

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

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

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

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

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

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

(i) environmental security;

(ii) physical site security;

(iii) computer hardware security;

(iv) computer software security;

(v) application security;

(vi) data access and storage;

(vii) client/user security;

(viii) secure processes and procedures;

(ix) Telecommunications and network security; and

(x) general support systems (GSS) security;

SECTION 11.09 ***MCO's Incident and Breach Notice, Reporting and Mitigation***

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

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

Section 11.09.1 Notification to HHSC

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

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

(c) Incident Notice:

1. Initial Notice.

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

2. Formal Notice.

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

3. Annual Notice

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

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

Section 11.09.2 MCO Investigation, Response and Mitigation.

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

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

Section 11.09.3 Breach Notification to Individuals and Reporting to Authorities.

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

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

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

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

Article 12. Remedies & Disputes

Section 12.01 ***Understanding and expectations.***

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

Section 12.02 ***Tailored remedies.***

(a) Understanding of the Parties.

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

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

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

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

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

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

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

(c) Corrective action plan.

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

(2) The Corrective Action Plan must provide:

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

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

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

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

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

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

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

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

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

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

(i) Excuse MCO's prior substandard performance;

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

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

(d) Administrative remedies.

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

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

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

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

(iv)

(Decline to renew or extend the Contract;

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

(vi) Initiate disenrollment of a Member or Members;

(vii) Suspend enrollment of Members;

(viii) Withhold or recoup payment to MCO;

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

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

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

(i) Violates a material provision of the Contract;

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

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

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

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

(e) Damages.

(1) HHSC will be entitled to actual and

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

(2) The liquidated damages prescribed in this Section are not intended to be in the nature of a

penalty but are intended to be reasonable estimates of HHSC's projected financial loss and damage resulting from the MCO's nonperformance, including financial loss as a result of project delays. Accordingly, in the event MCO fails to perform in accordance with the Contract, HHSC may assess liquidated damages as provided in this Section.

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

(4) HHSC may elect to collect liquidated damages:

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

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

(f) Equitable Remedies

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

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

(g) Suspension of Contract

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

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

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

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

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

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

(i) Be delivered in writing to MCO;

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

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

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

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

(a) Termination in the best interest of HHSC.

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

(b) Termination for cause.

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

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

HHSC may terminate the Contract at any time if MCO:

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

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

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

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

HHSC may terminate the Contract if a court of competent jurisdiction finds MCO failed to adhere to any laws, ordinances, rules, regulations or

orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of MCO's duties under the Contract. HHSC will provide at least 30 Days advance written notice of such termination.

(3) Breach of confidentiality.

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

(4) Failure to maintain adequate personnel or resources.

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

(5) Termination for gifts and gratuities.

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

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

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

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

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

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

(6) Termination for non-appropriation of funds.

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

(7) Judgment and execution.

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

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

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

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

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

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

HHSC will have the right to terminate the Contract in whole or in part if HHSC determines, at its sole discretion, that MCO has materially breached the Contract.

(9) Termination for Criminal Conviction

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

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

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

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

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

(c) Pre-termination Process

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

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

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

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

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

(a) Failure to pay.

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

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

(b) Change to HHSC Uniform Managed Care Manual.

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

(c) Change to Capitation Rate.

If HHSC proposes an initial Capitation Rate or a modification to the Capitation Rate that is unacceptable to the MCO, the MCO may terminate the Contract. MCO must submit a written notice of intent to terminate due to a change in the Capitation Rate no later than 30 Days after HHSC's notice of the proposed change. HHSC will not enforce the rate change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(d) Expiration of Contract.

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

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

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

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

Section 12.05 ***Termination by mutual agreement.***

The Contract may be terminated by mutual written agreement of the Parties.

Section 12.06 ***Effective date of termination.***

Except as otherwise provided in the Contract, termination will be effective as of the date specified in the notice of termination. The Turnover Phase obligations of the MCO will continue to apply after the effective date of the Contract termination.

Section 12.07 ***Extension of termination effective date.***

The Parties may extend the effective date of termination one or more times by mutual written agreement.

Section 12.08 ***Payment and other provisions at Contract termination.***

(a) In the event of termination pursuant to this Article, HHSC will pay the Capitation Payment for Services and Deliverables rendered through the effective date of termination. All pertinent provisions of the Contract will form the basis of settlement.

(b) MCO must provide HHSC all reasonable access to records, facilities, and documentation as is required to efficiently and expeditiously close out the Services and Deliverables provided under the Contract.

(c) MCO must prepare a Turnover Plan, which is acceptable to and approved by HHSC. The Turnover Plan will be implemented during the time period between receipt of notice and the termination date.

Section 12.09 ***Modification of Contract in the event of remedies.***

HHSC may propose a modification of the Contract in response to the imposition of a remedy under this Article. Any modifications under this Section must be reasonable, limited to the matters causing the exercise of a remedy, in writing, and executed in accordance with **Article 8**. MCO must negotiate such proposed modifications in good faith.

Section 12.10 ***Turnover assistance.***

Upon receipt of notice of termination of the Contract by HHSC or by the MCO, MCO will provide any turnover assistance reasonably necessary to enable HHSC or its designee to effectively close out the Contract and move the work to another vendor or to perform the work itself.

During the Turnover Phase, MCO must continue performing under the Contract, including rendering all contracted Services, until such time HHSC determines that the MCO has completed all requirements in accordance with the Turnover Plan.

Section 12.11 ***Rights upon termination or expiration of Contract.***

In the event that the Contract is terminated for any reason, or upon its expiration, HHSC will, at HHSC's discretion, retain ownership of any and all associated work products, Deliverables or documentation in whatever form that they exist.

Section 12.12 ***MCO responsibility for associated costs.***

If HHSC terminates the Contract for Cause, the MCO will be responsible to HHSC for all reasonable costs incurred by HHSC, the State of Texas, or any of its administrative agencies to replace the MCO. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation that is reasonably attributable to MCO's failure to perform any Service in accordance with the terms of the Contract

Section 12.13 ***Dispute resolution.***

(a)General agreement of the Parties.

The Parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the Parties employ all reasonable and informal means to resolve any dispute under the Contract. The Parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

(b)Duty to negotiate in good faith.

Any dispute that in the judgment of any Party to the Contract may materially or substantially affect the performance of any Party will be reduced to writing and delivered to the other Party. The Parties shall then negotiate in good faith and use every reasonable effort to resolve such dispute and the Parties must not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible. The resolution of any dispute disposed of by Contract between the Parties shall be reduced to writing and delivered to all Parties within 10 Business Days.

(c) Claims for breach of Contract.

(1) *General requirement.* MCO's claim for breach of the Contract will be resolved in accordance with the dispute resolution process established by HHSC in accordance with Chapter 2260, Texas Government Code.

(2) *Negotiation of claims*. The Parties expressly agree that the MCO's claim for breach of the Contract that the Parties cannot resolve in the ordinary course of business or through the use of all reasonable and informal means will be

submitted to the negotiation process provided in Chapter 2260, Subchapter B, Texas Government Code.

(i) To initiate the process, MCO must submit written notice to HHSC that specifically states that MCO invokes the provisions of Chapter 2260, Subchapter B, Texas Government Code. The notice must comply with the requirements of Title 1, Chapter 392, Subchapter B of the Texas Administrative Code.

(ii) The Parties expressly agree that the MCO's compliance with Chapter 2260, Subchapter B, Texas Government Code, will be a condition precedent to the filing of a contested case proceeding under Chapter 2260, Subchapter C, of the Texas Government Code.

(3) *Contested case proceedings*. The contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be MCO's sole and exclusive process for seeking a remedy for any and all alleged breaches of contract by HHSC if the Parties are unable to resolve their disputes under Subsection (c)(2) of this Section.

The Parties expressly agree that compliance with the contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be a condition precedent to seeking consent to sue from the Texas Legislature under Chapter 107, Civil Practices & Remedies Code. Neither the execution of the Contract by HHSC nor any other conduct of any representative of HHSC relating to the Contract shall be considered a waiver of HHSC's sovereign immunity to suit.

(4) *HHSC rules.* The submission, processing and resolution of MCO's claim is governed by the rules adopted by HHSC pursuant to Chapter 2260, Texas Government Code, found at Title 1, Chapter 392, Subchapter B of the Texas Administrative Code.

(5) *MCO's duty to perform.* Neither the occurrence of an event constituting an alleged breach of contract nor the pending status of any claim for breach of contract is grounds for the suspension of performance, in whole or in part, by MCO of any duty or obligation with respect to the performance of the Contract. Any changes to the Contract as a result of a dispute resolution will be implemented in accordance with **Article 8** ("Amendments and Modifications").

Section 12.14 ***Liability of MCO.***

(a) MCO bears all risk of loss or damage to HHSC or the State due to:

(1) Defects in Services or Deliverables;

(2) Unfitness or obsolescence of Services or Deliverables; or

(3) The negligence or intentional misconduct of MCO or its employees, agents, Subcontractors, or representatives.

(b) MCO must, at the MCO's own expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC and State employees, officers, directors, contractors and agents from and against any losses, liabilities, damages, penalties, costs, fees, including without limitation reasonable attorneys' fees, and expenses from any claim or action for property damage, bodily injury or death, to the extent caused by or arising from the negligence or intentional misconduct of the MCO and its employees, officers, agents, or Subcontractors. HHSC will not unreasonably withhold approval of counsel selected by MCO.

(c) MCO will not be liable to HHSC for any loss, damages or liabilities attributable to or arising from the failure of HHSC or any state agency to perform a service or activity in connection with the Contract.

Article 13. Assurances & Certifications

Section 13.01 ***Proposal certifications.***

MCO acknowledges its continuing obligation to comply with the requirements of the certifications contained in its Proposal and will immediately notify HHSC of any changes in circumstances affecting the certifications.

Section 13.02 ***Conflicts of interest.***

(a) Representation.

MCO agrees to comply with applicable state and federal laws, including 41 U.S.C. § 423, rules, and regulations regarding conflicts of interest in the performance of its duties under this Contract. MCO warrants that it has no interest and will not acquire any direct or indirect interest that would conflict in any manner or degree with its performance under this Contract.

(b) General duty regarding conflicts of interest.

MCO will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain. MCO will operate with complete independence and objectivity without actual, potential or apparent conflict of interest with respect to the activities conducted under this Contract.

Section 13.03 ***Organizational conflicts of interest.***

(a) Definition.

An organizational conflict of interest is a set of facts or circumstances, a relationship, or other situation under which an MCO or a Subcontractor has past, present, or currently planned personal or financial activities or interests that either directly or indirectly:

(1) Impairs or diminishes the MCO's or Subcontractor's ability to render impartial or objective assistance or advice to HHSC; or

(2) Provides the MCO or Subcontractor an unfair competitive advantage in future HHSC procurements (excluding the award of this Contract).

(b) Warranty.

Except as otherwise disclosed and approved by HHSC prior to the Effective Date of the Contract, MCO warrants that, as of the Effective Date and to the best of its knowledge and belief, there are no relevant facts or circumstances that could give rise to an organizational conflict of interest affecting this Contract. MCO affirms that it has neither given, nor intends to give, at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, at any time during the procurement process or in connection with the procurement process except as allowed under relevant state and federal law.

(c) Continuing duty to disclose.

(1) MCO agrees that, if after the Effective Date, MCO discovers or is made aware of an organizational conflict of interest, MCO will immediately and fully disclose such interest in writing to the HHSC project manager. In addition, MCO must promptly disclose any relationship that might be perceived or represented as a conflict after its discovery by MCO or by HHSC as a potential conflict. HHSC reserves the right to make a final determination regarding the existence of conflicts of interest, and MCO agrees to abide by HHSC's decision.

(2) The disclosure will include a description of the actions that MCO has taken or proposes to take to avoid or mitigate such conflicts.

(d) Remedy.

If HHSC determines that an organizational conflict of interest exists, HHSC may, at its discretion, terminate the Contract pursuant to **Subsection 12.03(b)(9).** If HHSC determines that MCO was aware of an organizational conflict of interest before the award of this Contract and did not disclose the conflict to the contracting officer, such nondisclosure will be considered a material breach of the Contract. Furthermore, such breach may be submitted to the Office of the Attorney General, Texas Ethics Commission, or appropriate State or Federal law enforcement officials for further action.

(e) Flow-down obligation.

MCO must include the provisions of this Section in all Subcontracts for work to be performed similar to the service provided by MCO, and the terms "Contract," "MCO," and "project manager" modified appropriately to preserve the state's rights.

Section 13.04 ***HHSC personnel recruitment prohibition.***

MCO has not retained or promised to retain any person or company or utilized or promised to utilize a consultant that participated in HHSC's development of specific criteria of the RFP or who participated in the selection of the MCO for this Contract.

Unless authorized in writing by HHSC, MCO will not recruit or employ any HHSC personnel who have worked on projects relating to the subject matter of this Contract, or who have had any influence on decisions affecting the subject matter of this Contract, for two years following the completion of this Contract.

Section 13.05 ***Anti-kickback provision.***

MCO certifies that it will comply with the Anti-Kickback Act of 1986, 41 U.S.C. §§ 51-58 and Federal Acquisition Regulation § 52.203-7, to the extent applicable.

Section 13.06 ***Debt or back taxes owed to State of Texas.***

In accordance with Section 403.055 of the Texas Government Code, MCO agrees that any payments due to MCO under the Contract will be first applied toward any debt and/or back taxes MCO owes State of Texas. MCO further agrees that payments will be so applied until such debts and back taxes are paid in full.

Section 13.07 ***Outstanding debts and judgments.***

MCO certifies that it is not presently indebted to the State of Texas, and that MCO is not subject to an outstanding judgment in a suit by State of Texas against MCO for collection of the balance. For purposes of this Section, an indebtedness is any amount or sum of money that is due and owing to the State of Texas and is not currently under dispute. A false statement regarding MCO's status will be treated as a material breach of this Contract and may be grounds for termination at the option of HHSC.

Article 14. Representations & Warranties

Section 14.01 ***Authorization.***

(a) The execution, delivery and performance of this Contract has been duly authorized by MCO and no additional approval, authorization or consent of

any governmental or regulatory agency is required to be obtained in order for MCO to enter into this Contract and perform its obligations under this Contract.

(b) MCO has obtained all licenses, certifications, permits, and authorizations necessary to perform the Services under this Contract and currently is in good standing with all regulatory agencies that regulate any or all aspects of MCO's performance of this Contract. MCO will maintain all required certifications, licenses, permits, and authorizations during the term of this Contract.

Section 14.02 ***Ability to perform.***

MCO warrants that it has the financial resources to fund the capital expenditures required under the Contract without advances by HHSC or assignment of any payments by HHSC to a financing source.

Section 14.03 ***Minimum Net Worth.***

The MCO has, and will maintain throughout the life of this Contract, minimum net worth that complies with standards adopted by TDI. Minimum net worth means the excess total admitted assets over total liabilities, excluding liability for subordinated debt issued in compliance with Chapter 843 of the Texas Insurance Code.

Section 14.04 ***Insurer solvency.***

(a) The MCO must be and remain in full compliance with all applicable state and federal solvency requirements, including those set forth in 42 C.F.R. § 438.116, for basic-service health maintenance organizations, including but not limited to, all reserve requirements net worth standards, debt-to-equity ratios, or other debt limitations. Provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI. In the event the MCO fails to maintain such compliance, HHSC, without limiting any other rights it may have by law or under the Contract, may terminate the Contract.

(b) If the MCO becomes aware of any impending changes to its financial or business structure that could adversely impact its compliance with the requirements of the Contract or its ability to pay its debts as they come due, the MCO must notify HHSC immediately in writing.

(c) The MCO must have a plan and take appropriate measures to ensure adequate provision against the risk of insolvency as required by TDI. Such provision must be adequate to provide for the following in the event of insolvency:

(1) continuation of Covered Services, until the time of discharge, to Members who are confined on the date of insolvency in a hospital or other inpatient facility;

(2) payments to unaffiliated health care providers and affiliated healthcare providers whose Contracts do not contain Member "hold harmless" clauses acceptable to the TDI;

(3) continuation of Covered Services for the duration of the Contract Period for which a capitation has been paid for a Member;

(4) provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI and the Contract.

Should TDI determine that there is an immediate risk of insolvency or the MCO is unable to provide Covered Services to its Members, HHSC, without limiting any other rights it may have by law, or under the Contract, may terminate the Contract.

Section 14.05 ***Workmanship and performance.***

(a) All Services and Deliverables provided under this Contract will be provided in a manner consistent with the standards of quality and integrity as outlined in the Contract.

(b) All Services and Deliverables must meet or exceed the required levels of performance specified in or pursuant to this Contract.

(c) MCO will perform the Services and provide the Deliverables in a workmanlike manner, in accordance with best practices and high professional standards used in well-managed operations performing services similar to the Services described in this Contract.

Section 14.06 ***Warranty of deliverables.***

MCO warrants that Deliverables developed and delivered under this Contract will meet in all material respects the specifications as described in the Contract during the period following its acceptance by HHSC, through the term of the Contract, including any subsequently negotiated by MCO and HHSC. MCO will promptly repair or replace any such Deliverables not in compliance with this warranty at no charge to HHSC.

Section 14.07 ***Compliance with Contract.***

MCO will not take any action substantially or materially inconsistent with any of the terms and conditions set forth in this Contract without the express written approval of HHSC.

Section 14.08 ***Technology Access***

All technological solutions offered by the MCO must comply with the requirements of Texas Government Code § 531.0162. This includes providing

technological solutions that meet federal accessibility standards for persons with disabilities, as applicable.

Section 14.09 ***Electronic & Information Resources Accessibility Standards***

(a) Applicability

The following Electronic and Information Resources (EIR) requirements apply to the Contract because the MCO perform services that include EIR that: (i) HHSC employees are required or permitted to access; or (ii) members of the public are required or permitted to access. This Section does not apply to incidental uses of EIR in the performance of a Contract, unless the Parties agree that the EIR will become property of the State or will be used by the HHSC's clients or recipients after completion of the Contract. Nothing in this section is intended to prescribe the use of particular designs or technologies or to prevent the use of alternative technologies, provided they result in substantially equivalent or greater access to and use of a Product.

(b) Definitions.

For purposes of this Section:

"Accessibility Standards" means the Electronic and Information Resources Accessibility Standards and the Web Site Accessibility Standards/Specifications.

"**Electronic and Information Resources**" means information resources, including information resources technologies, and any equipment or interconnected system of equipment that is used in the creation, conversion, duplication, or delivery of data or information. The term includes, but is not limited to, telephones and other Telecommunications products, information kiosks, transaction machines, Internet websites, multimedia resources, and office equipment, including copy machines and fax machines.

"Electronic and Information Resources Accessibility Standards" means the accessibility standards for electronic and information resources contained in 1 Tex. Admin. Code Chapter 213.

"Web Site Accessibility Standards/ Specifications" means standards contained in 1 Tex. Admin. Code Chapter 206.

"Product" means information resources technology that is, or is related to, EIR.

(c) Accessibility Requirements.

Under Texas Government Code Chapter 2054, Subchapter M, and implementing rules of the Texas Department of Information Resources, HHSC must procure Products that comply with the Accessibility Standards when such Products are available in the commercial marketplace or when such Products are developed in response to a procurement solicitation. Accordingly, MCO must provide electronic and information resources and associated Product documentation and technical support that comply with the Accessibility Standards.

(d) Evaluation, Testing, and Monitoring.

(1) HHSC may review, test, evaluate and monitor MCO's Products and associated documentation and technical support for compliance with the Accessibility Standards. Review, testing, evaluation and monitoring may be conducted before and after the award of a contract. Testing and monitoring may include user acceptance testing.

Neither (1) the review, testing, including acceptance testing, evaluation or monitoring of any Product, nor (2) the absence of such review, testing, evaluation or monitoring, will result in a waiver of the State's right to contest the MCO's assertion of compliance with the Accessibility Standards.

(2) MCO agrees to cooperate fully and provide HHSC and its representatives timely access to Products, records, and other items and information needed to conduct such review, evaluation, testing and monitoring.

(e) Representations and Warranties.

(1) MCO represents and warrants that: (i) as of the Effective Date of the Contract, the Products and associated documentation and technical support comply with the Accessibility Standards as they exist at the time of entering the Contract, unless and to the extent the Parties otherwise expressly agree in writing; and (ii) if the Products will be in the custody of the state or an HHS Agency's client or recipient after the Contract expiration or termination, the Products will continue to comply with such Accessibility Standards after the expiration or termination of the Contract Term, unless HHSC or its clients or recipients, as applicable, use the Products in a manner that renders it noncompliant.

(2) In the event MCO should have known, becomes aware, or is notified that the Product and associated documentation and technical support do not comply with the Accessibility Standards, MCO represents and warrants that it will, in a timely manner and at no cost to HHSC, perform all necessary steps to satisfy the Accessibility Standards, including but not limited to remediation, replacement, and upgrading of the Product, or providing a suitable substitute.

(3) MCO acknowledges and agrees that these representations and warranties are essential inducements on which HHSC relies in awarding this Contract.

(4) MCO's representations and warranties under this subsection will survive the termination or expiration of the Contract and will remain in full force and effect throughout the useful life of the Product.

(f) Remedies.

(1) Pursuant to Texas Gov't Code § 2054.465, neither MCO nor any other person has cause of action against HHSC for a claim of a failure to comply with Texas Gov't Code Chapter 2054, Subchapter M, and rules of the Department of Information Resources.

(2) In the event of a breach of MCO's representations and warranties, MCO will be liable for direct, consequential, indirect, special, and/or liquidated damages and any other remedies to which HHSC may be entitled under this Contract and other applicable law. This remedy is cumulative of any and all other remedies to which HHSC may be entitled under this Contract and other applicable law.

Article 15. Intellectual Property

Section 15.01 *Infringement and misappropriation.*

(a) MCO warrants that all Deliverables provided by MCO will not infringe or misappropriate any right of, and will be free of any claim of, any third person or entity based on copyright, patent, trade secret, or other intellectual property rights.

(b) MCO will, at its expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC, its employees, officers, directors, contractors, and agents from and against any losses, liabilities, damages, penalties, costs, and fees from any claim or action against HHSC that is based on a claim of breach of the warranty set forth in the preceding paragraph. HHSC will promptly notify MCO in writing of the claim, provide MCO a copy of all information received by HHSC with respect to the claim, and cooperate with MCO in defending or settling the claim. HHSC will not unreasonably withhold, delay or condition approval of counsel selected by the MCO.

(c) In case the Deliverables, or any one (1) or part thereof, is in such action held to constitute an infringement or misappropriation, or the use thereof is enjoined or restricted or if a proceeding appears to MCO to be likely to be brought, MCO will, at its own expense, either:

(1) Procure for HHSC the right to continue using the Deliverables; or

(2) Modify or replace the Deliverables to comply with the Specifications and to not violate any intellectual property rights.

Section 15.02 *Exceptions.*

MCO is not responsible for any claimed breaches of the warranties set forth in Section 15.01 to the extent caused by:

(a) Modifications made to the item in question by anyone other than MCO or its Subcontractors, or modifications made by HHSC or its contractors working at MCO's direction or in accordance with the specifications; or

(b) The combination, operation, or use of the item with other items if MCO did not supply or approve for use with the item; or

(c) HHSC's failure to use any new or corrected versions of the item made available by MCO.

Section 15.03 *Ownership and Licenses*

(a) Definitions.

For purposes of this Section 15.03, the following terms have the meanings set forth below:

(1) "**Custom Software**" means any software developed by the MCO for HHSC; in connection with the Contract; and with funds received from HHSC. The term does not include MCO Proprietary Software or Third Party Software.

(2) "**MCO Proprietary Software**" means software: (i) developed by the MCO prior to the Effective Date of the Contract, or (ii) software developed by the MCO after the Effective Date of the Contract that is not developed: for HHSC; in connection with the Contract; and with funds received from HHSC.

(3) "**Third Party Software**" means software that is: developed for general commercial use; available to the public; or not developed for HHSC. Third Party Software includes without limitation: commercial off-the-shelf software; operating system software; and application software, tools, and utilities.

(b) Deliverables.

The Parties agree that any Deliverable, including without limitation the Custom Software, will be the exclusive property of HHSC.

(c) Ownership rights.

(1) HHSC will own all right, title, and interest in and to its Confidential Information and the Deliverables provided by the MCO, including without limitation the Custom Software and associated documentation. For purposes of this Section 15.03, the Deliverables will not include MCO Proprietary Software or Third Party

Software. MCO will take all actions necessary and transfer ownership of the Deliverables to HHSC, including, without limitation, the Custom Software and associated documentation prior to Contract termination.

(2) MCO will furnish such Deliverables, upon request of HHSC, in accordance with applicable State law. All Deliverables, in whole and in part, will be deemed works made for hire of HHSC for all purposes of copyright law, and copyright will belong solely to HHSC. To the extent that any such Deliverable does not qualify as a work for hire under applicable law, and to the extent that the Deliverable includes materials subject to copyright, patent, trade secret, or other proprietary right protection, MCO agrees to assign, and hereby assigns, all right, title, and interest in and to Deliverables, including without limitation all copyrights, inventions, patents, trade secrets, and other proprietary rights therein (including renewals thereof) to HHSC.

(3) MCO will, at the expense of HHSC, assist HHSC or its nominees to obtain copyrights, trademarks, or patents for all such Deliverables in the United States and any other countries. MCO agrees to execute all papers and to give all facts known to it necessary to secure United States or foreign country copyrights and patents, and to transfer or cause to transfer to HHSC all the right, title, and interest in and to such Deliverables. MCO also agrees not to assert any moral rights under applicable copyright law with regard to such Deliverables.

(d) License Rights

HHSC will have a royalty-free and non-exclusive license to access the MCO Proprietary Software and associated documentation during the term of the Contract. HHSC will also have ownership and unlimited rights to use, disclose, duplicate, or publish all information and data developed, derived, documented, or furnished by MCO under or resulting from the Contract. Such data will include all results, technical information, and materials developed for and/or obtained by HHSC from MCO in the performance of the Services hereunder, including but not limited to all reports, surveys, plans, charts, recordings, video or sound, pictures, drawings, analyses, graphic representations, computer printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the Scope of Work performed as a result of the Contract.

(e) Proprietary Notices

MCO will reproduce and include HHSC's copyright and other proprietary notices and product identifications provided by MCO on such copies, in whole or in part, or on any form of the Deliverables.

(f) State and Federal Governments

In accordance with 45 C.F.R. § 95.617, all appropriate State and Federal agencies will have a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, translate, or otherwise use, and to authorize others to use for Federal Government purposes all materials, the Custom Software and modifications thereof, and associated documentation designed, developed, or installed with federal financial participation under the Contract, including but not limited to those materials covered by copyright, all software source and object code, instructions, files, and documentation.

Article 16. Liability

Section 16.01 *Property damage.*

(a) MCO will protect HHSC's real and personal property from damage arising from MCO's, its agent's, employees.' Consultants', and Subcontractors' performance of the Scope of Work, and MCO will be responsible for any loss, destruction, or damage to HHSC's property that results from or is caused by MCO's, its agents', employees', consultant's, or Subcontractors' negligent or wrongful acts or omissions. Upon the loss of, destruction of, or damage to any property of HHSC, MCO will notify the HHSC Project Manager thereof and, subject to direction from the Project Manager or her or his designee, will take all reasonable steps to protect that property from further damage.

(b) MCO agrees to observe and encourage its employees and agents to observe safety measures and proper operating procedures at HHSC sites at all times.

(c) MCO will distribute a policy statement to all of its employees and agents that directs the employee or agent to promptly report to HHSC or to MCO any special defect or unsafe condition encountered while on HHSC premises. MCO will promptly report to HHSC any special defect or an unsafe condition it encounters or otherwise learns about.

Section 16.02 *Risk of Loss.*

During the period Deliverables are in transit and in possession of MCO, its carriers or HHSC prior to being accepted by HHSC, MCO will bear the risk of loss or damage thereto, unless such loss or damage is caused by the negligence or intentional misconduct of HHSC. After HHSC accepts a Deliverable, the risk of loss or damage to the Deliverable will be borne by HHSC, except loss or damage attributable to the negligence or intentional misconduct of MCO's agents, employees, consultants, or Subcontractors.

Section 16.03 ***Limitation of HHSC's Liability.***

HHSC will not be liable for any incidental, indirect, special, or consequential, exemplary, or punitive damages under contract, tort (including negligence), or other legal theory. This will apply regardless of the cause of action and even if HHSC has been advised of the possibility of such damages.

HHSC's liability to MCO under the contract will not exceed the total charges to be paid by HHSC to MCO under the contract, including change order prices agreed to by the parties or otherwise adjudicated.

MCO's remedies are governed by the provisions in Article 12.

Article 17. Insurance & Bonding

Section 17.01 ***Insurance Coverage.***

(a) Statutory and General Coverage

MCO will maintain, at the MCO's expense, the following insurance coverage:

(1) Business Automobile Liability Insurance for all owned, non-owned, and hired vehicles for bodily injury and property damage;

(2) Comprehensive General Liability Insurance of at least $1,000,000.00 per occurrence and $5,000,000.00 in the aggregate (including Bodily Injury coverage of $100,000.00 per each occurrence and Property Damage Coverage of $25,000.00 per occurrence); and

(3) If MCO's current Comprehensive General Liability insurance coverage does not meet the above stated requirements, MCO will obtain Umbrella Liability Insurance to compensate for the difference in the coverage amounts. If Umbrella Liability Insurance is provided, it must follow the form of the primary coverage.

(b) Professional Liability Coverage.

(1) MCO must maintain, or cause its Network Providers to maintain, Professional Liability Insurance for each Network Provider of $100,000.00 per occurrence and $300,000.00 in the aggregate, or the limits required by the hospital at which the Network Provider has admitting privileges.

(2) MCO must maintain an Excess Professional Liability (Errors and Omissions) Insurance Policy for the greater of $3,000,000.00 or an amount, rounded to the nearest $100,000.00 that represents the number of Members enrolled in the MCO in the first month of the applicable State Fiscal Year multiplied by $150.00, not to exceed $10,000,000.00.

(c) General Requirements for All Insurance Coverage

(1) Except as provided herein, all exceptions to the Contract's insurance requirements must be approved in writing by HHSC. HHSC's written approval is not required in the following situations:

(i) An MCO is prohibited from requiring a Network Provider to obtain the insurance coverage described in Section 17.01 if the Network Provider qualifies as a state governmental unit or municipality under the Texas Tort Claims Act, and is required to comply with, and subject to the provisions of, the Texas Tort Claims Act.

(ii) An MCO may waive the Professional Liability Insurance requirement described in Section 17.01(b)(1) for a Network Provider of Community-based Long-term Services and Supports. An MCO may not waive this requirement if the Network Provider provides other Covered Services in addition to Community-based Long Term Services and Supports, or if a Texas licensing entity requires the Network Provider to carry such Professional Liability coverage. An MCO that waives the Professional Liability Insurance requirement for a Network Provider pursuant to this provision is not required to obtain such coverage on behalf of the Network Provider.

(iii) The Professional Liability Insurance requirements described in Section 17.01(b)(1) do not apply to Nursing Facility Providers.

(iv) An MCO may waive the Professional Liability Insurance requirement described in 17.01(b)(1) for Network Providers of durable medical equipment. An MCO that waives the Professional Liability Insurance requirement for a Network Provider pursuant to this provision is not required to obtain such coverage on behalf of the Network Provider.

(2) MCO or the Network Provider is responsible for any and all deductibles stated in the insurance policies.

(3) Insurance coverage must be issued by insurance companies authorized to conduct business in the State of Texas.

(4) With the exception of Professional Liability Insurance maintained by Network Providers, all insurance coverage must name HHSC as an additional insured. In addition, with the exception of Professional Liability Insurance maintained by Network Providers and Business Automobile Liability Insurance, all insurance coverage must name HHSC as a loss payee.

(5) Insurance coverage kept by the MCO must be maintained in full force at all times during the

Term of the Contract, and until HHSC's final acceptance of all Services and Deliverables. Failure to maintain such insurance coverage will constitute a material breach of this Contract.

(6) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must have extended reporting periods of two years. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, the Contract Effective Date.

(7) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must provide that prior written notice be given to HHSC at least 30 Days before coverage is reduced below minimum HHSC contractual requirements, canceled, or non-renewed. MCO must submit a new coverage binder to HHSC to ensure no break in coverage.

(8) The Parties expressly understand and agree that any insurance coverages and limits furnished by MCO will in no way expand or limit MCO's liabilities and responsibilities specified within the Contract documents or by applicable law.

(9) MCO expressly understands and agrees that any insurance maintained by HHSC will apply in excess of and not contribute to insurance provided by MCO under the Contract.

(10) If MCO, or its Network Providers, desire additional coverage, higher limits of liability, or other modifications for its own protection, MCO or its Network Providers will be responsible for the acquisition and cost of such additional protection. Such additional protection will not be an Allowable Expense under this Contract.

(11) MCO will require all insurers to waive their rights of subrogation against HHSC for claims arising from or relating to this Contract.

(d) Proof of Insurance Coverage

(1) Except as provided in Section 17.01(d)(2), the MCO must furnish the HHSC Project Manager original Certificates of Insurance evidencing the required insurance coverage on or before the Effective Date of the Contract. If insurance coverage is renewed during the Term of the Contract, the MCO must furnish the HHSC Project Manager renewal certificates of insurance, or such similar evidence, within five Business Days of renewal. The failure of HHSC to obtain such evidence from MCO will not be deemed to be a waiver by HHSC and MCO will remain under continuing obligation to maintain and provide proof of insurance coverage.

(2) The MCO is not required to furnish the HHSC Project Manager proof of Professional Liability Insurance maintained by Network Providers on or before the Effective Date of the Contract but must provide such information upon HHSC's request during the Term of the Contract.

Section 17.02 ***Performance Bond.***

(a) The MCO must obtain a performance bond with a one (1) year term. The performance bond must be renewable and renewal must occur no later than the first Day of each subsequent State Fiscal Year. The performance bond must continue to be in effect for one year following the expiration of the final renewal period or the date the contract terminates. MCO must obtain and maintain the performance bonds in the form prescribed by HHSC and approved by TDI, naming HHSC as Obligee, securing MCO's faithful performance of the terms and conditions of this Contract. The performance bonds must comply with Chapter 843 of the Texas Insurance Code. At least one performance bond must be issued. The amount of the performance bond(s) should total $100,000.00 for each MCO Program within each Service Area that the MCO covers under this Contract. Performance bonds must be issued by a surety licensed by TDI and specify cash payment as the sole remedy. MCO must deliver each renewal prior to the first Day of the State Fiscal Year.

(b) Since the CHIP Perinatal Program is a subprogram of the CHIP Program, neither a separate performance bond for the CHIP Perinatal Program nor a combined performance bond for the CHIP and CHIP Perinatal Programs is required. The same bond that the MCO obtains for its CHIP Program within a particular Service Area also will cover the MCO's CHIP Perinatal Program in that same Service Area.

(c) Prior performance bonds received for a specific SFY will be released upon completion of the audit of the 334-Day FSR for the corresponding SFY.

Section 17.03 ***TDI Fidelity Bond***

The MCO will secure and maintain throughout the life of the Contract a fidelity bond in compliance with Chapter 843 of the Texas Insurance Code. The MCO must promptly provide HHSC with copies of the bond and any amendments or renewals thereto.