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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	September 1, 2011	Initial version of Attachment B-1, RFP Section 8, "Operations Phase Requirements."
Revision	2.1	March 1, 2012	Section 8.1.1.1 is modified to change the timeframes for PIPs from SFY to calendar year and to revise the due dates. Section 8.1.3 is modified to clarify PCP requirement's application (does not apply to CHIP Perinates (unborn children) and add a requirement regarding timely access to Network Providers, as required by 42 C.F.R. §438.206(c)(1)(ii). Section 8.1.3.2 is modified to add pharmacy access requirements effective 9/1/12. These standards are derived from Medicare Part D access standards, and the standards currently being met in the fee-for-service program. Section 8.1.4 is modified to require MCOs to enter into network provider agreements with any willing State Hospital and to clarify requirements for contracting with specialty pharmacies. Section 8.1.5.5 is modified to require the MCOs to include a link to financial literacy information on the OCCC web page as required by HB 2615. Section 8.1.8 is modified to add prior authorizations by pharmacists. Section 8.1.17 is modified to remove the requirement to submit an accounting policy manual. Section 8.1.17.1 "Financial Disclosure Report" is renamed "MCO Disclosure Statement" and the submission date is updated. Section 8.1.18.1 is modified to require MCOs to submit pharmacy encounter data no later than 25 calendar days after the date of adjudication. Section 8.1.18.4 is modified to clarify claims transaction formats for pharmacy claims. Section 8.1.18.5 is modified to require MCOs to maintain a mechanism to receive claims in addition to the HHSC claims portal. Section 8.1.19 is modified to require MCOs to designate a primary and secondary contact for all OIG requests and to outline the process and timeframes for responding to the OIG, to change the 60 day timeline for submitting the annual plan to 90 days, and to require MCOs to ensure their subcontractors receiving or making annual Medicaid

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			payments of at least $5 million comply with 1902(a)(68)(A) of the Social Security Act. Section 8.1.20.2 is modified to add DUR reporting requirements. Section 8.1.21 is revised to delete MCO developed PDLs and to clarify the reimbursement process. Section 8.1.21.1 is revised to clarify legal references and Clinical Edit requirements, and to add requirements regarding 340B drugs. Section 8.1.21.4 is modified to add requirements for the rebate dispute resolution process. Section 8.1.21.5 is modified to clarify that HHSC will provide up to 1 year of medication history to the MCOs for new Members with previous Medicaid eligibility. Section 8.1.21.9 is modified to clarify requirements for contracting with specialty pharmacies. Section 8.1.21.10 is deleted in its entirety. Section 8.1.23.1 is modified that copayment amounts are capped at the MCO's cost and that CHIP copayments do not apply to preventive services or pregnancy-related services. Section 8.1.24 is modified to clarify that MCOs must notify Medicaid and CHIP Providers of availability of vaccines through Texas Vaccines for Children Program and work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac Registry. Section 8.2.2.3.4 is modified to require MCOs to use standard Texas Health Steps language in their Member Materials as provided in the UMCM. Section 8.2.2.8 is amended to clarify the requirements regarding non-capitated dental services and to add "Texas Health Steps environmental lead investigation (ELI)". Remainder of list is renumbered. Section 8.2.4.2 is modified to add a reference to Gov't Code §533.005(a)(19). Section 8.2.8 is modified to add the phrase "unless an exception applies under federal law" to the first sentence. Section 8.2.13 is modified to specify that MCOs may be required to provide other wrap-around services at a date to be determined by HHSC.

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			Section 8.3.2 is modified to require the MCO to consider the availability of the PACE program when considering whether to refer a member to a nursing facility or other long-term care facility. Section 8.3.7.1 is modified to clarify the MA Dual SNP requirements. Section 8.4.3 is modified to correct a cross-reference.
Revision	2.2	June 1, 2012	Section 8.1.21 is modified to add pharmaceutical delivery requirements.
Revision	2.3	September 1, 2012	Section 8.1.1.1 is modified to conform to the timelines in the UMCM. Section 8.1.3 is modified to replace references to "1915(c) STAR+PLUS Waiver" with "HCBS STAR+PLUS Waiver". Section 8.1.3.2 is modified to clarify language regarding additional benchmark performance standards. Section 8.1.4 is modified to correct reference to TMPPM. Section 8.1.4.6 is modified to require HHSC review of all provider materials relating to Medicaid managed care or CHIP. Section 8.1.4.8 is modified to clarify the applicable federal regulations. Section 8.1.5.1 is modified to prohibit the MCOs from including any language in their member materials which limits the members' ability to contest or appeal denial of a benefit. Section 8.1.5.2 is modified to clarify that PCP name is not required for Dual Eligible STAR+PLUS Members or CHIP Perinates. Section 8.1.5.7 is modified to remove the acronym "CPW". Section 8.1.9 is modified to clarify the requirements regarding IFSPs. Section 8.1.12.2 is modified to remove the acronym "CPW". Section 8.1.14 is renamed and modified to remove all references to Health Home Services. Section 8.1.14.1 is renamed and modified to remove all references to Health Home Services.

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			Section 8.1.14.2 is renamed and modified to remove all references to Health Home Services. Section 8.1.19 is modified to update the time frames for responding to the OIG and to add language regarding Credible Allegation of Fraud notices. Section 8.1.20.2 items (j) and (l) are modified to correct UMCM references. Items (n) and (o) are modified to include pharmacy providers. Item (s) "Medicaid Managed Care Texas Health Steps Medical Checkups Quarterly Utilization Reports" is added. Section 8.1.20.2 is modified to add STAR+PLUS LTSS Utilization reporting requirements. Section 8.1.24 is modified to change the Texas Health Steps Periodicity Schedule to ACIP Immunization Schedule. Section 8.1.25 is modified to replace references to "1915(c) STAR+PLUS Waiver" with "HCBS STAR+PLUS Waiver". Section 8.1.26 Health Home Services is added. Section 8.1.26.1 Health Home Services and Participating Providers is added. Section 8.1.26.2 MCO Health Home Services Evaluation is added. Section 8.2.2.3.2 is modified to correct the acronym for Oral Evaluation and Fluoride Varnish. Section 8.2.2.3.3 is modified to clarify statutory authority. Section 8.2.2.3.5 is modified to add training requirements for pharmacy and DME. Section 8.2.2.8 is modified to remove the acronym "CPW". Section 8.2.2.11 is modified to replace the acronym CPW with "Case Management for Children and Pregnant Women" and the acronym THSteps with "Texas Health Steps". Section 8.2.7.1 is modified to correct URL for UM guidelines. Section 8.2.8 is modified to clarify the pay and chase requirements for prenatal and preventative care, and recoveries in the context of state child support enforcement actions (SSA §1902(a)(25)(E) and (F); and to correct contract cross reference. Section 8.2.10 is modified to remove the acronym "CPW" and to replace it with Case Management for Children and Pregnant Women.

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			Section 8.3.1.1 is modified to clarify eligibility for DAHS. Section 8.3.1.2 is modified to replace references to "1915(c) STAR+PLUS Waiver" with "HCBS STAR+PLUS Waiver" and to add DAHS to the list of Community Based LTSS under the HCBS STAR+PLUS Waiver. Section 8.3.2.6 is modified to replace references to "1915(c) Nursing Facility Waiver" with "HCBS STAR+PLUS Waiver". Section 8.3.2.8 is modified to update the MAO reference. Section 8.3.3 is modified to replace references to "1915(c) Nursing Facility Waiver" with "HCBS STAR+PLUS Waiver". Section 8.3.4 is modified to replace references to "1915(c) Nursing Facility Waiver" with "HCBS STAR+PLUS Waiver" and to increase the cost of care threshold from 200% to 202%. Section 8.3.4.1 is modified to replace references to "1915(c) STAR+PLUS Waiver" and "SPW" with "HCBS STAR+PLUS Waiver". In addition, risk criteria language is removed. Section 8.3.4.2 is modified to change the section name from "For Medical Assistance Only (MAO) Non-Member Applicants" to "For 217-Like Group Applicants' and to replace references to "1915(c) STAR+PLUS Waiver" and "SPW" with "HCBS STAR+PLUS Waiver". In addition, risk criteria language is removed. Section 8.3.4.3 is modified to replace references to "1915(c) Nursing Facility Waiver" with "HCBS STAR+PLUS Waiver". Section 8.3.5 is modified to replace references to "1915(c) STAR+PLUS Waiver" with "HCBS STAR+PLUS Waiver". Section 8.3.6.4 is modified to replace references to the 1915(b) and 1915(c) waivers with the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver. Section 8.4.3 is modified for consistency with the Medicaid pay and chase requirements.
Revision	2.4	March 1, 2013	All references to the previous Executive Commissioner Suehs are changed to his successor, Executive Commissioner Janek. Section 8.1.2.1 is modified to add language regarding reducing or deleting Value-added Services. Section 8.1.3.2 is modified to clarify network provider access and compliance rating.

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			Section 8.1.4.11 Provider Advisory Groups is added. Section 8.1.5.10 Member Advisory Groups is added. Section 8.1.18.5 is modified to add new language modeled off of insurance code requirements. Section 8.2.3 is modified to add new language regarding terminating Significant Traditional Providers. Section 8.2.13 is modified to address supplemental payments to MCOs for wrap-around services for outpatient drugs and biological products for STAR+PLUS Members. Section 8.2.13.1 Medicaid Wrap-Around Services for Outpatient Drugs and Biological Products is added. Section 8.3.1.1 is modified to delete Personal Attendant Services and delete language after (DAHS) is the service column. Section 8.3.1.2 is modified to delete DAHS service description and Licensure and Certification Requirements and modify Personal Assistance Services.
Revision	2.5	June 1, 2013	Contract amendment did not revise Attachment B-1, Section 8, “Operations Phase Requirements.”
Revision	2.6	September 1, 2013	Section 8.1.1.1 is modified to remove references to overarching goals and to clarify that HHSC will provide the PIP topics. Section 8.1.2.1 is modified to clarify that MCOs may not charge copayments for Value-added Services, but may offer discounts for non-covered services as Value-added Services as required by SB 632. Section 8.1.3.1 is modified to clarify timeframes for PCP referrals. Section 8.1.3.2 is modified to add a requirement for 2 PCPs within 30 miles for Medicaid child Members to comply with the Frew Corrective Action order. Section 8.1.4 is modified to add new pharmacy requirements as required by SB 1106 and HB 1358. Section 8.1.4.2 is modified for clarification and to comply with requirements of SB 406, 83R. Section 8.1.4.4 is modified to add timeframes for completing the credentialing process and to comply with requirements of SB 365, 83R.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.4.8 is modified to clarify the MCO's obligations for payment and Network Provider agreements and to comply with requirements of SB 7, 83R. Section 8.1.4.8.1 is modified to correct "Provider Preventable Conditions" to "Potentially Preventable Complications". Section 8.1.4.8.2 is modified to clarify provider incentives. Section 8.1.4.10 is modified for clarification and to comply with requirements of SB 1401, 83R. Section 8.1.4.12 Provider Protection Plan is added as required by SB 1150, 83R. Section 8.1.5.5 is modified to allow MCOs to offer provider search functionality on their websites instead of PDF versions of the Provider Directory. In addition, duplicative language is removed. Section 8.1.5.6 is modified to require the MCO's Member Services representatives to be trained regarding the override process for Members in the HHSC OIG Lock-in Program. Section 8.1.5.6.1 is modified to require the MCO's nurseline staff to be trained regarding the override process for Members in the HHSC OIG Lock-in Program. Section 8.1.5.7 is modified to allow MCOs to use certified community health workers/promotoras to conduct outreach and member education activities. Section 8.1.5.9 is modified to correct cross references. Section 8.1.8 is modified to update the URL for UM guidelines. Section 8.1.8.1 "Compliance with State and Federal Prior Authorization Requirements" is added as required by SB8, SB 644, and SB1216, 83R. Section 8.1.9 is modified to update the T.A.C. references and to align the age reference with the definition. Section 8.1.14 is modified to add a new Subsection 8.1.14.1 Special Populations. Subsequent subsections are renumbered. Section 8.1.14.3 is modified to add requirements for special populations. Section 8.1.15 is modified to clarify which DSM edition is referenced.

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			Section 8.1.15.7 is modified to delete the duplicative definition. The term "Court-Ordered Commitment" is defined in Attachment A. Section 8.1.18.1 is modified to require MCO Provider Agreements to comply with Texas Gov't. Code regarding reimbursement of claims based on orders or referrals by supervising providers. Section 8.1.18.5 is modified for clarification, for consistency with Section 1213.005 of the Insurance Code, and to comply with requirements of House Bill 15, 83R Section 8.1.19 is modified to include the HHSC OIG Lock-in Program. Section 8.1.20 is modified for clarification that records must be provided "at no cost." Section 8.1.20.1 is modified to correct the name to which the acronym HEDIS refers. Section 8.1.20.2 is modified to add Service Coordination reporting requirements. Section 8.1.21 Pharmacy Services is modified to reorganize the section and to add requirements as required by SB 644, HB 1358, 83R. Section 8.1.21.1 Formulary and Preferred Drug List (PDL) is added. Section 8.1.21.2 Prior Authorization for Prescription Drugs is modified to add "and 72-hour Emergency Supplies" to the title and to add requirements as required by SB 644, HB 1358, 83R Section 8.1.21.3 Coverage Exclusions is modified for clarity. Section 8.1.21.5 Pharmacy Rebate Program is modified to require MCOs to include NDCs on all encounters. Section 8.1.21.6 Drug Utilization Review (DUR) Program is modified to add requirements as required by SB 644, HB 1358, 83R Section 8.1.21.7 Pharmacy Benefit Manager (PBM) is modified to add requirements as required by SB 644, HB 1358, 83R Section 8.1.21.8 Financial Disclosures for Pharmacy Services is modified for clarity. Section 8.1.21.9 Limitations Regarding Registered Sex Offenders is modified for clarity

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			Section 8.1.21.10 Specialty Drugs is modified to add requirements as required by SB 644, HB 1358, 83R Section 8.1.21.11 Maximum Allowable Cost (MAC) Requirements is added. Section 8.1.21.12 Mail-order and Delivery is added. Section 8.1.21.13 Health Resources and Services Administration 340B Discount Drug Program is added. Section 8.1.21.14 Pharmacy Claims and File Processing is added. Section 8.1.21.15 Pharmacy Audits is added. Section 8.1.21.16 E-prescribing is added. Section 8.1.22 is modified to add more detail regarding FQHC/RHC payments. Section 8.1.27 Cancellation of Product Orders is added. Section 8.2.2.4 is modified to include education and care coordination for Members who are at high risk for pre-term labor. Section 8.2.2.8 is modified to add ECI Specialized Skills Training, to clarify the requirements for DADS hospice services, and to add court-ordered commitments to inpatient mental health facilities as a condition of probation. Section 8.2.4.2 is modified for clarification and to comply with requirements of SB 7, 83R. Section 8.2.13 is modified to clarify the language. Section 8.2.13.1 is modified to clarify the language. Section 8.3.2 is modified to add new subsections 8.3.2.1 “Service Coordination Plan Requirements,” and 8.3.2.2 “Service Coordination Structure.” Subsequent subsections are renumbered. -Section 8.3.2.3 is modified to include minimum requirements for Service Coordinators. Section 8.3.4.3 is modified to require the MCO to inform the Member about CDS during the annual reassessment. Section 8.3.4.4 STAR+PLUS Utilization Reviews is added as required by SB 348, 83R. Section 8.3.7.2 is modified to remove the reference to Attachment B-6.

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			Section 8.3.8 Minimum Wage Requirements for STAR+PLUS Attendants in Community Settings Reviews is added as required by Article II, Rider 61 of the General Appropriations Act (83R).
Revision	2.7	September 1, 2013	Section 8.2.16 “Supplemental Payments for Qualified Providers” is added. Additional detail regarding the process, including payment and reporting requirements will be added to the UMCM.
Revision	2.8	January 1, 2014	Section 8.1.4.4 is modified to clarify the timeframes for completing the credentialing process. Section 8.1.12.2 is modified to add Former Foster Care Child (FFCC) Members. Section 8.1.13 is modified to add Former Foster Care Child (FFCC) Members. Section 8.1.21.6 is modified to add requirements for assessing prescribing patterns for psychotropic medications. Section 8.1.21.14 is modified to clarify timeframes. Section 8.3.6.6 “Cost Reporting for LTSS Providers” is added.
Revision	2.9	February 1, 2014	Section 8.1.1.1 is modified to clarify that absent HHSC’s direction the MCO may choose to collaborate with other MCOs in the Service Area on one PIP per year. Section 8.1.1.1.1 “MCO Report Cards” is added. Section 8.1.2 is modified to remove the reference to Texas Medicaid Bulletins. Section 8.1.3 is modified to clarify Member payment responsibilities for services in a 24-hour setting as an alternative to Nursing Facility or hospitalization and for services in a Nursing Facility. Section 8.1.3.2 is modified to remove the definition of Qualified Mental Health Provider from Outpatient Behavioral Health Service Provider Access. In addition, Nursing Facility Access and Mental Health Rehabilitative Service Provider Access are added. Section 8.1.4 is modified to clarify licensure or certification requirements for all providers. In addition, Nursing Facility Services, Hospice Services, and Mental Health Rehabilitative Services are added.

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			Section 8.1.4.2 is modified to include physicians serving Members residing in Nursing Facilities. Section 8.1.4.4 is modified to require MCOs to use state-identified credentialing criteria for Nursing Facilities. In addition, a sub-section heading is added for 8.1.4.4.1 Expedited Credentialing Process. Section 8.1.4.6 is modified to require STAR+PLUS MCOs to assign a provider relations specialist proficient in Nursing Facility billing to each Nursing Facility. In addition, the role of Service Coordinators and early notification of and participation in discharge planning are added to the required Provider training. In addition, requirements for Mental health Rehabilitative Services are added. Section 8.1.4.8 is modified to update the UMCM chapter reference. Section 8.1.4.8.1 is modified to include CHIP. Section 8.1.4.8.3 “Nursing Facility Incentives” is added. Section 8.1.4.10 is modified to add TAC reference for pharmacy. Section 8.1.4.12 is modified to update the UMCM chapter reference. Section 8.1.5.2 is modified to clarify that the PCP’s name and telephone number are not required for Nursing Facility residents. Section 8.1.5.7 is modified to add Service Coordination for Cognitive Rehabilitation Therapy, Nursing Facility residents; Nursing Facility Services; discharge planning, transitional care, and other education programs for Nursing Facility residents; and supported employment and employment services. Section 8.1.5.11 “Member Eligibility” is added. Section 8.1.8 is modified to add that compensation to individuals or entities conducting UM activities cannot be structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services as required by 42 C.F.R. 438.210(e). Section 8.1.12.1 is modified to delete unnecessary information and clarify use of the term CSHCN. Section 8.1.12.2 is modified to clarify use of the term CSHCN.

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			Section 8.1.15.8 is modified to remove the requirement to comply with additional BH requirements as described in Section 8.2.8. Section 8.1.18.5 is modified to add timeframes for Nursing Facility claims and to clarify the MCO must provide a web portal at no cost to the Provider and its functionality. Section 8.1.19 is modified to require the MCOs to meet all requirements in Texas Government Code § 531.105. Section 8.1.20.2 is modified to add Nursing Facility Reports. Section 8.1.23 is modified to allow STAR+PLUS MCOs to assist with the collection of applied income from Nursing Facility Members. Section 8.1.28 Preadmission Screening and Resident Review (PASRR) Referring Entity Requirements is added. Section 8.2.1 is modified to clarify timeframes for prior authorizations for transitioning Members. Section 8.2.2.8 is modified to add PASRR Evaluations; and to clarify DSHS Targeted Case Management, Personal Care Services and Nursing Facility Services. Section 8.2.3 is modified to add Nursing Facilities as STPs for STAR+PLUS. Section 8.2.7.1 “Local Mental Health Authority (LMHA)” will be deleted in its entirety effective September 1, 2014. Section 8.2.7.3 “Mental Health Rehabilitative Services and Targeted Case Management Services” is added. Section 8.3.1 is clarified that LTSS providers must be licensed or certified. Section 8.3.1.1 is modified to clarify that MCOs must ensure access to PAS and DAHS for “qualified” STAR+PLUS Members. Section 8.3.1.2 is modified to add licensure, certification and other minimum qualification requirements for Employment Assistance, Supported Employment, Support Consultation, and Cognitive Rehabilitation Therapy. In addition, Consumer Directed Services (CDS) is renamed Financial Management Services and the requirements for Adult Foster Care are clarified. Section 8.3.2.1 is modified to add Level 1 requirements for Members in Nursing Facilities.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.3.2.2 is modified to add Behavioral Health outpatient services and Mental Health Rehabilitative Services, and Employment Assistance/Supported Employment. Section 8.3.2.3 is modified to clarify Member needs, and to add Employment Assistance/Supported Employment and Targeted Case management for Members receiving Mental Health Rehabilitative Services. Section 8.3.2.5 is modified to require the MCO to provide discharge planning, transition care, and other education programs to Network Providers regarding all available long term care settings and options. In addition Nursing Facilities are added. Section 8.3.2.6 is modified to include Nursing Facility Services and to change “Service Plan” to “transition plan.” Section 8.3.2.8 “Nursing Facilities” will be deleted in its entirety effective September 1, 2014. Section 8.3.2.9 “MCO Four-Month Liability for Nursing Facility Care” will be deleted in its entirety effective September 1, 2014. Section 8.3.3 is modified to add assessment requirements for Members in Nursing Facilities. Section 8.3.6.3 is modified to include Nursing Facility Providers. Section 8.3.6.7 “Electronic Visit Verification” is added. The UMCM chapter is under development. Section 8.3.9 “Nursing Facility Services Available to All Members” is added. Section 8.3.9.1 Preadmission Screening and Resident Review (PASRR) is added. Section 8.3.9.2 “Participation in Texas Promoting Independence Initiative’ is added. Section 8.3.9.3 “Nursing Facilities Training” is added. Section 8.3.9.4 “Nursing Facility Claims Adjudication, Payment, and File Processing” is added. Section 8.3.10 “Acute Care Services for Recipients of ICF-IID Program and IDD Waiver services” is added. Section 8.3.11 “Cognitive Rehabilitation Therapy” is added.

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Revision	2.10	April 1, 2014	Section 8.1.4 is amended to include "any willing provider" language for Nursing Facilities. Section 8.2.17 "Electronic Visit Verification "is added to include both STAR and STAR+PLUS. Section 8.3.6.7 is deleted in its entirety and the language is moved to Section 8.2.17.
Revision	2.11	September 1, 2014	Section 8.1.1.1 is modified to change the due date for PIP projects and to require the MCOs to complete a mid-year review process. Section 8.1.3 is amended to clarify that a STAR+PLUS Member receiving Adult Foster Care in his or her home is not required to pay room and board to the provider of that care and to remove duplicative language. Section 8.1.3.2 is modified to update the mileage requirements for Outpatient Behavioral Health Service Provider Access. Section 8.1.4 is modified to add a reference to utilization standards for CHIP (the Rule will be effective in December 2014), to clarify licensure requirements for all Providers, and include updated Nursing Facility dates. Section 8.1.4.2 is modified to change the date by which the MCO's network may include physicians serving Nursing Facilities. Section 8.1.4.4 is modified to specifically refer to anti-discrimination requirements. Section 8.1.4.6 is modified to add training materials pertaining to ADHD. Section 8.1.4.8 is modified to include language requiring compliance with Tex. Ins. Code § 1458.051 and §§ 1458.101-102. Section 8.1.4.8.1 is modified to add the UMCM chapter reference and to remove the HHSC approved methodology. Section 8.1.4.8.2 is modified to change the name from "Provider Incentives" to "MCO Value Based Contracting." In addition, the language is clarified. Section 8.1.4.12 is modified to include notice requirements for changes to the prior authorization process. Section 8.1.5.7 is revised to reflect the accurate date of Nursing Facility carve-in.

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			Section 8.1.5.8 is modified to remove reference to Section 7. Section 8.1.12.2 is modified to add a reference to women's health and family planning programs. Section 8.1.14.1 is modified to update the requirements. Section 8.1.18 is revised to define Major Systems Changes and to outline notice requirements. Section 8.1.18.4 is revised to clarify notice requirements. Attachment B-1, Section 8.1.18.5 is modified to clarify notice requirements and reflect updated Nursing Facility date. Section 8.1.19 is modified to include language related to requirements regarding a provider in the MCO's network who is under investigation by HHSC OIG. Section 8.1.20.2 is modified to remove the Medicaid Disproportionate Share Hospital (DSH) Report. In addition the Provider Referral and Perinatal Risk Reports are added. Section 8.1.21.2 is modified to require the MCOs to have an automated PA process. Section 8.1.21.7 is modified to add language prohibiting spread pricing. Section 8.1.21.11 is modified to clarify the process for making the MAC list accessible to Providers. Section 8.1.23.1 is modified to clarify requirements with respect to CHIP copayments. Section 8.2.1 is revised to clarify prior authorization requirements with respect to new Members. Section 8.2.2.2 is revised to update family planning requirements. Section 8.2.2.4 is updated to include requirements regarding outreach, education, and care coordination for Members at risk of a preterm birth. Section 8.2.2.8 is modified to remove DSHS Targeted Case management and DSHS mental health rehabilitation and to update Nursing Facility services. Section 8.2.3 is revised to reflect updated dates for Nursing Facilities. Section 8.2.4.2 is revised to include a requirement for the physician resolving the claims dispute.

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			Section 8.2.7.1 Local Mental Health Authority (LMHA) is deleted in its entirety. Section 8.2.10 is revised to include a reference to women's health and family planning programs. Section 8.2.13 is modified to reference newly added 8.2.13.2. Section 8.2.13.2 is added to set out coinsurance obligations for Members in Nursing Facilities. Section 8.2.17 is revised to reflect the modified date for EVV. Section 8.2.18 "Telemedicine, Telehealth, and Telemonitoring Access" is added. Section 8.3.1.2 is modified to remove the effective date and correct the experience requirements for Employment Assistance and Supported Employment. In addition, the effective date is removed for Cognitive Rehabilitation Therapy. Section 8.3.2.1 is modified to reflect Nursing Facility date. Section 8.3.2.2 is revised to reflect Nursing Facility date. Section 8.3.2.3 is revised to reflect Nursing Facility date. Section 8.3.2.4 is revised to use updated terminology. Section 8.3.2.6 is revised to reflect Nursing Facility date. Section 8.3.2.8 Nursing Facilities is modified to change the deletion date. Section 8.3.2.9 MCO four-Month Liability for Nursing Facility Care is revised to reflect updated Nursing Facility dates. Section 8.3.3 is modified to change the DADS Form 2060 to Form H2060and any applicable addendums; and Form 3671 to Form H1700. In addition, section is modified to require assessments for Members receiving DAHS and HCBS waiver services. Section 8.3.6.2 is modified to remove the reference to UMCM Chapter 2.1.2 and replace it with the STAR+PLUS Handbook. Section 8.3.6.3 is revised to reflect updated Nursing Facility date. Section 8.3.7.1 is modified to add a reference to a Dual Eligible Medicare-Medicaid (MMP) Plan.

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			Section 8.3.9 is revised to reflect updated Nursing Facility date. Section 8.3.9.4 is revised to include requirements for retroactive rate adjustments. Section 8.3.9.5 "Nursing Facility Direct Care Rate Enhancement "is added.
Revision	2.12	October 1, 2014	Section 8.1.21.17 "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.' Section 8.1.1.1 is modified to remove the references to "annual." Section 8.1.2.1 is modified to require MCOs to clarify restrictions and limitations to their VAS and notification process when deleting a VAS. Section 8.1.3.1 is modified to add Community Long-Term Services and Supports. Section 8.1.4 is modified to change an effective date. Section 8.1.4.4 is modified to add language regarding credentialing for new providers from Section 8.1.4.4.1 and to move the last sentence of the section to the end of the second paragraph. Section 8.1.4.4.1 is modified to move language regarding credentialing for new providers to Section 8.1.4.4 Section 8.1.4.4.2 Minimum Credentialing Requirements for Unlicensed or Uncertified LTSS Providers is added. Section 8.1.4.6 is modified to clarify language, require Provider training on the claims appeal and recoupment processes and Abuse or Neglect and Abuse, Neglect, or Exploitation. This section is also modified to clarify that if HHSC has not approved Provider Materials within 15 days, the MCO may use them only after first notifying HHSC of its intent to use. Section 8.1.4.8 is modified to clarify requirements for requesting an across-the-board rate reduction. Section 8.1.4.8.1 is modified to change "Potentially Preventable Complications" back to "Provider Preventable Conditions" and to clarify that PPC includes any hospital-acquired conditions or healthcare acquired conditions identified in the TMPPM.

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			Section 8.1.4.8.2 MCO Value-Based Contracting (Expansion of Alternative Payment Structures for Providers) is deleted in its entirety and the requirements added as Section 8.1.7.8.2. Section 8.1.4.8.3 is revised to state compliance with 42 C.F.R. § 438.60. Section 8.1.5.1 is modified to clarify approval requirements for Member Materials. Section 8.1.5.4 is modified to clarify the format for submission to the HHSC Administrative Services Contractor. Section 8.1.5.5 is revised to refer to UMCM chapters that set out general and pharmacy website requirements. Section 8.1.5.6 is modified to require the MCO's Member Service representatives be knowledgeable about how to identify and report a Critical Event or Incident such as Abuse or Neglect (CPS) and Abuse, Neglect, or Exploitation (APS). Section 8.1.5.7 is modified to remove effective dates. Section 8.1.5.8 is modified to clarify that MCOs are responsible for reimbursing Providers for language services. Section 8.1.7.8 Network Management is modified to add sub-section heading 8.1.7.8.1 Physician Incentive Plans. Section 8.1.7.8.2 MCO Value-Based Contracting is added. Section 8.1.8.2 is added to require that MCOs offer a toll-free fax line for service authorizations. Section 8.1.9 is modified to add subsection headings and clarify the roles and responsibilities of the MCOs. Section 8.1.12.1 is modified to list groups of Members considered MSHCN and to clarify identification requirements. Section 8.1.12.2 is modified to update the section name and to clarify service management requirements. Section 8.1.12.3 Service Management for MSHCN is added. Section 8.1.13 Service Management for Certain Populations is deleted in its entirety and the section is intentionally left blank. Section 8.1.14.1 is modified to update the due date. Section 8.1.15.3 is modified to clarify that the MCO must submit separate hotline reports for BH and other routine Member calls.

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			Section 8.1.15.9 Data Sharing with NorthSTAR is added. Section 8.1.17.1 is modified to remove unintentional language differences between the UMCC and the other contracts. Section 8.1.18.5 is modified to clarify claims processing and payment requirements. Section 8.1.19 is modified to add some additional OIG commonly requested information to the current list. Section 8.1.20.2 (a) is modified to add Nursing Facility Claims Summary Report requirements. In addition, the Enrollment Denial Report, Long-Term Services and Supports Report, and Pharmacy Quarterly Report are added. Section 8.1.21.1 is modified to remove the date. Section 8.1.21.2 is modified to reflect the new clinical edit review process. Section 8.1.21.3 is modified to add link to CMS list of participating drug companies. Section 8.1.21.5 is modified to clarify that MCOs are not allowed to negotiate rebates on *any* drugs and to add the Government Code citation. In addition, item c. is modified to require the MCO to provide HHSC with an update on the status of a claim correction. Section 8.1.21.6 is modified to remove a report that is no longer needed and to add language to conform to the STAR+PLUS MRSA contract. Section 8.1.21.8 is modified to require the MCO to disclose all financial terms and arrangements for their PBMs. Section 8.1.21.11 is modified to require MCOs and PBMs to use therapeutically equivalent A rated drugs when formulating MAC prices. Section 8.1.21.12 is modified to require the MCOs and PBMs to accept retail pharmacy POS claims for specialty drugs and to require MCOs to implement a process to ensure that Members receive free outpatient pharmaceutical deliveries from community retail pharmacies. In addition, it is clarified that mail order delivery is not an appropriate substitute for delivery unless requested by the Member. Section 8.1.25 is modified to clarify medical benefits coverage of some dental related services.

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			Section 8.1.26.2 MCO Health Home Services Evaluation is deleted in its entirety. Section 8.1.27 is modified to clarify MCO requirements related to delivery services for covered products. Section 8.2.2.3.1 is modified to clarify that checkups are due to children under the age of three and to refer to TMPPM for the most recent periodicity schedule. Section 8.2.2.3.5 is modified to add language requiring Provider training about blood level reporting and Medicaid coverage for lead screening, follow-up testing, and environmental lead investigations. Section 8.2.2.8 is modified to remove Nursing Facility services for STAR+PLUS. Section 8.2.6.1 is modified to clarify disenrollment requirements. Section 8.2.7.3 is modified to change "authorize" to "must contract with". Section 8.2.9.2 is modified to add language requiring Providers to coordinate with local authorities when following up on suspected or confirmed cases of childhood lead exposure. Section 8.2.10 is modified to add legal citations to language requiring Providers to report, coordinate, and follow-up on suspected or confirmed cases of childhood lead exposure. Section 8.2.17 is modified to remove the dates and clarify the requirements. Section 8.3.1.3 Member Education on Abuse or Neglect (CPS) and Abuse, Neglect, or Exploitation (APS) is added. Section 8.3.2.3 is modified to clarify the term Targeted Case Management and to include training for Abuse or Neglect and Abuse, Neglect, or Exploitation. Section 8.3.3 is modified to correct a date. Section 8.3.4.1 is modified to clarify timelines for assessment for and implementation of HCBS STAR+PLUS Waiver services. Section 8.3.6.3 is modified to reflect current requirements. Section 8.3.6.4 is modified to remove the reference to DADS. Section 8.3.9 is modified to change the section heading from “Nursing Facility Services Available to All Members” to

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			"Nursing Facility Services" and the section is modified to clarify that children under age 21 will remain in fee-for-service. In addition, Nursing Facility residents who are federally recognized tribal members over age 21 or who receive PACE may optionally enroll in STAR+PLUS. Section 8.3.9.2 is amended to include a statement that residents may choose to stay in a nursing facility if requirements are met. Section 8.3.9.4 is modified to add language requiring the MCO to use SAS data and to require MCOs to make minimum payment amounts to Qualified Nursing Facilities. Section 8.3.12 Reporting Abuse, Neglect, or Exploitation is added.
Revision	2.14	May 1, 2015	Section 8.1.4.4.2 is modified to clarify exceptions for the 7th requirement.
Revision	2.15	June 1, 2015	Section 8.1.5.7 is modified to remove effective dates and to add Community First Choice (CFC) services. Section 8.2.2.8 is modified to add Community First Choice services for STAR. Section 8.2.3 is modified to add Community First Choice providers as STPs for STAR+PLUS. Section 8.3.1.4 Community First Choice Services Available to Qualified Members is added. Section 8.3.2.1 is modified to add CFC Services for Level II Members. Section 8.3.2.3 is modified to add Community First Choice (CFC) services. Section 8.3.3 is modified to add CFC assessment requirements. Section 8.3.5 is modified to add Community First Choice services. Section 8.3.5.1 is modified to add Community First Choice services. Section 8.3.5.2 is modified to add Community First Choice services. Section 8.3.5.3 is modified to add Community First Choice services.

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			Section 8.3.6.3 is modified to add Community First Choice services. Section 8.3.8 is modified to add Community First Choice services. Section 8.3.13 Community First Choice Eligibility is added.
Revision	2.16	September 1, 2015	Section 8.1.1.1 is modified to clarify the requirements for collaboration. Section 8.1.2.1 is modified to change the due dates. Section 8.1.3 is modified to clarify the language. Section 8.1.3.2 is modified to remove past effective dates. Section 8.1.3.3 is modified to add requirements for a mandatory survey of Providers. Section 8.1.4 is modified to remove "when effective" from the CHIP Tex. Admin. Code references. Section 8.1.4.2 is modified to remove past effective dates. Section 8.1.4.4 is modified to clarify the requirement and to add applicability to LTSS providers. Section 8.1.4.6 is modified to qualify the cultural competency training requirement and to remove "Abuse or Neglect (CPS)" from the list. Section 8.1.4.9 is modified to require the MCOs to notify HHSC when a Provider termination impacts more than 10% of its Members. Section 8.1.5.5 is revised to correct the UMCM chapter number for the MMC/CHIP Website Critical Elements. Section 8.1.5.6 is modified to remove "Abuse or Neglect (CPS)" from the list. Section 8.1.5.8 is modified to require the MCOs to update the plan within 60 days if directed by HHSC. Section 8.1.7.7 is modified to change the section name to "Provider Credentialing and Profiling" and to add credentialing requirements. Section 8.1.9.5 is modified to reflect the new IFSP form and instructions developed by ECI. Section 8.1.11 is deleted in its entirety. Section 8.1.15.10 Mental Health Parity is added.

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			Section 8.1.16 is modified to correct a cross reference. Section 8.1.18.1 is modified to clarify the language and to add the STAR+PLUS Handbook Appendices Section XVI and to add requirements for the Quarterly Encounter Reconciliation Report. Section 8.1.18.5 is modified to remove out-of-date effective dates. Section 8.1.19 is modified to address issues of material misrepresentation. In addition, sub-section headings are added, and the section is reorganized for clarity. Section 8.1.20.1 is modified to change the section name from "Healthcare Effectiveness Data and Information Set (HEDIS) and Other Statistical Performance Measures" to "Performance Measurement" and to remove unnecessary language. Section 8.1.20.2 is modified to remove the "Nursing Facility Reports" and the "Provider Referral Report." Section 8.1.21.1 is modified to add certain LHHS and vitamins and minerals. Section 8.1.21.2 is modified to require the MCO to submit all clinical edit proposals in compliance with the required information outlined in the UMCM. Section 8.1.21.4 is deleted in its entirety. Section 8.1.21.7 is modified to comply with the requirements of SB 94. Section 8.1.21.11 is modified to clarify requirements regarding PSAOs. Section 8.2.2.8 is modified to add the qualifier "For STAR+PLUS" to DADS hospice services. Section 8.2.3 is modified to remove out-of-date effective dates. Section 8.2.6.2 is modified to clarify MCO payment responsibility for overturned DME prior authorization denials. Section 8.2.7.3 is modified to clarify eligibility requirements. Section 8.2.8 is amended to clarify requirement. Section 8.2.13.1 is modified to remove out-of-date effective date. Section 8.2.13.2 is modified to remove out-of-date effective date.

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			Section 8.2.19 is added to clarify requirements for STAR Members who enroll in the DADS Medicaid Hospice Program. Section 8.3.1.2 is modified to clarify Respite Care licensure requirements. Section 8.3.1.3 is modified to remove "Abuse or Neglect (CPS)." Section 8.3.2.1 is amended to remove the out of date effective date, to move Members with Behavioral Heath diagnoses to Level 1, to add exceptions to when Level 3 Members must have named Service Coordinators, and to clarify the service coordination performance standards. Section 8.3.2.2 is modified to change notification from 15 days to 5 days and to remove out-of-date effective dates. Section 8.3.2.3 is modified to remove "Abuse or Neglect (CPS)." Section 8.3.2.5 is modified to include inpatient psychiatric facilities. Section 8.3.2.6 is modified to remove out-of-date effective dates. Section 8.3.2.8 is being modified to add language regarding coordination with the Section 811 Project Rental Assistance Program. Section 8.3.3 is modified to remove out-of-date effective dates. Section 8.3.4 is modified to add "at annual reassessment and for assessments related to change in condition" to plan of care requirements and to clarify the role of HHSC Utilization Management Review (UMR) if the cost of care will exceed the 202% limit. Section 8.3.4.1 is modified to clarify the requirements. Section 8.3.8.2 is modified to apply only to SFY 2015. Section 8.3.8.3 "State Fiscal Year 2016 and After" is added. Section 8.3.9 is modified to remove out-of-date effective dates. Section 8.3.9.4 is modified to remove out-of-date effective dates. Section 8.3.9.5 is modified to require the MCOs to pay a rate enhancement that is no less than the rate that would be

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			developed under the methodology existing at HHSC on August 31, 2015. Section 8.3.10 is modified to remove out-of-date effective dates. Section 8.3.12 is modified to update the legal citations. Section 8.4.3 is amended to clarify the requirement.
Revision	2.17	March 1, 2016	All references to the previous Executive Commissioner Janek are changed to his successor, Executive Commissioner Traylor. All references to “Fraud and Abuse” are changed to “Fraud, Waste, and Abuse” Section 8.1.1.2 is modified to require the MCO to allow HHSC access for remote monitoring. Section 8.1.2 is modified to require MCOs to monitor claims data for delivery of prior authorized acute and long-term care services and to require the MCOs to utilize evidence based medical policies. Section 8.1.3.1 is modified to remove “non-HCBS STAR+PLUS Waiver” from item 5. Section 8.1.4.4.2 is modified to remove “Abuse or Neglect (CPS)” and “(APS)” from items 4 and 5. Section 8.1.4.9 is modified to the timeframe. Section 8.1.5.11 is modified to require MCOs to adhere to the minimum requirements set in the UMCM. Section 8.1.6 is modified to correct the UMCM reference. Section 8.1.12.1 is modified to require the MCOs to submit a quarterly MSHCN report as described in the UMCM. Section 8.1.20.2 is modified to add “Critical Incidents and Abuse, Neglect, and Exploitation Report” and “MSHCN Quarterly Report.” Section 8.1.21.1 is modified to change “Clinical Edits” to “Clinical PAs.” Section 8.1.21.2 is modified to add language regarding VDP’s Clinical PA process and dispensing or refilling a prescription without a prior authorization during a Governor-declared disaster.

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			Section 8.1.21.6 is modified to correct a C.F.R. reference, to remove the prospective review and POS requirement, and to add a reference to UMCM Chapter 5.13.4 Section 8.1.21.15 is modified to prohibit the use of extrapolation in pharmacy audits and to remove the requirement to comply with Texas Insurance Code § 843.3401 Section 8.1.21.17 "Second Generation Direct Acting Antivirals for Hepatitis C" is deleted in its entirety. Section 8.2.6.4 is modified to require MCOs to ensure appropriate staff attends all Fair Hearings as scheduled. Section 8.2.15 "Abuse, Neglect, or Exploitation" and Section 8.2.15.1 "Member Education on Abuse, Neglect, or Exploitation" are added. Section 8.2.15.2 "Abuse, Neglect, and Exploitation Email Notifications" is added. Section 8.2.18.1 "School-based Telemedicine Services" is added. Section 8.3.1.3 "Member Education on Abuse, Neglect, or Exploitation" is deleted in its entirety and moved to Section 8.2.15.1. Section 8.3.2.2 is modified to clarify that an integrated Health Home may perform Service Coordination functions and serve as an identified Service Coordinator. Section 8.3.3 is modified to move requirements for Members needing Nursing Facility Services; to add subsection headings 8.3.3.1 "CFC Services" and 8.3.3.2 "HCBS STAR+PLUS Waiver" and to clarify the requirements. In addition, Section 8.3.3.2 is modified to require MCOs to monitor claims data for delivery of prior authorized services. Section 8.3.4 is modified to clarify eligibility for the HCBS STAR+PLUS Waiver. Section 8.3.4.1 is renamed "Members Eligible for HCBS STAR+PLUS Waiver" and the requirements are clarified. Section 8.3.4.2 is renamed "Non-Member Applicants Eligibility for HCBS STAR+PLUS Waiver" and the requirements are clarified. Section 8.3.4.3 is modified to clarify the requirements. Section 8.3.12 "Reporting Abuse, Neglect, or Exploitation" is deleted in its entirety.

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Revision	2.18	June 1, 2016	Contract amendment did not revise Attachment B-1, Section 8, "Operations Phase Requirements."
Revision	2.19	September 1, 2016	All instances of "Frew v. Traylor" are changed to "Frew v. Smith" and all instances of "Alberto N., et al. v. Traylor, et al." are changed to "Alberto N., et al. v. Smith, et al." to conform to the change in HHSC leadership on June 1, 2016. Section 8.1.4 is modified to modify Children's Hospitals/Hospitals with specialized pediatric services and to add Adult Foster Care and Prescribed Pediatric Extended Care Centers (PPECC) as a provider type. Section 8.1.4.1 is modified to require the MCOs to provide each provider with a copy of the executed provider contract within 45 days of execution. Section 8.1.4.4.1 is modified to add provider types for which the MCOs must expedite credentialing. Section 8.1.4.6 is modified to clarify item 7; and to remove item 16 "requirements of the *Frew v. Traylor* Consent Decree and Corrective Action Orders". Section 8.1.4.8 is modified to align the contract language with the Texas Government Code. Section 8.1.4.8.2 Safety-net Hospital Incentives is added. Section 8.1.4.9 is modified to clarify the reporting requirement. Section 8.1.5.1 is modified to clarify delivery of hard copies of the Provider Directories. Section 8.1.5.4 is modified to clarify the requirements and to add Subsections 8.1.5.4.1 Hard Copy Provider Directory and 8.1.5.4.2 Online Provider Directory. Section 8.1.5.5 is modified to add a reference to the Online Provider Directory and to add requirements for mobile device use. Section 8.1.5.11 is modified to change "may" to "must" and to update the UMCM reference. Section 8.1.7.5 is modified to note that NorthSTAR will discontinue beginning January 1, 2017. Section 8.1.9.5 is modified to note that NorthSTAR will discontinue beginning January 1, 2017. Section 8.1.11 Coordination with Texas Department of Family and Protective Services is added.

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			Section 8.1.12.1 is modified to clarify "Members identified by NorthSTAR" or the MCO. Section 8.1.12.3 is modified to clarify that Service Management includes coordination to prevent duplication of services. Section 8.1.15 is modified to note that NorthSTAR will discontinue beginning January 1, 2017. Section 8.1.15.9 is modified to note that NorthSTAR will discontinue beginning January 1, 2017. Section 8.1.19 is modified to clarify MCO level of cooperation and assistance. Section 8.1.19.2 is modified to clarify and provide support to the Deliverables/Liquidated Damages Matrix. Section 8.1.20.2 is modified to update the requirements for items (d) (e) (f) (g) and (h); to delete items (n) (o) and (r) and re-letter all subsequent items; and to add item (w). Section 8.1.24 is modified to require the MCOs to educate providers on documentation for immunizations. Section 8.2.1 is modified to require the MCO to honor prior authorizations from the NorthSTAR BHO. Section 8.2.2.3.2 is modified to require the MCOs to educate providers on OEFV documentation. Section 8.2.2.3.5 is modified to clarify items 3 and 4 and to remove the requirement for the MCO to educate and train Providers regarding the requirements of the *Frew v. Traylor* Consent Decree and Corrective Action Orders. Section 8.2.2.8 is modified to add item 16 "Mental Health Targeted Case Management and Mental Health Rehabilitative Services for Dual Eligible Members." Sections 8.2.2.13 Prescribed Pediatric Extended Care Centers and 8.2.2.13.1 Prior Authorization for PPECC Services are added. Section 8.2.7.2.1 is modified to note that NorthSTAR will discontinue beginning January 1, 2017. Section 8.2.7.3 is modified to add clinic/group practices to the list of qualified Network entities. Section 8.2.14 is modified to remove the reference to the requirements of the *Frew v. Traylor* Consent Decree and Corrective Action Orders.

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			Section 8.2.15.3 MCO Training on Abuse, Neglect, and Exploitation is added. Section 8.2.20 Carve-in Readiness is added. Section 8.3.1.2 is modified to clarify the Adult Foster Care Licensure requirements. Section 8.3.1.4 is modified to add TAC reference. Section 8.3.2.1 is modified to require notification to Members be in writing. Section 8.3.2.2 is modified to require notification to Members be in writing. Section 8.3.2.3 is modified to clarify Service Coordinator qualifications for Level 1 Members. In addition, Service Coordinators are required to complete 20 hours of training every 2 years and to attend all HHSC UM trainings. Section 8.3.3 is modified to clarify when the MCO must use Form H2060 or Form H6516. Section 8.3.3.1 is modified to change language from "renewal" to "annual reassessment" to be consistent with the portal and forms and to clarify the time frame for when the MCO can conduct and submit the annual reassessment. Section 8.3.3.2 is modified to change language from "renewal" to "annual reassessment" to be consistent with the portal and forms and to clarify the time frame for when the MCO can conduct and submit the annual reassessment. Section 8.3.4.3 is modified to remove the 45-day language and remove "annual" from reassessment to be consistent with form instructions. Section 8.3.4.3.1 "Reassessment Following a Change in Condition" is added. Section 8.3.6.5 Annual Contact with STAR+PLUS Members is deleted in its entirety. Section 8.3.9.4 is modified to clarify that the MPAP terminated on September 1, 2016 and to outline payment adjustment requirements.
Revision	2.20	December 1, 2016	Contract amendment did not revise Attachment B-1, Section 8, “Operations Phase Requirements.”
Revision	2.21	February 1, 2017	Contract amendment did not revise Attachment B-1, Section 8, “Operations Phase Requirements.”

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Revision	2.22	March 1, 2017	All references to OIG or IG are changed to HHSC OIG. Section 8.1.1.1 is modified to align to the UMCM and to remove the reference to the NorthSTAR program. Section 8.1.3.1 is modified to change the section name from "Waiting Times for Appointments" to "Appointment Accessibility" and the requirements are updated. Senate Bill 760, 84th Legislature, requires HHSC to start several network adequacy initiatives in Medicaid managed care. This contract language clarifies requirements for appointment wait times. Section 8.1.3.2 is modified to clarify time and mileage standards for network providers. Senate Bill 760, 84th Legislature, requires HHSC to start several network adequacy initiatives in Medicaid managed care. CMS also requires states to implement network adequacy requirements with time and distance standards by Sept. 2018. See C.F.R. 438.68 (b). Section 8.1.3.3 is modified to change the mandatory challenge survey to a Provider Directory Verification Survey and to update the requirements. Section 8.1.4 is modified to clarify that qualified PPECCs include those with a temporary, initial, or renewal license. Section 8.1.4.4.1 is modified to add Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Psychologists to the list of providers allowed to provide services to members on a provisional basis while in the credentialing process. Section 8.1.4.6 is modified to require the MCOs to notify Providers of changes to provider relations specialists and to remove the requirement for HHSC's review of provider materials and to add a reference to UMCM chapters 3, 4, and 8 for material and submission requirements. Section 8.1.5.1 is modified to remove review timeframe. Review timeframes can be found in UMCM Chapter 4.6 MCO Materials Submission Process. Section 8.1.5.6 is modified to add requirements that Member Service representatives be knowledgeable about service management and service plans and trained to assist with scheduling an appointment. Section 8.1.5.8 is modified to add CLAS requirements. Section 8.1.7.5 is modified to remove NorthSTAR language.

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			Section 8.1.5.12 Member Service Email Address is added to comply with SB 760, 84th Legislature which requires MCOs to have an email address for assistance with appointments. Section 8.1.9.5 is modified to remove NorthSTAR language. Section 8.1.12.1 is modified to remove NorthSTAR language. Section 8.1.12.2 is modified to clarify credentialing requirements, to update the name of the Healthy Texas Women Program, and to remove the Expanded Primary Health Care Program. Section 8.1.12.3 is modified to add a cross reference to Section 8.1.12.4; the section is split to add Section 8.1.12.4 "Service Plan for MSHCN"; and the Service Plan requirements are clarified. Section 8.1.12.4.1 "Service Plan for STAR+PLUS Members" is added. Section 8.1.15 is modified to remove NorthSTAR language. Section 8.1.15.7 is modified to obligate MCOs to pay for court ordered services when they are a Medicaid benefit (outside the IMD exclusions age range of 21-64); to remove a provision that specifically prohibits MCOs paying for court ordered commitments; and to require MCOs to cover SUD treatment as a condition of probation. Section 8.1.15.9 "Data Sharing with NorthSTAR" is deleted in its entirety. Section 8.1.15.10 is modified to conform to CMS clarifying guidance regarding mental health parity. Section 8.1.18.2 is modified to remove the phrase "at the beginning of each State Fiscal Year" from the first and second paragraph. Section 8.1.19 is modified to add a reference to Texas Government Code § 531.1131. Section 8.1.19.3 is modified to add item 2 and all subsequent items are renumbered. Section 8.1.20.2 is modified to remove (p) and add items (w) (x) and (y). Section 8.1.22 is modified to clarify the payment requirements. Section 8.2.1 is modified to remove the reference to NorthSTAR and to add requirements for newly enrolled

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			Members who were receiving a service that did not require a prior authorization in FFS, but does require one by the new MCO. Section 8.2.2.2 is modified to update the name of the Healthy Texas Women Program and to remove the Expanded Primary Health Care Program. Section 8.2.7.2.1 is modified to remove NorthSTAR language. Section 8.2.2.8 is modified to remove item 11 "Court-Ordered Commitments to inpatient mental health facilities as a condition of probation" and all subsequent items are renumbered. Section 8.2.14 "Medical Transportation" is deleted in its entirety as being not necessary. Section 8.3.2.2 is modified to add Trauma-informed care and trauma-informed practices; Working with individuals with Intellectual or Development Disabilities (IDD); and LTSS and medical services that may be required for individuals with IDD to the list. Section 8.3.2.3 is modified to change the date for required comprehensive training on Person-Centered Practices and Person-Centered Plan Facilitation. Section 8.3.2.8 is modified to clarify the requirement. Section 8.3.3 is modified to address Provider concerns regarding Member and Provider notification of any changes or denial of changes to a Member's current authorization for community based LTSS following the reassessment of a Member who experiences a change in condition. Section 8.3.3.2 is modified to add a missing word. Section 8.3.4.3.1 is modified to address Provider concerns regarding Member and Provider notification of any changes or denial of changes to a Member's current authorization for community based LTSS following the reassessment of a Member who experiences a change in condition. Section 8.3.6.2 is modified to remove the reference to a UMCM chapter that has been withdrawn. Section 8.3.9.2 is modified to specify the assessments and align the timeframe with existing policy. Section 8.4.5 “Continuity of Care and Out-of-Network Providers” is added.

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Revision	2.23	June 1, 2017	Contract amendment did not revise Attachment B-1, Section 8, "Operations Phase Requirements."
Revision	2.24	September 1, 2017	Section 8.1.1.3 is added to allow HHSC utilization review unit to perform its duties of review and evaluation of the MCOs delivery of services under the contract by reviewing MCO policies, procedures, and documents related to the delivery of such services. Section 8.1.1.2 is modified to add material subcontractor site visit language and to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement. Section 8.1.2 is modified to comply with 42 C.F.R. §438.210. Section 8.1.2.1 is modified to reduce the opportunity for changes to Value-added Services from biannual to annual. Section 8.1.3 is modified to comply with a court order requiring FQHC non-emergency unauthorized out-of-network services to be fully reimbursed. Section 8.1.3.2 is modified to align the age requirements for PCPs with the American Academy of Pediatrics; add oncology to Specialist Physician Access standards; and to comply with managed care access requirements to be based on distance or travel time rather than both. Section 8.1.4 is modified to comply with 42 C.F.R. §457.990 regarding enrollment of CHIP providers. In addition, the reference to the DSHS website is changed to HHSC. Section 8.1.4.2 is modified to add Indian Health Care Providers to comply with 42 C.F.R. §438.14 and to align the age requirements for PCPs with the American Academy of Pediatrics Section 8.1.4.4 is modified to reference compliance with all of 42 C.F.R. §438.214 Section 8.1.4.6 is modified to clarify requirements regarding provider relations specialists to ensure a sufficient number of staff are available to nursing facilities and their information is easily accessible. Additional training on specific issues raised by nursing facilities has also been added. Section 8.1.4.7 is modified to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to

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			discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement. Section 8.1.4.8.4 is added to comply with a new CMS managed care requirement in 438.602(d)(2). Section 8.1.4.9 is modified to comply with 42 C.F.R. §438.10(f)(1), which relates to written notice of termination of a contracted provider. Section 8.1.5.1 is modified to comply with 42 C.F.R. §438.10. Section 8.1.5.4.2 is modified to comply with 42 C.F.R. §438.10, which relates to provider directories, member handbooks, and formularies. Section 8.1.5.6 is modified to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement. Section 8.1.5.7 is modified to include MBCC Members. Section 8.1.5.9 is modified to change the performance standard for applying liquidated damages on Member appeals to be applicable to standard and expedited appeals. Section 8.1.5.10 is modified to comply with 42 C.F.R. §438.110. Section 8.1.7.1 is modified to comply with 42 C.F.R. §438.332. Section 8.1.7.8.2 "MCO Value-Based Contracting" is renamed "MCO Alternative Payment Models with Providers" and the requirements are updated to establish targets for MCOs regarding levels of payments tied to APMs with Providers. Section 8.1.7.9 is modified to clarify that MCOs using HEDIS hybrid measures are responsible for conducting chart reviews and submitting results to the EQRO. Section 8.1.9.1 is modified to add Member Handbook to the list of policies and procedures and substituting HHSC for DARS. Section 8.1.12.1 is modified to add AA and PCA Members. Section 8.1.12.2 is modified to reflect the family planning program changes. Section 8.1.12.4 is modified to comply with 42 C.F.R. §438.208 and to add person-centered language in item 3.

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			Section 8.1.12.4.2 "STAR Service Management and Service Plan for AA and PCA Members" is added. Section 8.1.14.1 is modified to change the submission of the Plan for Special Populations from an annual report to an ad hoc report. Section 8.1.15.3 is modified to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement. Section 8.1.15.10 is modified to add specificity to the requirement. Section 8.1.17 is modified to clarify reasonable costs. Section 8.1.17.1 is modified to add item (n) "Medical Loss Ratio (MLR) Report" to comply with 42 C.F.R. §438.8. Section 8.1.18 is modified to reduce the need for HHSC staff to pay out of pocket for meals and direct MCOs to discontinue requesting personal information from HHSC staff as a requirement for travel reimbursement. Section 8.1.18.5 is modified to require the STAR+PLUS MCOs to display member eligibility verification data on their MCO portals; and to upload that data within 24 hours of receiving the file from HHSC; to keep online automated NF claims payment history for the most current 24 months; and to require MCOs to notify Providers regarding reprocessing of adjudicated claims. Section 8.1.18.5.1 is added to ensure MCOs are completing their claims projects and submitting final claims in a timely fashion. Section 8.1.19.2 is modified to add a five business day timeframe for requests submitted to the MCO/DMO for policy guidance, interpretations or clarifications. Section 8.1.19.4 (7) clarifies how settlements under the False Claims Act will be handled. Section 8.1.20.2 is modified to change the reporting requirements for "Claims Summary Report" to Program only, to delete "Children of Migrant Farmworkers Annual Plan" and to change the report title "Children of Migrant Farmworkers Annual Report (FWC Annual Report)" to "Migrant Farmworker Child Annual Report (FWC Annual Report) and Annual FWC Report Log" and update the requirements.

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			Section 8.1.21 is modified to comply with 42 C.F.R. §438.3(s) and the Mental Health Parity and Addiction Equality Act (MHPAEA) of 2008. Section 8.1.21.1 is modified to comply with 42 C.F.R. §438.10, which relates to provider directories, member handbooks, and formulary information. Section 8.1.21 is modified to comply with 42 C.F.R. §438.3(s). Section 8.1.22 is modified to comply with a court order related to the Legacy lawsuit requiring FQHC non-emergency unauthorized out-of-network services be fully reimbursed. Section 8.2.1 modified to comply with 42 C.F.R. §438.208(b)(3). Section 8.2.1.1 "Residential and HCBS LTSS Continuity of Care" is added to comply with 42 C.F.R. §438.56(d)(2)(iv). Section 8.2.2.1 is modified to update the citation to 42 C.F.R. §438. 113. Section 8.2.2.3.4 is modified to clarify requirements as a result of the Frew settlement agreement. Section 8.2.2.3.5 is modified to clarify requirements as a result of the Frew settlement agreement. Section 8.2.2.7 is modified to comply with 42 C.F.R. §438.102. Section 8.2.2.12 is modified to provide consistency with contract definitions and implement administrative efficiencies for MCOs and HHSC staff. Section 8.2.3 is modified to add STPs for AA/PCA and MBCC and to remove Pharmacy providers and all other provider types in the table as the dates have passed. Section 8.2.4 “Provider Complaints and Appeals” is renamed “Provider Complaints and Internal MCO Appeals”; Section 8.2.4.1 Provider Complaints is amended to provide greater clarification regarding proper and timely dissemination of information to the noted parties. Section 8.2.4.2 "Appeal of Provider Claims" is renamed “Provider Appeal of MCO Claims Determinations" and to comply with 42 C.F.R. §438.414. Section 8.2.6.1 "Member Complaint Process" is renamed "MCO Member Complaint Process".

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			Section 8.2.6.2 "Medicaid Standard Appeal Process" is renamed "Medicaid MCO Appeal Process" modified to change the performance standard for applying liquidated damages on member appeals to be applicable to standard and expedited appeals, to clarify that MCOs must not recover costs from Members without written permission from HHSC, and to comply with 42 C.F.R. §§438.402, 438.406, and 438.420(b)(5). Section 8.2.6.7 is modified to clarify that both Members and any entity acting on behalf of the Member must receive appeal resolutions in writing. Section 8.2.8 is modified to clarify the requirements. Section 8.2.10 is modified to reflect the family planning program changes. Section 8.3.1.2 is modified to comply with 42 C.F.R. §438.3(o). Section 8.3.1.4 is modified to comply with 42 C.F.R. §438.3(o). Section 8.3.2.1 is modified to add MBCC requirements. Section 8.3.2.2 is modified to add Service Coordination phone requirements. Section 8.3.2.3 is modified to include additional education requirements based on deficits verbalized by Service Coordinators and seen in UR reviews. Section 8.3.3 is modified to align the timeframes with the requirements in Section 8.3.4.3.1. Section 8.3.3.2 is modified to clarify eligibility requirements for HCBS STAR+PLUS waiver services and to shorten the time period for the MCO to identify and resolve lack of service provision which can place the Member at risk for harm. Section 8.3.6.1 is modified to delete transition language. Section 8.3.9.2 is modified to add relocation functions to educate and support member's transition from institutions to the community. Section 8.3.9.3 is modified to delete transition language. Section 8.3.9.4 is modified to require the MCO to automatically adjust retroactive payment and to meet the benchmark outlined in UMCM Chapter 2.3.

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			Section 8.3.9.5 is modified to require the MCO automatically adjust retroactive payment and to meet the benchmark outlined in UMCM Chapter 2.3. Section 8.4.2 is modified to change the performance standard for applying liquidated damages on member appeals to be applicable to standard and expedited appeals.
Revision	2.25	March 1, 2018	The following changes were made throughout the attachment: Updates to citations Removal of hyperlinks Change “patient” to “Member” Change “shall” to “must” Change “Network Provider Agreement” and “Provider Agreement” to “Provider Contract” Change “day(s)” and “calendar day(s)” to “Day” Remove numeric number for those numbers under 10 Capitalized defined terms Changed order of terms Fraud, Waste and/or Abuse to consistent use of phrase Changed “Expedited Appeal” to “Expedited MCO Internal Appeal” Changed “Fair Hearing System” to “State Fair Hearing System” Section 8.1.2.2 is modified to accommodate 42 C.F.R. § 438.3(e). Section 8.1.3 is modified to comply with a court order requiring FQHC non-emergency unauthorized out-of-network services to be fully reimbursed. Section 8.1.4 is modified to comply with Government Code § 533.00251(e) Nursing Facility credentialing and to comply with implementation of HB 3675, 85r. Section 8.1.4.2 is modified to comply with American Academy of Pediatrics. Section 8.1.4.4 is modified to comply with Government code § 533.00251(e). Section 8.1.4.4.1 is modified to comply with term of the contract between the MCO and the Nursing Facility.

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			Section 8.1.4.8.1 is modified to comply with 42 C.F.R. § 438.3(g). Section 8.1.4.8.5 is added to include the implementation of Uniform Hospital Rate Increase Program effective March 1, 2018. Section 8.1.4.8.6 is modified to reflect that HHSC is now calculating quality incentive payment program payments, rather than MCOs. HHSC will tell MCOs how much to pay the Nursing Facilities, and MCOs have 20 Days to make the payments. If a Nursing Facility is paid an amount different from what was calculated by HHSC, the MCO will resolve the discrepancy directly with the Nursing Facility. Additionally, quality incentive payment program is moved to a new section specifically about direct payment programs. Section 8.1.4.12 is modified to state expectations related to retaliation, to withdraw MCO geo-mapping and MCO requirement to participate in HHSC's work group. Section 8.1.5.1 is modified to remove references to potential members from requirements, to remove references to written materials, and to ensure all information provided by MCOs to Members complies with 42 C.F.R. § 438.10. Section 8.1.5.4.1 is modified to comply with 42 C.F.R. § 438.10(h)(3). Section 8.1.5.4.2 is modified to add "at least" to weekly updates to online provider directories. Section 8.1.5.7 is modified to add MBCC Members and oncology to the list of education initiatives. Section 8.1.5.8 is modified to add standardized requirements for cultural competency plans and to clarify services for Competent Interpreters. Section 8.1.8 is modified to include "outside of these hours". Section 8.1.8.2 is modified to include "Provider portal". Section 8.1.12.1 is modified to clarify requirements regarding Service Management for Members with Special Health Care Needs (MSHCN). Section 8.1.12.4 is modified to clarify requirements regarding Service Management for Members with Special Health Care needs.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.12.4.2 is modified to comply with ongoing outreach requirements with STAR Kids & to clarify outreach requirements in cases of retroactive enrollment. Section 8.1.18.1 is modified to comply with 42 C.F.R. §§ 438.242 and 438.818. Section 8.1.19.6 is modified to convert the timing from ad hoc to annual. Section 8.1.20.2 is modified to standardize language across all MCOs. Section 8.1.21 is modified to limit HHSC and MCO liability. Section 8.1.21.2 is modified to give more flexibility to the MCOs by allowing the pharmacy to dispense a 72-hour supply of drug in emergency situations. Section 8.1.21.3 is modified to add flexibility to deny certain claims for compound medications and to add clarity to the automatic approval of compounded medications. Section 8.1.21.4 “Compounded Medications” is added. Section 8.1.21.6 is modified to provide a clear set of expectations for compliance with UMCC requirements for PMUR. Section 8.1.21.13 is modified to require MCOs to deny retail claims of 340B drugs. Section 8.1.22 is modified to comply with a court order requiring wrap payments and that FQHC non-emergency unauthorized out-of-network services be fully reimbursed. Section 8.1.24 is modified to include “appropriate designee”. Section 8.2.1 is modified to make certain MCOs ensure continuity of care of newly enrolled Members. Section 8.2.1.1 title and related section language is moved down within the contract and is modified to clarify Provider requirements to notify Members of their option to change MCOs. Section 8.2.2.3.4 is modified to replace the term “must” with “should” when informing Members of available Texas Health Steps services. Section 8.2.2.3.5 is modified to remove reference to MCOs encouraging Network pharmacies to become Medicaid enrolled DME providers.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.2.4 is modified to change the title from "Provider Complaints Internal MCO and Appeals" to "MCO Internal Provider Complaints and Appeals Process". Sections 8.2.6 and 8.2.6.1 are modified to move the definition of authorized representative from 8.2.6.1 to 8.2.6. Section 8.2.6.1 is modified to include the term "Internal" in the title and remove the term "appeal" from this section. Section 8.2.6.2 is modified to update language surrounding State Fair Hearings. Section 8.2.6.3 is modified to comply with 42 C.F.R. § 438.410, and "three Business Days" is replaced with "72 hours" when the MCO must notify the Member of the Expedited MCO Internal Appeal outcome. Section 8.2.6.4 is modified to comply with 42 C.F.R. § 438.408, and to clarify Members rights to access the State Fair Hearing process. Section 8.2.6.6 is modified to replace the term "Appeal" with "Complaint". Section 8.2.8 is modified to require MCOs to submit a yearly plan/TPL process and clarify deadlines for billing & collection of TPL recoveries. Section 8.2.11 is modified to a 6th grade reading comprehensive level. Section 8.3.2.2 modified to remove the sentence "Service Coordination teams will have an overarching philosophy of independent living, self-determination, and community integration". Section 8.3.3.2 is modified to provide additional guidance and flexibility to MCOs in operationalizing the follow-up requirements. Section 8.3.9 is modified to comply with Tex. Gov't. Code § 533.00251(e), remove two paragraphs, move to S+P Handbook. Section 8.3.9.2 is modified to add a requirement for MCOs to distribute supplemental funds for essential household or transition expenses not covered by Transition Assistance Services or other resources. Section 8.3.9.4 is modified to remove reference to MPAP because it was terminated September 1, 2016. Section 8.4.3 is modified to align with Section 8.2.8.

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Revision	2.25.1	July 1, 2018	Contract amendment did not revise Attachment B-1, Section 8, "Operations Phase Requirements."
Revision	2.26	September 1, 2018	Section 8.1.1.1 is modified to allow health plans to collaborate with community organizations. Section 8.1.2.1 is modified to update UMCM Chapter reference. Section 8.1.2.2 is modified to provide clarity for Case-by-case Services. Section 8.1.3 is modified to be in full compliance with 42 C.F.R. § 438.14. Section 8.1.3.2 is modified to comply with S.B. 760 of the 84th Legislative Session and recent managed care rules related to network adequacy, it is also modified to allow geo mapping for audiology providers. In addition, this section is modified to comply with 42 C.F.R. §§ 438.3(I), 438.68, and 457.1201(j). Lastly, this section is modified to bring contract language into alignment with current practice. Section 8.1.3.4 is added to outline requirements permitting Members to see out-of-network Indian Health Care Providers in order to comply with 42 C.F.R. 438.14. Section 8.1.4 is modified to clarify pharmacy services are included in the requirements supported by the CDC. Section 8.1.4.2 is modified to comply with S.B. 654 of the 85th Legislative Session which will allow MCOs to include advanced practice registered nurses as Network Primary Care Providers. Section 8.1.4.6 is modified to clarify the responsibility of the MCO to coordinate substance use disorder services. Section 8.1.4.8 is modified to reflect the new program area name, Managed Care Compliance and Operations. Section 8.1.4.8.2 is modified to clarify how hospitals will receive incentives/disincentives for PPC and PPR. Section 8.1.4.8.3 is modified to ensure all facilities have the opportunity to participate in NF incentive programs regardless of their size, and that MCOs hold NFs participating in QIPP to a higher standard. Section 8.1.4.8.5 is modified to update the date so that the contract terms are applicable to State fiscal year beginning on September 1, 2018, and to clarify MCOs are required to pay the UHRIP rate increase to network facilities only in

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			Service Areas included in their HHSC managed care contracts. Section 8.1.8 is modified to comply with S.B. 74 of the 85th Legislative Session to require all MCOs as opposed to only those subcontracting Behavioral Health Services for continuity. Section 8.1.12.1 is modified to clarify and streamline criteria for identifying Members with Special Health Care Needs. Section 8.1.12.4 is modified to clarify the responsibility of the MCO to coordinate substance use disorder services. Section 8.1.13 is added to streamline criteria for identifying Members with Special Health Care Needs. Section 8.1.18 is modified to comply with S.B. 74 of the 85th Legislative Session to require all MCOs as opposed to only those subcontracting Behavioral Health Services for continuity. Section 8.1.18.5 is modified to comply with S.B. 74 of the 85th Legislative Session to require all MCOs as opposed to only those subcontracting Behavioral Health Services for continuity. Section 8.1.19.3 is modified to clarify language on operational processes. Section 8.1.19.4 is modified to comply with Texas Government Code § 531.102(g). Section 8.1.19.5 is modified to comply with 42 C.F.R. 438.608(d)(1)(i) and CMS MCE Checklist 1.1.6. Section 8.1.20.2(q) is modified to update the reference to the UMCM chapter, (s) is modified to comply with 1915 (c) waiver requirements, and (y) is added to create a new deliverable which captures utilization data for clinician-administered drugs paid through the non-risk based model. Section 8.1.21.1 is modified to comply with H.B. 1296 of the 85th Legislative Session. Section 8.1.21.2 is modified to move language regarding “prescriber authorization during a Governor-declared disaster” to new Section 8.1.29. Section 8.1.22 is modified to be in full compliance with 42 C.F.R. § 438.14. Section 8.1.29 is added to ensure MCOs have plans in place for future disasters.

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			Section 8.2.1 is modified to clarify and streamline criteria for identifying Members with Special Health Care Needs. Section 8.2.7.2.3 is modified to comply with S.B. 74 of the 85th Legislative Session to require all MCOs as opposed to only those subcontracting Behavioral Health Services for continuity Section 8.2.17 is modified to streamline and improve the EVV process/system. Section 8.3.2.2 is modified to clarify the responsibility of the MCO to coordinate substance use disorder services. Section 8.3.2.5 is modified to clarify the responsibility of the MCO to coordinate substance use disorder services. Section 8.3.2.6 is modified to clarify the responsibility of the MCO to coordinate substance use disorder services. Section 8.3.9.2 is modified to clarify the responsibility of the MCO to coordinate substance use disorder services. Section 8.4 is modified to comply with 42 C.F.R. §457.1201 (p).
Revision	2.27	January 1, 2019	Section 8.1.15.7 is modified to identify types of court orders that are Medicaid or CHIP-payable. Section 8.2.2.1 is modified to clarify court orders that are Medicaid-payable. Section 8.2.8 is modified to comply with The Bipartisan Budget Act of 2018. Section 8.4.3 is modified to comply with The Bipartisan Budget Act of 2018.
Revision	2.28	March 1, 2019	Section 8.1.4.8.5 is modified to remove references to specific time periods.
Revision	2.29	September 1, 2019	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.” Section 8.1.3.1 is modified to clarify required appointment wait time standards for Specialty Therapy Services. Section 8.1.3.3 is modified to comply with managed care Network Adequacy initiatives.

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			Section 8.1.4 is modified to ensure Providers are not being paid for claims after a sanction or exclusion; clarify pharmacy contract arrangements; and correct the terminology regarding licensing, certification and Medicaid contracting per guidance from HHSC Licensing. Section 8.1.4.4 is modified to correct the terminology regarding licensing, certification and Medicaid contracting per guidance from HHSC Licensing. Section 8.1.4.4.1 is modified to clarify the requirement for MCOs to pay network rate for claims with a date of service in the first 30 Days following submission of an expedited credentialing application applies to NFs. 8.1.4.6 is modified to clarify the term “Nursing Facility Unit Rate.” Section 8.1.4.8 to modified to change timeframes for fee schedule changes. Section 8.1.4.8.3 is modified to clarify the requirement that MCOs endure Nursing Facility Providers have equal opportunity to participate in a Nursing Facility incentive program only applies to the Network Nursing Facility Providers serving their Members. Section 8.1.4.8.6 is modified to clarify the MCO must pay the Nursing Facility the payment amount calculated by HHSC. Section 8.1.5.4 is modified to comply with managed care Network Adequacy initiatives. Section 8.1.5.4.1 is modified to comply with managed care Network Adequacy initiatives. Section 8.1.5.4.2 is modified to comply with managed care Network Adequacy initiatives. Section 8.1.5.6 is modified to comply with managed care Network Adequacy initiatives. Section 8.1.5.8 is modified to clarify the interpreter service requirements available to MCOs, including advance notice. Section 8.1.7.8.2 is modified to add pharmacies and pharmacist as types of providers MCOs can work with to meet the APM requirement. Section 8.1.8 is modified comply with CFR. Section 8.1.12.2 is modified to update the access to care for Members with Special Health Care Needs (MSHCN) v to

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			add DFPS NFP to the list of community series for MSHCN referrals. Section 8.1.16 is modified to align TPL language across contracts. Section 8.1.18 is modified to ensure standardized reporting of provider addresses for analytical network adequacy reporting. Section 8.1.18.5 is modified to add a sentence which was removed from the definition of "Clean Claim" Section 8.1.19 is modified to ensure MCOs comply with nursing facility utilization review findings and discovery. Section 8.1.19.1 is modified to comply with Rider 152, Article II, 85th Legislature. Section 8.1.19.2 is modified to add a requirement to retain certain documents for review by the OAG. Section 8.1.20.2 modifies reports and corrects UMCM Chapter. Section 8.1.21.10 is modified to clarify MCOs requirement to adhere to the Specialty Drug List. Section 8.1.29 is modified to align with UMCM Chapter 16.1.13. Section 8.2.1.1 is modified to clarify MCOs must ensure continuity of care when a Provider undergoes a CHOW. Section 8.2.6.1 is modified to align with MCO appeal standards. Section 8.2.6.2 is modified to comply with CFR and to ensure managed care Members have 10 Business days to request continued benefits. Section 8.2.7.2.2 is modified to clarify narcotic/opiate treatment programs must be included the network. Also updated references to DSHS to HHSC and STP requirements consistent across contracts. Section 8.2.7.2.3 is modified to updated references from DSHS to HHSC. Section 8.2.8 is modified to clarify current language and alignment of the TPL language across all MCO contracts and to implement updated Section 1902(a)(25)(E) of the Social Security Act (42 U.S.C. §1396a(a)(25)(E)) as

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			amended by the Bipartisan Budget Act of 2018 (Pub. L. 115-123) effective February 9, 2018. Section 8.2.13 is modified to add Medicare Coinsurance. Section 8.2.13.2 is modified to add Medicare Coinsurance. Section 8.2.15.3 is modified to align Critical Incident and Abuse, Neglect, and Exploitation efforts 2014 federal guidance from CMS. Section 8.2.17 is modified to comply with the requirement to streamline and standardize the EVV process per the OIG audit findings and the 21st CURES Act and Texas Govt. Code §531.024172. Section 8.3.2.1 is modified to address an OIG audit that found NFs were not timely submitting resident transaction notice forms required at admission and discharge. Section 8.3.2.3 is modified to align Critical Incident and Abuse, Neglect, and Exploitation efforts 2014 federal guidance from CMS and to shorten the timeframe for newly employed service coordinator or service manager is required to obtain person-centered planning training. Section 8.3.2.4 is modified to add language to refer members to programs that address their housing needs. Section 8.3.2.9 is added to comply with Rider 45, Senate Bill 1, 85th Legislature. Section 8.3.3 is modified to ensure MCO documents notification source and action taken when the MCO learns of a S+P HCBS Member's change in condition. Section 8.3.3.2 is modified to align with similar Service Coordinator requirements as in the STAR Kids contract. Section 8.3.4.1 is modified to comply with CFR. Section 8.3.4.2 is modified to comply with CFR. Section 8.3.4.3 is modified to ensure the MCO completes reassessments for Members who may require general revenue. Section 8.3.4.3.1 is modified to ensure MCO documents notification source and action taken when the MCO learns of a S+P HCBS Member's change in condition. Section 8.3.5 is modified to add the term "habilitation."

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			Section 8.3.9 is modified to correct the terminology regarding licensing, certification and Medicaid contracting per guidance from HHSC Licensing. Section 8.3.9.4 is modified to add Medicare Coinsurance, adds definition for clean claim, and adds Nursing Facility to Unit Rate. Section 8.4.3 is modified to clarify current language and alignment of the TPL language across all MCO contracts and to implement updated Section 1902(a)(25)(E) of the Social Security Act (42 U.S.C. §1396a(a)(25)(E)) as amended by the Bipartisan Budget Act of 2018 (Pub. L. 115-123) effective February 9, 2018.
Revision	2.30	March 1, 2020	Section 8.1.8 is modified to require MCOs to review and issue prior authorization determinations within specific timeframes for members who are hospitalized. The changes are necessary to comply with SB 1096. Section 8.2.18. is modified to comply with SB670 and allow Member's to utilize telemedicine services from a provider other that their PCP.
Revision	2.30.1	June 1, 2020	Contract Extension
Revision	2.31	September 1, 2020	Global change for the phrase, IMMTrac is now IMMTrac2. Global change is modified to update UMCM chapter reference Section 8.1.1.2 is modified to align review requirements across all contracts Section 8.1.2.2 is modified to specify what information is required for each authorized case-by-case service. Section 8.1.3.2 is modified to align all contract to ensure consistency Section 8.1.4 is modified to align with all contracts and include distinguishing access standards in response to the HHSC Business Plan. And to remove a reference that is no longer a requirement. Section 8.1.4.7 is modified to remove language that is no longer required by CMS..

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.4.8.5 is modified to remove references to specific time periods. Section 8.1.4.9 is modified to update chapter reference. Section 8.1.5.6 is modified to remove measures that are no longer required by CMS and to update chapter reference Section 8.1.5.8 is modified to remove reference to UMCM Chapter that do not exist. Section 8.1.7.8.1 is modified to correct citation. Section 8.1.7.8.2 is modified facilitate in advance to approval of MCOs APMs involving the outpatient drug benefit. Section 8.1.8 is modified to include requirement from SB 1207 related to prior authorizations and to comply with Legislative direction -HB 3041. Section 8.1.8.1 is modified to clarify language when providing new information to providers. Section 8.1.15.3 is modified to remove measures that Is no longer required by CMS and update chapter reference. Section 8.1.16 is modified to add language to reflect the order when Medicaid is obligated pay. Section 8.1.17.1 (d) is modified to make language consistent across all contracts. Section 8.1.17.1 (n) is modified to update Chapter reference. Section 8.1.18.5 is modified to comply with SB 749. Section 8.1.18.5.1 is modified to exclude Nursing Facility Daily/Unit as part of a claims project. Section 8.1.19.1 Is modified delete the language that allows MCOs to submit a letter in lieu of a full Fraud, Waste and Abuse compliance plan.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.19.3 is modified to remove a report that is no longer required. Section 8.1.20.2 is modified to update chapter references and report descriptions. Section 8.1.21.1 is modified to align with TDI. Section 8.1.21.5 is modified to be consistent with current contract language. Section 8.1.21.11 modifies language to clearly state HHSC's right to review MAC lists as they pertain to this contract. Section 8.1.24 is modified to be in alignment with other schedule for immunization. Section 8.2.2.3.4 is modified to be consistent throughout the contracts. Section 8.2.2.3.5 is modified to be consistent throughout the contracts. Section 8.2.6.2 is modified to clarify contract language with other contracts. Section 8.2.6.2 is modified to comply with S.B. 1207, 86TH Legislature, Regular Session, 2019, and in compliance with 42 C. Section 8.2.6.3 is modified to comply with S.B. 1207, 86TH Legislature, Regular Session, 2019, and in compliance with 42 C.F.R 438. 402.. F. R 438.402. Section 8.2.6.4 is modified to comply with S.B. 1207, 86TH Legislature, Regular Session, 2019, and in compliance with 42 C.F.R 438. 402.. F. R 438.402. Section 8.2.6.6 is modified to comply with the updates to SB 1207. Section 8.2.6.7 is modified to comply with S.B. 1207, 86TH Legislature, Regular Session, 2019, and in compliance with 42 C.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.2.7.2.2 is modified language moved to provider network section. Section 8.2.7.2.5 is Added to comply with SB 1564 86th Legislature requirements. Section 8.2.8 is modified to be consistent across all contracts. Section 8.2.10 is modified to conform with Transformation requirement and to be consistent throughout the contracts. Section 8.3.2.1 is modified to clarify contract language requirements. Section 8.3.6.2 is modified to comply with Audit recommendations. Section 8.4.3 is modified to be consistent across all contracts.
Revision	2.32	March 1, 2021	Section 8.1.3.2 is modified to comply with Rider 157 from the 86TH Legislature, Regular Session, 2019 requirements. Section 8.1.4.8.7 is added to comply with SB 1621, 86TH Legislature, Regular Session, 2019. Section 8.1.15 is modified to comply with SB 1177, 86TH Legislature, Regular Session, 2019, amended Government Code § 533.005 updating contract requirements to include the provisions of this bill. Section 8.1.15.7.1 is modified to comply with SB 1177, 86TH Legislature, Regular Session, 2019, amended Government Code § 533.005 updating contract requirements to include the provisions of this bill. Section 8.1.30 is added to comply with federal law and CMS requirements. Section 8.1.30.1 is added to comply with federal law and CMS requirements.
Revision	2.33	June 1, 2021	Global Changes for NEMT Carve-in:

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			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 in addition to more traditional transportation providers. • Requires MCOs to provide NMT services. • Moves the responsibility to provide NEMT services from managed transportation organizations (MTOs) to managed care organizations (MCOs) for managed care members. This amendment implements these changes to the following sections: Section 8.1 is modified; Section 8.1.2 is modified; Section 8.1.3.2 is modified; Section 8.1.3.3 is modified; Section 8.1.4 is modified; Section 8.1.4.1 is modified; Section 8.1.4.4.1 is modified; Section 8.1.4.6 is modified; Section 8.1.4.8 is modified; Section 8.1.4.8.4 is modified; Section 8.1.4.10 is modified; Section 8.1.4.11 is modified; Section 8.1.4.12 is modified; Section 8.1.5.1 is modified;

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.5.4 is modified; Section 8.1.5.6 is modified; Section 8.1.5.6.2 is added; Section 8.1.5.7 is modified; Section 8.1.8.2 is modified; Section 8.1.12.2 is modified; Section 8.1.12.4 is modified; Section 8.1.16. is modified; Section 8.1.18.1.1 is added; Section 8.1.18.2 is modified; Section 8.1.19 is modified; Section 8.1.19.7 is modified; Section 8.1.20.2 – (d), (e), (f), and (g), are modified; Section 8.1.25 is modified; Section 8.2.2.3.4 is modified; Section 8.2.2.3.5 is modified; Section 8.2.2.8 is modified; Section 8.2.2.145 is added; Section 8.2.2.14.1 is added; Section 8.2.2.14.1.1 is added; Section 8.2.2.14.1.2 is added;

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.2.2.14.1.3 is added; Section 8.2.2.14.1.4 is added; Section 8.2.2.14.1.5 is added; Section 8.2.2.14.1.6 is added; Section 8.2.2.14.2 is added; Section 8.2.2.14.3 is added; Section 8.2.2.14.3.1 is added; Section 8.2.2.14.3.2 is added; Section 8.2.4 is modified; Section 8.2.5 is modified; Section 8.2.6.4 is added to comply with (S.B.) 1207, 86th Legislature, requirements for IRO contractors Section 8.2.10 is modified; Section 8.3.2.2 is modified; and Section 8.3.9 is modified.
Revision	2.34	September 1, 2021	Global change is modified to update UMCM chapter reference. Section 8.1.1.3 is modified to give HHSC authority to require MCO provide proof of CAP actions. Section 8.1.2.1 is modified to update requirements for contract changes to VAS. Section 8.1.3.2 Pharmacy is modified to correct the current citation. Section 8.1.3.2 Long Term Services & Support (LTSS) is modified to add a requirement for MCOs to have workforce development capacity to support provider agencies, per Rider157 report.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.4.8.5 is modified to document UHIRP will be re-named to Comprehensive Hospital Increase Reimbursement Program (CHIRP); to document HHSC is combining the rural private hospital class and rural public hospital class to align with new classes in CHIRP; add language to clarify existing language on recouping disallowance by CMS.and and notification to the MCO of the program start date. 8.1.4.8.6 is modified to add notification to MCO of the program start date. Section 8.1.4.8.8 added to reflect the new directed payment programs and notification to the MCO of the program start date. Section 8.1.4.8.9 added to reflect the new directed payment programs and notification to the MCO of the program start date. Section 8.1.4.8.10 added to reflect the new payment programs and notification to the MCO of the program start date. Section 8.1.7.8.3 added to update the contract language to include guidance issued in July 2017. Section 8.1.8 is modified to be consistent with existing language. Section 8.1.8.1 is modified to correct language to differentiate between Medicaid and CHIP requirements for PA. Section 8.1.16 is modified to remove language specific to tort/subrogation requirements as of 9/1/2017. Section 8.1.18.5 is modified to add the MCO requirements related to coordination of benefits for secondary payors. Section 8.1.19.5 is modified to clarify MCO requirements for referring FWA. Section 8.1.20.2 (d) is deleted as the information in this report is being captured in another deliverable by MCCO.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.20.2 (y) is modified to remove the section as the referenced survey is obsolete. Section 8.1.21.2 is modified to correct language to differentiate between Medicaid and CHIP requirements for prior authorization. Section 8.1.21.12 is modified to correct existing language Section 8.1.21.14 is modified to clarify language is consistent in each applicable contract. Section 8.2.1.2 Single Case Agreements is added as per CMS requirement.Section 8.2.2.2 is modified clarify requirements of the MCOs to educate members aging out. Section 8.2.2.3.4 is modified to clarify THSteps-CCP description and language. Section 8.2.2.3.7 Texas Health Steps-Comprehensive Care Program is added to clarify THSteps-CCP description and language. Section 8.2.5 is modified to clarify HCBS member safeguards. Section 8.2.6.2 is modified to align with CMS proposed rules dated 11/13/20. Section 8.2.6.2 is modified to change the Member appeal filing to 10 Calendar days. Section 8.2.6.2 is modified to add Medicaid to the type of MCO. Section 8.2.6.4 is modified to replace the requirement for IRO EMR decision notification. Section 8.2.8 is modified to clarify HHSC file submission timeframe. Section 8.2.9.1 is modified to revise language to strengthen coordination between MCOs and Public Health Entities. Section 8.2.9.2 is modified to strengthen coordination between MCOs and Public Health Entities. Section 8.2.10 is modified to update names of programs that provide primary and family planning services and clarify requirements of the MCOs to educate members who are aging out of Medicaid about services available to them. Section 8.2.17 is modified to replace existing provision

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			language. Section 8.3.2.5 is modified to include timeframe for discharge planning from other psychiatric facilities. Section 8.3.3.2 is modified to clarify MCO four-week follow up requirement. Section 8.3.5 is modified to change title name. Section 8.3.5.1 is modified to clarify the MCOs responsibilities related to the CDS option. Section 8.3.8. Minimum Wage Requirements for STAR+PLUS Attendants in Community Settings modified to add reference to the TAC rule. Section 8.3.8.1 State Fiscal Year 2014 is deleted. Section 8.3.8.2 State Fiscal Year 2015 is deleted. Section 8.3.8.3 State Fiscal Year 2016 and After is deleted. Section 8.4.3 is modified to clarify HHSC file submission timeframe. Section 8.4.6 is added to update names of programs that provide primary and family planning services. Section 8.4.7 is added to include language to differentiate between Medicaid and CHIP requirements for PA.
Revision	2.35	March 1, 2022	Section 8.1.4 is modified to add additional language to address current contract reimbursement and reporting issues. Section 8.1.4.8 is modified to clarify language used for pharmacy provider reimbursements. Section 8.1.21 is modified Add-on, proactive approach to address current MCO/PBM/Provider contract reimbursement, ensure complete/accurate encounter data, MCO FSRA reporting/transparency issues to HHSC. Section 8.1.21.7 is modified Add-on, proactive approach to address current MCO/PBM/Provider contract reimbursement, ensure complete/accurate encounter data, and MCO FSRA reporting/transparency issues to HHSC.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Also, to ensure section language is consistent among the applicable contracts. Section 8.1.21.8 is modified Add-on, proactive approach to address current MCO/PBM/Provider contract reimbursement, ensure complete/accurate encounter data, and MCO FSRA reporting/transparency issues to HHSC. Also, to ensure section language is consistent among the applicable contracts. Section 8.1.21.11 is modified to add-on, proactive approach to address current MCO/PBM/Provider contract reimbursement and MCO FSRA reporting/transparency issues to HHSC. Section 8.2.1 is modified to include language to meet CMS requirements to allow single case agreements for members. Section 8.2.1.2 is deleted, Section 8.2.6.4 is modified to clarify MCO process and revising timeline requirements for providing Member EMR request information to HHSC. Section 8.4.5. is modified to include language to meet CMS requirements to allow single case agreements for members.
Revision	2.36	September 1, 2022	Global change in Section 8: Service Management to Service Coordination. Section 8.1.1.4 is added Section 8.1.3 is modified, language is being added to clarify the requirements around the provision of services when members are temporarily traveling outside the state Section 8.1.3.1 is modified a defined term that is inclusive of substance use disorder Section 8.1.3.1 is modified to comply with HB 133, 87th Legislature, Regular Session, 2021 Section 8.1.4 is modified to comply with HB 133, 87th Legislature, Regular Session, 2021 Section 8.1.4.4 is modified to ensure compliance with the federal Home and Community Based Services (HCBS) Settings regulations at 42 CFR §441.301(c)(4), §441.530, and §441.710(4)(i). The Centers for Medicare & Medicaid Services (CMS) requires states to fully comply with the regulations by March 2023

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.4.8.4 is modified to comply with Implementation of SB 1991 - 86th-R Section 8.1.4.8.5 is modified including clarification around the program period start date and updated language regarding reporting and quality metric requirements Section 8.1.4.8.8 is modified including clarification around the program period start date and updated language regarding reporting and quality metric requirements Section 8.1.4.8.9 is modified including clarification around the program period start date and updated language regarding reporting and quality metric requirements Section 8.1.4.8.10 is modified including clarification around the program period start date and updated language regarding reporting and quality metric requirements Section 8.1.5.4.1 is modified to update language to reflect current hard copy provider directories processes Section 8.1.7.1 is modified to comply with HB 4533, 86th Legislature, 2019 Section 8.1.7.8.2 is modified to update language in the Contract for the respective sections have been replaced with new language to support a more comprehensive approach to APMs Section 8.1.7.8.2.1 is added Section 8.1.9.1 is modified to update the citation to the TAC rules for the ECI program due to it having been moved to new section Section 8.1.9.2 is modified to update the citation to the TAC rules for the ECI program due to it having been moved to new section Section 8.1.9.5 is modified to update the citation to the TAC rules for the ECI program due to it having been moved to new section and is modified to correct citation Section 8.1.11 is modified to match the terminology for this service that is used by DFPS, the agency that operates this service Section 8.1.12.2 is modified to comply with HB 133, 87th Legislature, Regular Session, 2021 Section 8.1.12.4.3 is added Section 8.1.15.10 is modified to provide clarification to Code of Federal Regulations references in the mental health parity

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.16 is modified to update language due to Rider 39 from SB1, from the 87th Regular Legislative Session Section 8.1.16 is modified to add clarifying language to be consistent across all MCO contracts Section 8.1.17.1 is modified to add clarifying language to be consistent across all MCO contracts Section 8.1.19 is modified to align Compliance Plan language in one section Section 8.1.19.1 is modified to align Compliance Plan language in one section Section 8.1.19.2 is modified to update claims data due date to align with current practice Section 8.1.19.4 is modified to update contact information with current OIG area Section 8.1.19.5 is modified to comply with Implementation of SB 1991 - 86th-R. Section 8.1.20.2 (e) is modified to comply with requirement to have MCOs submit a quarterly report that includes all NEMT Services providers Section 8.1.20.2 (r) is modified to replace the Critical Incidents and Abuse, Neglect, and Exploitation quarterly report (in UMCM Chapter 5.24.11) Section 8.1.20.2 (y) is added to comply with 42 CFR §431.428. Section 8.1.21.2 is modified to address pharmacy related information. Section 8.1.21.11 is modified – due to the pending withdrawal of the liquated damages for Pharmacy (PH) performance standard PH-11 Section 8.1.31 is added Section 8.1.31.1 is added moved from 8.2.18.1 Section 8.2.1 is modified to clarify language in the context, continuity of care is ensuring seamless transitions for newly enrolled members Section 8.2.2.8 is modified to comply with HB 133, 87th Legislature, Regular Session, 2021 Section 8.2.2.11 is modified to comply with HB 133, 87th Legislature, Regular Session, 2021

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.2.3 is modified to comply with HB 133, 87th Legislature, Regular Session, 2021 Section 8.2.5 is modified to remove old TAC Section 8.2.6.4.1 is modified to inform the MCOs that HHSC will require MCOs to reimburse IROs for partial EMR reviews if the Member decides to withdraw the EMR request Section 8.2.6.5 is modified to remove UMCM chapter reference that was never added Section 8.2.6.10 is modified to remove chapter not yet created. Section 8.2.8 is modified to make word changes and/or corrections made for consistency across all MCO contracts Section 8.2.10 is modified to comply with HB 133, 87th Legislature, Regular Session Section 8.2.13 is modified to clarify the specific services covered by Medicaid MCOs Section 8.2.13.1 is modified to clarify the specific services covered by Medicaid MCOs Section 8.2.13.2 is modified to clarify the specific services covered by Medicaid MCOs Section 8.2.13.3 is added Section 8.2.17 is modified to clarify language Section 8.2.18 is deleted in its entirety and the language is moved to new section 8.1.31 Section 8.3.1.5 is added Section 8.3.2.1 is modified to comply with 1115 Transformation Waiver STC 24.6 Section 8.3.2.1 is modified for clarity and appropriateness, while adding a requirement that the SC document the types of contact needed Section 8.3.2.2 is modified for accuracy; and to align this language across program contracts Section 8.3.2.11 is added Section 8.3.4 is modified to comply with HB 4533, 86th Texas Legislature, Regular Session, 2019 Section 8.3.4.3 is modified to comply with HB 4533, 86th Texas Legislature, Regular Session, 2019

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.3.4.3 is modified for accuracy; and to align this language across program contracts Section 8.3.5 is modified for accuracy; and to align this language across program contracts Section 8.3.5.2 is modified for accuracy; and to align this language across program contracts Section 8.3.5.3 is modified for accuracy; and to align this language across program contracts Section 8.3.6.2 is modified to – ensure Electronic Visit Verification (EVV) in the provision of attendant care services Section 8.4.3 is modified to make word changes and/or corrections made for consistency across all MCO contracts Section 8.3.11 is modified to remove invalid CPT codes.
Revision	V2.37	March 1, 2023	Contract amendment did not revise Attachment B-1, Section 8, “Operations Phase Requirements.”
Revision	V2.38	September 1, 2023	Section 8.1.4 is modified to address a provider contracting issue with private non-profit T-CCBHCs Section 8.1.4.8.2 is modified to remove incentives to safety-net hospitals for exemplary performance Section 8.1.5.3 is modified to clarify how an MCO should notify their members and which members should be notified when there is a change in covered services Section 8.1.5.11 to follow any federal rules or CMS guidance regarding renewal assistance Section 8.1.7.8.2.1 is modified to address a provider contracting issue with private non-profit T-CCBHCs Section 8.1.8 is modified to clarify TDI statute prohibits group health insurers from requiring the observation of psychotherapy sessions and submission of psychotherapy notes as part of utilization review. Section 8.1.8 is modified to clarify the prior authorization review and determination must be finalized within the mentioned timelines Section 8.1.12.4 is modified to align with Children and Pregnant Women Carve-In Section 8.1.19.2 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

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.19.3 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 8.1.20 is modified to align with CFR requirement in § 438.608(d) Section 8.1.20.2 is modified to remove contract requirements for LTSS Actions Report Section 8.1.21 is modified to clarify intent of the contract language Section 8.1.21.11 is modified to clarify intent of the contract language Section 8.1.31 is modified to clarify language regarding modifiers Section 8.2.2.2 is modified to include STAR members who are aging out of STAR Section 8.2.2.8 is modified to clear references regarding Inpatient Hospital facilities Section 8.3.1.4 is modified to update existing language Section 8.3.3.1 is modified to update existing language Section 8.3.3.2 is modified to clarify requirements regarding ISP Section 8.3.6.3 is modified to clarify CMS requirement Section 8.4.8 is added to clarify CHIP-P postpartum coverage
Revision	V2.39	March 1, 2024	Section 8.1.7.8.2 is modified for consistency across all contracts Section 8.1.17.1 is modified to align all contracts with current financial requirements based on MCO and OIG response Section 8.2.8 is modified in response to federal law changes to 42 USC §1396a(a)(25), as amended by the Deficit Reduction Act of 2005 and, further, by H.R. 2471 (2022), and state law changes made by SB 1342, 88th Texas Legislature, Regular Session, 2023, by Perry, that codify the federal law changes in state law Section 8.4.3 is modified in response to federal law changes to 42 USC §1396a(a)(25), as amended by the Deficit Reduction Act of 2005 and, further, by H.R. 2471 (2022), and state law changes made by SB 1342, 88th

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			Texas Legislature, Regular Session, 2023, by Perry, that codify the federal law changes in state law.
Revision	V2.40	September 1, 2024	Section 8.1.4.2 is modified to clarify the current requirements for certain PCPs to have admitting privileges to hospitals or to make referral arrangements Section 8.1.4.8.11 is added ensure accurate estimates and resulting payments through these multi-billion dollar directed payment programs Section 8.1.5.1 is modified to clarify and update the delivery of member materials Section 8.1.5.2 is modified to clarify and update the delivery of member materials Section 8.1.5.3 is modified to clarify and update the delivery of member materials Section 8.1.7.1 is modified to meet certain state and federal requirements and reduce the administrative burden for MCOs. Section 8.1.8 is modified to comply with Texas Government Code Sec. 533.00282. and Texas Government Code Sec. 533.002821 Section 8.1.12.1 is modified to improve maternal and infant health outcomes for Members with Special Health Care Needs Section 8.1.12.1 is modified to update reporting requirements in accordance with UMCM 5.24.10 Section 8.1.12.4 is modified to outline minimum contact effort for STAR and CHIP MCOs to update initial and annual service plans for STAR and CHIP MSHCN. Section 8.1.12.4 is modified to strengthen the existing contract language and to ensure all discharge planning requirements are connected in the managed care contracts. Section 8.1.13.3 is added to comply with H.B. 1575, 88th Legislature, Regular Session, 2023, which requires HHSC to adopt standardized screening questions designed to screen for, identify, and aggregate data regarding the nonmedical health-related needs of pregnant women Section 8.1.15 is modified to more accurately identify ILOS C.F.R. references

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 8.1.15.5 is modified to strengthen the existing contract language and to ensure all discharge planning requirements are connected in the managed care contracts. Section 8.1.15.10 is modified to remove the CFR references regarding the Mental Health Parity and Addiction Equity Act of 2008 Section 8.1.20.2 is modified to update reporting requirements in accordance with UMCM 5.24.10 Section 8.1.21.1 is modified as required by Texas Government Code Section 531.0691, as added by HB 3286, 88th session. Section 8.1.31 is modified to clarify that telemedicine and telehealth are a means to deliver Covered Services, rather than distinct Covered Services Section 8.1.31.1 is modified to align provisions across contracts, also align with government code. Section 8.2.6 is modified as part of HB 44, 88th Leg to provide direction to MCOs on how to handle member allegations against a provider related to discrimination based on immunization status Section 8.2.15.1 is modified to comply with House Bill (H.B.) 4696 (88th legislature, 2023) relating to regulatory and reporting changes for abuse, neglect and exploitation (ANE) critical incidents Section 8.4.1 is modified as part of HB 44, 88th Leg to provide direction to MCOs on how to handle member allegations against a provider related to discrimination based on immunization status Section 8.4.1 is modified to update section number Section 8.4.2.1 is modified to include requirements regarding CHIP continuation of benefits for a member during a CHIP appeals process

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

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8. OPERATIONS PHASE REQUIREMENTS

This Section describes Scope of Work requirements for the Operations Phase of the Contract.

Section 8.1 includes the general Scope of Work that applies to all MCO Programs (STAR, STAR+PLUS, and CHIP).

Section 8.2 includes the additional Medicaid Scope of Work that applies only to the STAR and STAR+PLUS MCOs.

Section 8.3 includes the additional Scope of Work that applies only to STAR+PLUS MCOs.

Section 8.4 includes the additional CHIP Scope of Work that applies only to CHIP MCOs.

The CHIP Perinatal Program is a CHIP subprogram. CHIP Program requirements apply to the CHIP Perinatal Program, unless the Contract otherwise indicates.

Additional information regarding the STAR, STAR+PLUS, and CHIP Program requirements, such as reporting timeframes and formats is included in **Attachment A**, "Uniform Managed Care Contract Terms and Conditions," and the Uniform Managed Care Manual (UMCM). HHSC reserves the right to modify these documents as it deems necessary using the procedures set forth in the **Attachment A**, “Uniform Managed Care Contract Terms and Conditions.”

8.1 General Scope of Work

In each MCO Program and Service Area, HHSC will select MCOs to provide Health Care Services and NEMT Services, prescription drug benefits to Members. The MCO must have approval from the Texas Department of Insurance (TDI) to operate as an HMO, ANHC, and/or an EPO in all zip codes in the respective Service Area(s).

Coverage for benefits will be available to enrolled Members effective on the Operational Start Date. The Operational Start Date is March 1, 2012, for all MCO Programs and Service Areas.

8.1.1 Administration and Contract Management

The MCO must comply, to the satisfaction of HHSC, with: (1) all provisions set forth in this Contract, and (2) all applicable provisions of state and federal laws, rules, regulations, and waiver agreements with the Centers for Medicare and Medicaid Services (CMS).

8.1.1.1 Performance Evaluation

HHSC will provide the MCO with two Performance Improvement Project (PIP) topics per Program. The MCO must develop one PIP per topic. The MCO must conduct one PIP in collaboration with other MCOs, Dental Contractors, participants in Delivery System Reform Incentive Payment (DSRIP) projects established under the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, or community organizations. HHSC will determine the PIP topics, and the MCO must complete each PIP template in accordance with UMCM Chapter 10.. Each MCO must also complete progress reports as outlined in UMCM Chapter 10. PIPs will follow CMS protocol, as described below. The purpose of health care quality PIPs is to assess and improve processes, and thereby outcomes, of care. In order for these projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner.

MCOs must use the following ten step CMS protocol when conducting PIPs:

1. select the study topic(s);
2. define the study question(s);
3. select the study indicator(s);
4. use a representative and generalizable study population;
5. use sound sampling techniques (if sampling is used);
6. collect reliable data;
7. implement intervention and improvement strategies;
8. analyze data and interpret study results;
9. plan for “real” improvement; and
10. achieve sustained improvement.

See UMCM Chapter 10.

HHSC will track MCO performance on PIPs. It will also track other key facets of MCO performance through the use of a Performance Indicator Dashboard for Quality Measures in accordance with UMCM Chapter 10. HHSC will compile the Performance Indicator Dashboard based on MCO submissions, data from the External Quality Review Organization (EQRO), and other data available to HHSC. HHSC will share the Performance Indicator Dashboard measures and high and minimum performance standards established using the methodology set forth in **UMCM Chapter 10** with the MCO on an annual basis.

8.1.1.1.1 MCO Report Cards

Texas Government Code § 536.051 requires HHSC to provide information to Medicaid and CHIP Members regarding MCO performance on outcome and process measures during the enrollment process. To comply with this requirement, HHSC will develop annual MCO report cards. HHSC will develop a separate report card for each Program Service Area to allow enrollees to easily compare the MCOs on quality measures. HHSC may publish the report cards on its website and include them in the enrollment

packets. HHSC will provide a copy of the report card to the MCO before publication and the MCO will have the opportunity to review and provide comments. However, HHSC reserves the right to publish the results while awaiting MCO feedback.

HHSC may charge the MCO any costs related to recalculating the report card measures if the EQRO determines the original data was valid.

8.1.1.2 Operations Phase Readiness, Operational, and Targeted Reviews

HHSC may conduct desk and/or onsite reviews related to Contract performance. HHSC may also require Contractors to submit detailed policies and procedure that document day-to-day business activities related to Contract requirements for HHSC review and approval.

The MCO may be subject to additional Readiness Reviews if it makes changes deemed by HHSC to require such Readiness Reviews. Changes made during the Operational Phase that may lead to additional Readiness Reviews include, but are not limited to:

1. Location change;
2. Processing system changes, including changes in Material Subcontractors performing MIS or claims Processing Functions;
3. Carve-ins of new membership; and
4. Carve-ins of new Services.

HHSC will determine whether the proposed changes will require a desk review and/or an onsite review. The MCO must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent for onsite reviews conducted as part of Readiness Review or HHSC's normal Contract monitoring efforts. For purposes of this section, "authorized reimbursable travel costs" may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite reviews. Reimbursement by the MCO will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

Unless the MCO receives HHSC approval for an exception in writing, the MCO must provide HHSC with secure access rights as an authorized guest user to all Member and Provider access points, including but not limited to Member and Provider portals and call center services, for remote monitoring capability. To qualify for an exception to this requirement, the MCO must demonstrate to HHSC the required functionality for Member and Provider portals via WebEx or onsite reviews. Portal demonstrations must be conducted in the MCO or Subcontractor's production environment or an environment that mirrors the production environment functionality.

The MCO must develop and submit a Risk Management Plan and Contingency Plan, as required by the UMCM, to ensure risks and issues are effectively monitored and managed as to limit impact to business operations.

The MCO must document and report resolution of system or service related issues to HHSC, including the length of time from discovery to resolution, severity level, and provide corrective measures, and a root cause analysis to prevent future problems from occurring.

For MIS Changes Only: The MCO must provide HHSC updates to the MCO's organizational charts and descriptions of MIS responsibilities at least 30 days prior to the effective date of an MIS change. The MCO must provide up-to-date official points of contact to HHSC for MIS issues on an ongoing basis.

The MCO or its designee must be able to demonstrate, upon HHSC's request, oversight of each Material Subcontractor based on MCO's assessed risk of Material Subcontractor's performance.

Refer to **Section 7**, "Transition Phase Requirements," and **Section 8.1.18**, "Management Information System Requirements," for additional information regarding MCO Readiness Reviews. Refer to **Attachment A**, "Uniform Managed Care Contract Terms and Conditions," **Section 4.08(c)** for information regarding Readiness Reviews of the MCO's Material Subcontractors.

8.1.1.3 HHSC Performance Review and Evaluation

In accordance with **Section 12.01** of this Contract's Uniform Terms and Conditions, HHSC, at its discretion, will review, evaluate and assess the development and implementation of the Medicaid MCO's policies and procedures related to the timely and appropriate delivery of services as required under this Contract. Reviews, evaluations and assessments may include the following: MCO corrective actions taken, including demonstration by the MCO that the corrective action(s) or intervention(s) included in the Corrective Action Plan (CAP) have been completed or implemented using a method approved or provided by HHSC; MCO internal policies; MCO internal procedures; MCO workflows; MCO use of prior authorizations; MCO utilization review process; assessment of the MCO service planning package; the potential for underutilization of services; assessments; delivery of services; and case notes.

Upon notice and at no charge to HHSC, the MCO and its Subcontractors must cooperate with HHSC and provide any assistance required to complete the review, evaluation or assessment including prompt and adequate access to related documents, internal systems containing Member information and records, and appropriate staff, as well as utilization management documentation, case notes, and service locations or facilities that are related to the scope of services provided under this Contract.

HHSC shall monitor the Medicaid MCO to confirm the MCO is using prior authorization and utilization review processes that ensure appropriate utilization and prevent overutilization or underutilization of services. An MCO providing STAR+PLUS services must also comply with the terms of **Section 8.3.4.4** STAR+PLUS "Utilization Reviews."

8.1.1.4 Material Subcontractors

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

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

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

8.1.2 Covered Services

The MCO is responsible for assessing, authorizing, arranging, coordinating, approving, and providing Covered Services, including NEMT Services, Community-based Long Term Services and Supports and Nursing Facility services, in accordance with the requirements of the Contract. The MCO must provide Medically Necessary Covered Services to all Members beginning on the Member's date of enrollment regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior Health Care Services. STAR+PLUS MCOs must also provide Functionally Necessary Community Long-term Services and Supports to all Members beginning on the Member's date of enrollment regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior Health Care Services. The MCO must not impose any pre-existing condition limitations or exclusions or require Evidence of Insurability to provide coverage to any Member.

MCOs must authorize Community-based Long-term Services and Supports, including Private Duty Nursing and services provided in a Prescribed Pediatric Extended Care Center, and Nursing Facility services based on the Member's current required needs assessment and consistent with the Member's SP or ISP. The services supporting Members with ongoing or chronic conditions or who require long-term services and supports must be authorized in a manner that reflects the Member's ongoing need for such services and supports. Members receiving Community-based Long-term Services and Supports must have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

MCOs must approve NEMT Services in accordance with Section 8.2.2.14 of this Contract.

The MCO must provide full coverage for Medically Necessary Covered Services to all Members and, for STAR+PLUS Members, Functionally Necessary Community Long-term Services and Supports, without regard to the Member's:

1. previous coverage, if any, or the reason for termination of such coverage;
2. health status;
3. confinement in a health care facility; or
4. for any other reason.

The MCO must not practice discriminatory selection or encourage segregation among the total group of eligible Members by excluding, seeking to exclude, or otherwise discriminating against any group or class of individuals.

Covered Services for all Medicaid MCO Members are listed in **Attachments B-2**, "STAR Covered Services," and **B-2.2**, "STAR+PLUS Covered Services." Medicaid MCOs are responsible for providing all services and benefits available to clients of the Medicaid Fee-for-Service (FFS) Program to the MCO's Medicaid Members, in at least the same amount, duration, and scope as is available through FFS as reflected in the state plan under Title XIX of the Social Security Act Medical Assistance Program and detailed in the Texas Medicaid Provider Procedures Manual (TMPPM), and as required by 42 C.F.R. § 440.230 for Members 21 and older and by 42 C.F.R. Subpart B of Part 441 for Members under the age of 21, and in accordance with 42 C.F.R. § 438.210, with the exception of Non-capitated Services (**Section 8.2.2.8**). Medicaid MCOs must provide the services and benefits described in the most recent **Texas Medicaid Provider Procedures Manual** and any updates thereto.

A description of CHIP Covered Services and exclusions is provided in **Attachment B-2.1**, "CHIP Covered Services." CHIP MCOs are responsible for providing all Covered Services in accordance with the state plan under Title XXI and Attachment B-2.1, "CHIP Covered Services." Covered Services are subject to change due to changes in federal and state law; changes in Medicaid, CHIP or CHIP Perinatal Program policy; and changes in medical practice, clinical protocols, or technology.

The MCO must have a process in place to monitor a Member's claims history for acute and long-term care services that receive a prior authorization to ensure that these services are being delivered. On an ongoing basis, the MCO must monitor claims data for all approved prior authorizations for delivery of the services. The MCO must research and resolve any services not received as a result of the lack of claims data.

In the development of medical policies and medical necessity determinations, the MCO must adopt practice guidelines that:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

(2) Consider the needs of the MCO's enrollees;

(3) Are adopted in consultation with contracting health care professionals; and

(4) Are reviewed and updated periodically as appropriate.

8.1.2.1 Value-added Services

MCOs may propose additional services for coverage. These are referred to as "Value-added Services." Value-added Services may be actual Health Care Services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improved

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.

The MCO generally must offer Value-added Services to all MCO Program Members in a Service Area. For Medicaid Acute Care services, the MCO may distinguish between the Dual Eligible and non-Dual Eligible populations. The MCO is not required to offer the same Value-added Services to CHIP Perinate Members as traditional CHIP Members and CHIP Perinate Newborn Members. Value-added Services do not need to be consistent across more than one MCO Program or across more than one Service Area.

Any Value-added Services that a MCO elects to provide must be provided at no additional cost to HHSC. The costs of Value-added Services are not reportable as allowable medical or administrative expenses, and therefore are not factored into the rate setting process. In addition, the MCO must not pass on the cost of the Value-added Services to Members or Providers.

The MCO may offer discounts on non-covered benefits to Members as Value-added Services, provided that the MCO complies with Texas Insurance Code § 1451.155 and § 1451.2065. The MCO must ensure that Providers do not charge Members for any other cost-sharing for a Value-added Service, including copayments or deductibles.

The MCO must specify the conditions and parameters regarding the delivery of each Value-added Service and must clearly describe any limitations or conditions specific to each Value-added Service in the MCO's Member Handbook. The MCO must also include a disclaimer in its Marketing Materials and Provider Directory indicating that restrictions and limitations may apply.

During the Operations Phase, Value-added Services can be added or removed. MCOs will be given the opportunity to add, enhance, delete or reduce Value-added Services once per State Fiscal Year, with changes to be effective September 1. HHSC may allow additional modifications to Value-added Services if Covered Services are amended by HHSC during a SFY. HHSC will coordinate annual revisions to HHSC's MCO Comparison Charts for Members. MCO's must submit requests to add, enhance, delete, or reduce a Value-added Service to HHSC by April 1 of each year to be effective September 1 for the following contract period. The MCOs cannot reduce or delete any Value-added Services until September 1 of the next SFY. The MCO must include information regarding the processes by which the MCO will notify Members and revise materials with its request to delete a Value-added Service. See UMCM Chapter 4.

A MCO's request to add a Value-added Service must:

a. define and describe the proposed Value-added Service;
b. specify the Service Areas and MCO Programs for the proposed Value-added Service;

c. identify the category or group of Members eligible to receive the Value-added Service if it is a type of service that is not appropriate for all mandatory Members;
d. note any limitations or restrictions that apply to the Value-added Service;
e. identify the Providers or entities responsible for providing the Value-added Service;
f. Describe how the MCO will identify the Value-added Service in administrative data (Encounter Data) and/or in its Financial Statistical Report (FSR), as applicable;
g. propose how and when the MCO will notify Providers and Members about the availability of such Value-added Service;
h. describe the process by which a Member may obtain or access the Value-added Service, including any action required by the Member, as appropriate; and
i. include a statement that the MCO will provide such Value-added Service for at least 12 months from the September 1 effective date.

A MCO cannot include a Value-added Service in any material distributed to Members or prospective Members until the Value-added Service is approved by HHSC. If a Value-added Service is deleted, the MCO must notify each Member receiving the service, at a minimum of 30 Days prior to discontinuing the the Value-added Service, that the service will no longer be available as a Value-added Service through the MCO. The MCO must also revise all materials distributed to prospective Members to reflect the change in Value-added Services. Materials are subject to review and approval by HHSC.

8.1.2.2 Case-by-Case Services

Except as provided below, the MCO may offer additional benefits that are outside the scope of services to individual Members on a case-by-case basis. Case-by-case Services may be based on Medical Necessity, cost-effectiveness, the wishes of the Member or the Member's Legally Authorized Representative (LAR), the potential for improved health status of the Member, and for STAR+PLUS Members based on Functional Necessity. The MCO does not have to receive HHSC approval for Case-by-case Services and does not have to provide such services to all MCO Members. MCO has the discretion to offer Case-by-case Services, which are not included in the capitation rate. The MCO must maintain documentation of each authorized Case-by-case Service provided to each Member. At a minimum, this documentation must include the reason for providing the service. Case-by-case Services are not included in the rate setting process.

This section does not apply to the CHIP Perinate Members (unborn children).

8.1.3 Access to Care

All Covered Services must be available to Members on a timely basis in accordance with the Contract's requirements and medically appropriate guidelines, and consistent with generally accepted practice parameters. The MCO must comply with the access

requirements as established by the Texas Department of Insurance (TDI) for all MCOs doing business in Texas, except as otherwise required by this Contract.

The MCO must comply with Texas Medicaid State Plan Section 2.7, 42 C.F.R § 431.52, and 42 C.F.R § 435.403 when authorizing and monitoring Covered Services provided to Members who are temporarily out-of-state.

The MCO must provide coverage for Emergency Services to Members 24 hours a Day and 7 Days a week, without regard to prior authorization or the Emergency Service provider's contractual relationship with the MCO. The MCO's policy and procedures, Covered Services, claims adjudication methodology, and reimbursement performance for Emergency Services must comply with all applicable state and federal laws and regulations, whether the provider is Network or Out-of-Network.

A Medicaid or CHIP MCO is not responsible for payment for unauthorized non-emergency services provided to a Member by Out-of-Network providers, except when that provider is an Indian Health Care Provider (IHCP) enrolled as a Federally Qualified Health Center (FQHC) as provided in **Section 8.1.22**.

The MCO must also have a toll-free emergency and crisis Behavioral Health Services Hotline available 24 hours a Day, 7 Days a week. The Behavioral Health Services Hotline must meet the requirements described in **Section 8.1.15.3.** For Medicaid Members, a MCO must provide coverage for Emergency Services in compliance with 42 C.F.R. § 438.114, and as described in more detail in **Section 8.2.2.1**. The MCO may arrange Emergency Services and crisis Behavioral Health Services through mobile crisis teams.

For CHIP Members, Emergency Covered Services, including emergency Behavioral Health Services, must be provided in accordance with the requirements of the Texas Insurance Code and TDI regulations.

MCO must require, and make best efforts to ensure, that PCPs are accessible to STAR, STAR+PLUS, CHIP, and CHIP Perinate Newborn Members 24 hours a Day, 7 Days a week and that Network Primary Care Providers (PCPs) have after-hours telephone availability consistent with **Section 8.1.4.** The MCO must ensure that Network Providers offer office hours to Members that are at least equal to those offered to the MCO's commercial lines of business or Medicaid fee-for-service participants, if the provider accepts only Medicaid Members.

CHIP MCOs are not required to establish PCP Networks for CHIP Perinates (Unborn Child).

The MCO must provide that if Medically Necessary Covered Services are not available through Network Providers , the MCO must, upon the request of a Network Provider, allow a referral to a non-network physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the Member, but in no event to exceed five Business Days after receipt of reasonably requested documentation. The MCO must fully reimburse the non-network provider in accordance

with the Out-of-Network methodology for Medicaid as defined by HHSC in 1 Tex. Admin. Code § 353.4, and for CHIP, at the usual and customary rate defined by TDI in 28 Tex. Admin. Code § 11.506.

The MCO may not require the Member to pay for any Medically Necessary or Functionally Necessary Covered Services other than:

(1) HHSC-specified copayments for CHIP Members, where applicable;

(2) HHSC-specified copayments for Medicaid Members, where applicable, if HHSC implements Medicaid cost sharing after the Effective Date of the Contract; and

(3) STAR+PLUS Members who enter a 24-hour setting are required to pay the provider of care room and board costs and any income in excess of the personal needs allowance, as established by HHSC. Therefore, the MCO is not required to pay the provider of care room and board costs and any income in excess of the personal needs allowance for these Members. However, the MCO is responsible for notifying HHSC when it becomes aware that a Member is not paying the provider of care. Neither the MCO nor the Member are required to pay the provider of care room and board costs for a Member receiving Adult Foster Care in his or her home.

(4) STAR+PLUS Members who enter a Nursing Facility on or after March 1, 2015, will be required to pay the provider of care room and board costs and any income in excess of the personal needs allowance, as established by HHSC.

8.1.3.1 Appointment Accessibility

Through its Provider Network composition and management, the MCO must ensure that the following standards for appointment accessibility are met. The standards are measured from the date of presentation or request, whichever occurs first.

1. Emergency Services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities;
2. An Urgent Condition, including urgent specialty care and Behavioral Health Services, must be provided within 24 hours; treatment for Behavioral Health Services may be provided by a licensed Behavioral Health clinician.
3. Primary Routine Care must be provided within 14 Days;
4. Specialty Routine Care must be provided within 21 Days;
5. Specialty Therapy evaluations must be provided within 21 Days of submission of a signed referral. If an additional evaluation or assessment is required (e.g. audiology testing) as a condition for authorization of therapy evaluation, the additional required evaluation or assessment should be scheduled to allow the Specialty Therapy evaluation to occur within 21 Days from date of submission of a signed referral;
6. initial outpatient Behavioral Health visits must be provided within 14 Days (this requirement does not apply to CHIP Perinate);

7. Community Long-Term Services and Supports for Members must be initiated within seven Days from the start date on the Individual Service Plan as outlined in **Section 8.3.4.1** or the eligibility effective date for non-waiver LTSS unless the referring provider, Member, or STAR+PLUS Handbook states otherwise;
8. pre-natal care must be provided within 14 Days for initial appointments except for high-risk pregnancies or new Members in the third trimester, for whom an initial appointment must be offered within five Days, or immediately, if an emergency exists. Appointments for ongoing care must be available in accordance to the treatment plan as developed by the provider;
9. Preventive health services including annual adult well checks for Members 21 years of age or older must be offered within 90 Days;
10. Preventive health services for Members less than 6 month of age must be provided within 14 Days. Preventive health services for Members 6 months through age 20 must be provided within 60 Days. CHIP Members should receive preventive care in accordance with the American Academy of Pediatrics (AAP) periodicity schedule. Medicaid Members should receive preventive care in accordance with the Texas Health Steps periodicity schedule. MCOs must encourage new Members 20 years of age or younger to receive a Texas Health Steps checkup within 90 Days of enrollment. For purposes of this requirement, the term “New Member” is defined in Chapter 12 of the UMCM; and
11. Case Management for Children and Pregnant Women services must be provided to Medicaid Members within 14 Days.

8.1.3.2 Access to Network Providers

This section does not apply to NEMT Services providers.

The MCO’s Network must include all of the provider types described in this section and in UMCM Chapter 5, Access to Network Providers Performance Standards and Specifications in sufficient numbers, and with sufficient capacity, to provide timely access to all Covered Services in accordance with the appointment accessibility standards in **Section 8.1.3.1**. The MCO’s Network must provide timely access to regular and preventive care to all Members, and Texas Health Steps services to all child Members in Medicaid. The MCO must allow each Member to choose his or her Network Provider, to the extent possible and appropriate, in accordance with federal and state law and policy, including 42 C.F.R. § 438.3(l) and § 457.1201(j). The MCO must ensure that access is consistent with 1 Tex. Admin. Code § 353.411.

For each provider type, the MCO must provide access to at least 90 percent of Members in each Program and Service Area within the prescribed distance or travel time standard. Counties will be designated as metro, micro, or rural. The county designation is based on population and density parameters. A map of counties by designation and parameters is available in **Attachment B-5**. Members' residence in eligibility files with HHSC will be used to assess distance and travel times. The MCO must comply with the requirements set forth in UMCM Chapter 5, Access to Network Providers Performance Standards and Specifications).

HHSC will track MCO performance. HHSC will use the MCO Provider Files to run the Geo-Mapping Report which will measure provider choice, distance, and travel time. HHSC will compile the reports based on each MCOs network. HHSC will share identified deficiencies with the MCO. The MCO may be subject to liquidated damages specified in **Attachment B-3**.

Community Attendant Care Services: MCOs must ensure that a minimum of 90% of Members who are authorized to receive community attendant care services have timely access to such services. For purposes of this paragraph, timely access is within seven Days from the authorization as stated in section 8.1.3.1. Reference UMCM Chapter 10 for reporting information and templates.

The STAR+PLUS MCO must have workforce development capacity and make concerted efforts to assist agencies contracted to provide community attendant care services in the agencies' role to improve recruitment and retention of provider agency community attendant staff.

Primary Care Provider (PCP): At a minimum, the MCO must ensure that all adult and child Members have access to a choice of age-appropriate Network PCPs with an Open Panel.

This provision does not apply to CHIP Perinates, but it does apply to CHIP Perinate Newborns.

An internist who provides primary care to adults only is not considered an age-appropriate PCP choice for a Member birth through age 17, and a pediatrician is not considered an age-appropriate choice for a Member age 18 and over.

Obstetrician/Gynecologist (OB/GYN): At a minimum, the MCO must ensure that all female Members have access to an OB/GYN in the Provider Network. If an OB/GYN is acting as the Member's PCP, the MCO must follow the access requirements for the PCP.

Prenatal: Members who are pregnant must have access to a Network Provider for prenatal care.

The MCO must allow a pregnant Member who is past the 24th week of pregnancy to remain under the Member's current OB/GYN's care through the Member's post-partum checkup, even if the OB/GYN provider is, or becomes, Out-of-Network.

Mental Health - Outpatient: At a minimum, the MCO must ensure that all Members have access to a covered outpatient mental health Service Provider in the Network. Outpatient mental health Service Providers must include Masters and Doctorate-level trained practitioners practicing independently or at clinics/group practices, or at outpatient Hospital departments as detailed in the UMCM Chapter 5, Access to Network Providers Performance Standards and Specifications, Outpatient Mental Health. The outpatient mental health Service Provider should be the appropriate Provider type to

meet each individual Member's needs, including child psychiatrists, and outpatient mental health Service Providers who serve children and adolescents.

At a minimum, the MCO must also ensure that all CHIP Members have access to covered outpatient mental health Service Providers, including rehabilitative day treatment providers and partial hospitalization Providers, in the Network.

Outpatient Substance Use Disorder Treatment: The MCO must ensure all Members have access to a choice of outpatient Substance Use Disorder service providers in the Network.

Mental Health Targeted Case Management and Mental Health Rehabilitative Services (TCM/MHR): The MCO must ensure the Member has access to a Network Provider of Mental Health Targeted Case Management and Mental Health Rehabilitative Services.

Specialist Physician Access: At a minimum, the MCO must ensure that all Members have access to a Network specialist physician for all covered services. PCPs must make referrals for the following providers on a timely basis, based on the urgency of the Member's medical condition, but no later than five Days:

Audiologist, Cardiovascular Disease, Otolaryngologist (ENT), General Surgeon, Ophthalmologist, Orthopedist, Pediatric Sub-specialty, Psychiatrist, Urologist, and all other specialties not listed above.

In addition, all Members must be allowed to: 1) select a Network ophthalmologist or therapeutic optometrist to provide eye Health Care Services, other than surgery; and 2) have access without a PCP referral to eye Health Care Services from a Network specialist who is an ophthalmologist or therapeutic optometrist for non-surgical services.

Therapies –Occupational, Physical, and Speech Therapy Provided in an Outpatient Clinic or Facility: The MCO must ensure the Member has access to a Network Provider for occupational therapy (OT), physical therapy (PT), and speech therapy (ST).

Acute Care Hospital: The MCO must ensure that all Members have access to an Acute Care Hospital in the Provider Network.

Nursing Facility: At the minimum, the MCO must ensure that Members have access to a Nursing Facility in the Provider Network.

Pharmacy: At the minimum, the MCO must ensure that all Members have Pharmacy access. The MCO must ensure that access is consistent with UMCM Chapter 5, Access to Network Providers Performance Standards and Specifications.

Long Term Services & Support (LTSS) Providers: At a minimum, the MCO must ensure that all Members have access to the following LTSS providers for all covered

services: Assisted Living Facility; Attendant Care; CFC Habilitation Services; Consumer Directed Services (CDS); In-Home Therapies – OT, PT, and ST; In-Home Skilled Nursing; and Private Duty Nursing.

Assisted Living Facilities: STAR+PLUS MCOs must ensure that 90 percent of Members in every county must have a choice of at least two Assisted Living Facilities (ALF) within specified distance or travel time requirements, as noted below, of each Member depending on whether county of residence is classified as Metro, Micro or Rural. For purposes of access to ALFs the county classification in the chart below is based on Medicare Advantage designations developed by CMS, as included in Attachment B-7 to the Contract.

All other Covered Services, except for services provided in the Member's residence: At a minimum, the MCO must ensure that all Members have access to a Network Provider for all other Covered Services. This access requirement includes, but is not limited to, specialists not previously referenced in this section, oncology including surgical and radiation, specialty Hospitals, psychiatric Hospitals, diagnostic services, and single or limited service health care physicians or Providers, as applicable to the Program.

The MCO is not precluded from making arrangements with physicians or providers outside the MCO's Service Area for Members to receive a higher level of skill or specialty than the level available within the Service Area, including but not limited to, treatment of cancer, burns, and cardiac diseases.

Exception Process: HHSC will consider requests for exceptions to the access standards for all provider types under limited circumstances. Each exception request must be supported by information and documentation as specified in the template provided by HHSC Managed Care Compliance and Operations Network Adequacy. Exceptions may be granted on a case-by-case basis for an area that does not meet the performance standards as outlined in UMCM Chapter 5, Access to Network Providers Performance Standards and Specifications. The MCO must establish, through applicable supporting documentation, a normal pattern for securing Health Care Services or that the MCO is providing care of a higher skill level or specialty than the level available within the Service Area.

8.1.3.3 Monitoring Access

This section does not apply to NEMT Services providers.

The MCO must verify that Covered Services furnished by Network Providers are available and accessible to Members in compliance with the standards described in **Sections 8.1.3.1 and 8.1.3.2**, and for Covered Services furnished by PCPs, the standards described in **Section 8.1.4.2**.

The MCO must develop and implement a Provider Directory verification survey to verify that the Provider information maintained by the MCO is correct and in alignment with the Provider information maintained by the HHSC Administrative Services Contractor.

The survey must be conducted each fiscal year. At a minimum, the survey must include verification of provider directory critical elements in accordance with **UMCM Chapter 5**.

The MCO may conduct the survey through its online Provider Portal, telephone calls, onsite visits, email, or other method that collects and verifies information. For each Service Area the MCO must conduct a statistically valid random sample (95 percent confidence level with a margin of error +/- 5 percent) of Network PCPs and Specialists. The MCO must collect, analyze, and submit survey results and supporting documentation as specified in **UMCM Chapter 5**.

The MCO must enforce access and other Network standards required by the Contract and take appropriate action with noncompliant Providers.

8.1.3.4 Indian Health Care Providers

The MCO must demonstrate a sufficient number of Indian Health Care Providers (IHCP) are participating in its Provider Network to ensure that Indian Members who are eligible to receive services have timely access to services available from an Network IHCP. The MCO must allow an Indian Member to designate a Network IHCP as a Primary Care Provider (PCP), as long as that provider has capacity to provide the services. The MCO must allow an Indian Member to receive Covered Services from an Out-of-Network (OON) IHCP from whom the Indian Member is otherwise eligible to receive such services.

If the MCO cannot ensure timely access to Covered Services because of few or no Network IHCPs, the MCO will be considered as compliant with this Contract in accordance with 42 C.F.R. §438.14(b)(1), and §457.1209 if Indian Members are allowed to access IHCPs out-of-state or if the circumstance is deemed good cause for disenrollment from managed care in accordance with 42 C.F.R. §438.56(c) and §457.1212. The MCO must permit an OON IHCP to refer an Indian Member to a Network Provider.

The MCO must pay for Covered Services provided by an IHCP to an Indian Member, regardless of whether the IHCP is a Network Provider. The MCO must (1) pay the IHCP an agreed to negotiated rate, or (2) in the absence of a negotiated rate, pay a rate not less than the level and amount that would be paid to a Network Provider that is not an IHCP; and (3) make payment to all IHCPs in its Network in a timely manner as required for payments to practitioners in individual or group practices under 42 C.F.R. §447.45 and §447.46.

If an IHCP is not enrolled in Medicaid as an FQHC and regardless of whether an IHCP is a Network Provider, the IHCP must be paid the applicable encounter rate published annually in the Federal Register by the Indian Health Service, or, in the absence of a published encounter rate, the amount the IHCP would be paid if services were provided under the State Plan in Medicaid FFS. If an IHCP is enrolled in Medicaid as an FQHC, the IHCP must be reimbursed as described in **Section 8.1.22**.

8.1.4 Provider Network

This section does not apply to NEMT Services providers.

The MCO must enter into written contracts with properly credentialed Providers as described in this Section. The Provider contracts must comply with the UMCM's requirements and include reasonable administrative and professional terms.

The MCO must maintain a Provider Network sufficient to provide all Members with access to the full range of Covered Services required under the Contract. The MCO must ensure its Providers and Subcontractors meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the Contract.

The Provider Network must be responsive to the linguistic, cultural, and other unique needs of any minority, elderly, or disabled individuals, or other special populations served by the MCO. This includes the capacity to communicate with Members in languages other than English, when necessary, as well as with those who are deaf or hearing impaired.

The MCO must seek to obtain the participation in its Provider Network of qualified providers currently serving the Medicaid and CHIP Members in the MCO's proposed Service Area(s). MCOs utilizing Out-of-Network providers to render services to their Members must not exceed the utilization standards established in 1 Tex. Admin. Code § 353.4 for Medicaid and 1 Tex. Admin. Code § 370.604 for CHIP. HHSC may modify this requirement for MCOs that demonstrate good cause for noncompliance, as set forth in 1 Tex. Admin. Code § 353.4(e)(3) for Medicaid and 1 Tex. Admin. Code § 370.604(d) for CHIP.

The MCO must seek participation in the Provider Network from the following types of entities that may serve American Indian and Alaskan Native children:

1. health clinics operated by a federally-recognized tribe in the Service Area;
2. Federally Qualified Health Centers (FQHC) operated by a federally-recognized tribe in the Service Area; and
3. Urban Indian organizations in the Service Area.

All Providers: Except as provided in **Section 8.1.4.10**, all Providers must comply with State of Texas licensure requirements and all state and federal laws governing the provision of Covered Services. Providers may not be under sanction or exclusion from the Medicaid program. All Acute Care Providers serving Medicaid Members must be enrolled as Medicaid providers and have a Texas Provider Identification Number (TPIN). All Providers serving only CHIP members must be enrolled with HHSC by January 1, 2018. All Pharmacy Providers must be enrolled with HHSC's Vendor Drug Program. Long-term Services and Supports Providers are not required to have a TPIN but must have a LTSS Provider number. Providers must also have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D.

The MCO is prohibited from employing, contracting with, or entering into a Provider agreement with Providers whose license is expired or cancelled or who are excluded, suspended, or terminated from participation in the Texas Medicaid and CHIP programs. The MCO must reconcile their list of credentialed Providers to the master Provider file as often as the HHSC Administrative Services Contractor makes it available.

Inpatient Hospital and medical services: The MCO must ensure access to Acute Care Hospitals and Specialty Hospitals in the MCO's Network. Covered Services provided by such Hospitals must be available and accessible 24 hours per Day, 7 Days per week. The MCO must enter into a Provider Contract with any willing State Hospital that meets the MCO's credentialing requirements and agrees to the MCO's contract rates and terms.

Children's Hospitals/Hospitals with specialized pediatric services: The MCO must ensure Members access to Hospitals designated as Children's Hospitals by Medicare and Hospitals with specialized pediatric services, such as teaching Hospitals and Hospitals with designated children's wings. Covered Services provided by such Hospitals must be available and accessible 24 hours per Day, 7 Days per week. If the MCO does not have a designated Children's Hospital and/or Hospital with specialized pediatric services in proximity to the Member's residence in its Network, the MCO must enter into written arrangements for services with Out-of-Network Hospitals. Provider Directories including the online Provider Directory, Member Materials, and Marketing Materials must clearly distinguish between Hospitals designated as Children's Hospitals and Hospitals that have designated children's units.

Trauma: The MCO must ensure Members access to Texas Department of State Health Services (DSHS)-designated Level I and Level II trauma centers within the State, or Hospitals meeting the equivalent level of trauma care in the MCO's Service Area or in close proximity to such Service Area. The MCO must make written Out-of-Network reimbursement arrangements with the DSHS-designated Level I and Level II trauma centers or Hospitals meeting equivalent levels of trauma care if the MCO does not include such a trauma center in its Network.

Transplant centers: The MCO must ensure Member access to HHSC-designated transplant centers or centers meeting equivalent levels of care. HHSC utilizes the CMS list for the HHSC-designated transplant centers list, which may be found on the CMS website. If the MCO's Network does not include a designated transplant center or center meeting equivalent levels of care in proximity to the Member's residence, the MCO must make written arrangements with Out-of-Network providers for such care.

Hemophilia centers: The MCO must ensure Member access to hemophilia centers supported by the Centers for Disease Control (CDC), which include pharmacy services provided by the centers. A list of these hemophilia centers is maintained by the CDC. If the MCO's Network does not include CDC-supported hemophilia centers in proximity to the Member's residence, the MCO must make written arrangements with Out-of-Network providers for such care.

Physician services: The MCO must ensure that Primary Care Providers are available and accessible 24 hours per Day, 7 Days per week, within the Provider Network. The MCO must contract with a sufficient number of participating physicians and specialists within each Service Area to comply with **Section 8.1.3**'s access requirements and meet Members' needs for all Covered Services.

The MCO must ensure that an adequate number of participating physicians have admitting privileges at one or more participating Acute Care Hospitals in the Provider Network to ensure that necessary admissions are made. In no case may there be less than one Network PCP with admitting privileges available and accessible 24 hours per Day, 7 Days per week for each Acute Care Hospital in the Provider Network.

The MCO must ensure that an adequate number of participating specialty physicians have admitting privileges at one or more participating Hospitals in the MCO's Provider Network to ensure necessary admissions are made. The MCO must require that all physicians who admit to Hospitals maintain Hospital access for their Members through appropriate call coverage.

Urgent Care Clinics: The MCO must ensure that Urgent Care Clinics, including multi-specialty clinics serving in this capacity, are included within the Provider Network.

Laboratory services: The MCO must ensure that Network reference laboratory services are of sufficient size and scope to meet Members' non-emergency and emergency needs and the access requirements in **Section 8.1.3**. Reference laboratory specimen procurement services must facilitate the provision of clinical diagnostic services for physicians, Providers, and Members through the use of convenient reference satellite labs in each Service Area, strategically located specimen collection areas in each Service Area, and the use of a courier system under the management of the reference lab. For Medicaid Members, Texas Health Steps requires Providers to use the DSHS Laboratory Services for specimens obtained as part of a Texas Health Steps medical checkup, including Texas Health Steps newborn screens; blood lead testing; hemoglobin electrophoresis; and total hemoglobin tests that are processed at the Austin Laboratory. Providers may submit specimens for glucose, cholesterol, HDL, lipid profile, HIV and RPR to the DSHS Laboratory or to a laboratory of the provider's choice. Hematocrit may be performed at the provider's clinic if the provider needs an immediate result for anemia screening. Providers should refer to the Texas Health Steps Online Provider Training Modules referencing specimen collection on the Texas Health Steps website and to the Texas Medicaid Provider Procedures Manual and the Children's Services Handbook on the TMHP website for the most current information and any updates. The Children's Services Handbook is located within the Texas Medicaid Provider Procedures Manual.

Pharmacy Providers: The MCO must ensure that all Pharmacy Network Providers meet all requirements under 1 Tex. Admin. Code § 353.909. Providers must not be under sanction or exclusion from the Medicaid or CHIP Programs. The MCO must enter into a Provider Contract with any willing pharmacy provider that meets the MCO's credentialing requirements and agrees to the MCO's contract rates and terms for participation in the MCO's retail pharmacy network. The MCO may also enter into

selective contracts for drugs listed on the HHSC specialty drug list published on the Medicaid Vendor Drug Program website in accordance with 1 Tex. Admin. Code § 354.1853 with one or more pharmacy providers but any selective arrangement must comply with Texas Government Code § 533.005(a)(23)(G) and 1 Tex. Admin. Code § 353.905(e), and § 370.701.

MCOs may have only retail pharmacy networks and specialty pharmacy networks. Except for selective arrangements for drugs on the HHSC Specialty Drug List, MCOs may not have preferred pharmacy or selective pharmacy networks. MCOs must allow pharmacies in the retail pharmacy network to dispense any drug listed on the VDP formulary, with the exception of drugs listed on the HHSC Specialty Drug List. MCOs may limit the dispensing of drugs on the HHSC Specialty Drug List to pharmacies enrolled in the MCOs specialty pharmacy network.

The MCO and its Subcontractors must not require Medicaid/CHIP pharmacy providers to enroll in other lines of business as a condition for Medicaid/CHIP enrollment.

Diagnostic imaging: The MCO must ensure that diagnostic imaging services are available and accessible to all Members in each Service Area in accordance with the access standards in **Section 8.1.3**. The MCO must ensure that diagnostic imaging procedures that require the injection or ingestion of radiopaque chemicals are performed only under the direction of physicians qualified to perform those procedures.

Home health services: All Members living within the MCO's Service Area must have access to at least one Network Provider of home health Covered Services. These services are provided as part of the Acute Care Covered Services, not the Community Long Term Services and Supports.

Community Long Term Services and Supports: All Members living within a STAR+PLUS MCO's Service Area must have access to Medically Necessary and Functionally Necessary Covered Services.

Nursing Facility Services: The STAR+PLUS MCO must ensure Members have access to Nursing Facility services effective March 1, 2015. PCPs associated with a Nursing Facility must either have admitting privileges at a Hospital that is part of the MCO's Provider Network or make referral arrangements with a Provider who has admitting privileges to a Network Hospital. The STAR+PLUS MCO must enter into a Provider Contract with any willing Nursing Facility Provider that is licensed, certified, and has a Medicaid contract with HHSC; that meets the Nursing Facility credentialing standards and minimum performance standards in UMCM Chapter 8, and agrees to the MCO's contract rates and terms. MCOs must comply with the rate requirements set forth in UMCC 8.3.9.4. A STAR+PLUS MCO is prohibited from contracting with a Nursing Facility if the Nursing Facility does not meet credentialing standards. A STAR+PLUS MCO may refuse to contract with a Nursing Facility if the Nursing Facility does not meet the minimum performance standards in UMCM Chapter 8.

Hospice Services: Effective March 1, 2015, Nursing Facility residents in STAR+PLUS MCOs must have access to Hospice Services as Non-capitated Services.

Ambulance providers: The MCO must enter into a Provider Contract with any willing ambulance provider that meets the MCO's credentialing requirements and agrees to the MCO's contract rates and terms.

Optometrists and Ophthalmologists: The MCO must enter into a Provider Contract with any willing optometrists, ophthalmologists, therapeutic optometrists, and enrolled providers within institutions of higher education that provide an accredited program for training as a Doctor of Optometry or an optometrist residency or training as an ophthalmologist or an ophthalmologist residency that meets the MCO's credentialing requirements and agrees to the MCO's contract terms and rates.

Mental Health Rehabilitative Services: The MCO must ensure Members have access to Mental Health Rehabilitative Services.

Adult Foster Care: MCOs must make reasonable effort to contract with qualified Adult Foster Care (AFC) services within their Service Area.

Prescribed Pediatric Extended Care Centers (PPECC): MCOs must make reasonable effort to contract with qualified PPECCs within the service delivery area, if available. Qualified PPECCs include those with a temporary, initial or renewal license.

LMHAs and LBHAs: The MCO must enter into a Provider Contract with any willing LMHA or LBHA that meets the MCO's credentialing requirements and agrees to the MCO's contract rates and terms.

Outpatient Substance Use Disorder Service Providers: The MCO must make reasonable effort to contract with outpatient Substance Use Disorder (SUD) service providers. The MCO's network for outpatient SUD service providers must include chemical dependency treatment facilities, including facilities licensed by HHSC to serve adolescents. The network must also include the following for medication assisted treatment: licensed narcotic (opioid) treatment programs, chemical dependency treatment facilities licensed by HHSC, and appropriately trained physicians and other qualified prescribers as specified in the Texas Medicaid Provider Procedures Manual.

CHIP MCOs must include providers capable of providing SUD intensive outpatient services and SUD partial hospitalization.

The MCO must include Significant Traditional Providers (STPs) of this benefit in its Network and provide such STPs with expedited credentialing. Medicaid MCOs must enter into Provider Contracts with any willing STP of these benefits that meets the Medicaid enrollment requirements, MCO credentialing requirements, and agrees to the MCO's contract terms and rates. For purposes of this section, STPs are providers who meet the Medicaid enrollment requirements and have a contract with HHSC to receive funding for treatment under the Federal Substance Abuse Prevention and Treatment block grant. The STP requirements described herein apply to all SAs, and unlike other STP requirements are not limited to the first three years of operation.

Case Management for Children and Pregnant Women (Medicaid only): The MCO must make a reasonable effort to contract with Case Management for Children and Pregnant Women providers within its Service Area. The MCO must ensure all Members have access to Case Management for Children and Pregnant Women Services.

Residential Substance Use Disorder Service Providers: The MCO must make reasonable effort to contract with residential SUD service providers. The MCO's network for residential outpatient SUD service providers must include chemical dependency treatment facilities licensed by HHSC to provide residential services, including those licensed to serve adolescents in a residential setting. The MCO must ensure access to providers who offer residential treatment services, and providers who offer residential withdrawal management services.

The MCO must include Significant Traditional Providers (STPs) of this benefit in its Network and provide such STPs with expedited credentialing. Medicaid MCOs must enter into Provider Contracts with any willing STP of these benefits that meets the Medicaid enrollment requirements, MCO credentialing requirements, and agrees to the MCO's contract terms and rates. For purposes of this section, STPs are providers who meet the Medicaid enrollment requirements and have a contract with HHSC to receive funding for treatment under the Federal Substance Abuse Prevention and Treatment block grant. The STP requirements described herein apply to all SAs, and unlike other STP requirements are not limited to the first three years of operation.

Texas Certified Community Behavioral Health Clinics (T-CCBHCs): The MCO must enter into a Provider Contract with any willing T-CCBHC provider that meets the MCO's credentialing requirements and agrees to the MCO's contract rates and terms.

8.1.4.1 Provider Contract Requirements

The MCO is prohibited from requiring a provider or provider group to enter into an exclusive contracting arrangement with the MCO as a condition for Network participation.

The MCO's contract with health care Providers, and NEMT Services providers as applicable, must be in writing, must be in compliance with applicable federal and state laws and regulations, and must include minimum requirements specified in **Attachment A**, "Uniform Managed Care Contract Terms and Conditions," and UMCM Chapter 8. The MCO must give each Provider a copy of this executed contract within 45 Days of execution. For an executed contract, the Provider needs to be credentialed, and the Provider and MCO must both sign the contract. Credentialing requirements do not apply to NEMT Services providers.

As described in Section 7, the MCO must submit model Provider contracts to HHSC for review during Readiness Review. The MCO must resubmit the model Provider contracts any time it makes substantive modifications to such agreements. HHSC retains the right to reject or require changes to any Provider contract that does not comply with MCO Program requirements or the HHSC-MCO Contract.

8.1.4.2 Primary Care Providers

The MCO's PCP Network may include Providers from any of the following practice areas: General Practice; Family Practice; Internal Medicine; Pediatrics; Obstetrics/Gynecology (OB/GYN); Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) (when APRNs and PAs are practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP under this contract); Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and similar community clinics; physicians serving Members residing in Nursing Facilities; and specialist physicians who are willing to provide a Medical Home to selected Members with special needs and conditions. In addition, if applicable the MCOs Network must include a sufficient number of Indian Health Care Providers to ensure that eligible Members enrolled in the MCO have timely access to services. The MCO may include an advanced practice registered nurse (APRN) as a Network PCP, even if the APRN's supervising physician is not a Network Provider. The MCO must treat APRNs and PAs in the same manner as other Network PCPs with regard to: (1) selection and assignment as PCPs, (2) inclusion as PCPs in the MCO's Provider Network, and (3) inclusion as a PCP in any Provider Directory maintained by the MCO.

An internist or other Provider who provides primary care to adults only is not considered an age-appropriate PCP choice for a Member birth through age 18. An internist or other Provider who provides primary care to adults and children may be a PCP for children if:

1. the Provider assumes all MCO PCP responsibilities for such child Members in a specific age range from birth through age 20,

~~1.~~2. the Provider has a history of practicing as a PCP for the specified age range, as evidenced by the Provider's primary care practice including an established Member population within the specified age range, and

~~2.~~3. the Provider has admitting privileges, or makes referral arrangements with a Provider who has admitting privileges, to a local Hospital that includes admissions to pediatric units.

For programs other than STAR+PLUS, a pediatrician is not considered an age-appropriate choice for a Member age 21 and over. For STAR+PLUS only, a pediatrician is not considered an age-appropriate choice for a Member age 18 and over.

The PCP for a Member with disabilities, Special Health Care Needs, Chronic or Complex Conditions, or in a Nursing Facility may be a specialist physician who agrees to provide PCP services to the Member. The specialist physician must agree to perform all PCP duties required in the Contract, and PCP duties must be within the scope of the specialist's license. Any interested person may initiate the request through the MCO for a specialist to serve as a PCP for a Member with disabilities, Special Health Care Needs, or Chronic or Complex Conditions. The MCO must handle these requests in accordance with 28 Tex. Admin. Code Chapter 11, Subchapter J.

PCPs who provide Covered Services for STAR and CHIP newborns must either have admitting privileges at a Hospital that is part of the MCO's Provider Network or make referral arrangements with a Provider who has admitting privileges to a Network Hospital. STAR+PLUS PCPs must either have admitting privileges at a Network Hospital or make referral arrangements with a Provider who has admitting privileges to a Network Hospital.

The MCO must require, through contract provisions, that PCPs are accessible to Members 24 hours a Day, 7 Days a week. The MCO is encouraged to enter into Provider Contracts with sites that offer primary care services during evening and weekend hours. The following are acceptable and unacceptable telephone arrangements for contacting PCPs after their normal business hours.

Acceptable after-hours coverage:

1. the office telephone is answered after-hours by an answering service that meets language requirements of the Major Population Groups and that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes;
2. the office telephone is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the Member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable; and
3. the office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, or another designated medical provider, who can return the call within 30 minutes.

Unacceptable after-hours coverage:

1. the office telephone is only answered during office hours;
2. the office telephone is answered after-hours by a recording that tells Members to leave a message;
3. the office telephone is answered after-hours by a recording that directs Members to go to an Emergency Room for any services needed; and
4. returning after-hours calls outside of 30 minutes.

The CHIP MCOs must require PCPs, through contract provisions, to provide children birth through age 20 with preventive services in accordance with the AAP recommendations. Medicaid MCOs must require PCPs, through contract provisions, to provide children birth through age 20 with preventive services in accordance with the Texas Health Steps periodicity schedule. The MCO must require PCPs, through contract provisions, to provide adults with preventive services in accordance with the U.S. Preventive Services Task Force requirements. The MCO must make best efforts to ensure that PCPs follow these periodicity requirements for children and adult Members. Best efforts must include, but not be limited to, Provider education, Provider profiling, monitoring, and feedback activities.

The MCO must require PCPs, through contract provisions, to assess the medical needs of Members for referral to specialty care providers and provide referrals as needed. PCPs must coordinate Members' care with specialty care providers after referral. The MCO must make best efforts to ensure that PCPs assess Member needs for referrals and make such referrals. Best efforts must include, but not be limited to, Provider education activities and review of Provider referral patterns.

8.1.4.3 PCP Notification

The MCO must furnish each PCP with a current list of Members enrolled or assigned to that Provider no later than five Business Days after the MCO receives the Enrollment File from the HHSC Administrative Services Contractor each month. The MCO may offer and provide such enrollment information in alternative formats, such as through access to a secure Internet site, when such format is acceptable to the PCP.

8.1.4.4 Provider Credentialing and Re-credentialing

This section does not apply to NEMT Services providers.

All Medicaid MCOs must utilize the Texas Association of Health Plans' (TAHP's) contracted Credentialing Verification Organization (CVO) as part of its Provider credentialing and recredentialing process regardless of membership in the TAHP. The CVO is responsible for receiving completed applications, attestations and primary source verification documents

At least once every three years, the MCO must review and approve the credentials of all participating licensed and unlicensed Providers who participate in the MCO's Network. The MCO may subcontract with another entity to which it delegates credentialing activities if the delegated credentialing is maintained in accordance with the National Committee for Quality Assurance (NCQA) delegated credentialing requirements and any comparable requirements defined by HHSC.

At a minimum, the scope and structure of an MCO's credentialing and re-credentialing processes must be consistent with recognized MCO industry standards and relevant state and federal regulations including 28 Tex. Admin. Code §§ 11.1902 and 11.1402(c), relating to provider credentialing and notice. Medicaid MCOs must also comply with 42 C.F.R. § 438.12 and § 438.214. The re-credentialing process must take into consideration Provider performance data including Member Complaints and Appeals, quality of care, and utilization management.

The MCO must complete the credentialing process for a new provider and its claim systems must be able to recognize the provider as a Network Provider no later than 90 Days after receipt of a complete application.

If an application does not include required information, the MCO must provide the provider written notice of all missing information no later than five Business Days after receipt.

Effective March 1, 2018, the MCOs may only contract with a Nursing Facility that is licensed, certified, and has a Medicaid contract with HHSC, and that meets the Nursing Facility credentialing standards outlined in the UMCM Chapter 8. The MCO may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the MCO declines to include individual or groups of providers in its Network, it must give the affected providers written notice of the reasons for its decision.

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

8.1.4.4.1 Expedited Credentialing Process

This section does not apply to NEMT Services providers.

The MCO must comply with the requirements of Texas Insurance Code Chapter 1452, Subchapters C, D, and E, regarding expedited credentialing and payment of physicians, podiatrists, and therapeutic optometrists who have joined established medical groups or professional practices that are already contracted with the MCO.

The MCO must also establish and implement an expedited credentialing process, as required by Texas Government Code § 533.0064, that allows applicant providers to provide services to Members on a provisional basis for the following provider types: 1) dentists, 2) dental specialists, including dentists and physicians providing dental specialty care, 3) licensed clinical social workers, 4) licensed professional counselors, 5) licensed marriage and family therapists, and 6) psychologists. To qualify for expedited credentialing the provider must: (1) be a member of an established health care provider group that has a current contract in place with an MCO, (2) be a Medicaid enrolled provider, (3) agree to comply with the terms of the contract between the MCO and the health care provider group, and (4) timely submit all documentation and information required by the MCO as necessary for the MCO to begin the credentialing process.

The MCO must also establish and implement an expedited credentialing process for nursing facilities that successfully underwent a change of ownership (CHOW). The requirements for applicant providers to qualify for expedited credentialing listed above apply to CHOWs with the exception of (1) and (3). An applicant provider must also agree to comply with the terms of the contract between the MCO and the Nursing Facility.

Additionally, if a Provider qualifies for expedited credentialing, the MCO must treat the Provider as a Network Provider upon submission of a complete application. This includes paying the in-network rate for claims with a date of service on or after the submission date of a complete application, even if the MCO has not yet completed the credentialing process. The MCO's claims system must be able to process claims from the provider no later than 30 Days after receipt of a complete application.

8.1.4.4.2 Minimum Credentialing Requirements for Unlicensed or Uncertified LTSS Providers

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

1. has not been convicted of a crime listed in Texas Health and Safety Code § 250.006;
2. is not listed as "unemployable" in the Employee Misconduct Registry or the Nurse Aide Registry maintained by DADS by searching or ensuring a search of such registries is conducted, before hire and annually thereafter;
3. is not listed on the following websites as excluded from participation in any federal or state health care program:
    a. HHS-OIG Exclusion; and
    b. HHSC-OIG Exclusion Search;

    by searching or ensuring a search of such registries is conducted, before hire and at least monthly thereafter;
4. is knowledgeable of acts that constitute Abuse, Neglect, or Exploitation of a Member;
5. is instructed on and understands how to report suspected Abuse, Neglect, or Exploitation;
6. adheres to applicable state laws if providing transportation; and
7. is not a spouse of, legally responsible person for, or employment supervisor of the Member who receives the service, except as allowed in the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver.

8.1.4.5 Board Certification Status

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

8.1.4.6 Provider Relations Including Manual, Materials and Training

The MCO must maintain a provider relations presence in each Service Area or, for the Medicaid Rural Service Area, in regions approved by HHSC. If the MCO has dedicated provider relations staff, the MCOs must notify within ten Days, the Providers and NEMT Services providers who are impacted by a permanent change in Provider relations specialists within their service area. Notification may be in writing, email, or in the provider portal. The notification must include the Provider relations specialist's name, phone number, and email address. Provider relations specialists must be able to assist Providers and NEMT Services providers with all Covered Services. Provider relations specialist assistance may include coordinating with other MCO staff or Subcontractors to address specific issues raised by providers, such as claims or contracting concerns.

The STAR+PLUS MCOs must assign a provider relations specialist to each Network Nursing Facility. The assigned Provider relations specialist may be assigned to more than one Network Nursing Facility however, the MCO must have the same number of

provider relations specialists available to NFs as the number of Service Areas served by the MCO. MCOs may request an exception to this requirement to account for Service Areas with low membership, staff changes, or other issues impacting the MCOs ability to meet the requirement. The specialist must be proficient in Nursing Facility billing and able to resolve provider billing and payment inquiries. The MCO must display on their Provider portal a contact number which NF Providers can call to get their current assigned Provider relations specialists. The MCO must notify all affected Nursing Facilities and update their online Provider relations staff directory within ten Days of any change to the assigned provider relations specialist.

MCOs must designate a dedicated Provider relations email address and/or telephone number for Provider relations issues requiring additional follow up or escalation. MCOs must provide an email response or returned phone call to the Providers or NEMT Services providers within three (3) Business Days to all inquiries received; an auto-generated or pre-recorded response acknowledging the inquiry does not meet this requirement.

The MCO must prepare and issue Provider Manual(s) to all Network Providers, including any necessary specialty manuals (e.g., Behavioral Health, Nursing Facility Services). For newly contracted Providers, the MCO must issue copies of the Provider Manual(s) no later than five Business Days after inclusion in the Network. The Provider Manual must contain the critical elements defined in UMCM Chapter 3, including sections relating to special requirements of the MCO Program(s) and the enrolled populations.

HHSC's initial review of the Provider Manual is part of the Operational Readiness Review described in **Section 7**, "Transition Phase Requirements." Following Operational Readiness Review, HHSC must review and approve any substantive revisions to the Provider Manual before the MCO publishes or distributes it to Providers.

The MCO must provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members. The MCO's STAR, STAR+PLUS, CHIP and/or CHIP Perinatal Program training must be completed within 30 Days of placing a newly contracted Provider on active status. The MCO must provide ongoing training to new and existing Providers as required by the MCO, or as required by HHSC to comply with the Contract. The MCO must maintain and make available upon request enrollment or attendance rosters dated and signed by each attendee, or other written evidence of training of each Provider and his or her staff.

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

1. Covered Services and the Provider's responsibilities for providing and coordinating these services;
    a. Special emphasis must be placed on areas that vary from commercial coverage rules (e.g., Early Childhood Intervention services, therapies and DME/Medical Supplies); pharmacy services and processes, including information regarding outpatient drug benefits, HHSC's drug formulary, preferred drugs, prior authorization processes, and 72 hour emergency supplies of prescription drugs;

b. For Medicaid, the MCO should also place special emphasis on Behavioral Health Services including: Substance Use Disorder (SUD) treatment options, including opioid use disorder treatment; Screening, Brief Intervention, and Referral to Treatment (SBIRT) (TMPPM, Behavioral Health and Case Management Services Handbook, Chapter 7); mental health treatment; Mental Health Rehabilitative Services and the availability of Mental Health Targeted Case Management for qualified Members; and the processes for making referrals and coordination with the provision of Non-capitated Services;

2. relevant requirements of the Contract;
3. the MCO's quality assurance and performance improvement program and the Provider's role in such a program;
4. the MCO's policies and procedures, especially regarding Network and Out-of-Network referrals;
5. Member cost-sharing obligations, benefit limitations, Value-added Services, and prohibitions on balance-billing Members for Covered Services;
6. Cultural Competency Training based on National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS);
7. Texas Health Steps benefits, periodicity, required components of a checkup, the importance of documenting all required components of the checkup in the medical record, and the necessity of documentation to support a complete checkup qualifying for reimbursement is provided;
8. NEMT Services available to Medicaid Members;
9. the importance of updating contact information to ensure accurate Provider Directories and the Medicaid Online Provider Lookup;
10. information about the MCO's process for acceleration of Texas Health Steps services for Children of Migrant Farm Workers;
11. missed appointment referrals and assistance provided by the Texas Health Steps Outreach and Informing Unit;
12. for STAR in the Medicaid Rural Service Area, the process for continuing up to six months of Community-based Long Term Care Services for Members receiving those services as of the Operational Start Date, including provider billing practices for these services and whom to contact at the MCO for assistance with this process;
13. for STAR+PLUS, the role of the MCO Service Coordinators and provider relations specialists;
14. for STAR+PLUS, information on discharge planning, transitional care, and other educational programs related to long-term care settings;
15. administrative issues such as claims filing (including the processes regarding claims appeals and recoupments) and services available to Members;
16. For Medicaid (excluding STAR+PLUS), specific information in training materials, such as the MCO's Provider Manual, pertaining to Attention Deficit Hyperactivity Disorder (ADHD) Covered Services for children including reimbursement for ADHD and availability of follow-up care for children who have been prescribed ADHD medications;
17. Providers' obligation to identify and report a Critical Event or Incident such as Abuse, Neglect, or Exploitation to the State related to LTSS delivered in the STAR+PLUS program; and

18. for STAR+PLUS Nursing Facility Providers the billing process for the Nursing Facility Unit Rate; the authorization and billing processes for Nursing Facility Add-on Services, Medicare Part A Nursing Facility readmissions and Medicare Part B therapy, with a description of the MCOs authorization response; UMCM Chapter 8.6, section 2.2 requirement to notify the MCO within one Business Day of an adverse change in medical condition and other events; and UMCM Chapter 8.6. section 2.23 requirement to submit Form 3618 or Form 3619, as applicable, no later than 72 hours after a Member's admission or discharge from the Nursing Facility, in compliance with 40 Tex. Admin Code § 19.2615 and UMCM Chapter 8, or immediately if the 72-hour submission requirement is expired.

Provider Materials must comply with state and federal laws; **Attachment A**, "Uniform Managed Care Contract Terms and Conditions;" and UMCM Chapter 3.

As described above, HHSC must approve the MCO's Provider Manual and all substantive revisions. See UMCM Chapter 3, Chapter 4, and Chapter 8, for material and submission requirements. HHSC reserves the right to require discontinuation or correction of any Provider Materials, including those previously approved by HHSC.

8.1.4.7 Provider Hotline

The MCO must operate a toll-free telephone line for Provider and NEMT Services provider inquiries from 8 a.m. to 5 p.m. local time for the Service Area, Monday through Friday, except for State-approved holidays. The State-approved holiday schedule is updated annually and can be found on the Texas State Auditor's Office website. The Provider Hotline must be staffed with personnel who are knowledgeable about Covered Services, each applicable MCO Program, and for Medicaid, about Non-capitated Services.

The MCO must ensure that after regular business hours the line is answered by an automated system with the capability to provide callers with operating hours information and instructions on how to verify enrollment for a Member with an Urgent Condition or an Emergency Medical Condition. The MCO must have a process in place to handle after-hours inquiries from Providers seeking to verify enrollment for a Member with an Urgent Condition or an Emergency Medical Condition, provided, however, that the MCO and its Providers must not require such verification prior to providing Emergency Services.

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

1. the average hold time is two minutes or less; and
2. the call abandonment rate is seven percent or less.

The MCO must conduct ongoing call quality assurance to ensure these standards are met. The Provider Hotline may serve multiple MCO Programs if Hotline staff is knowledgeable about all of the MCO's Programs. The Provider Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all Service Areas, including the Provider Network in each Service Area.

The MCO must monitor Provider Hotline performance and submit reports summarizing call center performance as required by **Section 8.1.20**. If the MCO subcontracts with a Behavioral Health Organization (BHO) that is responsible for Provider Hotline functions related to Behavioral Health Services, the BHO's Provider Hotline must meet the requirements in **Section 8.1.4.7**.

If HHSC determines that it will conduct onsite monitoring of the MCO's Provider Hotline functions, the MCO must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent(s) relating to such monitoring. For purposes of this section, "authorized reimbursable travel costs" may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite monitoring. Reimbursement by the MCO will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

8.1.4.8 Provider Reimbursement

The MCO must pay for all Medically Necessary Covered Services provided to Members. A STAR+PLUS MCO must also pay for all Functionally Necessary Covered Services provided to Members. The MCO's Provider Contract must include a complete description of the payment methodology or amount, as described in UMCM Chapter 8.

The MCO must ensure claims payment is timely and accurate as described in **Section 8.1.18.5,** "Claims Processing Requirements," and UMCM Chapter 2. The MCO must require tax identification numbers from all participating Providers. The MCO is required to do back-up withholding from all payments to Providers who fail to give tax identification numbers or who give incorrect numbers.

Provider payments must comply with all applicable state and federal laws, rules, and regulations, including the following sections of the Patient Protection and Affordable Care Act (PPACA) and, upon implementation, corresponding federal regulations:

1. Section 2702 of PPACA, entitled "Payment Adjustment for Health Care-Acquired Conditions;"
2. Section 6505 of PPACA, entitled "Prohibition on Payments to Institutions or Entities Located Outside of the United States;" and
3. Section 1202 of the Health Care and Education Reconciliation Act as amended by PPACA, entitled "Payments to Primary Care Physicians."

The MCO must comply with registration requirements in Tex. Ins. Code § 1458.051 and with reimbursement and fee schedule requirements in Tex. Ins. Code § 1451.451 and 1458.101–102.

As required by Texas Government Code § 533.005(a)(25), the MCO cannot implement significant, non-negotiated, across-the-board Provider and NEMT Services provider reimbursement rate reductions unless: (1) it receives HHSC's prior approval, or (2) the

reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by HHSC. For purposes of this requirement an across-the-board rate reduction is a reduction that applies to all similarly-situated providers or types of providers. This requirement includes across-the-board rate reductions made by Subcontractors including pharmacy provider reimbursement methodologies and reductions due to changes in PBM Subcontractor or PBM provider networks. The MCO must submit a written request for an across-the-board rate reduction to HHSC's Director of Managed Care Compliance and Operations and provide a copy to HHSC's Health Plan Manager, if the reduction is not based on a change in the Medicaid fee schedule or cost containment initiative implemented by HHSC. The MCO must submit the request at least 90 Days prior to the planned effective date of the reduction. If HHSC does not issue a written statement of disapproval within 45 Days of receipt, then the MCO may move forward with the reduction on the planned effective date.

Further, the MCO must give Providers at least 30 Days notice of changes to the MCO's fee schedule, excluding changes derived from changes to the Medicaid fee schedule, before implementing the change. If the MCO fee schedule is derived from the Medicaid fee schedule, the MCO must implement fee schedule changes after the Medicaid fee schedule change, and any retroactive claim adjustments must be completed within 60 Business Days after HHSC retroactively adjusts the Medicaid fee schedule.

8.1.4.8.1 Provider Preventable Conditions

MCOs must identify Present on Admission (POA) indicators as required in UMCM Chapter 2 and MCOs must reduce, deny, or recoup payments for Provider Preventable Conditions that were not POA as set forth in 42 C.F.R. § 434.6(a)(12) and §447.26. This includes any hospital-acquired conditions or healthcare acquired conditions identified in the Texas Medicaid Provider Procedures Manual.

As a condition of payment to hospital Providers, MCOs must require Providers to report Provider-Preventable Conditions on Institutional Claims using appropriate POA indicators. MCOs must include all identified POA indicators on Encounter Data submitted to the State. Upon request by the State, MCOs must report the amount of Provider payments denied, reduced, or recouped from an individual Provider for the requested service dates for provider-preventable conditions that were not POA.

8.1.4.8.2 Hospital Quality Based Payment Program

HHSC collects data on potentially preventable events and uses it to improve quality and efficiency of services. MCOs and hospitals are financially accountable for potentially preventable complications (PPCs) and potentially preventable readmissions (PPRs), two quality measures used by HHSC in its Hospital Quality Based Payment (HQBP) Program. For fee-for-service, HHSC or its designee makes reimbursement adjustments to inpatient hospital claims based on performance of these measures. For the managed care programs, HHSC builds the adjustments into MCO capitation payments to reflect hospital reductions related to PPR/PPC.

HHSC provides MCOs with an annual confidential report of hospitals with poor performance on the PPCs and PPRs. This report will contain the hospital's NPI, name and level of payment reduction based on HHSC's methodology. In order to receive credit for the HQBP Program as an Alternative Payment Model according to the criteria set forth in Section 8.1.7.8.2., MCOs must pass down payment reductions to the hospitals identified by HHSC.

8.1.4.8.3 Nursing Facility Incentives

The MCO will implement Nursing Facility incentive program(s). The goal of the program(s) will be to reduce potentially preventable events, as defined in Texas Government Code § 536.001, unnecessary institutionalization, and Acute Care costs. The program(s) will also encourage Nursing Facility culture change, including the development of resident-centered service delivery and improvements to Nursing Facility physical plant features. Any nursing facility incentive program will comply with 42 C.F.R. § 438.60. Effective January 1, 2019, if the MCO's Nursing Facility incentive program includes any metrics utilized in HHSC's Quality Incentive Payment Program (QIPP), the MCO must require Nursing Facilities participating in QIPP to achieve a benchmark for payment that is associated with better performance on those metrics than that of the QIPP benchmarks. Effective January 1, 2019, the MCO must ensure that all of its Network Nursing Facility Providers serving the MCO's Nursing Facility Members have equal opportunity to participate in a Nursing Facility incentive program, regardless of facility occupancy or licensed capacity, or the number or percentage of total residents as Members. The MCO must have built-in protections in any of its Nursing Facility incentive programs to safeguard against activities that are intended to influence Member choice of health plan or provider. The MCO must be able to demonstrate those safeguards and compliance with this section upon request from HHSC. MCOs must comply with the requirements set forth in the UMCM Chapter 8.

8.1.4.8.4 Provider Overpayments

The MCO must have a mechanism in place through which Network Providers and NEMT Services providers report Overpayments. The MCO must inform Providers and NEMT Services providers of this mechanism. The mechanism must allow Providers and NEMT Services providers to include a reason for the Overpayment. The MCO must require that the Provider or NEMT Services provider submit Overpayments within 60 Days from identification. For purposes of this section, "identification" refers to when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an Overpayment and quantified the amount of the Overpayment.

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

8.1.4.8.5 Comprehensive Hospital Increase Reimbursement Program (CHIRP)

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

purposes of this section, program period is defined in 1 Tex. Admin. Code § 353.1306; however, notwithstanding the definition of program period in § 353.1306, the start date of the program period may be a date other than September 1. HHSC will notify the MCO of the start date of the program period prior to that start date.

MCOs must increase base payment rates for inpatient and outpatient services performed in the MCO's Network CHIRP-participating hospitals by the uniform percent associated with the CHIRP-participating hospital's class and Service Area as set out in **Attachment B-6** "Comprehensive Hospital Increase Reimbursement Program Providers and Rate Increase STAR" and **Attachment B-6.1** "Comprehensive Hospital Increase Reimbursement Program Providers and Rate Increase STAR+PLUS" for the CHIRP-participating hospitals and uniform percent associated with the CHIRP-participating hospital's class and Service Area. The MCO must increase base payment rates only to CHIRP-participating hospitals geographically located in Service Areas where the MCO has been selected to provide Services.

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

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

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

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

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

MCOs must assist CHIRP-participating hospitals in collecting information necessary to complete CHIRP reporting obligations for all years in which the CHIRP is in effect. HHSC will notify MCOs of the required reporting assistance prior to the start date of the program period.

8.1.4.8.6 Quality Incentive Payment Program (QIPP)

STAR+PLUS MCOs are responsible for meeting all quality incentive payment program (QIPP) requirements outlined in 1 Tex. Admin. Code §§ 353.1301 and 353.1302. The start date of the program period may be a date other than September 1. HHSC will notify the MCO of the start date of the program period prior to that start date.

HHSC will provide a Nursing Facility with its facility-specific baseline as well as the national benchmark for each of the quality metrics each year, the specific date to be determined by HHSC.

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

Each quarter HHSC will assess Nursing Facility performance and issue to the MCO facility-specific data, with the associated payment amount on an accompanying scorecard. The MCO must send the Nursing Facility its facility-specific scorecard and pay the Nursing Facility the payment amount on the scorecard no later than 20 Days after the date the MCO receives the QIPP scorecard and associated payment amounts.

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

A Nursing Facility is considered paid on the date of: (1) issue of a check for payment and its corresponding Remittance and Status (R&S) Report or explanation of payment to the Provider by the MCO; or (2) the electronic transmission, if payment is made electronically. MCOs must attest to meeting these timely payment requirements in compliance with UMCM Chapter 5.

For all QIPP-related recoupments, improper payments, and overpayments, MCOs must follow the processes outlined in UMCM Chapter 8.6, section 2.33 Right to Recover and Recoupment. HHSC may recoup the amount of overpayments from MCOs and MCOs may recoup the amount of overpayments from Nursing Facility Providers as allowed by 1 Tex. Admin. Code § 353.1302(k).

8.1.4.8.7 Minimum Fee Schedule for Rural Hospital

MCOs must adopt HHSC's Medicaid minimum fee schedule for rural hospitals, as defined in Texas Government Code § 531.02194, as of September 1, 2020. The Medicaid minimum fee schedule for rural hospitals includes only the following categories of service or provider type: clinical laboratory, ambulatory surgical centers, and hospital outpatient imaging services. The Medicaid minimum fee schedule also includes inpatient

standard dollar amount rural rates. The Medicaid minimum fee schedule for rural hospitals can be found at the following links:

- https://rad.hhs.texas.gov/hospitals-clinic/hospital-services/outpatient-services
- https://rad.hhs.texas.gov/hopitals-clinic/hospital-services/inpatient-services
- http://public.tmhp.com/FeeSchedules/StaticFeeSchedule/FeeSchedules.aspx

8.1.4.8.8 Texas Incentives for Physician and Professional Services (TIPPS)

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

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

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

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

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

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

8.1.4.8.9 Rural Access to Primary and Preventative Services (RAPPS)

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

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

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

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

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

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

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

8.1.4.8.10 Directed Payment Program for Behavioral Health Services (DPP BHS)

MCOs must satisfy all Directed Payment Program for Behavioral Health Services (DPP BHS) requirements outlined in 1 Tex. Admin. Code §§ 353.1301 and 353.1320. For purposes of this section, program period is defined in 1 Tex. Admin. Code § 353.1320; however, notwithstanding the definition of program period in § 353.1320, the start date of the program period may be a date other than September 1. HHSC will notify the MCO of the start date of the program period prior to that start date.

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

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

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

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

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

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

8.1.4.8.11 Directed Payment Program (DPP) Payments

MCOs must separate DPP payments described by Section 8.1.4.8.5 (CHIRP), 8.1.4.8.6 (QIPP), 8.1.4.8.8 (TIPPS), 8.1.4.8.9 (RAPPS), or 8.1.4.8.10 (DPP BHS) from all other

payments in each electronic and hard copy provider explanation of payment document. MCOs must also separately report DPP payments and base payments on all applicable encounter data submissions.

8.1.4.9 Termination of Provider Contracts

The MCO must notify HHSC within five Days after termination of (1) a Primary Care Provider (PCP) contract that impacts more than 10 percent of its Members or (2) any Provider contract that impacts more than 10 percent of its Network for a provider type by Service Area and Program. The MCO must also notify HHSC of all Provider terminations in accordance with UMCM Chapter 5.

Additionally, the MCO must make a good faith effort to give written notice of termination of a Network Provider to each Member who receives his or her primary care, or who is seen on a regular basis by, the Network Provider as follows:

1. For involuntary terminations of a Provider (terminations initiated by the MCO), the MCO must provide notice to the Member of the Provider's termination from the network within 15 Days of either expiration of the provider's advance notice period or once the provider has exhausted rights to appeal.

   In cases of imminent harm to Member health, the MCO must give the Member notice immediately that the Provider will be terminated even if a final termination notice to the Provider has not been issued.
2. For voluntary terminations of a Provider (terminations initiated by the Provider), the MCO must provide notice to the Member 30 Days prior to the termination effective date. In the event that the Provider sends untimely notice of termination to the MCO making it impossible for the MCO to send Member notice within the required timeframe, the MCO must provide notice as soon as practical but no more than 15 Days after the MCO receives notice to terminate from the Provider.

The MCO must send notice to: (1) all its Members in a PCP's panel, and (2) all its Members who have had two or more visits with the Network Provider for home-based or office-based care in the past 12 months.

8.1.4.10 Out-of-State Providers

To participate in Medicaid, the provider must be enrolled with HHSC as a Medicaid provider. The MCO may enroll out-of-state providers in its Medicaid and CHIP Networks in accordance with 1 Tex. Admin. Code § 352.17 and Pharmacy Network Providers in accordance with 1 Tex. Admin. Code § 353.909.

The MCO may enroll out-of-state diagnostic laboratories in its Medicaid and CHIP Networks under the circumstances described in Texas Government Code § 531.066. This subsection does not limit the MCO's ability or responsibility to provide NEMT Services to a Member and his or her NEMT Attendant for out-of-state travel.

8.1.4.11 Provider Advisory Groups

The MCO must establish and conduct quarterly meetings with Network Providers and NEMT Services providers. Membership in the Provider Advisory Group(s) must include, at a minimum, acute, community-based LTSS (STAR+PLUS only), pharmacy providers, and NEMT Services providers. The MCO is not required to conduct quarterly meetings of Network Providers and NEMT Services providers simultaneously. The MCO must maintain a record of Provider Advisory Group meetings, including agendas and minutes, for at least three years.

The MCO or its designee must obtain feedback from Network Providers regarding the delivery of NEMT Services. The MCO must ensure records documenting Network Provider feedback about the delivery of NEMT Services are maintained in accordance with the retention period and requirements of Article 9 of Attachment A, Uniform Terms and Conditions. These records must be provided to HHSC upon request.

8.1.4.12 Provider Protection Plan

The MCO must comply with HHSC's provider protection plan requirements for reducing the administrative burdens placed on Network Providers and NEMT Services providers, as applicable, and ensuring efficiency in Network enrollment and reimbursement. At a minimum, the MCO must have a Provider protection plan that complies with the following:

1. Ensure no Retaliation by the MCO and MCO staff against a Provider for filing Appeals or Complaints against the MCO on the Provider's or Member's behalf.
2. Provide for timely and accurate claims adjudication and proper claims payment in accordance with UMCM Chapter 2
3. Include Network Provider training and education on the requirements for claims submission and appeals, including the MCO's policies and procedures (see also Section 8.1.4.6, "Provider Relations Including Manual, Materials and Training.")
4. Ensure Member access to care, in accordance with Section 8.1.3, "Access to Care."
5. Ensure prompt credentialing, as required by Section 8.1.4.4, "Provider Credentialing and Re-credentialing."
6. Ensure compliance with state and federal standards regarding prior authorizations, as described in **Section 8.1.8**, "Utilization Management," and **Section 8.1.21.2**, "Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies."
7. Provide 30 Days' notice to Providers before implementing changes to policies and procedures affecting the prior authorization process. However, in the case of suspected Fraud, Waste, or Abuse by a single Provider, the MCO may implement changes to policies and procedures affecting the prior authorization process without the required notice period.

8. Include other measures developed by HHSC or a provider protection plan workgroup, or measures developed by the MCO and approved by HHSC.

8.1.5 Member Services

The MCO must maintain a Member Services Department to assist Members and their family members or guardians in obtaining Covered Services for Members. The MCO must maintain employment standards and requirements (e.g., education, training, and experience) for Member Services Department staff and provide a sufficient number of staff for the Member Services Department to meet the requirements of this Section.

8.1.5.1 Member Materials

The MCO must design, print and distribute Member identification (ID) cards and a Member Handbook to Members. Within five Business Days following the receipt of an Enrollment File from the HHSC Administrative Services Contractor, the MCO must ~~mail~~ provide a Member's ID card and Member Handbook to the Case Head or Account Name for each new Member through one of the following methods:

(1) Mailing a printed copy of the information to the M~~m~~ember's address;

(2) Providing the information by email, as permitted by this Contract;

(3) Advising the Member in paper or electronic form that the information is available on the MCO's website and providing the applicable internet address; or

(4) Providing the information by any other method that can reasonably be expected to result in the Member receiving the information.

Prior to utilizing methods (2), (3) or (4) above, the MCO shall submit a written description to the HHSC Health Plan Manager of the process to ensure Members have access to a printed copy upon request.

When the Case Head or Account Name represents two or more new Members, the MCO is only required to send one Member Handbook. The MCO is responsible for ~~mailing~~ distributing materials only to those households for whom valid address data are contained in the Enrollment File.

The MCO must design, print and deliver hard copies of the Provider Directories to the HHSC Administrative Services Contractor as described in **Section 8.1.5.4.** Provider Directories must not include NEMT Services providers.

The MCO must ensure all information provided by the MCO to Members complies with the information requirements in 42 C.F.R. § 438.10, as applicable.

Member Materials must be at or below a 6th grade reading level as measured by the appropriate score on the Flesch reading ease test. Member Materials must be written and distributed in English, Spanish, and the languages of other Major Population Groups. HHSC will provide the MCO with reasonable notice when the enrolled population reaches the 10 percent threshold for a Major Population Group in the MCO's Service Area. All Member Materials must be available in a format accessible to the visually impaired, which may include large print, Braille, and CD or other electronic format.

The MCO must make Member Materials that are critical to obtaining services, including at a minimum, Provider directories, Member handbooks, Appeal and grievance notices, and denial and termination notices, available in the Prevalent Languages in its particular service area. These materials must also be made available in alternative formats upon request of the Member at no cost. Auxiliary aids and services must also be made available upon request of the Member at no cost. These materials must include taglines in the Prevalent Languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the MCO's Member Services Hotline. Large print means printed in a font size no smaller than 18 point. These materials must use a font no smaller than 12 point. These materials must also include a large print tagline and information on how to request auxiliary aids and services, including the provision of materials in alternative formats.

The MCO must submit Member Materials to HHSC for approval prior to publication or distribution, including revisions to previously approved Member Materials. See UMCM Chapter 3 and UMCM Chapter 4 for material and submission requirements. HHSC reserves the right to require discontinuation, revision, or correction of any Member Materials, including those previously approved by HHSC.

The MCO's Member Materials and other communications cannot contain discretionary clauses, as described in Section 1271.057(b) of the Texas Insurance Code. For CHIP MCOs, this restriction also applies to the MCO's Evidence of Coverage or Certificate of Coverage documents.

8.1.5.2 Member Identification (ID) Card

All Member ID cards must, at a minimum, include the following information:

1. the Member's name;
2. the Member's Medicaid or CHIP Program number;
3. the effective date of the PCP assignment (excluding CHIP Perinates);
4. the PCP's name (not required for Dual Eligible STAR+PLUS Members, CHIP Perinates, and Nursing Facility residents), address (optional for all products), and telephone number (not required for Dual Eligible STAR+PLUS Members, CHIP Perinates, and Nursing Facility residents);
5. the name of the MCO;
6. the 24-hour, 7 Day a week toll-free Member services telephone number and BH Hotline number operated by the MCO; and

7. any other critical elements identified in UMCM Chapter 3.

The MCO must reissue the Member ID card, according to the delivery method options in Section 8.1.5.1, if a Member reports a lost card or name change, if the Member requests a new PCP, or for any other reason that results in a change to the information disclosed on the ID card.

8.1.5.3 Member Handbook

HHSC must approve the Member Handbook, and any substantive revisions, prior to publication and distribution. As described in **Section 7**, "Transition Phase Requirements," the MCO must develop and submit to HHSC the draft Member Handbook for approval during the Readiness Review and must submit a final Member Handbook incorporating changes required by HHSC prior to the Operational Start Date.

The Member Handbook for each applicable MCO Program must, at a minimum, meet the Member materials requirements specified by **Section 8.1.5.1** and must include critical elements in UMCM Chapter 3. CHIP MCOs must issue Member Handbooks to both CHIP Perinates and CHIP Perinate Newborns. The Member Handbook for CHIP Perinate Newborns may be the same as that used for CHIP.

The MCO must produce a revised Member Handbook, or an insert informing Members of changes to Covered Services, upon HHSC notification and at least 30 Days prior to the effective date of such change in Covered Services, according to the delivery method options in Section 8.1.5.1. In addition to modifying the Member Materials for new Members, the MCO must notify all existing Members of changes to Covered Services. If HHSC notifies the MCO that the change in Covered Services is significant, the MCO must notify existing Members through a written notice, such as a mailed letter or electronic mail, during the timeframe specified in this subsection or within a timeframe approved by HHSC. If multiple Members reside within a single household, the MCO shall send only one written notice pursuant to this section. If HHSC notifies the MCO that the change in Covered Services is not significant, the MCO must notify existing Members through any method of communication during the timeframe specified in this subsection or within a timeframe approved by HHSC.

8.1.5.4 Provider Directory

This section does not apply to NEMT Services providers.

The MCO must have a process in place to compare the information in the master Provider file provided by the HHSC Administrative Services Contractor with the MCOs Provider directory. When the MCO identifies a discrepancy, the MCO must assist the Provider through the process of updating inaccurate information with the HHSC Administrative Services Contractor. MCOs must contact Providers monthly until the information on the master Provider file reflects the information attested to by the Provider. This includes but is not limited to, information identified through the MCO Provider Verification survey in Section 8.1.3.3 or other data sources provided to the MCOs by HHSC or identified by the MCO. The MCO must include in its Provider Contract that the Provider will update its information with

the HHSC Administrative Services Contractor in a timely fashion or immediately upon request by the MCO.

The Provider Directory for each MCO Program, including substantive revisions, must be approved by HHSC before publication and distribution. Substantive revisions are revisions to the information required by UMCM Chapter 3 (with the exception of information contained in actual the Provider listings and indices) and any additional information that the MCO adds to the directory at its discretion.

As described in **Section 7**, "Transition Phase Requirements," during Readiness Review the MCO must develop and submit to HHSC the draft Provider Directory template for approval and must submit a final Provider Directory incorporating changes required by HHSC prior to the Operational Start Date. Such draft and final Provider Directories must be submitted according to the deadlines established in **Section 7**, "Transition Phase Requirements."

The Provider Directory must comply with HHSC's marketing policies and procedures, as set forth in the UMCM Chapter 4.

The Provider Directory for each applicable MCO Program must, at a minimum, meet the Member Materials requirements specified by **Section 8.1.5.1** above and must include critical elements in UMCM Chapter 3. The Provider Directory must include only Network Providers credentialed by the MCO in accordance with **Section 8.1.4.4**. If the MCO contracts with limited Provider Networks, the Provider Directory must comply with the requirements of 28 Tex. Admin. Code §11.1600(b)(11), relating to the disclosure and notice of limited Provider Networks.

8.1.5.4.1 Hard Copy Provider Directory

The hard copy Provider Directory must contain the requirements of UMCM Chapter 3 as applicable.

The MCO must update the Provider Directory in accordance with 42 C.F.R. § 438.10 or as directed by HHSC. The MCO must make such updates available to existing Members upon request. For STAR+PLUS and STAR Kids, the MCO must provide copies of it's hard copy Provider Directory to the HHSC Administrative Services Contractor each quarter.

The MCO must send the most recent Provider Directory, including any updates, to Members within five Business Days of the request. The MCO must, at least annually, provide written communication to its Members to inform of and offer the most recent Provider Directory.

8.1.5.4.2 Online Provider Directory

The MCO must develop, implement, and maintain an online Provider Directory to provide an electronic provider look-up search of its Provider Network. The MCO must develop and maintain policies and operating procedures with respect to its Provider

Network database, which must include a predictable schedule for systematically updating the database. The MCO Online Provider Directory must be updated at least on a weekly basis to reflect the most current MCO Provider Network.

The MCO must inform Members that the Provider directory is available in paper form without charge upon the Member's request and provide it within five Business Days of the Member's request.

The MCO must maintain a mobile optimized site for the online Provider Directory, minimize download and wait time, and must not use tools or techniques that require significant memory, disk resources, or special intervention such as plug-ins or additional software. HHSC strongly encourages the development of mobile device applications in addition to the use of tools that take advantage of efficient data access methods, reduce server load, and consume less bandwidth.

The online Provider Directory must comply with the requirements set forth in UMCM Chapter 3.

8.1.5.5 Internet Website

The MCO must develop and maintain, consistent with HHSC standards and Texas Insurance Code § 843.2015 and other applicable state laws, a website to provide general information about the MCO's Program(s), its Provider Network (including an online Provider Directory as outlined in UMCM Chapter 3, its customer services, and its Complaints and Appeals process. The website must contain a link to financial literacy information on the Office of Consumer Credit Commissioner's webpage. The MCO may develop a page within its existing website to meet the requirements of this section. The MCO must also maintain a mobile optimized site for mobile device use.

The MCO must minimize download and wait time and not use tools or techniques that require significant memory, disk resources, or special user interventions.

The MCO's internet website must contain the requirements of UMCM **Chapter 3.**

The MCO's pharmacy website must contain the requirements of UMCM **Chapter 3.**

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

8.1.5.6 Member Hotline

The MCO must operate a toll-free hotline that Members can call 24 hours a Day, 7 Days a week. The Member hotline must be staffed with personnel who are knowledgeable about its MCO Program(s) and Covered Services between the normal business hours of 8:00 a.m. to 5:00 p.m. local time for the Service Area, Monday through Friday, excluding state-approved holidays. The State-approved holiday schedule is updated annually and can be found at the Texas State Auditor's Office website.

The MCO must ensure that after hours, on weekends, and on holidays the Member Services hotline is answered by an automated system with the capability to provide callers with operating hours and instructions on what to do in cases of emergency. All recordings must be in English, Spanish, and the languages of other Major Population Groups in the Service Area. A voice mailbox must be available after hours for callers to leave messages. The MCO's Member Services representatives must return calls received by the automated system from Members or their representatives on the next Business Day.

If the Member hotline does not have a voice-activated menu system, the MCO must have a menu system that will accommodate Members who cannot access the system through other physical means, such as pushing a button.

The MCO must ensure that its Member Service representatives treat all callers with dignity and respect the callers' need for privacy. At a minimum, the MCO's Member Service representatives must be:

1. knowledgeable about Covered Services;
2. able to answer non-technical questions about the role of the PCP, as applicable;
3. able to answer non-clinical questions about referrals or the process for receiving authorization for procedures or services;
4. able to give information about Providers in a particular area;
5. knowledgeable about Fraud, Waste, and Abuse including the Lock-in Program and the requirements to report any conduct that, if substantiated, may constitute Fraud, Waste, and Abuse;
6. trained regarding Cultural Competency; in accordance with Section 8.1.5.8, including arranging for interpreter services:
7. trained regarding the process used to confirm the status of persons with Special Health Care Needs;
8. for Medicaid Members, able to answer non-clinical questions about accessing Non-capitated Services;
9. for Medicaid Members, trained regarding: a) the emergency prescription process and what steps to take to immediately address problems when pharmacies do not provide a 72-hour supply of emergency medicines; b) how Members in the Lock-in Program can fill prescriptions at a non-designated pharmacy in an emergency situation; and c) DME processes for obtaining services and how to address common problems;
10. for CHIP Members, able to give correct cost-sharing information relating to premiums, co-pays or deductibles, as applicable. (Cost-sharing does not apply to CHIP Perinates (unborn child), CHIP Perinate Newborns, and some Members in the traditional CHIP Program. See UMCM Chapter 6, for additional information regarding CHIP cost-sharing;
11. hotlines must meet Cultural Competency requirements and must appropriately handle calls from non-English speaking (and particularly, Spanish-speaking) callers, as well as calls from individuals who are deaf or hard-of-hearing. To meet these requirements, the MCO must employ bilingual Spanish-speaking Member Services representatives and must secure the services of other contractors as

necessary to meet these requirements. The MCO must provide such oral interpretation services to all Hotline callers free of charge;

12. knowledgeable about how to identify and report a Critical Event or Incident such as Abuse, Neglect, or Exploitation to the State related to LTSS delivered in the STAR+PLUS program;
13. knowledgeable about Service Coordination, and Service Plans offered by the MCO for Members; and
14. trained to assist a Member, Member's authorized representative, or LAR with scheduling an appointment with a Provider during the Provider's hours of operation and within the Member's availability, in accordance with **Section 8.1.3.2**. The MCO may have dedicated staff to assist with scheduling non-emergency appointments and may use a three-way call with the Provider and Member or Member's representative to schedule the appointment. Hotline services staff must offer Members the opportunity to participate in a facilitated three-way call between the Member, Member's authorized representative, or LAR and a Provider's office to schedule an appointment. The MCO may have dedicated staff for this purpose. If the Member does not want to participate in the above described conference call option, the MCO must document refusal and offer the Member a list of Network Providers, including offering to send the Member a Provider Directory at no cost to the Member.

The MCO must process all incoming Member correspondence and telephone inquiries in a timely and responsive manner. The MCO cannot impose maximum call duration limits and must allow calls to be of sufficient length to ensure adequate information is provided to the Member. The MCO must ensure that the toll-free Member hotline meets the following minimum performance requirements for the MCO Program

1. at least 80 percent of calls must be answered by Hotline staff within 30 seconds; measured from the time the call is placed in queue after selecting an option;
2. the call abandonment rate is seven percent or less; and
3. the average hold time is two minutes or less.

The MCO must conduct ongoing quality assurance to ensure these standards are met.

The Member Services hotline may serve multiple MCO Programs if hotline staff is knowledgeable about all of the MCO's Medicaid or CHIP Programs. The Member Services hotline may serve multiple Service Areas if the hotline staff is knowledgeable about all Service Areas, including the Provider Network in each Service Area.

The MCO must monitor its performance regarding HHSC Member hotline standards and submit performance reports summarizing call center performance for the Member Hotline as indicated in Section 8.1.20 and UMCM Chapter 5.

If HHSC determines that it will to conduct onsite monitoring of the MCO's Member hotline functions, the MCO must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent(s) relating to such monitoring. For purposes of this section, "authorized reimbursable travel costs" may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel

expenses incurred by HHSC or its authorized agent in connection with the onsite monitoring. Reimbursement by the MCO will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

8.1.5.6.1 Nurseline

If the MCO provides a 24-hour nurse hotline, it must train hotline staff about: a) the emergency prescription process and what steps to take to immediately address Medicaid Members' problems when pharmacies do not provide a 72-hour supply of emergency medicines; b) the HHSC OIG Lock-in Program pharmacy override process to ensure Member access to Medically Necessary outpatient drugs; and c) DME processes for obtaining services and how to address common problems. The 24-hour Nurse Hotline will attempt to respond immediately to problems concerning emergency medicines by means at its disposal, including explaining the rules to Medicaid Members so that they understand their rights and, if need be, by offering to contact the pharmacy that is refusing to fill the prescription to explain the 72-hour supply policy, Lock-in Program override procedure, and DME processes.

8.1.5.6.2 NEMT Services Call Center Requirements

The MCO must ensure Members are able to request NEMT Services by phone. This requirement may be met through augmenting existing MCO Member Hotline staff, creating a dedicated NEMT Services call center, contracting with an entity to arrange NEMT Services requested by telephone, or another HHSC-approved model. In any arrangement, the NEMT Services call center must be staffed between the normal business hours of 8:00 a.m. to 5:00 p.m. local time for the Service Area, Monday through Friday, excluding state-approved holidays. The NEMT Services call center must be staffed sufficiently to answer calls regarding NEMT Services, including providing approval of services, scheduling and tracking rides, and answering Member questions related to ride status. If a dedicated NEMT Services call center or contracted entity is used, those staff are responsible for ensuring a warm transfer to the MCO's standard call center for questions related to program benefits that are received during MCO call center operating hours to ensure consistent and comprehensive support is provided to Members.

The NEMT Services call center must have the staffing capacity to handle all telephone calls at all times during the required hours of operation and have the ability to upgrade for handling additional call volume as needed. Calls cannot be answered by an answering service during business hours and recording devices cannot be used as the final point of destination for callers during business hours.

The MCO must have a "Where's My Ride" line and/or phone prompt for Members to call for their rides home and/or check on the status of their scheduled rides. The MCO must ensure the Members' calls are answered by live operators 5:00 a.m. through 7:00 p.m. local time Monday through Saturday. The MCO must ensure that Members can reach this

line and/or phone prompt and NEMT Services providers during observed holidays in which NEMT Services must be provided.

The MCO must properly train NEMT Services call center staff on NEMT Services policies, including the following:

1. Handling difficult callers;
2. Reporting Fraud, Waste, and Abuse;
3. Overview of managed care and NEMT Services;
4. Scheduling and coordination of NEMT Services;
5. Civil rights;
6. Cultural diversity training; and
7. Customer service.

The MCO must ensure a desk or training manual for NEMT Services call center staff is developed that includes all processes, policies, and procedures used in scheduling trips, authorization of services, and management of transportation services.

At the time of trip scheduling, NEMT Services call center staff must advise persons accompanying children that car safety seats are required and that the persons accompanying children are responsible for installing the child safety seat.

NEMT Services call centers, including the Where's my Ride? line, are subject to all Member Hotline performance standards and reporting.

Special Instructions for Limited Counties

The requirements in this section are necessary for compliance with Frew.

In addition to Member Hotline reporting requirements found in Section 8.1.5.6, the MCO will provide HHSC with "trunk reports." Trunk refers to telephone lines that are routed through a carrier network. Trunk reports are only required for the following counties: Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker.

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

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

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

8.1.5.7 Member Education

The MCO must, at a minimum, develop and implement health education initiatives that educate Members about:

2. how the MCO system operates, including the role of the PCP;
3. Covered Services, limitations and any Value-added Services offered by the MCO;
4. the value of screening and preventive care;
5. how to obtain Covered Services, including:
    a. Emergency Services;
    b. accessing OB/GYN and specialty care including oncology;
    c. Behavioral Health Services;
    d. Disease Management programs;
    e. Service Coordination, treatment for pregnant women, Members with Special Health Care Needs, including Children with Special Health Care Needs, Nursing Facility residents and Medicaid Breast and Cervical Cancer (MBCC) Members in STAR+PLUS, and other special populations;
    f. Early Childhood Intervention (ECI) Services;
    g. screening and preventive services, including well-child care (Texas Health Steps medical checkups for Medicaid Members);
    h. for CHIP Members, Member copayments responsibilities (note that copayments to do not apply to CHIP Perinates (unborn child) and CHIP Perinate Newborn Members);
    i. for Medicaid Members, Member copayment responsibilities (if HHSC implements Medicaid cost sharing after the Effective Date of the Contract);
    j. suicide prevention;
    k. identification and health education related to Obesity;
    l. obtaining 72-hour supplies of emergency prescriptions from Network pharmacies;
    m. how Members in the Lock-in Program can receive outpatient drugs in an emergency situation;
    n. Case Management for Children and Pregnant Women;
    o. Cognitive Rehabilitation Therapy for STAR+PLUS Members;
    p. Nursing Facility Services for STAR+PLUS Members;
    q. Discharge planning, transitional care, and other education programs on all available long term care settings for Nursing Facility residents in STAR+PLUS;
    r. Community First Choice (CFC) services;
    s. Supported Employment and Employment Assistance for STAR+PLUS Members; and
    t. NEMT Services for Medicaid Members.

The MCO must provide a range of health promotion and wellness information and activities for Members in formats that meet the needs of all Members. The MCO must propose, implement, and assess innovative Member education strategies for wellness care and immunization, as well as general health promotion and prevention. The MCO must conduct wellness promotion programs to improve the health status of its Members.

The MCO may cooperatively conduct health education classes with one or more of the contracted MCOs in the Service Area. The MCO must work with its Providers to integrate health education, wellness, and prevention training into each Member's care.

The MCO also must provide condition and disease-specific information and educational materials to Members, including information on its Service Coordination and Disease Management programs as described in **Sections 8.1.13** and **8.1.14.** Condition- and disease-specific information must be oriented to various groups of Members, such as children, the elderly, persons with disabilities and non-English speaking Members, as appropriate to the MCO's Medicaid or CHIP Programs.

Per Texas Health and Safety Code § 48.052(c), MCOs may use certified Community Health Workers to conduct outreach and Member education activities.

8.1.5.8 Cultural Competency Plan

The MCO must have a comprehensive written Cultural Competency plan describing how it will ensure culturally competent services, and provide Linguistic Access and Disability-related Access. The Cultural Competency plan must be developed in adherence to the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) as described in UMCM Chapter 16 in the format as required by HHSC. The Cultural Competency plan must adhere to the following: Title VI of the Civil Rights Act guidelines and the provision of auxiliary aids and services, in compliance with the Americans with Disabilities Act, Title III, Department of Justice Regulation 28 C.F.R. § 36.303, 42 C.F.R. § 438.206(c)(2), and 1 Tex. Admin. Code § 353.411. Additionally, the Cultural Competency plan must describe how the MCO will implement each component of the National CLAS Standards as described in UMCM Chapter 16.

The Cultural Competency plan must describe how the individuals and systems within the MCO will effectively provide services to people of all cultures, races, ethnic backgrounds, languages, communication needs, and religions as well as those with disabilities in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each. The MCO must submit the Cultural Competency plan to HHSC for Readiness Review. During Readiness Review, the Cultural Competency plan will be assessed to determine the extent to which it aligns with the National CLAS Standards as described in UMCM Chapter 16. The Cultural Competency plan must detail how the MCO implements each component of the National CLAS Standards 2 through 15. By implementing Standards 2 through 15, MCOs are working toward CLAS Standard 1, the Principal Standard: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

During the Operations Phase, the MCO must submit modifications and amendments to the Cultural Competency plan to HHSC no later than 30 Days prior to implementation of a change. The MCO must also make the Cultural Competency plan available to its Network Providers. HHSC may require the MCO to update the Cultural Competency

plan to incorporate new or amended requirements based on HHSC guidance. In that event, the MCO has 60 Days to submit the updated Cultural Competency plan to HHSC.

The MCO must arrange and pay for Competent Interpreter services, including written, spoken, and sign language interpretation, for Members to ensure effective communication regarding treatment, medical history, or health condition. The MCO must maintain policies and procedures outlining the manner in which Members, a LAR, as applicable, and the Members' Providers can access Competent Interpreter services, including written, spoken, and sign language interpretation, when the Member is receiving services from a Provider in an office or other location, or accessing Emergency Services.

Over-the-phone interpretation (OPI), including three-way calls facilitated between the MCO, Provider and telephone interpreter, must not require advance notification by the Member, LAR, or Provider.

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

8.1.5.9 Member Complaint and Appeal Process

The MCO must develop, implement and maintain a system for tracking, resolving, and reporting Member Complaints regarding its services, processes, procedures, and staff. The MCO must ensure that Member Complaints are resolved within 30 Days after receipt. The MCO is subject to remedies, including liquidated damages, if at least 98 % of Member Complaints are not resolved within 30 Days of the MCO's receipt. Please see **Attachment A**, "Uniform Managed Care Contract Terms and Conditions," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix."

The MCO must develop, implement and maintain a system for tracking, resolving, and reporting Member Appeals regarding the denial or limited authorization of a requested service, including the type or level of service and the denial, in whole or in part, of payment for service. Within this process, the MCO must respond fully and completely to each Appeal and establish a tracking mechanism to document the status and final disposition of each Appeal.

The MCO must ensure that standard and expedited Member Appeals are resolved within the specified timeframes, unless the MCO can document that the Member requested an extension or the MCO shows there is a need for additional information and the delay is in the Member's interest. The MCO is subject to liquidated damages for Member Appeals not resolved within the performance standard. Please see **Attachment A**, "Uniform Managed Care Contract Terms and Conditions," and **Attachment B-3**, “Deliverables/Liquidated Damages Matrix.”

Medicaid MCOs must follow the Member Complaint and Appeal Process described in **Section 8.2.6**. CHIP MCOs must comply with the CHIP Complaint and Appeal Process described in **Sections 8.4.2**.

8.1.5.10 Member Advisory Groups

The MCO must establish an advisory group consisting of Members, their authorized representatives or caregivers, and advocates. An advisory group must meet and conduct quarterly meetings with Members in each service area in which the MCO operates. Membership in the Member Advisory Group(s) must include at least five Members or their authorized representatives or caregivers attending each meeting as well as advocates for Members. The MCO must maintain a record of Member Advisory Group meetings, including agendas and minutes, for at least three years. For MCOs offering long term services and supports (LTSS), the Member advisory group must include a reasonably representative sample of the LTSS Member population or advocates. For the LTSS Member population, the advisory group must include at least three Members receiving LTSS through the MCO or their representative.

8.1.5.11 Member Eligibility

The MCO must, if possible, provide eligibility renewal assistance as allowed by federal law and CMS policy guidance for Members whose eligibility is about to expire.

8.1.5.12 Member Service Email Address

The MCO must have a secure email address through which a Member or the Member's Provider may contact the MCO to receive assistance with identifying Network Providers and schedule an appointment for the Member or to access services. The MCO must reply to the Member's request with an email response informing the Member or Provider that by communicating via email the Member or Provider consents to receive information through the same means. When the MCO receives the Member's email, Member Services staff must provide the Member or Member's Provider requested information within three Business Days following the receipt of the email.

8.1.6 Marketing and Prohibited Practices

The MCO and its Subcontractors must adhere to the Marketing Policies and Procedures as set forth in UMCM Chapter 4.

8.1.7 Quality Assessment and Performance Improvement

The MCO must provide for the delivery of quality care with the primary goal of improving the health status of Members and, where the Member's condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The MCO must work in collaboration with Providers to actively improve the quality of care provided to Members, consistent with the Quality Improvement Goals and all other requirements of the Contract. The MCO must provide mechanisms for Members and Providers to offer input into the MCO's quality improvement activities.

8.1.7.1 Quality Assessment and Performance Improvement Program Overview

The MCO must develop, maintain, and operate a Quality Assessment and Performance Improvement (QAPI) Program consistent with the Contract and TDI requirements, including 28 Tex. Admin. Code. § 11.1901(a)(5) and § 11.1902. Medicaid MCOs must also meet the requirements of 42 C.F.R. § 438.330.

The MCO must be accredited by a nationally recognized accreditation organization, either URAC or National Committee for Quality Assurance (NCQA), as required by Tex. Gov't Code § 533.0031. When seeking reaccreditation, the MCO must obtain either NCQA's Medicaid module or URAC's Medicaid Health Plan Accreditation. The MCO must provide HHSC and its EQRO a copy of its most recent accreditation review in accordance with 42 C.F.R. § 438.332. HHSC may use information from an accreditation organization in its oversight processes.

The MCO must have on file with HHSC an approved plan describing its QAPI Program, including how the MCO will accomplish the activities required by this section. The MCO must submit a QAPI Program Annual Summary in a format and timeframe specified by HHSC or its designee. The MCO must keep participating physicians and other Network Providers informed about the QAPI Program and related activities. The MCO must include in Provider contracts a requirement securing cooperation with the QAPI.

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

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

8.1.7.2 QAPI Program Structure

The MCO must maintain a well-defined QAPI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. The MCO must designate a senior executive responsible for the QAPI Program and the Medical Director must have substantial involvement in QAPI Program activities. At a minimum, the MCO must ensure that the QAPI Program structure:

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

8.1.7.3 Clinical Indicators

The MCO must engage in the collection of clinical indicator data. The MCO must use such clinical indicator data in the development, assessment, and modification of its QAPI Program.

8.1.7.4 QAPI Program Subcontracting

If the MCO subcontracts any of the essential functions or reporting requirements contained within the QAPI Program to another entity, the MCO must maintain detailed files documenting work performed by the Subcontractor. The file must be available for review by HHSC or its designee upon request.

8.1.7.5 Behavioral Health Integration into QAPI Program

The MCO must integrate Behavioral Health into its QAPI Program and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members. Except for CHIP Perinates (unborn children), the MCO must collect data, and monitor and evaluate for improvements to physical health outcomes resulting from Behavioral Health integration into the Member's overall care.

8.1.7.6 Clinical Practice Guidelines

The MCO must adopt not less than two (2) evidence-based clinical practice guidelines for each applicable MCO Program. Such practice guidelines must be based on valid and reliable clinical evidence, consider the needs of the MCO's Members, be adopted in consultation with Network Providers, and be reviewed and updated periodically, as appropriate. The MCO must develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

The MCO may coordinate the development of clinical practice guidelines with other HHSC MCOs in a Service Area to avoid providers receiving conflicting practice guidelines from different MCOs.

The MCO must disseminate the practice guidelines to all affected Providers and, upon request, to Members and potential Members.

The MCO must take steps to encourage adoption of the guidelines, and to measure compliance with the guidelines, until such point that 90% or more of the Providers are consistently in compliance, based on MCO measurement findings. The MCO must employ substantive Provider motivational incentive strategies, such as financial and non-financial incentives, to improve Provider compliance with clinical practice guidelines. The MCO's decisions regarding utilization management, Member education, coverage of services, and other areas included in the practice guidelines must be consistent with the MCO's clinical practice guidelines.

8.1.7.7 Provider Credentialing and Profiling

In accordance with **Section 8.1.4.4**, the MCO must review and approve the credentials of all participating licensed and unlicensed Providers who participate in the MCO's Network. Through the QAPI process, the MCO must report annually to HHSC the results of any credentialing activities conducted during the reporting year. The MCO must use the QAPI form found in UMCM Chapter 5.

The MCO must conduct PCP and other Provider profiling activities at least annually. As part of its QAPI Program, the MCO must describe the methodology it uses to identify which and how many Providers to profile and to identify measures to use for profiling such Providers.

Provider profiling activities must include, without limitation:

1. developing PCP and Provider-specific reports that include a multi-dimensional assessment of a PCP or Provider's performance using clinical, administrative, and Member satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;
2. establishing PCP, Provider, group, Service Area or regional Benchmarks for areas profiled, where applicable, including STAR, STAR+PLUS, and CHIP Program-specific Benchmarks, where appropriate; and
3. providing feedback to individual PCPs and Providers regarding the results of their performance and the overall performance of the Provider Network.

8.1.7.8 Network Management

The MCO must:

1. use the results of its Provider profiling activities to identify areas of improvement for individual PCPs and Providers, or groups of Providers;

2. establish Provider-specific quality improvement goals for priority areas in which a Provider or Providers do not meet established MCO standards or improvement goals;
3. develop and implement incentives, which may include financial and non-financial incentives, to motivate Providers to improve performance on profiled measures; and
4. at least annually, measure and report to HHSC on the Provider Network and individual Providers' progress, or lack of progress, towards such improvement goals.

8.1.7.8.1 Physician Incentive Plans

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

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

The MCO must make information regarding physician incentive plans available to Members upon request, in accordance with the UMCM's requirements. The MCO must provide the following information to the Member:

1. whether the Member's PCP or other Providers are participating in the MCO's physician incentive plan;
2. whether the MCO uses a physician incentive plan that affects the use of referral services;
3. the type of incentive arrangement; and
4. whether stop-loss protection is provided.

No later than five Business Days prior to implementing or modifying a physician incentive plan, the MCO must provide the following information to HHSC:

1. Whether the physician incentive plan covers services that are not furnished by a physician or physician group. The MCO is only required to report on items 2-4 below if the physician incentive plan covers services that are not furnished by a physician or physician group.
2. The type of incentive arrangement (e.g., withhold, bonus, capitation);
3. The percent of withhold or bonus (if applicable);
4. The panel size, and if Members are pooled, the method used (HHSC approval is required for the method used); and

5. If the physician or physician group is at substantial financial risk, the MCO must report proof that the physician or group has adequate stop-loss coverage, including the amount and type of stop-loss coverage.

8.1.7.8.2 MCO Alternative Payment Models with Providers

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

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

APM Performance Framework Components:

1. **Achieve a minimum Overall APM Ratio and a Risk-Based APM Ratio**. The ratios are expressions of APM-based provider payments relative to total provider payments. The calculations and yearly benchmarks for the APM Target Ratios are delineated in UMCM Chapter 8.

2. **Implement APMs that promote improvements in priority areas and quality measures specified by HHSC in UMCM Chapter 8.** Examples of HHSC priority areas include maternal health and improved birth outcomes, Behavioral Health integration, and addressing social drivers of health.

3. **Implement processes to support and incentivize Providers.** The MCOs must engage and support Providers' efforts to implement value-based care models and reward high-performing Providers, as defined by the MCO. To achieve this support, the MCOs must:

    a. Share data and performance reports with Providers on a regular basis and provide or make available the data Providers need to coordinate care in an APM. MCOs must provide evidence of these reports and processes upon request by HHSC.
    b. Dedicate enough resources for Provider outreach and negotiation, assistance with data and/or report interpretation, and other activities to support Provider's improvement.
    c. To the extent possible, collaborate with other MCOs within the same Service Area on the development of standardized formats for the Provider performance reports and data exchanged with Providers and align quality

measures. MCOs are encouraged to sponsor or support collaborative learning opportunities for Providers in a Service Area.

4. **Submit to HHSC its inventories of APMs with Providers by September 1st of each year.** The reporting will be completed using the data collection tool in UMCM Chapter 8, Alternative Payment Models Data Collection Tool (DCT). The DCT will capture APM activity for the previous year and will be used to calculate the APM ratios and determine whether the MCOs have achieved minimum progress on the components of the APM Performance Framework. Some requirements in the DCT will vary by program. Provider types include, but are not limited to, primary care providers, specialists, hospitals, long term services and supports providers, Chemical Dependency Treatment facilities, pharmacies, and pharmacists. Upon request by HHSC, the MCOs shall submit to HHSC underlying data for the information reported on the data collection tool (e.g., names of providers, NPIs, TPIs, etc.). HHSC will post on its web site basic information from reported APMs.

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

    a. The MCOs must evaluate the impact of their APMs. Upon request, the MCOs must report on methodologies used for APM evaluations along with results and findings related to the APM's impact on utilization, quality, costs, provider satisfaction, or ROI.
    b. The MCOs must report to HHSC, annually, the net financial impact to Providers of APMs, including the sum of incentive payments, shared savings, and payment reductions. The financial impact to Providers has to be reported in the DCT for each APM and Medicaid program.
    c. The MCOs are encouraged to develop and continually update a strategic plan for advancing value-based care and APMs to advance quality and efficiency.

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

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

8.1.7.8.2.1 MCO Alternative Payment Model with Texas Certified Community

Behavioral Health Clinic (T-CCBHCs)

MCOs must work with T-CCBHCs to establish an APM arrangement consistent with the requirements in UMCM Chapter 16.

8.1.7.8.3 Non-Pharmacy Preferred Provider Arrangement

A preferred provider arrangement is a contracted agreement between the MCO and one or more Providers. After the effective date of the agreement, services specified in the agreement will be delivered to Members by the Provider(s) in the preferred provider arrangement.

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

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

The MCO must provide to HHSC health plan manager all the Member and provider notices pertaining to the new preferred provider arrangement at least 90 Days before initiating any such arrangement. The MCO must ensure notices comply with UMCM Chapter 4.

To be counted as an APM under Section 8.1.7.8.2, a preferred provider arrangement must be based on a provider’s performance on metrics of quality or value and meet the requirements set forth in Section 8.1.7.8.2.

8.1.7.9 Collaboration with the External Quality Review Organization

The MCO will collaborate with HHSC’s external quality review organization (EQRO) to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The purpose of the studies, surveys, or other analytical approaches is to assess the quality of care and service provided to Members and to identify opportunities for MCO improvement. To facilitate this process, the MCO will supply claims data to the

EQRO in a format identified by HHSC in consultation with MCOs and will supply medical records for focused clinical reviews conducted by the EQRO. The MCO must also work collaboratively with HHSC and the EQRO to annually measure HHSC selected Healthcare Effectiveness Data and Information Set (HEDIS) measures that require chart reviews. MCOs must conduct chart reviews, for HEDIS hybrid measures and submit results to the EQRO in a format and timeline specified by HHSC. MCOs are responsible for all costs associated with these reviews.

8.1.8 Utilization Management

The MCO must have a written utilization management (UM) program description, which includes, at a minimum:

1. procedures to evaluate the need for Medically Necessary Covered Services;
2. the clinical review criteria used, the information sources, and the process used to review and approve the provision of Covered Services;
3. the method for periodically reviewing and amending the UM clinical review criteria; and
4. the staff position functionally responsible for the day-to-day management of the UM function.

The MCO must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate in making UM determinations. When making UM determinations, the MCO must comply with the requirements of 42 C.F.R. § 456.111 (Hospitals) and 42 C.F.R. § 456.211 (Mental Hospitals), as applicable as well as requirements of the Texas Insurance Code Chapter 4201 and all related TDI regulations, as applicable. The MCO may not require, as part of UM determinations, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes, except for the Member's mental health medical record summary as defined in 1 TAC 19.1703 (b)(19).

The MCO must make coverage determinations for authorization requests according to the following timelines:

1. within one Business Day of receiving, or identifying a need to extend, the request for concurrent Hospitalization decisions;
2. within one hour of receiving the request for post-stabilization or life-threatening conditions, except that for Emergency Medical Conditions and Emergency Behavioral Health Conditions, the MCO must not require prior authorization;
3. for a Member who is hospitalized at the time of the request, within one Business Day of receiving the request for services or equipment that will be necessary for the care of the Member immediately after discharge, including if the request is submitted by an Out-of-Network Provider, Provider of Acute Care Inpatient Services, or a Member;
4. within three Business Days after receipt of all other prior authorization requests. For prior authorization requests received with insufficient or inadequate documentation, MCOs must follow timeframes established by the commission as set forth in UMCM Chapter 3.

The MCO must have a process in place that allows a Provider to submit a prior authorization or service authorization request for services at least 60 Days prior to the expiration of the current authorization period. If practicable, the MCO must review the request and issue a determination prior to the expiration of the existing authorization. The MCO's process must consider if the request contains sufficient clinical information to justify reauthorization of services.

Before issuing an adverse benefit determination on a prior authorization request, including an authorization request for a hospitalized Member, the MCO must provide the physician requesting the authorization with a reasonable opportunity to discuss the request with another physician who practices in the same or a similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the Member on whose behalf the request is submitted, also known as a peer-to-peer consultation. The discussion must include, at a minimum, the clinical basis for the MCO's decision. An MCO must offer a reasonable opportunity for a peer-to-peer consultation within the following timeframes:

(A) no less than one Business Day prior to issuing an adverse benefit determination for a Member who is not hospitalized at the time of the request;

(B) prior to issuing an adverse benefit determination for a Member who is hospitalized at the time of the request.

The MCO's UM Program must include written policies and procedures to ensure:

1. consistent application of review criteria that are compatible with Members' needs and situations;
2. determinations to deny or limit services are made by physicians under the direction of the Medical Director;
3. at the MCO's discretion, pharmacy prior authorization determinations may be made by pharmacists, subject to the limitations described in Attachment A, Section 4.04, "Medical Director;"
4. the prior authorization process does not result in undue delays in services;
5. appropriate personnel are available to respond to utilization review inquiries 8:00 a.m. to 5:00 p.m., Monday through Friday, with a telephone system capable of accepting utilization review inquiries outside of these hours and that, the MCO responds to calls within one Business Day;
6. confidentiality of clinical information; and
7. compensation to individuals or entities conducting UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services as required by 42 C.F.R. § 438.210(e), and quality is not adversely impacted by financial and reimbursement-related processes and decisions.

For MCOs with preauthorization or concurrent review programs, qualified medical professionals must supervise preauthorization and concurrent review decisions.

The MCO UM Program must include policies and procedures to:

1. routinely assess the effectiveness and the efficiency of the UM Program;
2. evaluate the appropriate use of medical technologies, including medical procedures, drugs and devices;
3. target areas of suspected inappropriate service utilization;
4. detect over- and under-utilization;
5. routinely generate Provider profiles regarding utilization patterns and compliance with utilization review criteria and policies;
6. compare Member and Provider utilization with norms for comparable individuals;
7. routinely monitor inpatient admissions, emergency room use, ancillary, and out-of-area services;
8. ensure that when Members are receiving Behavioral Health Services from the Local Mental Health Authority, the MCO is using the same UM guidelines as those prescribed for use by Local Mental Health Authorities by MHMR which are published on the DSHS website under Utilization Management; and
9. refer suspected cases of Network Provider, Out-of-Network provider, or Member Fraud, Waste, or Abuse to the HHSC Office of Inspector General (HHSC OIG) as required by **Section 8.1.19**.

In accordance with the requirements in UMCM Chapter 16, MCOs must share utilization management data among all relevant MCO employees, including both physical and Behavioral Health staff, or, if applicable, between the MCO and the third party or subsidiary contracted with the MCO to manage Behavioral Health Services.

8.1.8.1 Compliance with State and Federal Prior Authorization Requirements

For Medicaid, the MCO must adopt prior authorization (PA) requirements that comply with state and federal laws governing authorization of health care services and prescription drug benefits, including 42 U.S.C. § 1396r-8 and Texas Government Code §§ 531.073 and 533.005(a)(23). In addition, the MCO must comply with Texas Human Resources Code § 32.073 and Texas Insurance Code §§ 1217.004 and 1369.304, which require MCOs to use national standards for electronic prior authorization of prescription drug and health care benefits no later than two years after adoption, and accept PA requests submitted using the TDI's standard form. For CHIP see Section 8.4.7.

Any prior authorization request for emergency or non-emergency ambulance transportation must comply with the requirements of Division 9, Subchapter A, of 1 TAC 354.

In the case of service code, procedure code, or benefit change that affects a current PA issued to a provider, the MCO must provide guidance to the provider holding the PA no less than 45 Days prior to effective date of the change. If the change is a result of a service code, procedure code, or benefit change adopted by HHSC, the MCO must issue notice of the change by the later of: (1) 45 Days prior to the effective date of the change, or (2) within 10 Business Days of receiving notice of the change from HHSC. MCOs may choose to reissue PAs or publish guidance to providers on updating current PAs. Information must be sufficient for providers to accurately bill for services. The MCO must establish and document a plan to inform all impacted providers of the changes. The MCO must be able to demonstrate that each impacted provider is notified

of the changes within the prescribed timeframe through broadcast messages or individual notifications. The MCO must provide a copy of the plan and any associated notifications to HHSC upon request.

8.1.8.2 Toll-free Fax Line for Service Authorizations

The MCO must provide access to a toll-free fax line and Provider portal where Providers may send requests for authorization of services and any supplemental information related to service authorization, including medical documentation supporting certain NEMT Services requested by the Member.

8.1.9 Early Childhood Intervention (ECI)

8.1.9.1 Referrals

The MCO must ensure Network Providers are educated regarding the federal laws on child find and referral procedures (e.g., 20 U.S.C. § 1435 (a)(5); 34 C.F.R. § 303.303). The MCO must require Network Providers to identify and provide ECI referral information to the LAR of any Member under the age of three suspected of having a developmental delay or disability or otherwise meeting eligibility criteria for ECI services in accordance with 26 Tex. Admin. Code Chapter 350 within seven Days from the day the Provider identifies the Member. The MCO must permit Members to self-refer to local ECI Providers without requiring a referral from the Member's PCP. The MCO's policies and procedures, including its Provider manual and Member handbook, must include written policies and procedures for allowing a self-referral to ECI providers. The MCO must use written educational materials developed or approved by HHSC ECI for these child find activities.

The MCO must inform the Member's LAR that ECI participation is voluntary. The MCOs is required to provide Medically Necessary services to a Member if the Member's LAR chooses not to participate in ECI.

8.1.9.2 Eligibility

The local ECI program will determine eligibility for ECI services using the criteria contained in 26 Tex. Admin. Code Chapter 350.

The MCO must cover medical diagnostic procedures required by ECI, including discipline specific evaluations, so that ECI can meet the 45-Day timeline established in 34 C.F.R. § 303.342(a). The MCO must require compliance with these requirements through Provider contract provisions. The MCO must not withhold authorization for the provision of such medical diagnostic procedures. Further, the MCO must promptly provide relevant medical records available as needed.

8.1.9.3 Providers

The MCO must contract with an adequate number of qualified ECI Providers to provide ECI Covered Services to Members under the age of three who are eligible for ECI

services. The MCO must allow an Out-of-Network provider to provide ECI covered services if a Network Provider is not available to provide the services in the amount, duration, scope and service setting as required by the Individual Family Service Plan (IFSP).

8.1.9.4 Individual Family Service Plan (IFSP)

The IFSP identifies the Member's present level of development based on assessment, describes the services to be provided to the child to meet the needs of the child and the family, and identifies the person or persons responsible for each service required by the plan. The IFSP is developed by an interdisciplinary team that includes the Member's LAR; the ECI service coordinator; ECI professionals directly involved in the eligibility determination and Member assessment; ECI professionals who will be providing direct services to the child; other family members, advocates, or other persons as requested by the authorized representative. If the Member's LAR provides written consent, the Member's PCP or MCO staff may be included in IFSP meetings. The IFSP is a contract between the ECI contractor and Member's LAR.

The Member's LAR signs the IFSP to consent to receive the services established by the IFSP. The IFSP contains information specific to the Member, as well as information related to family needs and concerns. If the Member's LAR provides written consent, the ECI program may share a copy of IFSP sections relevant only to the Member with the MCO and PCP to enhance coordination of the plan of care. These sections may be included in the Member's medical record or service plan.

8.1.9.5 Covered Services and Reimbursement

The interdisciplinary team, including a licensed practitioner of the healing arts, as defined in 26 Tex. Admin. Code § 350.103, practicing within the scope of their license, determines medical necessity for ECI covered services established by the Individual Family Service Plan (IFSP). The IFSP will serve as authorization for program-provided services, and the MCO must require, through contract provisions with the Provider, that all Medically Necessary health and Behavioral Health program-provided Services contained in the Member's IFSP are provided to the Member in the amount, duration, scope and service setting established by the IFSP. "Program-provided" services refers to services that are provided by the ECI contractor.

The MCO cannot create unnecessary barriers for the Member to obtain IFSP program-provided services, including requiring prior authorization for the ECI assessment or additional authorization for services, or establishing insufficient authorization periods for prior authorized services.

ECI Providers must submit claims for all covered services that are program-provided included in the IFSP to the MCO. The MCO must pay for claims for ECI covered services in the amount, duration, and scope and service setting established by the Individual Family Service Plan (IFSP).

ECI Targeted Case Management services and ECI Specialized Skills Training are Non-capitated Services, as described in **Section 8.2.2.8**.

Members in ECI will be classified as Members with Special Healthcare Needs (MSHCN) as described in **Section 8.1.12**. MCOs must offer Service Coordination and develop a Service Plan as appropriate for these Members. With the consent of the Member's authorized representative, the MCO must include key information from the IFSP in the development of the Member's Service Plan.

8.1.10 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) - Specific Requirements

The MCO must, by contract, require its Providers to coordinate with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin. The MCO must make referrals to WIC for Members who are potentially eligible for WIC. The MCO may use the nutrition education provided by WIC to satisfy certain health education requirements of the Contract.

8.1.11 Coordination with Texas Department of Family and Protective Services

The MCO must cooperate and coordinate with the Department of Family and Protective Services (DFPS) for a Member receiving family-based safety services or for a Member who is in DFPS conservatorship but not enrolled in the STAR Health program. Family-based safety services provided by CPS are in-home services to help stabilize the family and reduce the risk of future abuse or neglect.

For the purposes of **Section 8.1.11**, court order means an order entered by a court of continuing jurisdiction requiring participation in DFPS services or placing a child or young adult under DFPS conservatorship, including court orders consistent with the Texas Health and Safety Code Chapters 573, Subchapters B and C, Texas Health and Safety Code Chapter 574, Subchapters A through G, Texas Family code Chapter 55, Subchapter D, Texas Health and Safety Code Chapter 462, Subchapter D or as a condition of probation and in accordance with UMCM Section 16.1.

The MCO must comply with all provisions related to Covered Services, including Behavioral Health Services, in the following documents:

1. a Court Order or DFPS service plan requiring participation in DFPS services entered by a court of continuing jurisdiction;
2. a DFPS service plan requiring participation in DFPS services entered by a court of continuing jurisdiction; and
3. a DFPS service plan voluntarily entered into by DFPS and a Member receiving family-based safety services.

The MCO cannot deny or reduce the Medical Necessity of any Covered Services, including Behavioral Health Services, included in the above-referenced Court Orders or

service plans. Any modification or termination of court-ordered services must be approved by the court having jurisdiction over the matter.

A Member, or the parent or guardian who is subject to a Court Order or DFPS service plan, cannot use the MCO's Complaint or Appeal processes or the HHSC State Fair Hearing process to reduce the amount and scope of Services in a Court Order or DFPS service plan.

The MCO must include information in its Provider Manuals and training materials regarding:

1. providing medical records to DFPS;
2. testifying in hearings; and
3. scheduling medical and Behavioral Health Services appointments within 14 Days unless requested earlier by DFPS.

8.1.12 Services for Members with Special Health Care Needs

8.1.12.1 Identification

The MCO must develop and maintain a system and procedures for identifying Members with Special Health Care Needs (MSHCN). HHSC has designated Members in the following groups as MSHCN:

1. ECI program participants.
2. Pregnant women identified as high risk, including:
    a. Pregnant Members age 35 and older or 15 and younger;
    b. Pregnant Members diagnosed with preeclampsia, high blood pressure, ~~or~~ diabetes, or an infectious disease requiring treatment to prevent transmission to the infant, including human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), and syphilis;
    c. Pregnant Members with mental health or Substance Use Disorder diagnoses; and
    d. Pregnant Members with a previous pre-term birth, as identified on the perinatal risk report.
3. Members with high-cost catastrophic cases or high service utilization, such as a high volume of ER or hospital visits.
4. Members with mental illness and co-occurring Substance Use Disorder diagnoses.
5. Members with serious ongoing illness or a chronic complex condition that is anticipated to last for a significant period and requires ongoing therapeutic intervention and evaluation, such as:
    a. Members diagnosed with respiratory illness (such as COPD, chronic asthma, or cystic fibrosis), diabetes, heart disease, kidney disease, HIV, or AIDS;
    b. Child Members receiving ongoing therapy services which may include physical therapy, speech therapy, or occupational therapy (e.g. for longer than six months); and
    c. Member receiving CFC, PCS, PDN, or PPECC services.

6. Members identified by the MCO as having Behavioral Health issues, including Substance Use Disorders, or serious emotional disturbance or serious and persistent mental illness, that may affect their physical health or treatment compliance.
7. STAR+PLUS Members.

The MCO also may designate additional Members as MSHCN based on the MCO's assessment of the Members' needs.

The MCO must use methods such as codes in the Enrollment Files, claims data, and medical history data review to identify Members who are in one of the groups listed above, and other Members who have conditions requiring special services described in **Sections 8.1.12.2 and 8.1.12.3**.

The MCO's mechanisms to evaluate MSHCN must use appropriate health care professionals. In addition to the MCO's identification of MSHCN, Members may request to be assessed by the MCO to determine if they meet the criteria for MSHCN.

The MCO must provide information to the HHSC Administrative Services Contractor that identifies Members assessed to be MSHCN by the MCO. The information must be provided in a format and on a timeline as determined by HHSC. ~~The information must be updated with newly identified MSHCN by the tenth Day of each month.~~

The MCO must submit a ~~quarterly MSHCN~~monthly Service Coordination report as described in ~~the~~ UMCM Chapter 5.

8.1.12.2 Access to Care for MSHCN

The MCO must have effective systems to ensure the provision of Covered Services to meet the special preventive, primary Acute Care, and specialty health care needs appropriate for treatment of the Members with Special Health Care Needs' condition(s). The MCO must provide Service Coordination to MSHCN, including the development of a Service Plan and ensuring access to treatment by a multidisciplinary team when necessary, as further described in **Section 8.1.12.3**.

The MCO must provide access to identified PCPs and specialty care Providers with experience serving MSHCN. Such Providers should be board-qualified or board-eligible in their specialty and meet MCO credentialing requirements.

The MCO must have Network PCPs and specialty care Providers that have demonstrated experience with children who have special health needs in pediatric specialty centers such as children's Hospitals, teaching Hospitals, and tertiary care centers.

The MCO must have a mechanism in place to allow Members with Special Health Care Needs to have direct access to a specialist as appropriate for the Member's condition and identified needs, such as a standing referral to a specialty physician or Behavioral Health Provider. The MCO must also provide MSHCN with access to non-primary care

physician specialists as PCPs, as required by 28 Tex. Admin. Code §11.900, and **Section 8.1.4.2**.

The MCO must implement a systematic process to coordinate Non-capitated Services and enlist the involvement of community organizations that may not be providing Covered Services but are otherwise important to the health and wellbeing of Members. The MCO also must make a best effort to establish relationships with State and local programs and community organizations, such as those listed below, in order to make referrals for MSHCN and other Members who need community services:

1. Community Resource Coordination Groups (CRCGs);
2. ECI Program;
3. local school districts (Special Education);
4. Texas Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program;
5. Texas Department of State Health (DSHS) services, including Title V Maternal and Child Health, Children with Special Health Care Needs (CSHCN) Programs;
6. other state and local agencies and programs such as food stamps, and the Women, Infants, and Children's (WIC) Program;
7. family planning programs including the Healthy Texas Women, Family Planning, and Primary Health Care programs; and
8. civic and religious organizations and consumer and advocacy groups, such as United Cerebral Palsy, which also work on behalf of the MSHCN population.
9. Texas Department of Family and Protective Services (DFPS) Nurse – Family Partnership (NFP).

The MCO must provide information and education in its Member Handbook and Provider Manual about the care and treatment available to MSHCN, including the availability of Service Coordination.

8.1.12.3 Service Coordination for MSHCN

The MCO must have Service Coordination programs and procedures for MSHCN. The MCO must provide Service Coordination to MSHCN, including the development of a Service Plan and ensuring access to treatment by a multidisciplinary team when necessary.

For Members in STAR+PLUS, the Member who qualifies as an MSHCN will receive any needed Service Coordination activities through a Service Coordinator as described in **Section 8.3.2**. STAR+PLUS MCOs are required to develop Service Plans as described in **Section 8.1.12.4**, as applicable.

As part of Service Coordination, the MCO is responsible for working with MSHCNs, their health care providers, their families and, if applicable, legal guardians to develop a seamless package of care in which primary, Acute Care, and specialty service needs are met. Service Coordination includes coordination of services and authorizations to prevent duplication for clients who require THSteps - Comprehensive Care Program Services, such as coordination between Private Duty Nursing and PPECC providers.

8.1.12.4 Service Plan for MSHCN

The MCO must develop a Person-Centered Service Plan ~~(SP)~~ for all MSHCN and meet required timelines for Service Plan development or annual contract, unless the Member, Member's LAR, or Member's authorized representative declines Service Coordination or if the MCO is unable to reach the Member, and the MCO has documented the Member's decline or unable to reach status. For HCBS STAR+PLUS Members, the Service Plan must include the components of a person-centered ~~S~~service ~~P~~plan described in 42 C.F.R. § 441.301(c)(1) and (2). The Service Plan must be developed with and understandable to the Member and/or the Member's authorized representatives or LAR. The MCO must make a best effort to update the Service Plan at least annually. For the purpose of required MCO contacts for initial and annual Service Plan updates, best effort is defined as the completion of a minimum of three outreach attempts to make personal contact with the Member, Member's authorized representative, or the Member's LAR within the required timeframes. MCO follow-up outreach attempts for initial and annual Service Plan updates must include at least three outreach efforts via telephone unless the Member consents to being contacted through email or text. Telephonic outreach efforts must be made on separate days, over a period of no more than five Business Days, and must be made at a different time of day upon each attempt. If telephonic, email, or text outreach efforts are not successful, the MCO must mail written correspondence to the Member, Member's LAR, or Member's authorized representative explaining the need to contact the MCO and requesting that the Member, Member's LAR, or Member's authorized representative contact the MCO as soon as possible. The Service Plan may also be updated upon identifying changes in the Member's health condition or upon a Member's, Member's authorized representative's, or Member's LAR's request.

The Service Plan must include, but is not limited to, the following:

1. the Member's history;
2. the Member's service preferences;
3. short and long-term needs, personal preferences, and outcomes for the Member, Member's authorized representative, or Member's LAR;
4. the Member's natural strengths and supports, such as the Member's abilities or family members;
5. a summary of the Member's current medical and social needs and concerns including:
    a. Behavioral Health needs, including Substance Use Disorder treatment needs that meet the guidance outlined in UMCM Chapter 16;
    b. Physical, occupational, speech, or other specialized therapy services needs;
    c. Durable Medical equipment and medical supplies needs;
    d. Needed nursing services including Home Health Skilled Nursing, Private Duty Nursing, and Nursing Services offered through a Prescribed Pediatric Extended Care Center;
    e. Prescription drugs including psychotropic medications needs; and
    f. Transportation needs;
6. a list of covered services required for the Member, their frequency;
7. a description of who will provide the Member's services; and

8. a list of non-covered services, community supports, and other resources that the Member already receives or that would be beneficial to the Member.
9. For STAR MSHCN younger than 21 years old, the Member's need for Case Management for Children and Pregnant Women services to access educational service needs related to their health condition or health risk.

The Service Plan should incorporate as a component of the plan the Individual Family Service Plan (IFSP) for Members in the ECI Program. The Service Plan should also include information on how to access affordable, integrated housing.

Members must have access to treatment by a multidisciplinary team as outlined in a Member's Service Plan when the Member's PCP determines the treatment is Medically Necessary, or to avoid separate and fragmented evaluations and service plans. The team must include both physician and non-physician providers that the PCP determines are necessary for the comprehensive treatment of the Member. The team must:

1. participate in Hospital discharge planning;
2. for behavioral health hospitalizations, participate in discharge planning as described in Section 8.1.15.5;
~~1.~~3. participate in pre-admission Hospital planning for non-emergency Hospitalizations;
~~2.~~4. develop specialty care and support service recommendations to be incorporated into the Service Plan; and
~~3.~~5. provide information to the Member, or when applicable, the Member's authorized representatives or LAR concerning the specialty care recommendations.

8.1.12.4.1 Service Plan for STAR+PLUS Members

For STAR+PLUS Members, if the information listed in items one through eight in **Section 8.1.12.4** are not part of a Member's Service Plan and already included in a Member's case record as described in the STAR+PLUS Handbook, the MCO must collect and document this information in the Member's case record.

8.1.12.4.2 STAR Service Coordination and Service Plan for Adoption Assistance and Permanency Care Assistance Members

The MCO must conduct an initial telephonic Member screening for all Adoption Assistance (AA) and Permanency Care Assistance (PCA) Members. The telephonic screening must be used to prioritize which Members require the most immediate attention for Service Coordination and Service Plan development. For all AA and PCA Members who are enrolled with the STAR MCO from September 2017 through February 2018, the STAR MCO must conduct the initial telephonic Member screening within 15 Business Days of the effective date of the Member's enrollment or the date the MCO is notified of the Member's enrollment, whichever is later, unless notified by the Member, Member's authorized representative, Member's LAR, or Member's PCP by phone or in writing of a more urgent need. AA and PCA Members who enroll in STAR after February 2018 must receive the initial telephonic Member screening within 15 Business Days from

the effective date of the Member's enrollment with the MCO or the date the MCO is notified of the Member's enrollment, whichever is later, unless notified by the Member, Member's authorized representative, Member's LAR, or Member's PCP by phone or in writing of a more urgent need.

The MCO must make at least three efforts to contact new AA and PCA Members telephonically. If an MCO is unable to reach a Member or Member's authorized representative by telephone, the MCO must mail written correspondence to the Member and Member's authorized representative explaining the need to contact the MCO and requesting that the Member or Member's authorized representative contact the MCO as soon as possible. The MCO must attempt contact at least annually unless the Member, Member's authorized representative, or Member's LAR decline Service Coordination.

As a part of the telephonic communication with the AA or PCA Member or Member's authorized representative or through written materials provided by the MCO to the Member, the MCO must inform the Member about Service Coordination and Service Plan development and include the following details:

1. Information on the purpose and goals of Service Coordination and Service Plan;
2. The estimated timeframe it will take to complete the development of a Service Plan; and
3. Information the Member's family should be prepared to discuss as a part of Service Plan development as described in **Section 8.1.12.3**.

For all AA and PCA Members, the Service Plan must be developed within 30 Business Days of the effective date of the Member's enrollment or the date the MCO is notified of the Member's enrollment, whichever is later.

The MCO must reach out to AA and PCA Members at least biannually to assess whether there should be updates to the Service Plan and to make necessary adjustments to the Member's Service Plan. MCO follow-up outreach efforts must include telephonic outreach or In-Person contacts unless the AA or PCA Member consents to being contacted through email or text. If the Member, Member's authorized representative, or Member's LAR declines Service Coordination, biannual and ongoing outreach are not required.

If the Member, Member's authorized representative, or Member's LAR declines Service Coordination or the MCO is unable to reach the Member, Member's authorized representative, or Member's LAR, the MCO must document this in the Member's file. The MCO will not be required to meet required timelines for Service Plan development for Members who have refused Service Coordination if the refusal is documented or if the MCO is unable to reach the Member.

8.1.12.4.3 Service Plan and the Use of Telecommunication

MCOs must adhere to the provisions for services by Telecommunication located in UMCM Chapter 16, and Subchapter R of 1 Tex. Admin. Code, Chapter 353.

8.1.13 Initial Health Needs Screening

For the purposes of these sections, best effort is attempting to make contact with the Member a minimum of three times within the required timeframes.

If the MCO is unable to reach the Member, Member's LAR, or Member's authorized representative, the MCO must document this in the Member's file. If the Member, Member's LAR, or Member's authorized representative declines the initial health needs screening described in this section, the MCO must document this in the Member's file.

The MCO must use the initial health needs screening to gauge the need for a more comprehensive assessment, to identify MSHCN, and to prioritize Members for Service Coordination.

8.1.13.1 STAR, STAR+PLUS, and CHIP Members

90 Days best effort: With the exception of the groups listed in Section 8.1.13.2, the MCO must make a best effort to complete an initial health needs screening of all new Members within 90 Days of either the effective date of the Member's enrollment or the date the MCO is notified of the Member's enrollment, whichever is later, in accordance with 42 C.F.R. §§ 438.208(b) and 457.1230(c).

8.1.13.2 STAR and CHIP Members

30 Days best effort: For Members in the following listed groups, the MCO must make a best effort to complete an initial health needs screening within 30 Days of either the effective date of the Member's enrollment or the date the MCO is notified of the Member's enrollment, whichever is later in accordance with 42 C.F.R. §§ 438.208(b) and 457.1230(c):

1. Members identified as Farmworker Children (FWC);
2. Former Foster Care Child (FFCC) Members;
3. STAR and CHIP Members identified on the enrollment file as MSHCN; and Pregnant Members; and
4. Pregnant Members.

15 Business Days: Adoption Assistance (AA) and Permanency Care Assistance (PCA) Members must receive the initial telephonic Member screening required by Section 8.1.12.4.2 in accordance with the timeframes in that section, within 15 Business Days of either the effective date of the Member's enrollment or the date the MCO is notified of the Member's enrollment, whichever is later.

8.1.13.3 Nonmedical Health-Related Needs Screening for Pregnant Members

For all pregnant Members, the MCO must make a best effort, as described below, to conduct and complete a nonmedical health-related needs screening within 30 Days of enrollment with the MCO or after the MCO identifies a pregnant Member.

An MCO may conduct additional nonmedical health-related needs screenings following the end of the pregnancy or at the Member's request.

The MCO must make at least three efforts to contact pregnant Members.

If an MCO is unable to reach a Member, the MCO must mail written correspondence to the Member explaining the need to contact the MCO and requesting that the Member contact the MCO as soon as possible.

The MCO may conduct the nonmedical health-related needs screening in combination with the initial health needs screening described in Section 8.1.13 or the perinatal risk assessments described in Section 8.2.2.4.

The MCO must obtain the Member's informed consent before conducting a nonmedical health-related needs screening in accordance with UMCM Chapter 16. The MCO must store the Member's consent and provide documentation to HHSC upon request.

The MCO must use the nonmedical health-related needs screening to determine if the Member requires a more comprehensive assessment to determine the Member's eligibility for Service Coordination, Covered Services including Case Management for Children and Pregnant Women services, and non-covered services such as Value-added Services or community resources.

Upon request by the Member's PCP and/or prenatal care Provider, the MCO must provide a copy of the initial and any subsequent screening results to the Member's PCP and/or prenatal care Provider. Upon request by the Member, the MCO must provide a copy of the screening results to other individuals.

The MCO must submit to HHSC, in the form and manner identified by HHSC, and specified in UMCM Chapter 16, any data the MCO collects from the Member during the nonmedical health-related needs screening.

8.1.14 Disease Management (DM)

The MCO must provide or arrange the provision of comprehensive disease management (DM) programs consistent with state and federal statutes and regulations. The program design of these DM programs must focus on the whole person, typically high-risk enrollees with complex chronic or co-morbid conditions rather than traditionally-designed programs with restricted diagnoses or disease silos. These programs must identify enrollees at highest risk of utilization of medical services, tailor interventions to better meet enrollees' needs, encourage provider input in care plan development, and apply clinical evidence-based practice protocols for individualized care.

MCOs must focus their DM programs on 3 main components:

- Member self-management;
- provider practice/delivery system design; and

- technological support.

Under client self-management, a client becomes an informed and active participant in the management of physical and mental health conditions and co-morbidities. Under the provider practice/delivery system design approach, medical home providers take an active role in helping their Members make informed healthcare decisions. Technology, such as the use of predictive modeling, helps identify potential program Members and providers.

8.1.14.1 Special Populations

The MCO is also required to have a specialized program for targeting, outreach, education and intervention for Members who have excessive utilization patterns that indicate typical DM approaches are not effective. For the purposes of this contract, this group of Members is called “super-utilizers.” The MCO must have the following infrastructure in place to address super-utilizers’ needs, using, at a minimum, the following criteria.

1. Methodology for identification of super-utilizers on an ongoing basis, based on cost, utilization of the ER, utilization of inpatient or pharmacy, services, physical and Behavioral Health comorbidities, or other specified basis.

2. Resources dedicated to ongoing targeting and identification of super-utilizers such as staff, specialized analytical tools, etc.

3. Staff resources for effective outreach and education of Providers and super-utilizers.

4. Specialized intervention strategies for super-utilizers. The interventions must include an option for In-Person interactions with the Member that occur outside of a standard clinical setting. This In-Person intervention may be performed by medical care providers or other non-medical providers that are employed by the MCO or are subcontracted with the MCO.

5. Evaluation process to determine effectiveness of super-utilizer program. As part of the annual evaluation of effectiveness, the MCO should include a description or example of an intervention it found effective. It can be a Member case study with a description of the interventions and improvements or a specific project with demonstrated effectiveness.

Upon request, MCOs must demonstrate to HHSC their methodologies for identification and intervention strategies for this population, to include the MCO’s resources to support this effort. On an ad hoc basis, the MCO must provide its plan for management of super-utilizers including the criteria listed above using UMCM Chapter 9. HHSC will evaluate the plan and provide feedback to the MCO. Upon HHSC’s approval of the plan, each MCO will be retrospectively evaluated on their execution of the written plan, as described in **Section 8.1.14.3**. An MCO may reuse elements of the same plan from as long as the submission reflects the current state of their special population program and

is updated as necessary on evaluation methodologies and key findings. The disease management requirements do not apply to CHIP Perinate Members.

8.1.14.2 DM and Participating Providers

At a minimum, the MCO must:

1. implement a system for Providers to request specific DM interventions;
2. give Providers information, including differences between recommended prevention and treatment and actual care received by Members enrolled in a DM program, and information concerning such Members' adherence to a service plan; and
3. for Members enrolled in a DM program, provide reports on changes in a Member's health status to his or her PCP.

8.1.14.3 MCO DM Evaluation

HHSC or its EQRO will evaluate the MCO's DM program.

HHSC or its EQRO will also evaluate DM as it relates to specialized populations identified in 8.1.14.1. These evaluations will be on a retrospective basis and will include an analysis of MCO Encounter Data and other relevant data (e.g., reports). Evaluations could also include interviews with MCO staff that oversee the program as well as identified Providers. Based on HHSC's retrospective evaluation, MCOs may be required to submit a Corrective Action Plan if directed by HHSC.

It is HHSC's intent to hold quarterly collaborative calls or webinars with MCO medical directors to discuss plan implementation, barriers, successful strategies, etc.

8.1.15 Behavioral Health (BH) Network and Services

The requirements in this subsection pertain to all MCOs except the CHIP MCOs with respect to their Perinate Members (unborn children).

The MCO must provide, or arrange to have provided, to Members all Medically Necessary Behavioral Health (BH) Services as described in **Attachments B-2**, "STAR Covered Services," **B-2.1**, "CHIP Covered Services," and **B-2.2**, "STAR+PLUS Covered Services," All BH Services must comply with the access standards included in **Section 8.1.3**. For Medicaid MCOs, BH Services are described in more detail in the **Texas Medicaid Provider Procedures Manual**. When assessing Members for BH Services, the MCO and its Network Behavioral Health Service Providers must use the DSM multi-axial classification in effect at the time of service. HHSC may require use of other assessment instrument/outcome measures in addition to the DSM. Providers must document DSM and assessment/outcome information in the Member's medical record.

As allowed by 42 C.F.R. § 438.6(e) and § 438.3(e)(2), the MCO may provide certain HHSC-approved services in lieu of Behavioral Health Services, as described in UMCM Chapter 16.

8.1.15.1 BH Provider Network

The MCO must maintain a Behavioral Health Services Provider Network that includes psychiatrists, psychologists, and other Behavioral Health Service Providers. To ensure accessibility and availability of qualified Providers to all Members in the Service Area, the Provider Network must include Behavioral Health Service Providers with experience serving special populations among the MCO Program(s)' enrolled population, including, as applicable, children and adolescents, persons with disabilities, the elderly, and cultural or linguistic minorities.

8.1.15.2 Member Education and Self-referral for Behavioral Health Services

The MCO must maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.

The MCO must permit Members to self-refer to any Network Behavioral Health Services Provider without a referral from the Member's PCP. The MCOs' policies and procedures, including its Provider Manual, must include written policies and procedures for allowing such self-referral to Behavioral Health Services.

The MCO must permit Members to participate in the selection of the appropriate Behavioral Health providers and must provide the Member with information on accessible Network Providers with relevant experience.

8.1.15.3 Behavioral Health Services Hotline

This Section includes Member Hotline requirements. Requirements for Provider hotlines are found in **Section 8.1.4.7**.

The MCO must have an emergency and crisis Behavioral Health Services hotline staffed by trained personnel 24 hours a Day, 7 Days a week, toll-free throughout the Service Area. Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess Behavioral Health emergencies. Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. It is not acceptable for an emergency intake line to be answered by an answering machine.

The MCO must operate a toll-free hotline as described in **Section 8.1.5.6** to handle Behavioral Health-related calls. The MCO may operate one hotline to handle Behavioral Health calls (including emergency and crisis Behavioral Health calls) and other routine Member calls unrelated to Behavioral Health. However, the MCO must submit hotline performance reports separately as required by UMCM Chapter 5. The MCO cannot impose maximum call duration limits and must allow calls to be of sufficient length to ensure adequate information is provided to the Member. Hotline services must meet

Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.

The Behavioral Health Services hotline may serve multiple MCO Programs if the Hotline staff is knowledgeable about all of the MCO Programs. The Behavioral Health Services hotline may serve multiple Service Areas if the hotline staff is knowledgeable about all such Service Areas, including the Behavioral Health Provider Network in each Service Area. The MCO must ensure that the toll-free Behavioral Health Services hotline meets the following minimum performance requirements for the MCO Program:

1. at least 80 percent of calls must be answered by toll-free line staff within 30 seconds measured from the time the call is placed in queue after selecting an option;
2. the call abandonment rate is seven percent or less; and
3. the average hold time is two minutes or less.

The MCO must conduct ongoing quality assurance to ensure these standards are met.

The MCO must monitor the MCO's performance against the Behavioral Health Services hotline standards and submit performance reports summarizing call center performance as indicated in **Section 8.1.20** and the UMCM**.**

As a component of quality monitoring, HHSC may require the MCO to implement a system where callers are given the option of participating in an automated survey at the end of a call.

If HHSC determines that it will conduct onsite monitoring of the MCO's Behavioral Health Services hotline functions, the MCO must reimburse HHSC for all authorized reimbursable travel costs incurred by HHSC or its authorized agent(s) relating to such monitoring. For purposes of this section, "authorized reimbursable travel costs" may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite monitoring. Reimbursement by the MCO will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

8.1.15.4 Coordination between the BH Provider and the PCP

The MCO must require, through Provider contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected Behavioral Health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice.

The MCO must provide training to Network PCPs on how to screen for and identify Behavioral Health disorders, the MCO's referral process for Behavioral Health Services, and clinical coordination requirements for such services. The MCO must include training

on coordination and quality of care such as Behavioral Health screening techniques for PCPs and new models of Behavioral Health interventions.

The MCO must develop and disseminate policies regarding clinical coordination between Behavioral Health Service Providers and PCPs. The MCO must require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical Health Care Services if they are licensed to do so. This requirement must be specified in all Provider Manuals.

The MCO must require that Behavioral Health Providers send initial and quarterly, or more frequently if clinically indicated, summary reports of a Members' Behavioral Health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement must be specified in all Provider Manuals.

8.1.15.5 Follow-up after Hospitalization for Behavioral Health Services

The MCO must require, through Provider contract provisions, that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven Days from the date of discharge. The MCO must ensure that Behavioral Health Service Providers contact Members who have missed appointments within 24 hours to reschedule appointments.

The MCO must comply with discharge planning requirements for MSHCN as described in Section 8.1.12.4.

8.1.15.6 Chemical Dependency

The MCO must comply with 28 Tex. Admin. Code §§ 3.8001 *et seq*., regarding utilization review for Chemical Dependency Treatment. Chemical Dependency Treatment must comply with the standards set forth in 28 Tex. Admin. Code, Part 1, Chapter 3, Subchapter HH.

8.1.15.7 Court-Ordered Services

This section does not apply to CHIP Perinate Members.

The MCO is required to pay for Medicaid or CHIP Covered Services ordered by a court pursuant to the statutory citations listed below. The MCO cannot deny, reduce, or controvert the court orders for Medicaid or CHIP inpatient mental health Covered Services for Members birth through age 20 or ages 65 and older, provided:

1) pursuant to a court order; or
2) as a condition of probation.

The MCO cannot deny, reduce, or controvert the court orders for Medicaid inpatient mental health Covered Services for Members of any age if the court-ordered services are delivered in an Acute Care Hospital.

The MCO may not limit Substance Use Disorder treatment or outpatient mental health services for Members of any age provided pursuant to:

1) a court order; or
2) a condition of probation.

The MCO cannot apply its own utilization management criteria through prior authorizations, concurrent reviews, or retrospective reviews for such services.

Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A Member who has been ordered to receive treatment pursuant to a court order can only Appeal the court order through the court system.

MCOs are required to have a mechanism to receive court order documents from Providers at the time of an authorization request.

8.1.15.7.1 Psychiatric Services

The MCO must provide all Medicaid or CHIP inpatient psychiatric Covered Services to Members birth through age 20, and ages 65 and older, who have been ordered to receive the services:

1) by a court of competent jurisdiction including services ordered pursuant to the Texas Health and Safety Code Chapters 573, Subchapters B and C, Texas Health and Safety Code Chapter 574, Subchapters A through G, Texas Family code Chapter 55, Subchapter D; or
2) as a condition of probation.

These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.

The MCO must provide all Medicaid or CHIP inpatient psychiatric Covered Services to Members birth through age 20, and ages 65 and older, who have been ordered to receive the services:

1) by a court of competent jurisdiction ordered pursuant to the Texas Health and Safety Code Chapter 573, Subchapters B and C, Texas Health and Safety Code Chapter 574, Subchapters A through G: or
2) as a condition of probation, if the Member receives those services at an Acute Care Hospital.

These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.

8.1.15.7.2 Substance Use Disorder Treatment Services

MCOs must provide Medicaid or CHIP-covered Substance Use Disorder treatment services, including residential treatment, required as a:

1) court order consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code: or
2) condition of probation.

These requirements are not applicable when the Member is considered incarcerated as defined by UMCM Section 16.

8.1.15.8 Local Mental Health Authority (LMHA)

The MCO must coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facility regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law to the state psychiatric facility.

8.1.15.9 This Section Intentionally Left Blank

8.1.15.10 Mental Health Parity

The MCO must comply with all applicable provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and all related regulations, including 42 C.F.R. Part 438, Subpart K and~~,~~ 42 C.F.R §457.496~~, and 45 C.F.R. §§146.136, 147.136, and 147.160~~. The MCO must work with HHSC to be in compliance with parity, and must provide HHSC with a non-quantitative treatment limitation assessment tool(s); survey(s); or corrective action plan(s) related to compliance with MHPAEA; and statements of attestation stating compliance with MHPAEA and any other information as requested by HHSC. The information must be provided within the timeframe included in HHSC's request.

8.1.16 Financial Requirements for Covered Services

The MCO must pay for or reimburse Providers for all Medically Necessary Covered Services provided to all Members. STAR+PLUS MCOs must also provide Functionally Necessary Community Long-term Services and Supports to Members. The MCO is not liable for cost incurred in connection with health care or NEMT Services rendered prior to the date of the Member's Effective Date of Coverage in that MCO. When Medicaid provider rates are increased as a result of a legislative appropriation, MCOs must increase provider rates as required by HHSC to the extent allowed by federal laws and regulations.

Medicaid and CHIP are the payers of last resort for Covered Services, unless an exception applies under federal law or HHSC policy. If a Member is entitled to coverage for specific services payable under another insurance plan and the MCO paid for such

Covered Services, the MCO must obtain reimbursement from the responsible insurance entity not to exceed 100 percent of the value of Covered Services paid by the MCO. See **Sections 8.2.8** and **8.4.3,** "Third Party Liability and Recovery and Coordination of Benefits," for additional information regarding coordination of benefits and recoveries from third parties.

8.1.17 Accounting and Financial Reporting Requirements

The MCO's accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with Federal Acquisition Regulations ("FAR"), Generally Accepted Accounting Principles (GAAP), **Attachment A**, "Uniform Managed Care Contract Terms and Conditions," and the cost principles contained in the Cost Principles Document in UMCM Chapter 6. HHSC will not recognize or pay services that cannot be properly substantiated by the MCO and verified by HHSC.

The MCO must:

1. maintain accounting records for each applicable MCO Program separate and apart from other corporate accounting records;
2. maintain records for all claims payments, refunds and adjustment payments to providers, Capitation Payments, interest income and payments for administrative services or functions and must maintain separate records for medical and administrative fees, charges, and payments;
3. ensure and provide access to HHSC and/or its auditors or agents to the detailed records and supporting documentation for all costs incurred by the MCO. The MCO must ensure such access to its Subcontractors, including Affiliates, for any costs billed to or passed to the MCO with respect to an MCO Program; and
4. maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts.

MCO will reimburse HHSC, if reimbursement is sought from the MCOs for reasonable costs incurred by HHSC to perform examinations, investigations, audits, or other types of attestations that HHSC determines are necessary to ensure MCO compliance with this Contract. The use of and selection of any external parties to conduct examinations, investigations, audits, or other types of attestations as well as the scope of work of examinations, investigations, audits, or other types of attestations are also at HHSC's sole discretion.

8.1.17.1 Financial Reporting Requirements

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

CHIP Perinatal Program data will be integrated into the CHIP Program financial reports. Except for the Financial Statistical Report, no separate CHIP Perinatal Program reports are required. For all other CHIP financial reports, where appropriate, HHSC will designate specific attributes within the CHIP Program financial reports that CHIP MCOs must complete to allow HHSC to extract financial data particular to the CHIP Perinatal Program.

Any data submitted with respect to the required financial reports or filings that is in PDF (or similar file format such as TIF) must be generated in a text-searchable format.

Due dates, content, and formats for the following deliverables and reports may be referenced herein or in UMCM Chapter 5.

(a) **Financial-Statistical Report (FSR) –** The MCO must file four quarterly and two annual Financial-Statistical Reports (FSR) for each complete State Fiscal Year, in the format and timeframe specified by HHSC. HHSC will include FSR format and directions in UMCM Chapter 5. The MCO must incorporate financial and statistical data of delegated networks (e.g., IPAs, ANHCs, Limited Provider Networks), if any, in its FSR Reports. The FSR is one (1) of the primary financial reports used by HHSC to monitor Contract financial results. It is a modified (HHSC-defined) form of an income statement, with some other elements added. Not all expenses incurred may be included on the FSR.

All amounts reported in the FSRs must be reported in accordance with UMCM Chapter 6. Each FSR must provide amounts by month, with a year-to-date total (based on the SFY, or other Contract period as designated by HHSC). Each successive FSR will show the most current amounts for each month in the SFY; thus, a given month's amount may change in future FSRs as more claims run-out is experienced for the month. Quarterly FSRs are generally due 30 Days after the end of each State Fiscal Quarter. The MCO must transmit these reports electronically, in a locked MS Excel file.

After the 4th Quarter FSR, the first annual FSR for a given SFY (the "90-Day FSR") must reflect claims run-out and accruals through the 90th Day after the end of the Contract Year. This report must be filed on or before the 120th Day after the end of the Contract Period. If the MCO has made a pre-tax profit in excess of the thresholds as established in the Contract with respect to the Experience Rebate, then a payment for any amounts to be refunded to HHSC is due in conjunction with filing the 90-Day FSR. The second annual report for a given SFY (the "334-Day FSR") must reflect data completed through the 334th Day after the end of the Contract Period and must be filed on or before the 365th Day following the end of the Contract Period. The 334-Day FSR is routinely audited by HHSC and/or its independent auditors.

HHSC will post all or part of an FSR on the HHSC website.

As set forth above, CHIP MCOs are required to submit separate FSRs for the CHIP Perinatal Program, in accordance with UMCM Chapters 5.

(b) **Delivery Supplemental Payment (DSP) Report -** The MCO must submit a monthly DSP Report in accordance with UMCM Chapter 5. The Report must include only unduplicated deliveries and only deliveries for which the MCO has made a payment to either a Hospital or other provider.

(c) **Claims Lag Report -** The MCO must submit a Claims Lag Report on a quarterly basis, by the last Day of the month following the reporting period. The report must disclose the amount of incurred claims each month and the amount paid each month, on a contract-to-date basis. The report must be submitted in accordance with UMCM Chapter 5.

(d) **Third Party Liability and Recovery (TPL/TPR) Reports –** The MCO must submit TPL/TPR reports, in accordance with UMCM Chapter 5. MCOs must submit TPL/TPR reports quarterly, by MCO Program and plan code. TPL/TPR reports must include total dollars costs avoided, and total dollars recovered from third party payers through the MCO's coordination of benefits efforts during the Quarter.

(e) **Report of Legal and Other Proceedings and Related Events** - The MCO must comply with UMCM Chapter 5, regarding the disclosure of certain matters involving either the MCO, its Affiliates, or its Material Subcontractors. Reports are due both on an as-occurs basis and annually each September 1st. The as-occurs report is due no later than 30 Days after the event that triggered the notification requirement.

(f) **Audit Reports -** The MCO must comply with UMCM Chapter 5 regarding notification and/or submission of certain internal and external audit reports.

(g) **Affiliate Report –** The MCO must submit an Affiliate Report on an as-occurs basis and annually by September 1st of each year in accordance with the UMCM. The "as-occurs" update is due within 30 Days of the event that triggered the change. Note that "Affiliate" is a defined term (see **Attachment A**, "Uniform Managed Care Contract Terms and Conditions").

(h) **MCO Disclosure Statement -** The MCO must file:

1. an updated MCO Disclosure Statement by September 1st of each Contract Year; and
2. a "change notification" abbreviated version of the report, no later than 30 Days after any of the following events:

    a. entering into, renewing, modifying, or terminating a relationship with an affiliated party;
    b. after any change in control, ownership, or affiliations; or,
    c. after any material change in, or need for addition to, the information previously disclosed.

The MCO Disclosure Statement will include, at a minimum, a listing of the MCO's control, ownership, and any affiliations, and information regarding Affiliate transactions. This report will replace, and be in lieu of, the former "Section 1318

Financial Disclosure Report" and the "Form CMS 1513," and will disclose the same information, plus other information as may be required by HHSC or CMS Program Integrity requirements. Minor quarterly adjustments in stock holdings for publicly-traded corporations are excluded from the reporting requirements. The reporting format is included in the UMCM.

(i) **TDI Filings –** The MCO must provide HHSC with a copy of the following information no later than ten Days after the MCO's submission to TDI:

1. the "Health Annual Statement" and the "Annual Audited Financial Report" including all schedules, attachments, exhibits, supplements, management discussion, supplemental filings, etc., and any other annual financial filings, including any filings that may take the place of the above-named annual financial filings, and any financial filings that occur less frequently than on a quarterly basis;
2. the annual figures for controlled risk-based capital; and
3. the quarterly financial statements.

Additionally, if the MCO is a foreign carrier (i.e., domiciled in another state), copies of any filings with the National Association of Insurance Commissioners (NAIC), as well as the financial statements filed with the state insurance department in its state of domicile, must be submitted to HHSC no later than ten Days after submission to NAIC or the state of domicile.

Notwithstanding the ten Day deadlines described above, the MCO must notify HHSC if it cannot provide the most recent Annual Statements by March 31st each year, and the Annual Audited Financial Report by June 30th each year. The notice should include an expected submission date.

(j) **Registration Statement (also known as the "Form B") –** With the following exceptions, MCOs must submit a complete state insurance department registration statement, also known as Form B, and all annual and other amendments to this form, and any other related or similar information filed by the MCO with the insurance regulatory authority of its domiciliary jurisdiction. The exceptions to this requirement are those MCOs that are either (i) part of a County Hospital District or other governmental entity, or (ii) a stand-alone entity with no parent or other Affiliates. If the MCO is excepted from the TDI Form B filing requirement, the MCO must demonstrate this and explain the nature of the exemption.

The Form B is filed in 3 forms: (i) the initial registration; (ii) the annual amendment; and (iii) the every-five-years complete restatement of registration. For purposes herein, the MCO must submit:

1. the complete registration restatement that was due to TDI by approximately May 2010;
2. each annual registration amendment form (which is due to TDI within 120 Days of the end of the MCO's parent's fiscal year), commencing with the most recent one that the MCO has filed after May 2010;
3. future complete five-year registration re-statements (the first of which will be due to TDI by approximately May 2015); and

4. any other registration statement amendments or re-statements that may be submitted to TDI, per TDI regulations.

If the MCO was not yet subject to TDI requirements with respect to the May 2010 registration re-statement, it must submit its initial registration

If the MCO anticipates that the registration statement annual amendment form will be filed at some other date than approximately 120 Days after the end of the parent's fiscal year, then the MCO must notify HHSC of the anticipated filing date.

All registration statement submission items herein are due to HHSC by the later of: (i) ten Days after the MCO's submission of the item to TDI, or (ii) the date identified in this section.

(k) **TDI Examination Report -** The MCO must furnish HHSC with a full and complete copy of any examination report issued by TDI, including the financial, market conduct, target exam, quality of care components, and corrective action plans and responses. The MCO must submit this information to HHSC no later than ten Days after the MCO receives the final version of the examination report from TDI.

The MCO must furnish HHSC with a copy of any similar examination report issued by a state insurance department in any other states where the MCO operates a Medicaid, CHIP, or other managed care product. These reports are also due no later than ten Days after the MCO receives the final version of the examination report.

Each September 1st, the MCO must notify HHSC of the anticipated date of the next issuance of a state department of insurance financial examination report, unless the last submitted financial examination report is less than two years old. This annual notification should include a list of any other states in which the MCO is potentially subject to such examination reports, or a statement that there are no other states.

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

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

(m) **Filings with other entities, and other existing financial reports –** The MCO must submit an electronic copy of the following reports or filings pertaining to the MCO, or its parent, or its parent's parent:

(1) *SEC Form 10-K*. For publicly-traded (stock-exchange-listed) for-profit corporations, submit the most-recent annual SEC Form 10K filing.

(2) *IRS Form 990*. For nonprofit entities, submit the most recent annual IRS Form 990 filing, complete with any and all attachments or schedules. If a nonprofit entity is exempt from the IRS 990 filing requirement, demonstrate this and explain the nature of the exemption.

(3) If the MCO is a nonprofit entity that is a component or subsidiary of a County Hospital District, or otherwise an entity of a government, then submit the annual financial statements as prepared under the relevant rules or statutes governing annual financial reporting and disclosure for the MCO or its parent, including all attachments, schedules, and supplements.

(4) *Annual Report*. The MCO must submit this report if it is different than or supplementary to the audited financial statements or Form 10-K required herein, and if it is distributed to either shareholders, customers, employees, owner(s), parent, bank or creditor(s), donors, the community, or to any regulatory body or constituents, or is otherwise externally distributed or posted.

(5) *Bond or debt rating analysis*. If the MCO or its ultimate parent has been the subject of any bond rating analysis, ratings affirmation, write-up, or related report, such as by AM Best, Fitch Ratings, Moody's, Standard & Poor, etc., submit the most recent complete detailed report from each rating entity that has produced such a report.

All of the above such reports or filings are due to HHSC no later than 30 Days after such report is filed or otherwise initially distributed. Each report should include all exhibits, attachments, notes, supplemental data, management letters, auditor letters, etc., and any updates, revisions, clarifications, or supplemental filings. If the reporting entity has a regular required due date for any of the above reports, and receives an extension on the filing deadline, then the MCO should notify HHSC of any such extension and the estimated revised filing date.

(n) **Medical Loss Ratio (MLR) Report -** The MCO must submit an annual MLR Report in accordance with the specific requirements as stated in UMCM Chapter 5. The first report will apply to the rating period commencing September 1, 2017. The Deliverable will be due as specified in UMCM Chapter 5.

8.1.18 Management Information System Requirements

The MCO must maintain a Management Information System (MIS) that supports all functions of the MCO's processes and procedures for the flow and use of MCO data. If the MCO subcontracts a MIS function, the Subcontractor's MIS must comply with the requirements of this section.

The MCO must have hardware, software, and a network and communications system with the capability and capacity to handle and operate all MIS subsystems for the following operational and administrative areas:

1. Enrollment/Eligibility Subsystem;
2. Provider Subsystem;

3. Encounter/Claims Processing Subsystem;
4. Financial Subsystem;
5. Utilization/Quality Improvement Subsystem;
6. Reporting Subsystem;
7. Interface Subsystem; and
8. TPL/TPR Subsystem, as applicable to each MCO Program.

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

The MCO must have a system that can be adapted to changes in Business Practices/Policies within the timeframes negotiated by the Parties. The MCO is expected to cover the cost of such systems modifications over the life of the Contract.

MCOs must use an address verification and standardization software when contracting with Providers. The software must standardize Provider addresses by fixing spelling errors, correcting abbreviations and fixing capitalization so that the address matches the format preferred by the United States Postal Service (USPS). MCOs must validate addresses to the master provider file as it implements the new provider enrollment system.

The MCO is required to participate in the HHSC Systems Work Group.

The MCO must provide HHSC written notice of Major Systems Changes and implementations no later than 180 Days prior to the planned change or implementation, including any changes relating to Material Subcontractors, in accordance with the requirements of this Contract and **Attachment A**, "Uniform Managed Care Contract Terms and Conditions."

The MCO must notify HHSC of Major Systems Changes in writing, as well as by e-mail to HPM staff. The notification must detail the following.

- The aspects of the system that will be changed and date of implementation
- How these changes will affect the Provider and Member community, if applicable
- The communication channels that will be used to notify these communities, if applicable
- A contingency plan in the event of downtime of system(s)

Major Systems Changes are subject to HHSC desk review and onsite review of the MCO's facilities as necessary to test readiness and functionality prior to implementation. Prior to HHSC approval of the Major Systems Change, the MCO may not implement any changes to its operating systems. Failure to comply will result in contractual remedies, including damages. HHSC retains the right to modify or waive the notification requirement contingent upon the nature of the request from the MCO.

The MCO must provide HHSC any updates to the MCO's organizational chart relating to MIS and the description of MIS responsibilities at least 30 Days prior to the effective date of the change. The MCO must provide HHSC official points of contact for MIS issues on an ongoing basis.

HHSC, or its agent, may conduct a Systems Readiness Review to validate the MCO's ability to meet the MIS requirements as described in **Section 7**, "Transition Phase Requirements." The System Readiness Review may include a desk review and/or an onsite review and must be conducted for the following events:

1. a new plan is brought into the MCO Program;
2. an existing plan begins business in a new Service Area or a Service Area expansion;
3. an existing plan changes location;
4. an existing plan changes its processing system, including changes in Material Subcontractors performing MIS or claims processing functions; and
5. an existing plan in one or two HHSC MCO Programs is initiating a Contract to participate in any additional MCO Programs.

If HHSC determines that it will conduct an onsite review, the MCO must reimburse HHSC for all authorized reimbursable travel costs associated with such onsite reviews. For purposes of this section, "authorized reimbursable travel costs" may include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite reviews. Reimbursement by the MCO will be due to HHSC within 30 Days of the date that the invoice is issued by HHSC to the MCO. The MCO may not require a social security number or any W-2/W-9 tax information from state employees as a condition for travel cost reimbursement.

This provision does not limit HHSC's ability to collect other costs as damages in accordance with **Attachment A**, Section 12.02(e), "Damages." If for any reason an MCO does not fully meet the MIS requirements, then the MCO must, upon request by HHSC, either correct such deficiency or submit to HHSC a Corrective Action Plan and Risk Mitigation Plan to address such deficiency. Immediately upon identifying a deficiency, HHSC may impose contractual remedies according to the severity of the deficiency. Refer to **Attachment A**, "Uniform Managed Care Contract Terms and Conditions," Article 12 and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix," for additional information regarding remedies and damages. Refer to **Section 7**, "Transition Phase Requirements," and **Section 8.1.1.2**, "Additional Readiness Reviews and Monitoring Efforts," for additional information regarding MCO Readiness Reviews. Refer to **Attachment A**, "Uniform Managed Care Contract Terms and Conditions," Section 4.08(c) for information regarding Readiness Reviews of the MCO's Material Subcontractors.

In accordance with UMCM Chapter 16, the MCO must share and integrate service authorization data among all relevant MCO employees, including both physical and Behavioral Health staff, or, if applicable, between the MCO and the third party or subsidiary contracted with the MCO to manage Behavioral Health Services.

8.1.18.1 Encounter Data

The MCO must provide complete and accurate Encounter Data for all Covered Services, including Value-added Services. Encounter Data is subject to the requirements in 42 C.F.R. § 438.242 and § 438.818. The Encounter Data must be submitted by the MCO in accordance with HHSC's required format and required data elements for Medicaid and CHIP MCOs. Encounter Data must follow the format and data elements as described in the most current version of HIPAA-compliant 837 Companion Guides, NCPDP format (pharmacy), Encounters Submission Guidelines, and the STAR+PLUS Handbook Appendices Section XVI, Long Term Services and Supports Codes and Modifiers. HHSC will specify the method of transmission, the submission schedule, and any other requirements in UMCM Chapter 5. The MCO must submit Encounter Data transmissions at least monthly and include all Encounter Data and Encounter Data adjustments processed by the MCO. In addition, Pharmacy Encounter Data must be submitted no later than 25 Days after the date of adjudication and include all Encounter Data and Encounter Data adjustments processed by the MCO. Encounter Data quality validation must incorporate assessment standards developed jointly by the MCO and HHSC. The MCO must submit complete and accurate Encounter Data not later than the 30th Day after the last Day of the month in which the claim was adjudicated. The MCO must make original records available for inspection by HHSC for validation purposes. Encounter Data that does not meet quality standards must be corrected and returned within a time period specified by HHSC.

For reporting claims processed by the MCO and submitted on Encounter 837 and NCPDP format, the MCO must use the procedure codes, diagnosis codes, provider identifiers, and other codes as directed by HHSC. Any exceptions will be considered on a code-by-code basis after HHSC receives written notice from the MCO requesting an exception.

HHSC will use the Encounter Data to run the Quarterly Encounter Reconciliation Report, which reconciles the year-to-date paid claims reported in the Financial Statistical Report (FSR) to the appropriate paid dollars reported in the Vision 21 Data Warehouse. This report is based on querying the Vision 21 Data Warehouse 60 Days after the last Day of the quarter. The MCO may be subject to liquidated damages as specified in Attachment B-3.

The MCO's Provider Contracts must require Network Providers to comply with the requirements of Texas Government Code § 531.024161, regarding reimbursement of claims based on orders or referrals by supervising providers.

8.1.18.1.1 NEMT Services Encounter Data Submission

The MCO must provide complete and accurate Encounter Data for all applicable NEMT Services provided to Members. Encounter Data must follow the format and data elements as described in the 837P Companion Guides, Encounter Submission Guidelines, MT88 MCO Companion Guide, or comparable format as determined by HHSC. HHSC will specify the method of transmission. The MCO must submit to HHSC Encounter Data and Encounter Data adjustments processed by the MCO. Encounter

Data quality validation must incorporate assessment standards developed jointly by the MCO and HHSC. The MCO must submit complete and accurate Encounter Data no later than the 30th Day after the last Day of the month in which each claim was Adjudicated. The MCO must make original records available to HHSC upon request. Encounter Data that does not meet quality standards must be corrected and returned within a time period specified by HHSC.

For reporting claims processed by the MCO and submitted on the prescribed Encounter 837P format or comparable format as determined by HHSC, the MCO must use the HCPCS, provider identifiers, and other codes as directed by HHSC. Any exceptions will be considered on a case-by-case basis after HHSC receives written notice from the MCO requesting an exception.

The MCO must:

1. Implement and maintain policies and procedures to support Encounter Data reporting and submission and provide copies for HHSC review prior to implementation of the NEMT Services carve-in;
2. Establish quality control procedures and edits to allow for the detection and correction of errors prior to submission of Encounter Data to HHSC or its designee;
3. Ensure the paid amount on Encounter Data is the amount paid to the provider of the NEMT Services;
4. Have a system in place for verifying and ensuring that only approved NEMT Services are rendered and, as applicable, paid to NEMT Services providers;
5. Review its quality control procedures at least on a quarterly basis to mitigate issues with the submission of Encounter Data; and
6. Have a computer processing and reporting system that is capable of following or tracing the Encounter record within its system using the unique authorization number assigned to each of the NEMT Services.

8.1.18.2 MCO Deliverables related to MIS Requirements

The MCO must submit the following documents and corresponding checklists for HHSC's review and approval:

1. Disaster Recovery Plan;*
2. Business Continuity Plan;* and
3. Security Plan.

* The Disaster Recovery Plan and the Business Continuity Plan may be combined into one document. The Disaster Recovery Plan must include an inclement weather plan to minimize any disruption to NEMT Services during weather that does not constitute a disaster but could impact travel.

Additionally, if the MCO modifies the following documents, it must submit the revised documents and corresponding checklists for HHSC's review and approval:

1. Joint Interface Plan;

2. Risk Management Plan; and
3. Systems Quality Assurance Plan.

The MCO must submit plans and checklists in accordance with UMCM Chapter 5 and UMCM Chapter 7 Additionally, if a Systems Readiness Review is triggered by one of the events described in **Section 8.1.18**, the MCO must submit all of the deliverables identified in this **Section 8.1.18.2** in accordance with an HHSC-approved timeline.

The MCO must follow all applicable Joint Interface Plans (JIPs) and all required file submissions for HHSC's Administrative Services Contractor, External Quality Review Organization (EQRO), and HHSC Medicaid Claims Administrator. The JIPs can be accessed through UMCM Chapter 7.

8.1.18.3 System-wide Functions

The MCO's MIS system must include key business processing functions and/or features, which must apply across all subsystems as follows:

1. process electronic data transmission or media to add, delete or modify membership records with accurate begin and end dates;
2. track Covered Services received by Members through the system, and accurately and fully maintain those Covered Services as HIPAA-compliant Encounter transactions;
3. transmit or transfer Encounter Data transactions on electronic media in the HIPAA format to the contractor designated by HHSC to receive the Encounter Data;
4. maintain a history of changes and adjustments and audit trails for current and retroactive data;
5. maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure;
6. employ industry standard medical billing taxonomies (procedure codes, diagnosis codes, NDC codes) to describe services delivered and Encounter transactions produced;
7. accommodate the coordination of benefits;
8. produce standard Explanation of Benefits (EOBs) for providers;
9. Pay financial transactions to Network Providers and Out-of-Network providers in compliance with federal and state laws, rules and regulations;
10. ensure that all financial transactions are auditable according to GAAP guidelines;
11. ensure that Financial Statistical Reports (FSRs) comply with UMCM Chapter 6 with respect to segregating costs that are allowable for inclusion in HHSC-designed financial reports;
12. relate and extract data elements to produce report formats (provided within the UMCM) or otherwise required by HHSC;
13. ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS; and
14. maintain and cross-reference all Member-related information with the most current Medicaid, or CHIP-Program Provider number.

8.1.18.4 Health Insurance Portability and Accountability Act (HIPAA) Compliance

The MCO's MIS system must comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, P.L. 104-191 (August 21, 1996), as amended or modified. The MCO must comply with HIPAA Electronic Data Interchange (EDI) requirements, including the HIPAA-compliant format version. MCO's enrollment files must be in the 834 HIPAA-compliant format. Eligibility inquiries must be in the 270/271 HIPAA-compliant format, with the exception of pharmacy services. Pharmacies may submit eligibility inquiries in the NCPDP E1 HIPAA-compliant format. Claim transactions for pharmacy services must be in the NCPDP B1/B2 HIPAA-compliant formats; all others must be in the 837/835 HIPAA-compliant format.

The MCO must also be 5010 compliant by January 2012. The following website includes the final rules for 5010 Compliancy and ICD-10 Compliancy, which is located on the CMS website under Medicare and Coding.

The MCO must provide its Members with a privacy notice as required by HIPAA, including 45 C.F.R. § 164.520. The MCO must provide HHSC with a copy of its privacy notice during Readiness Review and any changes to the notice prior to distribution.

8.1.18.5 Claims Processing Requirements

The MCO must process and adjudicate all provider claims for Medically Necessary health care Covered Services that are filed within the timeframes specified in UMCM Chapter 2, pharmacy claims that are filed in accordance with the timeframes specified in UMCM Chapter 2, and Nursing Facility claims that are filed in accordance with the timeframes specified in UMCM Chapter 2. The MCO is subject to contractual remedies, including liquidated damages and interest, if the MCO does not process and adjudicate claims in accordance with the procedures and the timeframes listed in UMCM Chapter 2.

The MCO must administer an effective, accurate, and efficient claims payment process in compliance with federal laws and regulations, applicable state laws and rules, and the Contract, including UMCM Chapter 2. In addition, a Medicaid MCO must process and pay Medicaid provider claims in accordance with the benefit limits and exclusions as listed in the **Texas Medicaid Provider Procedures Manual**. The MCO and its Subcontractors cannot directly or indirectly charge or hold a Member or Provider responsible for claims adjudication or transaction fees.

The MCO must maintain an automated claims processing system that registers the date a claim is received by the MCO the detail of each claim transaction (or action) at the time the transaction occurs, and has the capability to report each claim transaction by date and type to include interest payments. The claims system must maintain information at the claim and line detail level. The claims system must maintain adequate audit trails and report accurate claims performance measures to HHSC.

The MCO's claims system must maintain online and archived files. The MCO must keep online automated claims payment history for the most current 18 months. STAR+PLUS

MCOs must keep online automated Nursing Facility claims payment history for the most current 24 months. The MCO must retain other financial information and records, including all original claims forms, for the time period established in **Attachment A**, "Uniform Managed Care Contract Terms and Conditions," Section 9.01, “Record Retention and Audit.” All claims data must be easily sorted and produced in formats as requested by HHSC.

The MCO must offer its Providers/Subcontractors the option of submitting and receiving claims information through electronic data interchange (EDI) that allows for automated processing and adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. Electronic claims must use HIPAA-compliant electronic formats.

The MCO may not require a physician or provider to submit documentation that conflicts with the requirements of 28 Tex. Admin. Code, Chapter 21, Subchapters C and T.

HHSC reserves the right to require the MCO to receive initial electronic claims through an HHSC-contracted vendor at a future date. This function will allow Providers to send claims to one location, which will then identify where the claim should be submitted. The MCO will be expected to have an interface that allows receipt of these electronic submissions. If HHSC implements this requirement, then the MCO must maintain a mechanism to receive claims in addition to the HHSC claims portal. Providers must be able to send claims directly to the MCO or its Subcontractor.

The MCO must provide a Provider portal that supports functionality to reduce administrative burden on Network Providers at no cost to the Providers. If an MCO and its Subcontractor or subsidiary maintains separate Provider portals for physical health and Behavioral Health Services Network Providers, the MCO must comply with the requirements in Chapter 16 of the UMCM. The Provider portal functionality must include the following:

- Client eligibility verification
- Submission of electronic claims
- Prior Authorization requests
- Claims appeals and reconsiderations
- Exchange of clinical data and other documentation necessary for prior authorization and claim processing

The Member eligibility verification information in STAR+PLUS MCO portals available to Nursing Facility Providers must, at a minimum, include data elements related to service authorization, RUG levels and applied income for current Members at the time the data elements are received by the MCO. STAR+PLUS MCOs must upload this Member eligibility verification data into their Provider Portals within 48 hours of receiving the file from HHSC. STAR+PLUS MCOs portals available to Nursing Facility Providers must keep online automated data for the most current 24 months.

To the extent possible, the provider portal should support both online and batch processing as applicable to the information being exchanged. To facilitate the exchange

of clinical data and other relevant documentation, the Provider Portal must provide a secure exchange of information between the Provider and MCO, including, as applicable, a Subcontractor of the MCO.

The MCO must make an electronic funds transfer (EFT) payment process for direct deposit available to Network Providers.

The MCO may deny a claim submitted by a provider for failure to file in a timely manner as provided for in UMCM Chapter 2. The MCO must withhold all or part of payment for any claim submitted by a provider:

(1) excluded or suspended from the Medicare, Medicaid, or CHIP programs for Fraud, Waste, or Abuse;
(2) on payment hold under the authority of HHSC or its authorized agent(s);
(3) with debts, settlements, or pending payments due to HHSC, or the state or federal government;
(4) for neonatal services provided on or after September 1, 2017, if submitted by a Hospital that does not have a neonatal level of care designation from HHSC;
(5) for maternal services provided on or after September 1, 2021, if submitted by a Hospital that does not have a maternal level of care designation from HHSC;
(6) if the provider's claim for Nursing Facility Unit Rates does not comply with UMCM Chapter 2.3 criteria for processing Clean Claims.

In accordance with Texas Health and Safety Code § 241.186, the restrictions on payment identified in items 4–5 above do not apply to emergency services that must be provided or reimbursed under state or federal law.

With the following exceptions, the MCO must complete all audits of a provider claim no later than two years after receipt of a clean claim, regardless of whether the provider participates in the MCO's Network. This limitation does not apply in cases of provider Fraud, Waste, or Abuse that the MCO did not discover within the two-year period following receipt of a claim. In addition, the two-year limitation does not apply when the officials or entities identified in Attachment A, Section 9.02(c), conclude an examination, audit, or inspection of a provider more than two years after the MCO received the claim. Finally, the two-year limitation does not apply when HHSC has recovered a capitation from the MCO based on a Member's ineligibility. If an exception to the two-year limitation applies, then the MCO may recoup related payments from providers.

If an additional payment is due to a provider as a result of an audit, the MCO must make the payment no later than 30 Days after it completes the audit. If the audit indicates that the MCO is due a refund from the provider, the MCO must send the provider written notice of the basis and specific reasons for the recovery no later than 30 Days after it completes the audit. If the provider disagrees with the MCO's request, the MCO must give the provider an opportunity to appeal and may not attempt to recover the payment until the provider has exhausted all appeal rights.

The MCO's Provider Contract must specify that program violations arising out of performance of the contract are subject to administrative enforcement by the Health and

Human Services Commission Office of Inspector General (HHSC OIG) as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G.

The MCO must obtain recovery of payment from a liable third party and not from the provider, unless the provider received payment from both the MCO and the liable third party. The MCO must notify HHSC of major claim system changes in writing no later than 180 Days prior to implementation. The MCO must provide an implementation plan and schedule of proposed changes. HHSC reserves the right to require a desk or onsite Readiness Review of the changes.

The MCO must make any policies affecting claims adjudication and claims coding and processing guidelines available to Providers for the applicable provider type. Providers must receive 90 Days' notice prior to the MCO's implementation of changes to these claims policies and guidelines.

8.1.18.5.1 Claims Project

For purposes of this section, claims project (Project) means a project initiated by an MCO outside of the Provider appeal process after payment or denial of claim(s) for the purpose of conducting any necessary research on the claim(s) or to adjust the claim(s), if appropriate, excluding Nursing Facility Daily/Unit rate claims.

MCO may initiate a Project at its own initiative. All claims included in a particular Project must be finalized within 60 Days of the Project being opened or within an agreed upon timeframe between the Provider and the MCO. If the MCO is unable to complete the Project within 60 Days, the MCO must enter a written agreement with the Provider before the expiration of the initial 60 Day period to establish the Project's agreed upon time frame. MCO must maintain the agreement for 18 months from the conclusion of the Project and make the agreement available to HHSC upon request. MCOs shall not include Nursing Facility Daily/Unit rate claims as part of a Project.

MCO will report monthly to HHSC the start and end date for all Projects using HHSC's report template. For Nursing Facility Daily/Unit rate claims, please see UMCM chapter 8.

8.1.18.6 National Correct Coding Initiative

MCOs must comply with the requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

8.1.19 Fraud, Waste, and Abuse

An MCO is subject to all state and federal laws and regulations relating to Fraud, Waste, and Abuse (FWA) in health care and the Medicaid and CHIP programs. The MCO must cooperate and assist the HHSC Office of Inspector General (HHSC OIG) and any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected FWA.

1. The MCO is subject to and must meet all requirements in Texas Government Code §§ 531.113, 531.1131, and 533.012, 1 Tex. Admin. Code §§ 353.501-353.505, and 1 Tex. Admin. Code §§ 370.501-370.505 as well as all laws specified in the Contract.
2. The MCO must submit a written Fraud, Waste, and Abuse compliance plan to HHSC OIG for approval each year per 1 Tex. Admin. Code § 353.502. The plan must be submitted 90 Days prior to the start of the State Fiscal Year. See Section 7, "Transition Phase Requirements" for requirements regarding timeframes for submitting the original plan.
3. The MCO must require all employees who process Medicaid claims, including Subcontractors, to attend annual training as provided by HHSC per Texas Government Code § 531.105.
4. The MCO must perform pre-payment review for identified providers as directed by HHSC OIG.
5. When requested by the HHSC OIG, the MCO will be required to provide employees to participate in administrative proceedings pursued by the HHSC OIG. Such employees must be knowledgeable about the subject matter on which they called to testify and must be available for preparatory activities and for formal testimony. The MCO must provide the employees at no cost to the State and the HHSC OIG.
6. For the purposes of Nursing Facility and Hospital Utilization Reviews, Section 8.1.19(4) also applies to HHSC requests.
7. With regard to NEMT Services, when monitoring for FWA, the MCO must consider whether appropriate medical documentation supports use of:
    a. other demand response transportation services in areas where public transportation services are an available option; and
    b. transportation to obtain care outside of the Member's Service Area.
8. Failure to comply with any requirement of Sections 8.1.19 and 8.1.20.2(c) and (d) may subject the MCO to liquidated damages and/or administrative enforcement pursuant to 1 Tex. Admin. Code Chapter 371 Subchapter G, in addition to any other legal remedy.

8.1.19.1 Special Investigative Units

In order to facilitate cooperation with HHSC OIG, the MCO must establish and maintain a special investigative unit (SIU), either in-house or by contract with another entity, to investigate possible acts of Fraud, Waste, or Abuse for all services provided under the Contract, including those that the MCO subcontracts to outside entities.

1. The MCO's SIU does not have to be physically located in Texas but must be adequately staffed to handle Texas volume. The SIU must have adequate staff and resources apportioned at the levels and experience sufficient to effectively work Texas cases based on objective criteria considering, but not necessarily limited to, the MCO's total Member population, claims processes, risk exposure, current caseload, and other duties as described in 1 Tex. Admin. Code §§ 353.501-353.505, and 1 Tex. Admin. Code §§ 370.501-370.505.

2. The MCO must maintain a full-time SIU manager dedicated solely to the Texas Medicaid and CHIP programs to direct oversight of the SIU and Fraud, Waste, and Abuse activities.
3. The MCO SIU must employ or subcontract, at minimum, one full-time investigator, in addition to the SIU manager, who is dedicated solely to the services provided under the Texas Medicaid and CHIP contracts. The investigator must hold credentials such as certification from the Association of Certified Fraud Examiners, an accreditation from the National Health Care Anti-Fraud Association or have a minimum of three years Medicaid or CHIP Fraud, Waste, and Abuse investigatory experience.

8.1.19.2 General requests for and access to data, records, and other information

The MCO and its subcontractors must allow access to all premises and provide complete and unredacted originals or copies of all records and information requested free of charge to the HHSC OIG, HHSC or its authorized agent(s), the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services (DHHS), Federal Bureau of Investigation, the Office of the Attorney General, the Texas Department of Insurance (TDI), or other units of state government.

1. Each MCO must designate one primary and one secondary contact person for all HHSC OIG records requests. Each MCO must also identify a central group email inbox that will receive all HHSC OIG records requests. HHSC OIG records requests will be sent to the central group email inbox and also may be sent to the designated MCO contact person(s) in writing by e-mail, fax, or mail, and will provide the specifics of the information being requested (see below).
2. The MCO must respond to the appropriate HHSC OIG staff member within the timeframe designated in the request. If the MCO is unable to provide all of the requested information within the designated timeframe, the MCO may request an extension in writing (e-mail) to the HHSC OIG requestor no less than two Business Days prior to the due date.
3. The MCO's response must include complete, unredacted, and accurate data for all data fields, as available. The data must be provided in the order and format requested. If any data field is left blank, an explanation must accompany the response. The MCO must not add or delete any additional data fields in its response. All requested information must be accompanied by a notarized Business Records Affidavit unless indicated otherwise in HHSC OIG's record request.
4. The MCO must retain records in accordance with UMCM Chapter 18.

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

- 1099 data and other financial information – three Business Days.
- Claims data for sampling and recipient investigations – ten Business Days.
- Urgent claims data requests – three Business Days (with HHSC OIG manager's approval).
- Provider education information – ten Business Days.

- Files associated with an investigation conducted by an MCO – 15 Business Days.
- Provider profile, UR summary reports, and associated provider education activities and outcomes – as indicated in the request.
- Member and/or pharmacy data as required by HHSC OIG.
- Requests submitted to the MCO/Dental Contractor for interpretations or clarifications of the MCO/Dental Contractor policy and procedure – five Business Days.
- The basis for providing specific authorized services, including case-by-case services, value-added services, and Comprehensive Care Program (CCP) services provided through Texas Health Steps – as needed.
- Other time-sensitive requests – as needed.

8.1.19.3 Claims Data Submission Requirements

The MCO and its subcontractors must submit Adjudicated Claims data per the frequency and scope prescribed by the HHSC OIG. This data must include submission of complete, unredacted, and accurate data for all fields required on standard billing forms or electronic claim formats. In the event that the MCO denies provider claims, either as Adjudicated-Denied Claims or Deficient-Denied Claims, the MCO must submit all available claims data, for such denied claims, to the HHSC OIG without alteration or omission. The MCO and its subcontractors shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with HHSC OIG data quality standards and requirements as originally defined or subsequently amended.

1. The MCO and its subcontractors must submit complete, unredacted, and accurate Adjudicated Claims data per the frequency and scope prescribed by the HHSC OIG. This data must include submission of complete, unredacted, and accurate data for all fields required on standard billing forms or electronic claim formats. In the event that the MCO denies provider claims, either as Adjudicated-Denied Claims or Deficient-Denied Claims, the MCO must submit all available claims data, for such denied claims, to the HHSC OIG without alteration or omission. The MCO and its subcontractors shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with HHSC OIG data quality standards and requirements as originally defined or subsequently amended.
2. The MCO and its subcontractors shall comply with industry-accepted clean claim standards for all data submissions to HHSC OIG, including submission of complete, unredacted, and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of all paid and denied claims. In the event that the MCO or its subcontractors denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the MCO and its subcontractors are required to submit all available claims data, for such denied claims, to HHSC OIG without alteration or omission.
3. The MCO and its subcontractors shall submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by HHSC OIG, in order to support comprehensive financial reporting, utilization analysis and investigative efforts.
4. The MCO and its subcontractors shall submit complete, unredacted, and accurate processed claims data according to standards and formats as defined by HHSC OIG,

complying with standard code sets and maintaining integrity with all reference data sources including provider and Member data. All data submissions by the MCO and its subcontractors will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing.

5. Any batch submission from an MCO or its subcontractors which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the MCO and its subcontractors for immediate correction. Re-submittals of rejected files, or notification of when the file will be resubmitted shall be completed within five Business Days. Due to the need for timely data and to maintain integrity of processing sequence, should the MCO or its subcontractors fail to respond in accordance with this Section, the MCO and its subcontractors shall address any issues that prevent processing of a claims batch in accordance with procedures specified and defined by HHSC OIG.
6. The MCO and its subcontractors shall supply Electronic Funds Transfer (EFT) account numbers on a monthly basis in a format defined by HHSC OIG for all Medicaid providers who have elected to receive payments via EFT and who are participating in their plans.
7. Failure by the MCO or its subcontractor to submit complete, unredacted, and accurate data as described in this section may result in administrative enforcement by HHSC OIG as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G or liquidated damages as specified in Attachment B-3.

8.1.19.4 Payment Holds and Settlements

1. 42 C.F.R. § 455.23 requires the State Medicaid agency to suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of Fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or suspend payment only in part. The rules governing payment suspensions based upon pending investigations of credible allegations of Fraud apply to Medicaid managed care entities. Managed care capitation payments may be included in a suspension when an individual Network Provider is under investigation based upon credible allegations of Fraud, depending on the allegations at issue.
2. The MCO must cooperate with HHSC OIG when HHSC OIG imposes payment suspensions or lifts a payment hold. When HHSC OIG sends notice that payments to a Provider have been suspended, the MCO must also suspend payments to the Provider within one Business Day. When notice of a payment hold or a payment hold lift is received, the MCO must respond to the notice within three Business Days and inform HHSC OIG of action taken.
3. The MCO must also report all of the following information to HHSC OIG after it suspends payments to the Provider: date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, outcome of any appeals, amount of adjudicated Medicaid payments held, and, if applicable, the good cause rationale for not suspending payment (for example, the Provider is not enrolled in the MCO's network) or imposing a partial payment suspension. If the MCO does not suspend payments to the Provider, or if the MCO does not correctly report the amount of adjudicated payments on hold, HHSC may impose contractual

or other remedies. The MCO must report the fully adjudicated hold amount on the monthly open case list report required by UMCM Chapter 5 and provide this information to HHSC OIG upon request.

4. The MCO must follow the requirements set forth in a settlement agreement involving a MCO's Provider and HHSC OIG. The MCO must withhold the designated percentage of funds to be paid toward an identified overpayment. Upon HHSC OIG request, the MCO must forward the held funds to HHSC OIG, Attn: Senior Case Analyst, along with an itemized spreadsheet detailing the Provider's claims paid so that the claims data can be reconciled with the monthly Remittance & Status statements.
5. For payment suspensions initiated by the MCO, the MCO must report the following information to HHSC OIG: the nature of the suspected fraud, basis for the suspension, date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, outcome of any appeals, the amount of payments held, the percentage of the hold, and, if applicable, the good cause rationale for imposing a partial payment suspension.
6. MCOs must maintain all documents and claim data on Providers who are under HHSC OIG investigation or any internal investigations that are referred to HHSC OIG for recoupment. The MCO's failure to comply with this **Section 8.1.19** and all state and federal laws and regulations relating to Fraud, Waste, and Abuse in healthcare and the Medicaid and CHIP programs are subject to administrative enforcement by HHSC OIG as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G.

8.1.19.5 Treatment of Recoveries by the MCO for Fraud, Waste and Abuse

Pursuant to 42 C.F.R. § 438.608(d)(1)(i), the MCO must comply with all state and federal laws pertaining to provider recoveries including Texas Government Code § 531.1131 and 1 Tex. Admin. Code Part 15 353.1454.

The MCO must have internal policies and procedures for the documentation, retention, and recovery of all overpayments, specifically for the recovery of overpayments due to Fraud, Waste, and Abuse.

1. In cases identified by the HHSC OIG, the HHSC OIG has the right to recover any identified overpayment directly from the provider or to require the MCO to recover the identified overpayment and distribute funds to the State.
2. The MCO will have no claim to any funds that are recovered by the State of Texas or the United States Government from a provider through an action under the Federal False Claims Act, Texas Medicaid Fraud Prevention Act, or similar laws. The recovery of an overpayment by an MCO from a provider does not preclude the prosecution of nor recovery from a provider under the Federal False Claims Act, Texas Medicaid Fraud Prevention Act, or similar laws.
3. Upon discovery of Fraud, Waste, or Abuse the MCO shall:
    a. Submit a referral using the fraud referral form through the Waste, Abuse, and Fraud Electronic Reporting System (WAFERS); and
    b. Proceed with recovery efforts per 1 Tex. Admin. Code § 353.505.
4. The MCO may retain recovery amounts pursuant to Texas Government Code § 531.1131(c) and (c-1).

5. Pursuant to Texas Government Code § 531.1131(c-3), the MCO is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services, or claims upon which the recoupment or withhold are based meet one or more of the following criteria:
    a. Upon written notice from HHSC OIG that it has begun recovery efforts, the MCO is prohibited from taking any actions to recoup or withhold improperly paid funds.
        i. The prohibition described in this subsection shall be limited to a specific provider(s), for specific dates, and for specific issues, services, or claims. The MCO must not engage in any reprocessing, recoupments, and other payment recovery efforts or claims adjustments of any kind based on the parameters set by HHSC OIG.
        ii. The prohibition does not impact any current MCO contractual obligations as well as any reprocessing, recoupment, other payment recovery efforts or claims adjustments for claims that fall outside those identified in the written notice from HHSC OIG.
    b. The improperly paid funds have already been recovered by HHSC OIG.
6. The MCO must report at least annually, or at the request of the HHSC OIG, to the status of their recoveries of overpayments, in the manner specified by the HHSC OIG.

8.1.19.6 Additional Requirements for STAR and STAR+PLUS MCOs:

In accordance with Section 1902(a)(68) of the Social Security Act, STAR and STAR+PLUS MCOs and their Subcontractors that receive or make annual Medicaid payments of at least $5 million must:

1. Establish written policies for all employees, managers, officers, contractors, Subcontractors, and agents of the MCO or Subcontractor. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
2. Include as part of such written policies detailed provisions regarding the MCO's or Subcontractor's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.
3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the MCO's or Subcontractor's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

8.1.19.7 Lock-in Actions

HHSC OIG's Lock-in Program (OIG-LP) restricts, or locks in, a Medicaid Member to a designated Provider or pharmacy if it finds that the Member used Medicaid services, including drugs, at a frequency or amount that is duplicative, excessive, contraindicated, or conflicting; or that the Member's actions indicate abuse, misuse, or Fraud.

The MCO is required to maintain written policies for all employees, managers, officers, contractors, subcontractors, and agents of the MCO or Subcontractor. The policies must provide detailed information related to the "HHSC OIG Lock-in Program MCO Policies and Procedures," including how NEMT Services are delivered to Members subject to the OIG-LP. MCOs must submit documentation on an annual basis demonstrating how the MCO complies with "HHSC OIG Lock-In Program Policies and Procedure" requirements. The MCO must submit the information 90 Days prior to the start of the State Fiscal Year in conjunction with the Fraud, Waste, and Abuse compliance plan.

8.1.20 General Reporting Requirements

The MCO must provide and must require its Subcontractors to provide at no cost to the Texas Health and Human Services Commission (HHSC):

1. all information required under the Contract, including but not limited to, the reporting requirements or other information related to the performance of its responsibilities hereunder as reasonably requested by the HHSC;
2. any information in its possession sufficient to permit HHSC to comply with the Federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats and instructions as specified by HHSC. Where practicable, HHSC may consult with MCOs to establish timeframes and formats reasonably acceptable to both parties; and
3. Ad hoc reports as requested by HHSC.

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

Any Deliverable or report not listed in UMCM Chapter 5 but referenced in **Section 8.1.20** without a specified due date is due quarterly on the last Day of the month following the end of the reporting period. Where the due date states 30 Days, the MCO is to provide the deliverable by the last Day of the month following the end of the reporting period. Where the due date states 45 Days, the MCO is to provide the deliverable by the 15th Day of the second month following the end of the reporting period. See UMCM Chapter 5.

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

Pursuant to CFR §438.606 and UMCM Chapter 5, Data Certification Instructions, the MCO's chief executive officer (CEO); chief financial officer (CFO); or an individual who reports directly to those positions with delegated authority to sign for them so that the CEO or CFO is ultimately responsible for the certification, must certify that the financial data, Encounter Data, and other data as specified by CFR §438.604, has been reviewed and is true and accurate to the best of the certifying person's knowledge. Such certification may not be delegated.

8.1.20.1 Performance Measurement

The MCO must provide to HHSC or its designee all information necessary to analyze the MCO's provision of quality care to Members using measures to be determined by HHSC in consultation with the MCO.

8.1.20.2 Reports

The MCO must provide the following reports, in addition to the Financial Reports described in **Section 8.1.17** and the reporting requirements listed elsewhere in the Contract. UMCM Chapter 5 includes a list of all required reports, and a description of the format, content, file layout and submission deadlines for each report.

For the following reports, MCO must integrate CHIP Perinatal Program data into CHIP Program reports. With the exception of FSR reporting, separate CHIP Perinatal Program reports generally are not required. Where appropriate, HHSC will designate specific attributes within the CHIP Program reports that the CHIP MCOs must complete to allow HHSC to extract data particular to the CHIP Perinatal population.

(a) **Claims Summary Report** – The MCO must submit one Claims Summary Report each month by Program to HHSC using the text file layout located in UMCM Chapter 5.

(b) **QAPI Program Annual Summary Report** – The MCO must submit a QAPI Program Annual Summary in a format and timeframe as specified in UMCM Chapter 5.

(c) **Fraudulent Practices** Referral – Utilizing the HHSC-Office of Inspector General (HHSC OIG) fraud referral form through the Waste, Abuse, and Fraud Electronic Reporting System (WAFERS), the MCO's assigned officer or director must report and refer all possible acts of Fraud, Waste, or Abuse to the HHSC OIG within 30 Business Days of receiving the reports of possible acts of Fraud, Waste, or Abuse from the MCO's Special Investigative Unit (SIU). This requirement applies to all referrals of possible acts of Fraud, Waste, or Abuse. Additional guidance is provided in UMCM Chapter 5.

Additional reports required by the Office of the Inspector General relating to Fraud, Waste, and Abuse are listed in UMCM Chapter 5.

(d) **Provider Termination Report:** The MCO must submit one Provider Termination Report each quarter by Program that identifies all Network Providers and NEMT Services providers who cease to participate in the MCO's Provider Network or transportation network, either voluntarily or involuntarily. The text file layout located in UMCM Chapter 5 must be submitted no later than 30 Days after the end of the reporting quarter.

(e) **Network & Capacity Report:** Each STAR and CHIP MCO must submit a quarterly report that includes all mail order pharmacies and 24-hour pharmacies in their Provider Networks. Each STAR+PLUS MCO must submit a quarterly report that includes all LTSS Providers, mail order pharmacies, and 24-hour pharmacies in its Provider Network. The report must be submitted using the text file layout located in UMCM Chapter 5 no later than 30 Days after the end of the reporting quarter.

(f) **Provider Complaints, Member Complaints, and Member Appeals** – The MCO must submit monthly Complaints and Member Appeals reports by Program. The MCO must include in its reports Complaints, including Initial Contact Complaints, and Appeals submitted to the MCO and/or any Subcontractor delegated to provide a service for the MCO. All Member or Provider complaints, including NEMT Services complaints, submitted orally or in writing (e.g. via email, call, letter, etc.) to the MCO and/or its Subcontractor must be included within the MCO's Complaint reports. An Inquiry must not be counted as a Complaint on the MCO's Complaint reports. The MCO Member Appeal report must include all appeals received prior to and during the month, appeals resolved during the month, and pending appeals. The MCO must submit its Member and Provider complaints and its Member appeals using the text file layouts in UMCM Chapter 5. The MCO must ensure that as many pending complaints and appeals as possible are resolved prior to submitting the reports.

(g) **Hotline Reports** – The MCO must submit a MCO Hotlines Report each month per Program and hotline type that includes the Member Services Hotline, the Behavioral Health Services Hotline, the Provider Hotline, the NEMT Services call center if the MCO operates a separate call center for this purpose, and Nurseline where applicable to measure the MCO's compliance in accordance with performance standards set out in **Sections 8.1.4.7** Provider Hotline, **8.1.5.6** Member Hotline, **8.1.15.3** Behavioral Health Services Hotline, using the text file layout located in UMCM Chapter 5. If the MCO does not use a separate call center for NEMT Services, NEMT data must be detailed in the Member Hotline monthly status report. NEMT Services call center data must also be reported with the "Where's My Ride" line data broken out.

If the MCO is not meeting a hotline performance standard, HHSC may require the MCO to implement corrective actions until the hotline performance standards are met.

(h) **Historically Underutilized Business (HUB) Reports** – Upon contract award, the MCO must attend a post award meeting, which will be scheduled by the HHSC HUB Program Office, to discuss the development and submission of a HUB Subcontracting Plan (HSP) Progress Assessment Report (PAR) for the inclusion of HUBs. The MCO must maintain its original HSP and submit monthly PAR reports documenting the MCO's good faith effort to comply with the originally submitted HSP. The report must be in the format included in UMCM Chapter 5 for the HUB monthly reports. The MCO must comply with the HUB Program's HSP and PAR requirements for all Subcontractors.

(i) **Medicaid Managed Care Texas Health Steps Medical Checkups Reports** – Medicaid MCOs must submit reports identifying the number of New Members and Existing Members receiving Texas Health Steps medical checkups or refusing to obtain the medical checkups. Medicaid MCOs must also document and report those Members refusing to obtain the medical checkups. The documentation must include the reason the Member refused the checkup or the reason the checkup was not received.

The definitions, timeframe, format, and details of the reports are contained and described in UMCM Chapter 12.

(j) **Migrant Farmworker Child(ren) Annual Report (FWC Annual Report) – and FWC Report Log - STAR** MCOs must submit an annual report and log, in the timeframe and format described in UMCM Chapter 12.

(k) **Frew Quarterly Monitoring Report** – Each calendar year quarter, HHSC prepares a report for the court that addresses the status of the Consent Decree paragraphs of the *Frew v. Smith* lawsuit. Medicaid MCOs must prepare responses to questions posed by HHSC on the Frew Quarterly Monitoring Report template. The timeframe, format, and details of the report are set forth in UMCM Chapter 12.

(l) **Out-of-Network (OON) Utilization Reports** – The OON Utilization Report will provide an overview of each MCO's out-of-network claims. The MCO must file quarterly OON Utilization Reports in the format and timeframe specified in UMCM Chapter 5.

(m) **Drug Utilization Review (DUR) Reports** – MCOs must submit the DUR reports in accordance with the requirements of HHSC's UMCM.

(n) **STAR+PLUS Long Term Services and Supports (LTSS) Utilization Quarterly Reports** – The STAR+PLUS MCO must file quarterly LTSS Utilization Reports in accordance with UMCM Chapter 5. Quarterly reports are due 30 Days after the end of each quarter.

(o) **Perinatal Risk Reports—**The MCO must submit a quarterly perinatal risk report as described in UMCM Chapter 5. Quarterly reports are due 30 Days after the end of each quarter.

(p) **Long-Term Services and Supports Report –** Beginning in CY 2015, the STAR+PLUS MCO must file quarterly Long-Term Services and Supports Reports including the data specified in UMCM Chapter 10. Quarterly reports are due 30 Days after the end of each quarter.

(q) **MCO Pharmacy Quarterly Report** – MCOs must complete and submit a MCO Pharmacy Quarterly Report for each Program using the HHSC-provided template in UMCM Chapter 5. Reports must be submitted for each MCO and cannot be grouped by the Pharmacy Benefit Manager (PBM).

(r) **Critical Incidents and Abuse, Neglect and Exploitation (ANE) Report** – Medicaid MCOs must submit a quarterly report that includes the number of Critical Incidents unrelated to ANE identified by the MCO or reported by Network Providers and ANE reports received from Adult Protective Services (APS) for Members receiving LTSS.

Upon written notification from HHSC, MCOs for STAR+PLUS HCBS must use the CIMS in lieu of the Critical Incidents and ANE Report.

(s) ~~**MSHCN Quarterly**~~**Service Coordination Report** – ~~STAR and CHIP~~The MCO~~s~~ must complete and submit a ~~quarterly~~ monthly report on MSHCN Service Coordination in the format and timeframe as described in UMCM Chapter 5. ~~Quarterly Reports are due 30 Days after the end of each quarter.~~

(t) **24-7 PCP Access Report** - STAR and STAR+PLUS MCOs must complete and submit an annual report as described in the UMCM Chapter 5 to assess compliance with ensuring access to providers 24 hours a Day and 7 Days a week (24-7). MCO Annual reports are due the 2nd Friday in December.

(u) **Individual Service Plan (ISP) Data** - STAR+PLUS MCOs must complete and submit a report summarizing ISP data for specific data elements using the template provided by the EQRO, upon request.

(v) **Value added Services (VAS) Utilization Report** - The MCO must submit a report of Member utilization of its value added services. The report must be submitted to HHSC using the VAS Utilization Report template in UMCM Chapter 4 and according to the timeframes identified in the UMCM Chapter 5.

(w) **TPR Report for Pharmacy TPL** – MCOs must complete and submit a TPR Report for Pharmacy TPL for each Program using the HHS-provided template in UMCM Chapter 5. Reports must be submitted for each MCO and cannot be grouped by the Pharmacy Benefit Manager (PBM).

(x) **STAR+PLUS HCBS Data Report**
For Members in STAR+PLUS HCBS waiver program, the MCOs must, through self-reported data, report on CMS assurances listed below in numbers 1-6. UMCM 5.7.5, Reports section outlines specific measures to be reported.

1. The MCO must demonstrate that it has designed and implemented an adequate system for assuring that all STAR+PLUS HCBS waiver services are provided by qualified providers.
2. The MCO verifies that providers initially and continually meet required licensure /certification standards.
3. The MCO monitors non-certified providers to assure adherence to STAR+PLUS waiver requirements.
4. The MCO must verify that their providers complete training in accordance with the STAR+PLUS HCBS program.
5. The STAR+PLUS HCBS services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.
6. The MCO must demonstrate it has designed and implemented an effective system for assuring STAR+PLUS HCBS participants' health and welfare including identifying, addressing and seeking to prevent instances of abuse, neglect and exploitation and unexplained deaths; that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible; and that policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

8.1.21 Pharmacy Services

The MCO must provide pharmacy-dispensed prescriptions as a Covered Service. The MCO must ensure that such coverage meets the standards provided for by 42 U.S.C. § 1396r-8, as applied to Medicaid managed care in accordance with 42 C.F.R. § 438.3(s). The MCO must submit pharmacy clinical guidelines and prior authorization policies for review and approval during Readiness Review, then after the Operational Start Date prior to any changes. In determining whether to approve these materials, HHSC will review factors such as the clinical efficacy and Members' needs.

The MCO must allow pharmacies to fill prescriptions for covered drugs ordered by any licensed provider regardless of Network participation. The MCO must ensure through its Provider Contract that a pharmacy only fills prescriptions for covered drugs that have been prescribed by a prescribing provider who is licensed to prescribe.

The MCO is responsible for negotiating reasonable pharmacy provider reimbursement rates. The MCO must ensure reasonable pharmacy provider reimbursement rates include a dispensing fee, administration fees (when applicable), and ingredient costs. The MCO must ensure that, as an aggregate, rates comply with 42 C.F.R. Part 50, Subpart E, regarding upper payment limits.

The MCO and its Subcontractor must disclose to HHSC the reimbursement rates and payment methodology used to develop the rates specific to the pharmacy provider during the contract negotiation between the PBM and pharmacy provider. The MCO, or its Subcontractor, as applicable, must disclose to pharmacy providers the reimbursement rates and payment methodology used to develop the rates specific to the pharmacy provider during the contract negotiation between the PBM and pharmacy provider. The disclosure must be specific to Medicaid/CHIP and must not include rates or methodologies for the MCO's or its Subcontractor's other lines of business. The MCO and its Subcontractors must not prohibit pharmacy providers from disclosing any information regarding the pharmacy provider agreement to HHSC.

The MCO or its Subcontractors must provide HHSC with all provider processes and procedures in a separate Texas Medicaid section specific to Medicaid and CHIP only.

The MCO must comply with all applicable provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 for pharmacy services. The MCOs must demonstrate compliance for all covered outpatient drugs on the formulary, including those provided under a non-risk based payment mode or otherwise carved-out of managed care. The MCO must demonstrate compliance with any fee-for-service edits or other prescription drug limitations applicable to managed care organizations or related to the HHSC's preferred drug list and any other state-mandated prior authorization or clinical edit.

8.1.21.1 Formulary and Preferred Drug List

The MCO must provide access to covered outpatient drugs, biological products, certain limited home health supplies (LHHS), and vitamins and minerals through formularies and a preferred drug list (PDL) developed by HHSC. HHSC will maintain separate ~~Medicaid and CHIP~~ formularies~~,~~ and separate provisional formularies for Medicaid and CHIP, and a Medicaid PDL. The MCO must administer the PDL in a way that allows access to all non-preferred drugs that are on the formulary through a structured automated PA process.

The MCO must educate Network Providers about how to access HHSC's formularies, ~~and~~ the Medicaid PDL and VDP PDL Criteria Guide on HHSC's website. In addition, the MCO must allow Network Providers access to the formularies and Medicaid PDL through a free, point-of-care web-based application accessible on smart phones, tablets, or similar technology. The application must also identify HHSC's formularies,

preferred/non-preferred drugs, Clinical PAs, and any preferred drugs that can be substituted for non-preferred ~~drugs~~. The MCO must update this information at least weekly. The MCO must feature all HHSC's formularies on the MCO's website. The MCO must also inform Members that the formulariesy ~~is~~ are available in paper form without charge and provide ~~it~~ them upon request within five Business Days.

In accordance with Texas Insurance Code Chapter 1369, Subchapter J, the MCO must establish a process by which the MCO, the Member, the prescribing physician or health care provider, and a pharmacist may jointly approve a medication synchronization plan. A medication synchronization plan may be used only for prescribed drugs that treat chronic illnesses and that complies with Texas Insurance Code §1369.453. The eligibility of a Member's prescriptions for medication synchronization must be determined on a case-by-case basis, considering Member-specific needs as determined by the Member's physician or health-care provider.

The MCO must submit its proposed medication synchronization plan to HHSC for approval before the MCO may undertake any implementation activities. All MCO implementation activities must adhere to the approved medication synchronization plan.

The MCO may not pro-rate the dispensing fee associated with a prescription that is eligible for medication synchronization. The MCO must pro-rate any associated co-payment, although this section may not be read to authorize an MCO to charge a co-payment.

8.1.21.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies

The MCO must adopt prior authorization (PA) policies and procedures that are consistent with **Section 8.1.8.1**, "Compliance with State and Federal Prior Authorization Requirements."

HHSC will identify both "required" and "optional" Clinical PAs on the Vendor Drug Program website, or as required under the Contract. If the information about a Member's medical condition meets the Clinical PA criteria, the claim or PA request may be approved. If a Member's medical condition does not meet the Clinical PA criteria, the claim or PA request may be denied. The MCO is responsible for managing Clinical PA denials through its appeal process.

The MCO must also adhere to HHSC VDP's PDL for Medicaid drugs. Preferred drugs must adjudicate as payable without PDL PA, unless subject to Clinical PAs. If a requested drug is subject to more than one drug PA (e.g., the drug is both non-preferred and subject to one or more Clinical PAs), the MCO must process all edits concurrently and independently so that each drug PA (Clinical PA or PDL PA) is checked for approval.

Any proposed MCO clinical criteria not listed on the Vendor Drug Program Website described above as a required or optional Clinical PA or listed in the Contract must be submitted to HHSC for review and approval following the process outlined in UMCM

Chapter 3. The MCO may choose to implement additional Clinical PAs once the criteria are approved by the Drug Utilization Review (DUR) Board or by HHSC.

The MCO must submit new Clinical PA proposals to HHSC for DUR Board review and approval. The MCO may also submit any proposed revisions to existing Clinical PAs to HHSC for DUR Board review and approval. The MCO must submit all clinical PA proposals in compliance with the required information outlined in UMCM Chapter 3. HHSC will conduct preliminary review of these edit proposals and respond to the MCO before the next DUR Board meeting. If the MCO has clinical PAs that are identical to HHSC VDP's Clinical PAs, the MCO can reference VDP's Texas Medicaid formulary on Epocrates.

HHSC's Medicaid PDL PA, Clinical PA, and other drug policies for the Vendor Drug Program are available on HHSC's Vendor Drug Program website. HHSC's website also includes exception criteria for each drug class included on HHSC's Medicaid PDL. These exception criteria describe the circumstances under which a non-preferred drug may be dispensed without a PDL PA. If HHSC modifies the policies described above on the Vendor Drug Program website, HHSC will notify MCOs.

The MCO must provide access to a toll-free call center for prescribers to call to request drugs requiring prior authorization.

Medicaid MCOs may require a prescriber's office to request a PA as a condition of coverage or pharmacy payment if the PA request is approved or denied within 24 hours of receipt. If the prescriber's office calls the MCO's PA call center, the MCO must provide a PA approval or denial immediately. For all other PA requests, the MCO must notify the prescriber's office of a PA denial or approval no later than 24 hours after receipt.

CHIP MCOs must comply with the prior authorization requirements applicable to the CHIP program in Texas Insurance Code Chapter 4201 and peer-to-peer requirements as required in 28 TAC §19.1710 (unless the time period is inappropriate to the Member's circumstances and condition, in which case the MCO has one hour to respond).

The MCO must allow the pharmacy to dispense a 72-hour supply of the drug if the MCO is unable to provide a PA response within the required timeframe or the prescriber cannot make a PA request because it is after the prescriber's office hours and the dispensing pharmacist determines it is an emergency situation.

In this context, emergency situation includes a situation in which, based on the dispensing pharmacist's judgement, a Member may experience a detrimental change in his or her health status within 72 hours from when the pharmacy receives the prescription due to the inability to obtain the drug. The MCO's pharmacy website must provide information explaining how to obtain a 72 hour emergency supply of medication. The MCO must ensure through its Provider Contracts, Provider Contract oversight, and Provider education that pharmacies do not use 72 hour emergency supplies routinely and continuously. The MCO must reimburse the pharmacy for dispensing the temporary supply of medication.

The MCOs must have an automated process that may be used to assess a Member's medical and drug claim history to determine whether the Member's medical condition satisfies the applicable criteria for dispensing a drug without an additional prior authorization request. (See Texas Government Code § 531.073(h).) This process must automatically evaluate whether a submitted pharmacy claim meets Prior Authorization criteria for both PDL and Clinical PAs. (See UMCM, Chapter 2.2, Section V for the definition of an Automated Prior Authorization Request.) The MCO's PA system must accept PA requests from prescribers that are sent electronically, by phone, fax, or mail. The MCO may not charge pharmacies for PA transaction, software, or related costs for processing PA requests.

If the MCO or its PBM operates a separate call center for PA requests, the PA call center must meet the provider hotline performance standards set forth in **Section 8.1.4.7**, "Provider Hotline." The MCO must train all PA, provider hotline, and pharmacy call center staff on the requirements for dispensing 72-hour emergency supplies of medication.

The MCO may not require a PA for any drug exempted from PA requirements by federal law.

For drug products purchased by a pharmacy through the Health Resources Services Administration (HRSA) 340B discount drug program, the MCO may impose Clinical PA requirements only. These drugs must be exempted from all PDL PA requirements.

A provider may appeal PA denials on a Member's behalf, in accordance with **Sections 8.2.6 (Medicaid) and 8.4.2 (CHIP)**.

If a Member changes Medicaid or CHIP health plans, the MCO must provide the new health plan information about the Member's PA and medication history at no cost and upon request. The MCO, in consultation with HHSC, will develop a standard process and timeline for implementing a standard format for sharing Member medication and PA history. HHSC expects the former MCO to respond with the requested information within 72-hours of the new MCO's request.

8.1.21.3 Coverage Exclusions

In accordance with 42 U.S.C. § 1396r-8, the MCO must exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program. The MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product. A list of participating drug companies can be found on the Medicaid website, under "Medicaid Drug Rebate Program," "Contact Information."

An MCO may restrict some compounded medications available through the pharmacy benefit. MCOs' coverage of compounded medications must follow the same requirements as outlined in this section and must be listed on the Texas Medicaid or

CHIP formulary. MCOs may not reimburse pharmacies for compounding powders since these are not included on the Texas Medicaid or CHIP formulary.

8.1.21.4 Compounded Medications

The MCO must allow approval for the following:

- Compounded medications prepared for Members with allergies to the commercially prepared medications.
- Compounded oral medications used for Members 12 years and younger or for Members with difficulty swallowing.
- Compounded medications if the FDA-approved product is not available or in short supply, but not because the drug has been withdrawn or removed from the market for safety reasons.
- Compounded medications, if the specific Member has a medical need for a different dosage, form, or strength than is commercially available.

The MCO may reject claims for compounded medications for which the MCO, based on the MCO's determination, finds no evidence that the compounded medication is safe and effective. The MCO may reject a claim for a compounded medication if the MCO determines the drug is included in one or more of the classes as defined in 1 Tex. Admin. Code §354.1923 (c). The MCO may reject a claim for a compounded medication if the active ingredients and the use of the compound prescriptions do not have a medically accepted use supported by the compendia or peer review literature. The MCO may select from and use the following compendia: Thomson Micromedex, American Hospital Formulary Service, clinical pharmacology, physician supported guidelines, or current primary literature when available. The MCO must have a process in place to allow a prescriber or pharmacy to dispute a rejected claim for compounded medications.

The MCO may pend a claim for compounded medication for $200 or more for further review to determine if the product is safe and effective.

8.1.21.5 Pharmacy Rebate Program

Under the provisions of, 42 U.S.C. §1396r-8, drug companies that wish to have their products covered through the Texas Medicaid Program must sign an agreement with the federal government to provide the pharmacy claims information that is necessary to return federal rebates to the state.

Under Texas Government Code § 533.005 (a)(23)(D)(i), the MCO may not negotiate rebates with drug companies for pharmaceutical products. HHSC or its designee will negotiate rebate agreements. If the MCO or its PBM has an existing rebate agreement with a manufacturer, all Medicaid and CHIP outpatient drug claims, including provider-administered drugs, must be exempt from such rebate agreements. The MCO must

include rebatable National Drug Codes (NDCs) on all encounters for outpatient drugs and biological products, including clinician-administered drugs. Encounters containing clinician-administered drugs must include, in addition to a CMS-rebate-eligible NDC, the correctly matched HCPCS code and billing units per the applicable date of service according to HHSC NDC-to-HCPCS Crosswalk.

The MCO must implement a process to timely support HHSC's Medicaid and CHIP rebate dispute resolution processes.

- The MCO must allow HHSC or its designee to contact Network pharmacy Providers to verify information submitted on claims, and upon HHSC's request, assist with this process.
- The MCO must establish a single point of contact where HHSC's designee can send information or request clarification.
- HHSC will notify the MCO of claims submitted with incorrect information. The MCO must correct this information on the next scheduled pharmacy encounter data transmission and respond in writing to the original request with the outcome of the correction.

8.1.21.6 Drug Utilization Review Program

The MCO must have a drug utilization review program (DUR) process in place to conduct prospective and retrospective utilization review of prescriptions. The MCO's DUR program must comply with 42 U.S.C. § 1396r-8 and 42 C.F.R. part 456, subpart K. The MCO must submit an annual report to HHSC Vendor Drug Program (VDP) that provides a detailed description of its DUR program activities, as provided for under 42 C.F.R. § 438.3(s).

Prospective review should take place at the dispensing pharmacy's point-of-sale (POS). The prospective review at the POS must include screening to identify potential drug therapy problems such as drug-disease contraindication, therapeutic duplication, adverse drug-drug interaction, incorrect drug dosage, incorrect duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse. The MCO's retrospective review must monitor prescriber and contracted pharmacies for outlier activities. Retrospective reviews must also determine whether services were delivered as prescribed and consistent with the MCO's payment policies and procedures.

The MCO's Drug Utilization Review should specifically assess prescribing patterns for psychotropic medications as defined by Texas Family Code § 266.001(7), for all Members. If the MCO identifies patterns outside of the MCO's parameters for psychotropic medications, or if HHSC notifies the MCO of outlier prescribing patterns, then the MCO must conduct a review and, if necessary, an intervention, such as a letter or phone call to the prescriber or a peer-to-peer review between the prescriber and the MCO. For children, the MCO must model its parameters on DFPS's "Psychotropic Medication Utilization Parameters for Foster Children."

For adults, the MCO must base its parameters for psychotropic medications on a peer-reviewed, industry standard. The MCO must submit a Psychotropic Medication Utilization Review Plan and Report on an annual basis as specified in UMCM Chapter 5.

8.1.21.7 Pharmacy Benefit Manager (PBM)

The MCO must use a pharmacy benefit manager (PBM) to process prescription claims.

The MCO must identify the proposed PBM and the ownership of the proposed PBM. If the PBM is owned wholly or in part by a retail pharmacy provider, chain drug store or pharmaceutical manufacturer, the MCO will submit a written description of the assurances and procedures that must be put in place under the proposed PBM Subcontract, such as an independent audit, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. The MCO must provide a plan documenting how it will monitor these Subcontractors. These assurances and procedures must be submitted for HHSC's review during Readiness Review (see Section 7, "Transition Phase Requirements") then prior to initiating any PBM Subcontract after the Operational Start Date.

The MCO must ensure its subcontracted PBM follows all pharmacy-related Contract, UMCM, state, and federal law requirements related to the provision of pharmacy services.

The MCO must ensure its Material Subcontract with a PBM does not include language that permits:

- pharmacy provider rate reductions without HHSC notification of approval as required under **Section 8.1.4.8**;
- reconciliation methodologies that include Medicaid or CHIP claims;
- mechanisms that facilitate "spread pricing," including pharmacy provider reimbursement clawbacks or discounts, which is described below in this section; or
- PBM restrictions that are greater than those required by HHSC for Medicaid/CHIP participation.

Further, the MCO's reimbursement methodology for the PBM must be based on the actual amount paid by the PBM to a pharmacy for dispensing and ingredient costs. However, this prohibition on the industry practice known as "spread pricing" is not intended to prohibit the MCO from paying the PBM reasonable administrative and transactional costs for services, as described in UMCM Chapter 6.

Unless directed by HHSC, the MCO and its PBM are prohibited from implementing an aggregate reconciliation process after the point-of-sale transaction such that the final cost of drugs for payors is changed or the price paid to pharmacy providers is changed. Such prohibition includes aggregate reconciliation processes for additional fees, contracted effective rate agreements, payment reductions, and the recoupments of funds based on financial performance measures. This prohibitive language does not apply to audit-related

claim reviews, approved Alternative Payment Models, or Fraud, Waste, and Abuse investigations.

The MCO must ensure its subcontracted PBM does not directly or indirectly charge or hold a pharmacist or pharmacy responsible for a fee for any step of or component or mechanism related to the claim adjudication process, including the development or management of a claim processing or adjudication network, or participation in a claim processing or adjudication network.

8.1.21.8 Financial Disclosures for Pharmacy Services

The MCO must disclose all financial terms and arrangements for remuneration of any kind that apply between the MCO or the MCO's PBM and any provider of outpatient drugs, any prescription drug manufacturer, or labeler, including formulary management, drug-switch programs, educational support, claims processing, payments, payment adjustments, overpayments, recoupments, pharmacy network fees, data sales fees, and any other fees. Article 9 of **Attachment A**, " Audit & Financial Compliance and Litigation Hold," provides HHSC with the right to request and timely receive such information from the MCO and its Subcontractors at any time. HHSC agrees to maintain the confidentiality of information disclosed by the MCO pursuant to this section, to the extent that the information is confidential under state or federal law.

8.1.21.9 Limitations Regarding Registered Sex Offenders

HHSC's Medicaid and CHIP formularies do not include sexual performance enhancing medications. If these medications are added to the Medicaid or CHIP formulary, then the MCO must comply with the requirements of Texas Government Code §531.089 prohibiting the provision of sexual performance enhancing medication to persons required to register as sex offenders under Chapter 62, Texas Code of Criminal Procedure.

8.1.21.10 Specialty Drugs

The MCO must adhere to the HHSC Specialty Drug List for specialty drugs provided through selective specialty pharmacy contracts. The MCO's policies and procedures must comply with 1 Tex. Admin. Code § 353.905 and § 354.1853 and include processes for notifying Network Pharmacy Providers.

8.1.21.11 Maximum Allowable Cost Requirements

The MCO must develop maximum allowable cost (MAC) prices and lists that comply with state and federal laws, including Texas Government Code § 533.005(a)(23)(K). To place an outpatient drug on a MAC list, the MCO must ensure that:

- the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's *Approved Drug Products with Therapeutic Equivalence Evaluations,* also known as the *Orange Book,* has an "NR" or "NA" rating or similar rating by a nationally recognized reference; and

- the drug is generally available for purchase by pharmacies in Texas from national or regional wholesalers and is not obsolete.

In formulating the MAC price for a "market basket" of drugs (a group of therapeutically related drugs that will be assigned the same price), MCOs and PBMs must use only the prices of the drugs listed as therapeutically equivalent in the most recent version of the *Orange Book*. Drugs listed as therapeutically equivalent are A-rated drugs. Therefore, MCOs and PBMs can only use A-rated drugs to set MAC prices. B-rated drugs cannot be used in MAC pricing calculation. MCOs and PBMs can include B-rated drugs in the same market basket, but those B-rated drugs must be assigned the same price as the A-rated drugs.

The MCO cannot set a MAC on a drug that is both preferred on HHSC's PDL and a brand name drug.

The MCO must provide a Network pharmacy the sources used to determine the MAC pricing at contract execution, renewal, and upon request. MCOs may not use as a pricing source provider performance standards, provider network performance standards, or effective rate agreements.

The MCO must review and update MAC prices at least once every seven Days to reflect any modifications of MAC pricing and establish a process for eliminating products from the MAC list or modifying MAC prices in a timely manner to remain consistent with pricing changes and product availability in the Service Area.

The MCO must provide HHSC a report regarding MAC price review and updates upon request in the manner and format specified by HHSC no later than 30 Days after the MCO receives the request.

The MCO must have a process for allowing Network pharmacies to challenge a drug price on the MAClist, including Network pharmacies that are contracted with a Pharmacy Services Administrative Organization (PSAO). The MCO must submit the process for HHSC's review and approval prior to implementation and modification. The MCO must respond and resolve a challenge by the 15th Day after it is received by the MCO. If the challenge is successful, the MCO must adjust the drug price on the MAC list, effective on the date the challenge is resolved, and apply the new price to all similarly situated Network pharmacies, as appropriate and determined by the MCO. If the challenge is denied, the MCO must provide the pharmacy the reasons for the denial. The MCO must provide a quarterly report regarding MAC price challenges in the manner and format specified in the UMCM.

The MCOs or PBMs, as applicable, must provide a process for each of its Network pharmacies to readily access the MAC list specific to that pharmacy directly from the MCO or PBM, even if the pharmacy is contracted with a PSAO. At a minimum, MCOs and PBMs must allow a Network pharmacy to download a searchable file of the MAC list specific to that pharmacy from the MCO or PBM website. Alternatively, MCOs or PBMs may allow a Network pharmacy to view and search the MAC list specific to that pharmacy on the website. The list provided on the website must be searchable by drug

name. The MCO must provide HHSC with access to MAC lists upon request as outlined in Article 9 of Attachment A, "Uniform Managed Care Contract Terms and Conditions" and sources used to determine the MAC pricing no later than 10 Days after the MCO receives the request. The MCO must submit the process for HHSC's review and approval prior to implementation and modification. As described in Texas Government Code § 533.005(a-2), a MAC price list that is specific to a Network pharmacy is confidential for all other purposes.

The MCO must inform HHSC no later than 21 Days after implementing a MAC price list for drugs dispensed at retail pharmacies but not by mail.

8.1.21.12 Mail-Order and Delivery

The MCO may include mail-order pharmacies in its pharmacy Network, but cannot require Members to use a mail-order pharmacy except in its specialty pharmacy network when a drug is available only from a mail-order pharmacy.

The MCO cannot charge a Member who opts to use a mail order pharmacy any fees for using this service, including postage or handling for standard or expedited deliveries. In Medicaid fee-for-service, the Vendor Drug Program pays qualified community retail pharmacies for pharmaceutical delivery services. The MCO must implement a process to ensure that Medicaid and CHIP Members receive free outpatient pharmaceutical deliveries from community retail pharmacies in their Service Areas, or through other methods approved by HHSC. Mail order delivery is not an appropriate substitute for delivery from a qualified community retail pharmacy unless requested by the Member. The MCO's process must be approved by HHSC, submitted using HHSC's template, and include all qualified community retail pharmacies identified by HHSC.

In Medicaid fee-for-service, the Vendor Drug Program pays qualified community retail pharmacies for pharmaceutical delivery services. The MCO must implement a process to ensure that Medicaid and CHIP Members receive free outpatient pharmaceutical deliveries from community retail pharmacies in their Service Areas, or through other methods approved by HHSC. Mail order delivery is not an appropriate substitute for delivery from a qualified community retail pharmacy unless requested by the Member. The MCO's process must be approved by HHSC, submitted using HHSC's template, and include all qualified community retail pharmacies identified by HHSC.

8.1.21.13 Health Resources and Services Administration 340B Discount Drug Program

The MCO must use a shared-savings approach for reimbursing Network Providers that participate in the federal Health Resources and Services Administration's (HRSA's) 340B discount drug program.

The MCO through its Provider Contract must require a 340B-covered entity seeking to use 340B stock to contract with the MCO as a 340B pharmacy and accept the payment terms of the MCO's shared-savings model. If the 340B covered entity does not accept the terms of the MCO's shared savings model for the reimbursement of 340B-purchased

drugs, then the MCO may contract with the covered entity as a retail pharmacy. If the covered entity contracts with the MCO as a retail pharmacy, the MCO must prohibit the entity from using 340B-purchased drugs.

The MCO cannot require a Network Provider to submit its actual acquisition cost (AAC) on outpatient drugs and biological products purchased through the 340B program, consistent with UMCM Chapter 2. In addition, the MCO cannot impose PA requirements based on non-preferred status ("PDL PAs") for these drugs and products.

8.1.21.14 Pharmacy Claims and File Processing

The MCO must process claims in accordance with UMCM Chapter 2 and Texas Insurance Code § 843.339. This law requires the MCO to pay clean claims that are submitted electronically no later than 18 Days after adjudication, and no later than 21 Days after adjudication if the claim is not submitted electronically. In addition, the MCO must comply with **Sections 8.2.1 (Medicaid) and 8.4.3 (CHIP)** regarding payment of out-of-network pharmacy claims.

HHSC will provide the MCO or its designee with pharmacy interface files, including formulary, PDL, third party liability, master provider, and drug exception files. Due to the point-of-sale nature of outpatient pharmacy benefits, the MCO must ensure all applicable MIS systems (including pharmacy claims adjudication systems) are updated to include the data provided in the pharmacy interface files. The MCO must update MIS systems within two Business Days of the pharmacy interface files becoming available through HHSC's file transfer process, unless clarification is needed or data/file exceptions are identified. The MCO must notify HHSC within the same two Business Days if clarification or data/file exceptions are needed. Additionally, the MCO must be able to perform off-cycle formulary and PDL updates at HHSC's request.

The MCO must ensure that all daily enrollment and eligibility files in the Joint Interface Plan are loaded into the pharmacy claims adjudication system within two Days of receipt.

8.1.21.15 Pharmacy Audits

The MCO and its PBM are prohibited from using extrapolation in pharmacy audits.

8.1.21.16 E-Prescribing

The MCO must provide the appropriate data to the national e-prescribing network, which at a minimum will support: eligibility confirmation, PDL benefit confirmation, identification of preferred drugs that can be used in place of non-preferred drugs ("alternative drugs"), medication history, and prescription routing.

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8.1.22 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

The MCO must make reasonable efforts to include FQHCs and RHCs (freestanding and Hospital-based) in its Provider Network. The MCO must pay full encounter rates to RHCs for Medically Necessary Covered Services using the prospective payment methodology described in Sections 1902(bb) and 2107(e)(1) of the Social Security Act. Because the MCO is responsible for the full payment amount in effect on the date of service for RHCs, cost settlements (or "wrap payments") will not apply.

When the MCO negotiates payment amounts with FQHCs for Medically Necessary Covered Services provided to its Members, the amounts must be greater than or equal to the average of the MCO's payment terms for other Providers providing the same or similar services. Because the MCO may negotiate payment amounts with FQHCs, wrap payments apply. MCOs may elect to pay the FQHC wrap payment at the time of claim adjudication but no later than the 15th Day of the following month for claims paid in the prior month. After the MCO pays a wrap payment, HHSC will make a supplemental payment to the MCO in the amount of the wrap payment by the last Day of the following month.

If a Member visits an FQHC, RHC, or a Municipal Health Department's public clinic (public clinic) for Health Care Services at a time that is outside of regular business hours, the MCO must reimburse the FQHC, RHC, or public clinic for Medically Necessary Covered Services. The MCO must do so at a rate that is equal to the allowable rate for those services as determined under Tex. Hum. Res. Code §32.028. The MCO must not require a referral from the Member's PCP. In this context, regular business hours has the meaning given to it in 1 Tex. Admin. Code §353.2, as required by 1 Tex. Admin. Code §353.407.

If a Member visits an Out-of-Network Indian Health Care Provider (IHCP) enrolled as an FQHC, for Medically Necessary Covered Services, the MCO must reimburse the OON IHCP a full encounter rate as if the Provider were a Network Provider. This encounter rate is paid entirely as a wrap payment no later than the 15th Day of the following month for services provided in the prior month. After the MCO pays a wrap payment, HHSC will make a supplemental payment to the MCO in the amount of the wrap payment by the last Day of the following month. An FQHC's Out-of-Network claim is subject to the same claim standards requirements as the MCO's Network Providers.

8.1.23 Payment by Members.

Except as provided in **Section 8.1.23.1**, MCOs, Network Providers, and Out-of-Network Providers are prohibited from billing or collecting any amount from a Member for Covered Services.

However, the STAR+PLUS MCO will work with Members or their representatives to help facilities collect applied income where applicable.

MCOs must also inform Members of their responsibility to pay the costs for non-covered services, and must require its Network Providers to:

1. inform Members of costs for non-covered services prior to rendering such services; and
2. obtain a signed private pay form from such Members.

8.1.23.1 Cost Sharing

CHIP Network Providers and Out-of-Network Providers may collect copayments authorized in the CHIP State Plan from CHIP Members.

CHIP families that meet the enrollment period cost share limit requirement must report it to the HHSC Administrative Services Contractor. The HHSC Administrative Service Contractor notifies the MCO that a family's cost share limit has been reached. Upon notification from the HHSC Administrative Services Contractor that a family has reached its cost-sharing limit for the term of coverage, the MCO will generate and mail to the CHIP Member a new Member ID card within five Days, showing that the CHIP Member's cost-sharing obligation for that term of coverage has been met. No cost-sharing may be collected from these CHIP Members for the balance of their term of coverage.

Providers are responsible for collecting all Member copayments at the time of service. Copayments that families must pay vary according to their income level.

Copayments do not apply, at any income level, to Covered Services that qualify as well-baby and well-child care services, preventive services, or pregnancy-related services as defined by 42 C.F.R. §457.520 and Social Security Act § 2103(e)(2).

Except for costs associated with unauthorized non-emergency services provided to a Member by Out-of-Network providers and for non-covered services, the copayments outlined in the CHIP Cost Sharing Table in UMCM Chapter 6 are the only amounts that an MCO may impose and a provider may collect from a CHIP-eligible family. If the cost of a Covered Service is less than the Member's CHIP copayment for that Covered Service, the copayment amount the Member pays will be capped at the cost of the Covered Service.

As required by 42 C.F.R. § 457.515, this includes, without limitation, Emergency Services that are provided at an Out-of-Network facility. Cost sharing for such Emergency Services is limited to the copayment amounts set forth in the CHIP Cost Sharing Table. If the MCO would have paid a lesser amount than the CHIP copayment in the absence of a CHIP copayment, then the copayment amount will be capped at the lesser amount.

Federal law prohibits charging premiums, deductibles, coinsurance, copayments, or any other cost-sharing to Members of Native Americans or Alaskan Natives. The HHSC Administrative Services Contractor will notify the MCO of Members who are not subject to cost sharing requirements. The MCO is responsible for educating Providers regarding the cost sharing waiver for this population.

An MCO's monthly Capitation Payment will not be adjusted for a family's failure to make its CHIP premium payment. There is no relationship between HHSC's Capitation Payment to the MCO for coverage provided during a month and the family's payment of its CHIP premium obligation for that month.

Cost sharing does not apply to CHIP Perinatal Program Members. The exemption from cost sharing applies through the end of the enrollment period.

As of the Effective Date of the Contract, cost sharing does not apply to Medicaid Members. If HHSC implements cost-sharing for Medicaid Members after the Effective Date of this Contract, the requirements of this section will apply, and HHSC will amend the UMCM to include Medicaid Cost Sharing Tables. Except for costs associated with unauthorized non-emergency services provided to a Member by Out-of-Network providers and for non-covered services, the Medicaid copayments outlined in the UMCM will be the only amounts that an MCO may impose and a provider may collect from a Medicaid-eligible family.

8.1.24 Immunizations

The MCO must educate Providers on the Immunization Standard Requirements set forth in Tex. Health and Safety Code, Chapter 161; the standards in the Advisory Committee on Immunization Practices (ACIP) Immunization Schedule; the AAP Periodicity Schedule for CHIP Members; and the ACIP Immunization Schedule for Medicaid Members. The MCO must educate Providers that Medicaid Members birth through age 20 must be immunized during the Texas Health Steps checkup according to the ACIP routine immunization schedule. The MCO must also educate Providers that the screening provider or its appropriate designee is responsible for administration of the immunization and should not refer children to Local Health Departments or other entities to receive immunizations.

The MCO must educate Providers about the importance of including documentation for immunizations in the Member's medical record, and the necessity of the Provider's documentation to support a qualification for reimbursement for appropriate provision of immunizations to eligible Members.

The MCO must educate Providers about, and require Providers to comply with, the requirements of Tex. Health and Safety Code Chapter 161, relating to the Texas Immunization Registry (ImmTrac2), to include parental consent on the Vaccine Information Statement.

The MCO must notify Medicaid and CHIP Providers that they may enroll, as applicable, as Texas Vaccines for Children Providers. In addition, the MCO must work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac2 registry.

8.1.25 Dental Coverage

The MCO is not responsible for reimbursing dental providers for preventive and therapeutic dental services obtained by Medicaid or CHIP Members, with the exception of the dental services available to STAR+PLUS Members in the enrolled in the HCBS STAR+PLUS Waiver. However, medical and/or Hospital charges, such as anesthesia, that are necessary in order for Medicaid or CHIP Members to access standard therapeutic dental services, are Covered Services for Medicaid or CHIP Members. The MCO must provide access to facilities and physician services that are necessary to support the dentist who is providing dental services to a Medicaid or CHIP Member under general anesthesia or intravenous (IV) sedation.

Medicaid medical benefits also provide for coverage of some dental related emergency services including but not limited to dislocated jaw, traumatic damage to teeth and supporting structures, removal of cysts, treatment of oral abscess of tooth or gum origin, treatment and devices for correction of craniofacial anomalies, and drugs. NEMT Services necessary for a Member to access Medicaid dental services are coordinated by the MCO.

The CHIP medical benefit provides limited emergency dental coverage for dislocated jaw, traumatic damage to teeth, and removal of cysts; treatment of oral abscess of tooth or gum origin; treatment and devices for craniofacial anomalies; and drugs.

The MCO must inform Network facilities, anesthesiologists, and PCPs what authorization procedures are required, and how Providers are to be reimbursed for the preoperative evaluations by the PCP and/or anesthesiologist and for the facility services. For dental-related medical Emergency Services, the MCO must reimburse Network and Out-of-Network providers in accordance with federal and state laws, rules, and regulations.

8.1.26 Health Home Services

The MCO must provide Health Home Services. The MCOs must include a designated Provider to serve as the health home. The designated provider must meet the qualifications as established by the U.S. Secretary of Health and Human Services. The designated provider may be a provider operating with a team of health professionals, or a health team selected by the enrollee. The Health Home Services must be part of a person-based approach and holistically address the needs of persons with multiple chronic conditions or a single serious and persistent mental or health condition.

Health Home Services must include:

1. Member self-management education;
2. provider education;
3. evidence-based models and minimum standards of care;
4. standardized protocols and participation criteria;
5. provider-directed or provider-supervised care;
6. a mechanism to incentivize providers for provision of timely and quality care;

7. implementation of interventions that address the continuum of care;
8. mechanisms to modify or change interventions that are not proven effective;
9. mechanisms to monitor the impact of the Health Home Services over time, including both the clinical and the financial impact.
10. comprehensive care management;
11. care coordination and health promotion;
12. comprehensive traditional care, including appropriate follow-up, from inpatient to other settings;
13. Member and family support (including authorized representatives);
14. referral to community and social support services, if relevant, and;
15. use of health information technology to link services, as feasible and appropriate.

The Health Home Services requirements do not apply to Dual Eligible Members unless HHSC enters into a Dual Eligible Demonstration Project with the CMS. Under a demonstration project, STAR+PLUS MCOs will be required to coordinate health home initiatives with their affiliated Medicare Advantage/Special Needs Plans.

8.1.26.1 Health Home Services and Participating Providers

HHSC encourages MCOs to develop provider incentive programs for designated Providers who meet the requirements for Member-centered medical homes found in Texas Government Code §533.0029.

At a minimum, the MCO must:

1. maintain a system to track and monitor all Health Home Services participants for clinical, utilization, and cost measures;
2. implement a system for Providers to request specific Health Home interventions;
3. inform Providers about differences between recommended prevention and treatment and actual care received by Members enrolled in a Health Home Services program and Members' adherence to a service plan; and
4. provide reports on changes in a Member's health status to his or her PCP for Members enrolled in a Health Home Services program.

8.1.27 Cancellation of Product Orders

If a Network Provider offers delivery services for covered products, such as durable medical equipment (DME), home health supplies, or outpatient drugs or biological products, then the MCO's Provider Contract must require the Provider to reduce, cancel, or stop delivery at the Member's or the Member's authorized representative's written or oral request. The Provider must maintain records documenting the request.

For automated refill orders for covered products, the MCO's Provider Contract must require the Provider to confirm with the Member that a refill, or new prescription received directly from the physician, should be delivered. Further, the MCO must ensure that the Provider completes a drug regimen review on all prescriptions filled as a result of the auto-refill program in accordance with 22 Tex. Admin. Code § 291.34. The Member or

Member's LAR must have the option to withdraw from an automated refill delivery program at any time.

8.1.28 Preadmission Screening and Resident Review (PASRR) Referring Entity Requirements

The MCO must follow any PASRR requirements when acting as a referring entity for Members as required by 26 Tex. Admin. Code §§ 303.101 and 303.301.

8.1.29 Responsibilities in the Event of a Federal Emergency Management Agency or Governor Declared Disaster, or Other Emergencies

In the event of a Federal Emergency Management Agency (FEMA) or State of Texas Governor-declared disaster, or other emergencies that are internal, man-made, or natural, the MCO must ensure the care of Members in compliance with the MCO's continuity of Member care emergency response plan (COMCER plan), particularly the care of Members whose health or Behavioral Health condition has been treated by specialty care providers or whose health could be placed in jeopardy if Covered Services are disrupted or interrupted. Requirements for the COMCER plan and other disaster-related requirements are described in Section 16.1.13 of the UMCM.

The MCO must have a continuity of Member care emergency response plan based on a risk assessment for each of the Service Areas in which Services are provided under the Contract, using an "all hazards" approach to respond. An "all hazards" approach focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies, man-made emergency or natural disasters. As part of the plan, the MCO must describe the method to ensure that Members are able to see Out-of-Network providers if Members have a permanent address in FEMA or State of Texas Governor-declared disaster areas, or areas in which internal, man-made, or natural disasters have occurred, and are unable to access Covered Services from Network Providers. The MCO must also describe the method it will use to ensure that prior authorizations are extended and transferred without burden to new Providers if directed by HHSC, and the method by which the MCO will identify the location of Members who have been displaced. Annually, the MCO must conduct exercises carrying out the plan's provisions, evaluate its performance and make necessary updates.

The MCO must coordinate with local emergency management departments or agencies prior to an event to understand local emergency management plans and processes, identify plans to escalate needs through local emergency management departments or agencies, and identify mechanisms for assistance at the local level.

Additionally, the MCO must maintain a continuity of operations business plan which includes a collection of resources, actions, procedures, and information that is developed, tested, and held in readiness for use to continue operations in the event of a major disruption of operations due to a FEMA or State of Texas Governor-declared disaster, or other emergencies that are internal, man-made, or natural. The continuity of operations business plan must address emergency financial needs, essential functions

for Member services, critical personnel, and the return to normal operations as quickly as possible.

During a FEMA or State of Texas Governor-declared disaster, or other emergency that are internal, man-made, or natural, the MCO is required to report to HHSC daily or at an interval determined by HHSC, when requested, on the status of Members and issues regarding Member access to Covered Services.

When directed by HHSC, by authority of waivers available through the CHIP State Plan, the CHIP MCO must be able to require Network Providers to waive all cost-sharing requirements for children of families living in FEMA or State of Texas Governor-declared disaster areas, or areas in which internal, man-made, or natural at the time of the disaster event.

The MCO/PBM claims system must have the capability to waive edits or allow override of edits by at least ZIP code and county for specific date ranges.

The MCO or its PBM may not use circumstances described in Texas Health and Safety Code § 483.047(b-1) as a justification for rejecting a claim provided the pharmacy or pharmacist meets Texas Health and Safety Code § 483.047(b-1)'s requirements.

8.1.30 CMS Interoperability and Patient Access

Effective January 1, 2021, MCOs and CHIP MCOs are required by federal law to implement and maintain a Patient Access Application Programming Interface (API) and a Provider Directory API using the required Health Level 7 Fast Healthcare Interoperability Resources-based standards.

The MCO must comply with the Patient Access API requirements in 42 C.F.R. § 438.242(b)(5) and the Provider Directory API requirements in 42 C.F.R. § 438.242(b)(6), including the provider directory information specified in 42 C.F.R. § 438.10(h)(1) and (2). The CHIP MCO must comply with the Patient Access API requirements in 42 C.F.R. § 457.1233(d) and the Provider Directory API requirements in 42 C.F.R. § 457.1233, including the provider directory information specified in 42 C.F.R. § 438.10(h)(1) and (2). More detailed information regarding the federal compliance requirements can be found in the CMS Interoperability and Patient Access Final Rule in the May 1, 2020 issue of the Federal Register (85 FR 25510-01). Additional guidance can also be found in the 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program in the May 1, 2020 issue of the Federal Register.

8.1.30.1 Payer-to-Payer Data Exchange

Effective January 1, 2022, the MCO must comply with an individual's request to have the individual's health data transferred from payer to payer.

The rule finalizes the requirements in 42 C.F.R. § 438.62(b)(1)(vi) and (vii) for the creation of a process for the electronic exchange of, at a minimum, the data classes and

elements included in the United States Core Data for Interoperability (USCDI) content standard adopted at 45 C.F.R. § 170.213.

8.1.31 Telemedicine, Telehealth, and Telemonitoring Access

~~Telemedicine, Telehealth, and~~ Telemonitoring is ~~are~~ a Covered Service~~s~~ and is ~~are~~ a benefit~~s~~ of Texas Medicaid. Telemedicine and Telehealth refer to modalities for the delivery of Covered Services.

CHIP Covered Services may be delivered by Telemedicine and Telehealth.

MCOs must contract with Providers offering these services to provide better access to healthcare for its Members.

The MCO must include information about Providers with Telemedicine, Telehealth, and Telemonitoring capabilities in its hard copy and electronic P~~p~~rovider D~~d~~irectory.

The Medicaid MCO must be able to accept and process Provider claims for Covered Services using modifier 95 (synchronous Audio-visual technology), 93 (synchronous Audio-only), or FQ modifier (BH synchronous Audio-only) when delivered by Telemedicine or Telehealth. In addition, the Medicaid MCO must be able to accept and process Provider claims for Telemonitoring. Procedure codes that already indicate the type of remote delivery in their description do not need to be billed with the 95, 93, or FQ modifiers.

CHIP MCOs must be able to accept and process Provider claims for Covered Services using modifier 95 (synchronous Audio-visual technology), 93 (synchronous Audio-only), or FQ modifier (BH synchronous Audio-only) when delivered by Telemedicine or Telehealth. In addition, the CHIP MCO must be able to accept and process Provider claims for Telemedicine and Telehealth. Procedure codes that already indicate the type of remote delivery in their description do not need to be billed with the 95, 93, or FQ modifiers.

The MCO must conduct outreach to its Providers to encourage more Providers to offer Telemedicine, Telehealth, and Telemonitoring, with emphasis on rural and medically underserved areas. The MCO must also outreach to specialty Providers as that term is defined in 1 TAC §353.7 and Behavioral Health Services Providers to assure engagement of qualified Providers offering Telemedicine, Telehealth, and Telemonitoring. During the outreach process, the MCO must offer trainings and supports to help establish Telemedicine, Telehealth, and Telemonitoring literacy and capabilities. In addition, the MCO must actively recruit additional rural providers in order to increase Member access to the services that can be delivered through Telemedicine or Telehealth.

MCOs are required to comply with Texas Government Code §531.0216 and §§531.02161(a), (c) and (d). CHIP MCOs are required to comply with Texas Health and Safety Code §62.1571 and Tex. Gov't Code §531.02161.

MCOs must not deny reimbursement for a Covered Service delivered by a Network Provider via Telemedicine or Telehealth solely because the Covered Service is not provided through an In-Person consultation. MCOs must not deny reimbursement for a Covered BH Service delivered by a Network Provider via Telemedicine or Telehealth, including Audio-only Behavioral Health Services, solely because the Covered Service is not provided through In-Person consultation. MCOs cannot limit, deny, or reduce reimbursement for a Covered Service or procedure delivered remotely by a Provider based upon the Provider's choice of Platform, except in the event a Provider utilizes an Audio-only Platform for providing a ~~Telemedicine or Telehealth~~ Covered ~~s~~Service that HHSC has found must not be provided via Audio-only.

MCOs must allow Members to receive Telemedicine or Telehealth ~~services~~ from providers other than the Member's PCP.

MCOs must adhere to the provisions for services by Telecommunication located in UMCM Chapter 16.

8.1.31.1 School-based Telemedicine Medical Services

As required by Texas Government Code §531.0217, school-based T~~t~~elemedicine medical services are a C~~c~~overed S~~s~~ervice for Members in a primary or secondary school-based setting. MCOs must reimburse an eligible ~~the~~ distant site physician providing treatment even if the physician is not the Member's primary care physician or P~~p~~rovider, or is an out-of-network physician. To be eligible for reimbursement, distant site physicians providing treatment must meet the service requirements outlined in Texas Government Code §531.0217 (c-4).

MCO~~'~~s may not requireest prior authorization for school-based ~~t~~Telemedicine medical services.

The ~~S~~school-~~B~~based Telemedicine medical ~~S~~services in this section are separate and distinct from School Health and Related Services (SHARS) services. The MCO must only reimburse school-based ~~t~~Telemedicine medical services that are not considered SHARS.

8.2 Additional Medicaid MCO Scope of Work

The following provisions apply to any MCO participating in the STAR or STAR+PLUS MCO Program.

8.2.1 Continuity of Care and Out-of-Network Providers

The MCO must ensure continuity of care such that the care of newly enrolled Members is not disrupted or interrupted. The MCO must ensure that the care of newly enrolled Members is not disrupted or interrupted for Members: (1) whose health or Behavioral Health condition has been treated by specialty care providers, or (2) whose health could be placed in jeopardy if Medically Necessary Covered Services are not provided. Effective December 1, 2022 for MSHCN this shall include contacting a Member's former MCO to request information such as the Member's needs, current Medical Necessity determinations, authorized care, and Service Plans or ISPs, as applicable.

The MCO must respond to requests from other MCOs for information, including but not limited to, information regarding the Member's needs, current Medical Necessity determinations, authorized care, Service Plans or ISPs, or other documents pertinent to the health and well-being of a former Member.

Additionally, the MCO must comply with the requirements of 42 C.F.R § 438.208(b) & (c)(2)-(4), related to coordination and continuity of care.

Upon notification from a Member or Provider of the existence of a prior authorization, the new MCO must ensure Members receiving services through a prior authorization from either another MCO or FFS receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following:

(1) 90 Days after the transition to a new MCO,

(2) until the end of the current authorization period, or

(3) until the MCO has evaluated and assessed the Member and issued or denied a new authorization.

See **Section 8.1.14**, "Disease Management (DM)." for specific requirements for new Members transferring to the MCO's Disease Management (DM) Program.

For instances in which a newly enrolled Member transitioning from FFS to managed care was receiving a service that did not require a prior authorization in FFS, but does require one by the new MCO, the MCO must ensure Members receive services for the same amount, duration, and scope for the shortest period of one of the following: (1) 90 Days after the transition to a new MCO, or (2) until the MCO has evaluated and assessed the Member and issued or denied a new authorization.

The MCO is also required to ensure that clients being transferred to a new MCO as part of an HHSC initiative, receiving acute care services through a prior authorization as of the STAR and STAR+PLUS Operational Start Date receive continued authorization of those services for the shorter period of one of the following: (1) 90 Days after Operational Start Date, or (2) until the expiration date of the prior authorization. The MCO is also required to ensure that these clients receiving Community-based Long Term Care Services as of the STAR+PLUS Operational Start Date receive continued

authorization of those services for up to 6 months after the Operational Start Date, unless a new assessment has been completed and new authorizations issued as described in **Section 8.3.2.4**. During transition, an HHSC's Administrative Services Contractor or an HHS Agency will provide the MCO with files identifying Members with prior authorizations for acute care services and Members receiving Community-based Long Term Care Services. The MCO is required to work with HHSC and its Administrative Services Contractor to ensure that all necessary authorizations are in place within the MCO's system(s) for the continuation of Community-based Long Term Care Services and prior authorized acute care services. The MCO must describe the process it will use to ensure continuation of these services in its Transition/Implementation Plan for the HHSC initiative as noted in **Section 7.2.1 Contract Start-Up and Planning**. The MCO is also required to ensure that Community-based Long Term Care Services Providers are educated about and trained regarding the process for continuing these services prior to the Operational Start Date (see **Section 8.3.6.1** Training).

As described in **Section 8.1.3.2**, the MCO must allow pregnant Members past the 24th week of pregnancy to remain under the care of the Member's current OB/GYN through the Member's postpartum checkup, even if the provider is Out-of-Network. If a Member wants to change her OB/GYN to one who is in the Network, she must be allowed to do so if the Provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

The MCO must pay a Member's existing Out-of-Network providers for Medically Necessary Covered Services until the Member's records, clinical information and care can be transferred to a Network Provider, or until such time as the Member is no longer enrolled in that MCO, whichever is shorter. Payment to Out-of-Network providers must be made within the time period required for Network Providers. The MCO must comply with Out-of-Network provider reimbursement rules as adopted by HHSC.

With the exception of pregnant Members who are past the 24th week of pregnancy this Article does not extend the obligation of the MCO to reimburse the Member's existing Out-of-Network providers for ongoing care for:

1. more than 90 Days after a Member enrolls in the MCO's Program, or
2. for more than nine months in the case of a Member who, at the time of enrollment in the MCO, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled in the MCO.

The MCO's obligation to reimburse the Member's existing Out-of-Network provider for services provided to a pregnant Member past the 24th week of pregnancy extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

If a Member moves out of a Service Area, the MCO must provide or pay Out-of-Network providers in the new Service Area who provide Medically Necessary Covered Services to Members through the end of the period for which the MCO received a Capitation Payment for the Member.

If Covered Services are not available within the MCO's Network, the MCO must provide Members with timely and adequate access to Out-of-Network services for as long as those services are necessary and not available in the Network, in accordance with 42 C.F.R. §438.206(b)(4). The MCO will not be obligated to provide a Member with access to Out-of-Network services if such services become available from a Network Provider.

The MCO must ensure that each Member has access to a second opinion regarding the use of any Covered Service. A Member must be allowed access to a second opinion from a Network Provider or Out-of-Network provider if a Network Provider is not available, at no cost to the Member, in accordance with 42 C.F.R. §438.206(b)(3). The MCO may use single case agreements with Out-of-Network providers to facilitate a Member's access to a second opinion.

The MCO is not required to include Members seeking a second opinion as part of its "Out-of-Network Utilization Reporting" requirements under UMCM Chapter 5.

8.2.1.1 HCBS LTSS Continuity of Care

For STAR+PLUS, if a Member resides in a Nursing Facility, an Assisted Living Facility, an Adult Foster Care home, or receives Supported Employment or employment assistance, and the Provider is terminated or otherwise leaves the MCO Network:

1. The MCO must notify the Member of the upcoming change within ten Days of receiving final termination notice from the provider or ten Days prior to the MCO's effective date of termination, whichever is earlier.
2. If the Member wishes to stay with the current Provider, the MCO may seek to obtain a single-case-agreement, out-of-network authorization, or similar arrangement with the provider to ensure the Member's continued care.

If the Provider refuses to enter into a single-case agreement, out-of-network authorization, or similar arrangement with the MCO, or if the MCO does not offer the Provider the option to enter in to one of those arrangements, the MCO must notify the Member of his or her option to change MCOs and how to make such a change. If the change in MCOs will occur after the Provider is terminated, the MCO must notify HHSC no later than five Days from the end of the month to request assistance expediting the Member's MCO change.

If the Member wishes to stay with the current MCO, the MCO must notify the Member of the date by which the Provider will no longer be in Network or eligible for reimbursement to serve the Member and assist the Member in locating and beginning services with a new Provider with minimal disruption in services.

For STAR+PLUS, if a Member resides in a Nursing Facility (NF) or an Assisted Living Facility (ALF), and the provider undergoes a change of ownership (CHOW), the MCO must ensure Continuity of Care such that the care of its enrolled Members residing in the NF or ALF that underwent a CHOW is not disrupted or interrupted, and its Members continue to receive services authorized prior to the CHOW. The MCO must ensure Members receiving services through a prior authorization receive continued

authorization of those services for the same amount, duration, and scope until the end of the current authorization period, or until the MCO has evaluated and assessed the Member and issued or denied a new authorization.

This section only pertains to residential and employment provider termination as a cause for disenrollment (42 C.F.R. § 438.56(d)(2)(iv); therefore, these requirements differ from those under **Section 8.1.4.9** of the Contract.

8.2.2 Provisions Related to Covered Services for Medicaid Members

8.2.2.1 Emergency Services

MCO policy and procedures, Covered Services, claims adjudication methodology, and reimbursement performance for Emergency Services must comply with all applicable state and federal laws, rules, and regulations including 42 C.F.R. § 438.114, whether the provider is Network or Out-of-Network. MCO policies and procedures must be consistent with the prudent layperson definition of an Emergency Medical Condition and the claims adjudication processes required under the Contract and 42 C.F.R. § 438.114.

The MCO must pay for professional, facility, and ancillary services provided in a Hospital emergency department that are Medically Necessary to perform the medical screening examination and stabilization of a Member presenting with an Emergency Medical Condition or an Emergency Behavioral Health Condition, whether rendered by Network Providers or Out-of-Network providers.

The MCO cannot require prior authorization as a condition for payment for an Emergency Medical Condition, an Emergency Behavioral Health Condition, including Emergency Detentions as defined under Chapter 573, Subchapter A of the Texas Health and Safety Code and Chapter 462, Subchapter C of the Texas Health and Safety Code, or labor and delivery. The MCO cannot limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. The MCO cannot refuse to cover Emergency Services based on the emergency room provider, Hospital, or fiscal agent not notifying the Member's PCP or the MCO of the Member's screening and treatment within ten Days of presentation for Emergency Services. The MCO may not hold the Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member. The MCO must accept the emergency physician or provider's determination of when the Member is sufficiently stabilized for transfer or discharge.

A medical screening examination needed to diagnose an Emergency Medical Condition must be provided in a Hospital based emergency department that meets the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 C.F.R. §§489.20, 489.24 and 438.114(b)&(c)). The MCO must pay for the emergency medical screening examination, as required by 42 U.S.C. §1395dd. The MCO must reimburse for both the physician's services and the Hospital's Emergency Services, including the emergency room and its ancillary services.

When the medical screening examination determines that an Emergency Medical Condition exists, the MCO must pay for Emergency Services performed to stabilize the Member. The emergency physician must document these services in the Member's medical record. The MCO must reimburse for both the physician's and Hospital's emergency stabilization services including the emergency room and its ancillary services.

The MCO must cover and pay for Post-Stabilization Care Services in the amount, duration, and scope necessary to comply with 42 C.F.R. § 438.114(b)&(e) and 42 C.F.R. § 422.113(c)(2). The MCO is financially responsible for post-stabilization care services obtained within or outside the Network that are not pre-approved by a Provider or other MCO representative, but administered to maintain, improve, or resolve the Member's stabilized condition if:

1. the MCO does not respond to a request for pre-approval within one (1) hour;
2. the MCO cannot be contacted; or
3. the MCO representative and the treating physician cannot reach an agreement concerning the Member's care and a Network physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a Network physician and the treating physician may continue with care of the Member until an Network physician is reached. The MCO's financial responsibility ends as follows: the Network physician with privileges at the treating Hospital assumes responsibility for the Member's care; the Network physician assumes responsibility for the Member's care through transfer; the MCO representative and the treating physician reach an agreement concerning the Member's care; or the Member is discharged.

8.2.2.2 Family Planning - Specific Requirements

The MCO must provide access to confidential family planning services.

The MCO must require, through Provider contract provisions, that Members requesting contraceptive services or family planning services are also provided counseling and education about the family planning and family planning services available to Members. The MCO must develop outreach programs to increase community support for family planning and encourage Members to use available family planning services.

The MCO must ensure that Members have the right to choose any Medicaid-enrolled family planning provider, whether the provider chosen by the Member is in or outside the Provider Network. The MCO must provide Members access to information about available providers of family planning services and the Member's right to choose any Medicaid-enrolled family planning provider.

The MCO must provide, at a minimum, the full scope of services available under the Texas Medicaid program for family planning services. The MCO will reimburse family planning agencies no less than the Medicaid fee-for service amounts for family planning services, including Medically Necessary medications, contraceptives, and supplies and will reimburse Out-of-Network family planning providers in accordance with HHSC's

administrative rules. The MCO cannot require prior authorization for family planning services whether rendered by a Network or Out-of-Network provider. The MCO must have procedures in place to educate the following Members about family planning programs, including the Healthy Texas Women Program, the HHSC Family Planning Program, and the HHSC Primary Health Care Program:

- Pregnant Members who will lose eligibility after delivery;
- Members who are aging out of STAR; and
- STAR Members ages 15-45.

The MCO must also have procedures in place to educate Providers about eligibility criteria and program services available under the Healthy Texas Women Program, including Healthy Texas Women Plus services; the HHSC Family Planning Program; and the HHSC Primary Health Care Program. The MCO must provide medically approved methods of contraception to Members, provided that the methods of contraception are Covered Services. Contraceptive methods must be accompanied by verbal and written instructions on their correct use. The MCO must establish mechanisms to ensure all medically approved methods of contraception are made available to the Member, either directly or by referral to a Subcontractor.

The MCO must develop, implement, monitor, and maintain standards, policies and procedures for providing information regarding family planning to Providers and Members, specifically regarding State and federal laws governing Member confidentiality (including minors). Providers and family planning agencies cannot require parental consent for minors to receive family planning services. The MCO must require, through contractual provisions, that Subcontractors have mechanisms in place to ensure Member's (including minor's) confidentiality for family planning services.

8.2.2.3 Texas Health Steps (EPSDT)

8.2.2.3.1 Medical Checkups

The MCO must develop effective methods to ensure that children birth through age 20 receive Texas Health Steps medical checkup services when due and according to the recommendations established by the Texas Health Steps periodicity schedule for children as described in the Texas Medicaid Provider Procedures Manual. The MCO must arrange for Texas Health Steps medical checkup services for all eligible Members, except when Members or their representatives knowingly and voluntarily decline or refuse services after receiving sufficient information to make an informed decision.

A checkup for an Existing Member from birth through 35 months of age is timely if received within 60 Days beyond the periodic due date based on the Member's birth date. A Texas Health Steps medical checkup for an Existing Member age three years and older is due annually beginning on the child's birthday and is considered timely if it occurs no later than 364 Days after the child's birthday. For New Members birth through age 20, overdue or upcoming Texas Health Steps medical checkups should be offered as soon as practicable, but in no case later than 14 Days of enrollment for newborns,

and no later than 90 Days of enrollment for all other eligible child Members. For purposes of this requirement, the terms “New Member” and “Existing Member” are defined in Chapter 12 of the UMCM.

8.2.2.3.2 Oral Evaluation and Fluoride Varnish

The MCO must educate Providers on the availability of the Oral Evaluation and Fluoride Varnish (OEFV) Medicaid benefit that can be rendered and billed by certified Texas Health Steps providers when performed on the same Day as the Texas Health Steps medical checkup. The MCO must educate Providers about the importance of OEFV documentation for inclusion in the Member’s medical record, and the necessity of documentation to support a qualification for reimbursement for appropriate provision of OEFV to eligible Members. The Provider education must include information about how to assist a Member with referral to a dentist to establish a dental home.

8.2.2.3.3 Lab

The MCO must require Providers to send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section or to a laboratory approved by the department under Section 33.016 of the Health and Safety Code. Providers must include detailed identifying information for all screened newborn Members and the Member’s mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.

All laboratory specimens collected as a required component of a Texas Health Steps checkup (see Texas Medicaid Provider Procedures Manual for age-specific requirements) must be submitted to the DSHS Laboratory Services Section or to a laboratory approved by the department under Section 33.016 of the Health and Safety Code for analysis unless the Texas Medicaid Provider Procedures Manual, Children’s Services Handbook provides otherwise. The MCO must educate Providers about Texas Health Steps Program requirements for submitting laboratory tests to the DSHS Laboratory Services Section.

8.2.2.3.4 Education/Outreach

The MCO must ensure that Members are provided information and educational materials about Texas Health Steps services, and how and when Members should obtain the preventive medical checkups, or diagnostic and treatment services, including Texas Health Steps Comprehensive Care Program services, and how the Member can request advocacy and assistance from the MCO. The information should tell the Member how they can access dental benefits and NEMT Services. The MCO must use the standard language describing Texas Health Steps services, including medical, dental and case management services as provided in the UMCM for Member Materials. Any additions to or deviations from the standard language must be reviewed and approved by HHSC prior to publication and distribution to Members.

The MCO should provide outreach to Members to ensure Members are effectively informed about available Texas Health Steps services and to ensure Member has

access to prompt services. Each month, the MCO must retrieve from the HHSC Administrative Services Contractor Bulletin Board System a list of Members who are due and overdue Texas Health Steps services. Using these lists and its own internally generated list, the MCO will contact such Members to encourage scheduling the service as soon as possible. The MCO outreach staff must coordinate with Texas Health Steps Outreach and Informing Unit and other agencies to ensure Member timely access to Texas Health Steps services.

The MCO must cooperate and coordinate with the State, outreach programs and Texas Health Steps regional program staff and agents to ensure prompt delivery of services to Farmworker Children and other migrant populations who may transition into and out of the MCO's Program more rapidly and/or unpredictably than the general population.

The MCO must make an effort to coordinate and cooperate with existing community and school-based health and education programs that offer services to school-aged children in a location that is both familiar and convenient to the Members. The MCO must coordinate with Head Start programs to assist Members enrolling or enrolled in Head Start with scheduling Texas Health Steps checkups. This coordination should include informing Head Start programs in the service area how to request scheduling assistance from the plan when a plan Member needs a Texas Health Steps checkup.

8.2.2.3.5 Training

The MCO must provide appropriate training to all Network Providers and Provider staff in the Providers' area of practice regarding the scope of Texas Health Steps services. Training must include:

1. Texas Health Steps benefits (preventive care, diagnostic services, and treatment);
2. the periodicity schedule for Texas Health Steps medical checkups and immunizations;
3. the required components of Texas Health Steps medical checkups, the importance of documenting all required components of the checkup in the medical record, and the necessity of documentation to support a complete checkup qualifying for reimbursement is provided;
4. providing or arranging for all required lab screening tests (including lead screening) at 12 and 24 months, the importance of documenting all lab screening and results for Texas Health Steps medical checkups;
5. Comprehensive Care Program (CCP) services available under the Texas Health Steps program to Members birth through age 20 years,
6. NEMT Services available to Members
7. importance of updating contact information to ensure accurate Provider Directories and the Medicaid Online Provider Lookup;
8. information about MCO's process for acceleration of Texas Health Steps services for Children of Migrant Farm Workers;
9. The process to submit missed appointment referrals (either to the Texas Health Steps Outreach and Informing Unit, or the MCO) and the assistance provided by the MCO for these referrals;

10. administrative issues such as claims filing and services available to Members;
11. 72-hour emergency supply prescription policy and procedures;
12. outpatient prescription drug prior authorization process;
13. how to access the Medicaid formulary and preferred drug list (PDL) on HHSC's website;
14. how to use HHSC's free subscription service for accessing the Medicaid formulary and PDL through the Internet or hand-held devices; and
15. scope of Durable Medical Equipment (DME) and other items commonly found in a pharmacy that are available for Members birth through age 20 years.

Providers should be educated and trained to treat each Texas Health Steps visit as an opportunity for a comprehensive assessment of the Member.

The MCO must educate Providers about blood lead level reporting under Tex. Health & Safety Code Chapter 88 and 25 Tex. Admin. Code Chapter 37, Subchapter Q; coordination with the Texas Childhood Lead Poisoning Prevention Program at DSHS; and appropriate follow-up testing and care, including the Centers for Disease Control and Prevention guidelines located on the DSHS website, "Texas Childhood Lead Poisoning Prevention", "Screening". The MCO must educate Providers about Medicaid coverage for lead screening, follow-up testing, and environmental lead investigations, whether as Non-capitated Services or Covered Services.

8.2.2.3.6 Data Validation

The MCO must require all Texas Health Steps Providers to submit claims for services paid (either on a capitated or fee-for service basis) on the CMS 1500 claim form and use the HIPAA compliant code set required by HHSC.

Encounter Data will be validated by chart review of a random sample of Texas Health Steps eligible enrollees against monthly Encounter Data reported by the MCO. HHSC or its designee will conduct chart reviews to validate that all screens are performed when due and as reported, and that reported data is accurate and timely. Substantial deviation between reported and charted Encounter Data could result in the MCO and/or Network Providers being investigated for potential Fraud, Waste, or Abuse without notice to the MCO or the Provider.

8.2.2.3.7 Texas Health Steps-Comprehensive Health Care Program

The MCO must prior authorize and provide all medically necessary services listed in Section 1905(a) of the Social Security Act to Members age 20 and younger through the Texas Health Steps Comprehensive Care Program in accordance with Section 1905(r) of the Social Security Act and the Omnibus Budget Reconciliation Act of 1989. The MCO must provide Texas Health Steps Comprehensive Care Program services in accordance with service limitations specified in the TMPPM, Children's Services Handbook, Chapter 2.

Services required by EPSDT, including Texas Health Steps Comprehensive Care Program services, are not considered Case-by-case Services or Value-added Services.

8.2.2.4 Perinatal Services

The MCO's perinatal Health Care Services must ensure appropriate care is provided to women and infant Members from the preconception period through the infant's first year of life. The MCO's perinatal health care system must comply with the requirements of the Texas Health and Safety Code, Chapter 32 (the Maternal and Infant Health Improvement Act) and administrative rules codified at 25 Tex. Admin. Code Chapter 37, Subchapter M.

The MCO must have a perinatal health care system in place that, at a minimum, provides the following services:

1. pregnancy planning and perinatal health promotion and education for reproductive-age women and adolescents;
2. perinatal risk assessment of non-pregnant women, pregnant and postpartum women, and infants up to one year of age;
3. access to appropriate levels of care based on risk assessment, including emergency care;
4. transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary;
5. availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems;
6. availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems; and
7. education and care coordination for Members who are at high-risk for preterm labor, including education on the availability of medication regimens to prevent preterm birth, such as hydroxyprogesterone caproate. The MCO should also educate Providers on the prior authorization processes for these benefits and services.

On a monthly basis, HHSC will supply the MCO with a file containing birth record data. The MCO must use this file to identify reproductive-age Members with a previous preterm birth. The MCO must provide outreach to, education to, and care coordination for identified Members as described in this section to prevent preterm births. Care coordination may include Service Coordination under Section 8.1.13 and Member referrals to Providers to assess the need for the use of hydroxyprogesterone caproate. The MCO must report on use of the data file as specified Section 8.1.20.2, "Reports" and in UMCM Chapter 5.

The MCO must have a process to expedite scheduling a prenatal appointment for an obstetrical exam for a Member that meets the eligibility criteria to be designated in the Pregnant Woman Risk Group no later than two weeks after receiving the daily Enrollment File verifying the Member's enrollment into the MCO or has a confirmed diagnosis indicating pregnancy.

The MCO must have procedures in place to contact and assist a pregnant/delivering Member in selecting a PCP for her baby either before the birth or as soon as the baby is born.

The MCO must provide inpatient care and professional services relating to labor and delivery for its pregnant/delivering Members for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated Caesarian delivery. The MCO must provide neonatal care for its newborn Members until the time of discharge.

The MCO must Adjudicate provider claims for services provided to a newborn Member in accordance with HHSC's claims processing requirements using the proxy ID number or State-issued Medicaid ID number. The MCO cannot deny claims based on a provider's non-use of State-issued Medicaid ID number for a newborn Member. The MCO must accept provider claims for newborn services based on mother's name or Medicaid ID number with accommodations for multiple births, as specified by the MCO.

The MCO must notify providers involved in the care of pregnant/delivering women and newborns, including Out-of-Network providers and Hospitals, of the MCO's prior authorization requirements. The MCO cannot require a prior authorization for services provided to a pregnant/delivering Member or newborn Member for a medical condition that requires Emergency Services, regardless of when the emergency condition arises.

8.2.2.5 Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV)

The MCO must provide STD services that include STD/HIV prevention, screening, counseling, diagnosis, and treatment. The MCO is responsible for implementing procedures to ensure that Members have prompt access to appropriate services for STDs, including HIV. The MCO must allow Members access to STD services and HIV diagnosis services without prior authorization or referral by a PCP.

The MCO must comply with Texas Family Code § 32.003, relating to consent to treatment by a child. The MCO must provide all Covered Services required to form the basis for a diagnosis by the Provider as well as the STD/HIV treatment plan.

The MCO must make education available to Providers and Members on the prevention, detection and effective treatment of STDs, including HIV.

The MCO must require Providers to report all confirmed cases of STDs, including HIV, to the local or regional health authority according to 25 Tex. Admin. Code §§ 97.131 - 97.134, using the required forms and procedures for reporting STDs. The MCO must require the Providers to coordinate with the HHSC regional health authority to ensure that Members with confirmed cases of syphilis, chancroid, gonorrhea, chlamydia and HIV receive risk reduction and partner elicitation/notification counseling.

The MCO must have established procedures to make Member records available to public health agencies with authority to conduct disease investigation, receive confidential Member information, and provide follow up activities.

The MCO must require that Providers have procedures in place to protect the confidentiality of Members provided STD/HIV services. These procedures must include,

but are not limited to, the manner in which medical records are to be safeguarded, how employees are to protect medical information, and under what conditions information can be shared. The MCO must inform and require its Providers who provide STD/HIV services to comply with all state laws relating to communicable disease reporting requirements. The MCO must implement policies and procedures to monitor Provider compliance with confidentiality requirements.

The MCO must have policies and procedures in place regarding obtaining informed consent and counseling Members provided STD/HIV services.

8.2.2.6 Tuberculosis (TB)

The MCO must provide Members and Providers with education on the prevention, detection and effective treatment of tuberculosis (TB). The MCO must establish mechanisms to ensure all procedures required to screen at-risk Members and to form the basis for a diagnosis and proper prophylaxis and management of TB are available to all Members, except services referenced in **Section 8.2.2.8** as Non-capitated Services. The MCO must develop policies and procedures to ensure that Members who may be or are at risk for exposure to TB are screened for TB. An at-risk Member means a person who is susceptible to TB because of the association with certain risk factors, behaviors, drug resistance, or environmental conditions. The MCO must consult with the local TB control program to ensure that all services and treatments are in compliance with the guidelines recommended by the American Thoracic Society (ATS), the Centers for Disease Control and Prevention (CDC), and DSHS policies and standards.

The MCO must implement policies and procedures requiring Providers to report all confirmed or suspected cases of TB to the local TB control program within one Business Day of identification, using the most recent DSHS forms and procedures for reporting TB. The MCO must provide access to Member medical records to DSHS and the local TB control program for all confirmed and suspected TB cases upon request.

The MCO must coordinate with the local TB control program to ensure that all Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT). The MCO must require, through contract provisions, that Providers report to DSHS or the local TB control program any Member who is non-compliant, drug resistant, or who is or may be posing a public health threat. The MCO must cooperate with the local TB control program in enforcing the control measures and quarantine procedures contained in Texas Health and Safety Code Chapter 81.

The MCO must have a mechanism for coordinating a post-discharge plan for follow-up DOT with the local TB program. The MCO must coordinate with the DSHS South Texas Hospital and Texas Center for Infectious Disease for voluntary and court-ordered admission, discharge plans, treatment objectives and projected length of stay for Members with multi-drug resistant TB.

8.2.2.7 Objection to Provide Certain Services

In accordance with 42 C.F.R. § 438.102, the MCO may file an objection based on moral or religions grounds to providing, reimbursing for, or providing coverage of a Covered Service or a counseling or referral service related to the Covered Service. The MCO must work with HHSC to develop a work plan to complete the necessary tasks and determine an appropriate date for implementation of the requested changes to the requirements related to Covered Services. The work plan will include timeframes for completing the necessary Contract and waiver amendments, adjustments to Capitation Rates, identification of the MCO and enrollment materials needing revision, and notifications to Members.

In order to meet the requirements of this section, no less than 120 Days prior to the proposed effective date of a policy change, the MCO must notify HHSC of grounds for and provide detail concerning its moral or religious objections and the specific services covered under the objection.

8.2.2.8 Medicaid Non-capitated Services

The following Texas Medicaid programs, services, or benefits have been excluded from MCO Covered Services. Medicaid Members are eligible to receive these Non-capitated Services on another basis, such as a Fee-for-Service basis, or through a Dental MCO (for most dental services). MCOs should refer to relevant chapters in the **Texas Medicaid Provider Procedures Manual** for more information.

- Texas Health Steps dental (including orthodontia);
- Texas Health Steps environmental lead investigation (ELI);
- Early Childhood Intervention (ECI) case management/Service Coordination;
- Early Childhood Intervention Specialized Skills Training;
- Texas School Health and Related Services (SHARS);
- Department of Assistive and Rehabilitative Services Blind Children's Vocational Discovery and Development Program;
- tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation);
- For STAR+PLUS, DADS hospice services;
- for STAR, Texas Health Steps Personal Care Services for Members birth through age 20;
- for STAR, Community First Choice (CFC) services;
- PASRR screenings, evaluations, and specialized services for STAR+PLUS Members;
- for Members who are enrolled in STAR or STAR+PLUS during an Inpatient Stay under one of the instances identified in **Attachment A**, Section 5.06(a)(2) where fee-for-service or the previous MCO is responsible for payment for Hospital facility charges associated with the Inpatient Stay, such charges are Non-Capitated Services; and
- Mental Health Targeted Case Management and Mental Health Rehabilitative Services for Dual Eligible Members.

8.2.2.9 Referrals for Non-capitated Services

Although Medicaid MCOs are not responsible for paying or reimbursing for Non-capitated Services, MCOs are responsible for educating Members about the availability of Non-capitated Services, and for providing appropriate referrals for Members to obtain or access these services. The MCO is responsible for informing Providers that bills for all Non-capitated Services must be submitted to HHSC's Claims Administrator for reimbursement.

8.2.2.10 Cooperation with Immunization Registry

The MCO must work with HHSC and health care providers to improve the immunization rate of Medicaid clients and the reporting of immunization information for inclusion in the Texas Immunization Registry, called "ImmTrac2."

8.2.2.11 Case Management for Children and Pregnant Women

The MCO must provide Case Management for Children and Pregnant Women Services. MCO efforts to provide these services include, but are not limited to, Member education, outreach, Service Coordination, and case collaboration with and referrals to and from Case Management for Children and Pregnant Women Providers. The MCO is required to follow referral procedures as outlined in UMCM Chapter 16.

The MCO must reimburse Out-of-Network Case Management for Children and Pregnant Women providers in accordance with HHSC's administrative rules regarding OON payment at 1 Tex. Admin. Code § 353.4.

The MCO must ensure Case Management for Children and Pregnant Women Providers have completed HHSC-approved training as required by Title 25, Part 1, Chapter 27, Subchapter C of the Texas Administrative Code.

The MCO must educate its Providers, including PCPs, Pediatric, and OB/GYN Providers, on the availability of Case Management for Children and Pregnant Women Services and how to provide referrals to Case Management for Children and Pregnant Women Providers.

Annually, all MCO Service Coordination staff must complete the Texas Health Steps Online module titled: Case Management Services in Texas and maintain proof of completion.

8.2.2.12 Farmworker Child(ren)

The MCO must identify community and statewide groups that work with Farmworker Child(ren) (FWC) in the MCO's service area(s). The MCO must cooperate and coordinate with as many of these groups as possible and encourage the groups to assist with identification of FWC.

The MCO must make efforts to reach identified FWC to provide timely Texas Health Steps checkups and needed follow-up care. Checkups and follow-up care must be in accordance with the Contract's timeframes, for appointment availability.

When necessary, the MCO must provide accelerated services to FWC Members. For purposes of this section, "Accelerated Services" are services that are provided to FWC prior to their leaving Texas for work in other states. Accelerated services include the provision of preventive services that will be due during the time the FWC Member is out of Texas or treatment that might be required prior to a travel date. The need for Accelerated Services must be determined on a case-by-case basis and according to the needs of the FWC.

The MCO must maintain accurate lists of all identified FWC. Additionally, the MCO must maintain the confidentiality of information about the identity of FWC.

In accordance with Chapter 12 of the UMCM, the MCO must submit an annual report that describes:

- methods used to identify FWC enrolled in the MCO and encourage timely checkups
- efforts to coordinate with community and statewide groups that work with FWC;
- methods used to assess Member health needs and provide accelerated services when necessary;
- how the MCO maintains accurate lists of FWC enrolled in the MCO; and
- how the MCO maintains confidentiality about the identify of FWC.

8.2.2.13 Prescribed Pediatric Extended Care Centers

Prescribed Pediatric Extended Care services must be prescribed by a physician and are considered an alternative to Private Duty Nursing (PDN). However, PPECC services must not supplant a child's right to receive PDN per Texas Health and Safety Code § 248A.151. Service hours in a PPECC are intended to be a one-to-one replacement of PDN service hours, unless additional hours are medically necessary, in accordance with Texas Health and Safety Code §248A.158. A Member who is eligible may receive both Private Duty Nursing and PPECC services. These services may be billed on the same Day but cannot be received at or billed for at the same time in that Day.

MCOs must ensure that Network PPECCs adhere to licensing requirements contained in Texas Health and Safety Code, Chapter 248A - Prescribed Pediatric Extended Care Centers and 26 Tex. Admin. Code, Chapter 550, "Licensing Standards for Prescribed Pediatric Extended Care Centers". MCOs and Network PPECCs must also adhere to Medicaid program rules contained in 1 Tex. Admin. Code § 363.201- § 363.217.

Pursuant to Texas Health and Safety Code § 248A.151, admission to a PPECC must be voluntary and based on the preference of the Member's parent or legal guardian. The MCO must ensure continuity of PPECC services in accordance with the authorization timeframes established in **Section 8.2.1**, "Continuity of Care and Out-of-Network (OON)

Providers." The MCO must also coordinate care and authorizations between PPECCs and a Member's other providers, including home health agencies, to ensure that the Member's PPECC plan of care does not include an overlap or duplication of Medically Necessary Covered Services, including, but not limited to PDN, PCS, Home Health Skilled Nursing, Home Health Aide services, and therapies. Members eligible for PPECC services will be classified as MSHCN as described in **Section 8.1.12**. MCOs must offer Service Coordination and develop a Service Plan as appropriate for these Members.

The cost of service must not be a factor in determining the most appropriate setting for an eligible Member to receive skilled nursing services. PPECC services are limited to no more than 12 hours a Day and may not be rendered overnight. Therapy services (occupational, speech, physical, and respiratory) rendered in a PPECC may be provided by (1) therapists employed by or contracted with the PPECC or (2) by credentialed Network therapists not employed by or contracted with the PPECC. Therapy services must be authorized and billed separately from PPECC services, and the MCO's claims systems must accommodate PPECCs as a place of service for therapy services.

8.2.2.13.1 Prior Authorization for PPECC Services

All PPECC services must be prior authorized. All prior authorization requests must contain documentation of medical necessity including a physician order and PPECC plan of care. MCOs may choose to utilize prior authorization forms used in fee-for-service Medicaid, such as the plan of care and Nursing Addendum, which includes a 24-hour daily care flow sheet, or similar plan-developed forms, as supplements to the standardized TDI prior authorization form.

An initial authorization for PPECC services may last for a maximum period of 90 Days, at which point a PPECC Provider must seek a new authorization of services, up to a maximum of 180 Days. Additionally, if there is a change in the Member's status before expiration of the authorization period, the PPECC Provider must modify the plan of care and seek a new authorization or a change in authorization.

8.2.2.14 NEMT Services

NEMT Services should be part of the MCO’s overall strategy to affect positive Member outcomes. The MCO must assess, approve, arrange, coordinate, and ensure delivery of NEMT Services in accordance with the Contract and Chapter 16 of the UMCM. NEMT Services include the following:

1. Demand response transportation services, including Nonmedical Transportation (NMT) Services, and public transportation services;
2. Mass transit;
3. Individual transportation participant (ITP) mileage reimbursement;
4. Meals;
5. Lodging;
6. Advanced funds; and
7. Commercial airline transportation services.

NEMT Services must be delivered using the most cost-effective and cost-efficient method of delivery that allows the Member to meet his or her health care needs, including delivering NMT Services through a Transportation Network Company (TNC) or other transportation vendor if available and medically appropriate.

The MCO must coordinate NEMT Services that enable Members to obtain Medicaid-covered dental benefits in the Dental Program.

The MCO must require NEMT Services within the Member's Service Area to be requested at least two Business Days in advance of the date of the requested trip. The MCO must require a request for a trip outside of the Member's Service Area (i.e., a "long-distance trip") to be received at least five Business Days in advance of the trip. The MCO must make an exception to either of these requirements for transportation to access treatment for an Urgent Condition, transportation after hospital discharge, and transportation to a pharmacy to pick up a prescription or obtain Health Care Services provided by a pharmacy, such as DME items. These trips may be requested with less than 48 hours' notice. Additional exceptions to these timeframe requirements may be granted at the MCO's discretion. The MCO is not required to approve requests for NEMT Services made with less than three hours' notice. The MCO must document actions taken in attempt to arrange the requested transportation.

The MCO must develop and maintain a database compliant with federal and state laws, rules, and regulations for tracking NEMT Services requests that is capable of interfacing with HHSC systems to provide electronic records in a prescribed media and format. At a minimum, the MCO must:

- Establish and maintain a computer system that complies with federal and state laws, rules, and regulations, including HIPAA.
- Maintain hardware, software, internet and communication equipment to support automated services necessary to carry out the requirements of the Contract using industry standard products.
- Maintain a reservation system capable of conducting NEMT Services reservations and confirmation of transactions.
- Track NEMT Services received by Members through the system and accurately and fully maintain those service records as HIPAA-complaint Encounter transactions.
- Maintain a history of changes and adjustments and audit trails for current and retroactive data.
- Maintain a vehicle management Platform capable of monitoring vehicle status including mileage, condition, and inspections routinely, including identification data for the vehicles including owner, plate number, and vehicle identification number.
- Maintain a driver management Platform capable of monitoring driver status including trainings, driver's license, criminal history checks, sex offender registry checks, motor vehicle reports from DPS, drug testing, and federal and state screening requirements.
- Maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure.

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8.2.2.14.1 Approval of NEMT Services

All NEMT Services provided to Members must be approved by the MCO. The MCO must have a process in place for modifying a Member's approved, scheduled trip to add a stop, such as to the pharmacy, clinic, or other health care facility as ordered by attending physician. The MCO must use an automated scheduling system to record, approve, and coordinate NEMT Services. This system must be capable of accommodating reservations for future trips as well as requests for same day trips and urgent trips. At minimum, for any delivered NEMT Services, the MCO must be able to provide documentation of the following upon request:

- The name and Medicaid number of the Member using the service.
- The pickup and destination addresses, including a telephone number for the trip destination.
- Evidence that the NEMT Service was for an allowable purpose and in conjunction with a covered health care service.
- Evidence that the Member had no other means of transportation (this may be met through self-attestation).
- Information on any special transportation needs, such as use of a wheelchair.
- If applicable, the justification for providing NEMT Services outside of the Service Area.

Each MCO may determine the means by which this information is collected, including whether the information is collected prior to each NEMT Service occurrence.

To avoid risk to Member health and safety, the MCO must determine appropriateness of using a TNC while authorizing the transportation.

Separate from, and in addition to the automated scheduling system, the MCO must provide an online reservation system for Members or providers to request NEMT Services.

8.2.2.14.1.1 Out-of-State Travel Requests

The MCO must permit and provide out-of-state NEMT Services to Members for authorized out-of-state Health Care Services. If a Member must travel to another state to receive Health Care Services, the MCO must not levy additional fees against the Member or HHSC.

8.2.2.14.1.2 Meals and Lodging

The MCO must provide the cost of meals and lodging for a Member birth through age 20 if the costs are either:

a. directly associated with a long-distance trip to obtain Health Care Services, or

b. necessary because a Member who is already outside his or her county of residence experiences an unplanned or urgent healthcare event that requires the Member or remain in the area overnight for treatment before the Member can return home.

Meals and lodging may be provided while en route to and from or while receiving a Health Care Service. The MCO may approve meals or lodging or both. If the Member requires an NEMT Attendant, the cost of meals and lodging for the NEMT Attendant must also be covered, except if the NEMT Attendant is a service animal.

The MCO is responsible for making the appropriate arrangements, reservations, and otherwise coordinating the stay with the lodging facility.

Meal Per Diem: The per diem rate for meals is $25 per day per person. The MCO must approve meals for an additional NEMT Attendant when a health care provider documents the need for the NEMT Attendant.

Lodging: The MCO must approve expenses to cover the Member's lodging for the night before a Health Care Service if travel cannot be reasonably accomplished on the day of the appointment, or if a health care provider's statement of need or equivalent documents the necessity to travel the night before a Health Care Service. The MCO must approve expenses for lodging services for the night after a Health Care Service if:

1. Travel to the Member's residence reasonably requires an additional day due to length or circumstances beyond the Members control; or
2. A health care provider's statement of need or equivalent documents the necessity for additional lodging.

Lodging services are limited to the overnight stay and do not include any amenities or incidentals used during the Member's stay, such as phone calls, room service, or laundry service. The Member may use amenities offered by charitable organizations, such as the Ronald McDonald House, at no cost to the Member or HHSC. The MCO must approve lodging for an additional NEMT Attendant when a health care provider documents the need, such as for both parents to receive training on the use of medical equipment or delivery of complex care or to allow both parents to accompany a child not expected to survive the trip.

8.2.2.14.1.3 Individual Transportation Participants (ITPs)

ITP services reimburse a Member or his or her family member, friend, or neighbor for the mileage, as calculated by the MCO, incurred when driving the Member to a Health Care Service. ITP services are available to Members of any age.

8.2.2.14.1.4 Advanced Funds

For Members age 20 and younger, the MCO must authorize advanced funds to be used to purchase gas, meals, or lodging prior to the trip if the Member requires these funds in

advance to access necessary Health Care Services. All other ITP requirements apply in these circumstances.

8.2.2.14.1.5 Nonmedical Transportation Services

The MCO must only authorize a TNC to provide NMT Services. If a TNC does not operate in the area where the Member or the Health Care Service is located, the MCO may not approve the use of NMT. Instead, the MCO must provide the requested transportation using another NEMT Service for the Member, including demand response transportation services with less than 48-hours' notice, if the trip is to access treatment for an Urgent Condition, transportation after hospital discharge, or transportation to a pharmacy.

8.2.2.14.1.6 NEMT Attendant Requirements

Members who need assistance while being transported may request an NEMT Attendant. The MCO may approve an NEMT Attendant for nonmedical reasons, such as to provide communication assistance to the Member, without a written statement from a healthcare provider. A written statement from the Member's primary healthcare provider is necessary for the MCO to approve an NEMT Attendant for medical reasons.

The NEMT Attendant must accompany the Member from the origin to the approved destination and on the return trip, including add-on trips. Except for parents or guardians, the MCO must document the need for the NEMT Attendant. If documentation states an NEMT Attendant is necessary, the trip may not proceed without an NEMT Attendant. If an NEMT Attendant is necessary but not present when the driver arrives to pick up the Member, the NEMT Service must be recorded as a Member "no-show" and rescheduled. The NEMT Attendant must remain at the location where Health Care Services are being provided but may remain in the waiting room during the Member's appointment. The NEMT Services provider must not require reimbursement from the NEMT Attendant.

Before the trip may commence, the NEMT Attendant must provide and install any necessary child safety seats.

8.2.2.14.2 Approval of Mass Transit NEMT Services

The MCO must not authorize mass transit if the Member's health care provider has documented that the Member:

1. has a high-risk pregnancy;
2. is in the eighth month of pregnancy or later;
3. has high-risk cardiac conditions;
4. has severe breathing problems; or
5. requires life sustaining medical care.

NEMT Services for Members with these health concerns must be scheduled to minimize wait times and riding times.

8.2.2.14.3 NEMT Services Providers

8.2.2.14.3.1 Transportation Network

The MCO will establish and maintain a transportation network that meets NEMT Services needs for Members within the Service Area. In establishing its network, the MCO must consider the following factors: Member characteristics; historical service utilization data; geographic location of heath care providers and Members, including distance, travel time, and available modes of transportation; and health care provider hours of operation that may be outside regular business hours, such as dialysis centers. The MCO's transportation network must include a sufficient and reliable fleet of vehicles and various modes of transportation, including buses, sedans, vans, wheelchair accessible vehicles, and the personal cars of drivers who are part of a TNC's network.

The MCO must ensure vehicles in its transportation network comply with all applicable state and federal laws, rules, and regulations, including Federal Motor Vehicle Safety Standards (49 C.F.R. Part 571) and Texas Transportation Code, Title 7, Chapter 547. MCOs must also ensure there are vehicles in their networks that comply with the ADA Accessibility Guidelines for Transportation Vehicles (36 C.F.R. Part 1192) in order to meet the needs of Members with special needs.

8.2.2.14.3.2 NEMT Services Provider Enrollment

The MCO must:

1. Comply with the provider selection requirements in 42 C.F.R. § 438.214 and the prohibitions against provider discrimination in 42 C.F.R. § 438.12, as applicable.
2. Ensure that NEMT Services providers are properly enrolled through the HHSC's Claims Administrator and appear on PEMS or other system application designated by HHSC in order to be eligible for inclusion in the MT88 MCO Network File prior to providing NEMT Services.
3. Enroll NEMT Services providers that will be part of the MT88 MCO Network File through the MCO enrollment process and enter into a written agreement with each of those providers of NEMT Services. An executed copy of the written agreement must be provided to HHSC no later than 10 Business Days after execution.
4. Enter into a Data Use Agreement (DUA) with the NEMT Services provider and maintain a signed copy of that DUA.

NEMT Services providers may have an Atypical Provider Identifier (API) or NPI.

8.2.3 Medicaid Significant Traditional Providers

Medicaid Significant Traditional Providers (STP) are defined as pharmacy providers and providers of Acute and Long Term Services and Supports and, for STAR+PLUS, Community-based Long Term Care providers in a county that provided a significant level

of care to Medicaid clients, as determined by HHSC. Beginning September 1, 2017, Medicaid STP requirements apply statewide for Providers serving individuals in the Medicaid Breast and Cervical Cancer (MBCC) program. In addition, STP provisions apply to Providers for AA Members and PCA Members identified by HHSC.

Beginning March 1, 2015, Medicaid STP requirements applied statewide for Nursing Facilities in STAR+PLUS. The MCO must treat a Nursing Facility as an STP if it holds a valid certification and license and it contracts with DADS as of September 1, 2013. Beginning June 1, 2015, Medicaid STP requirements apply statewide for CFC Providers in STAR+PLUS with a valid certification or license (as applicable) and who are:

a) Home and community support services agencies licensed under Texas Health and Safety Code Chapter 142 that are to provide services under the Community Living Assistance and Support Services (CLASS) or Deaf Blind Multiple Disabilities (DBMD) waiver programs; or
b) Providers exempted from licensing under Texas Health and Safety Code § 142.003(a)(19) and are contracted with DADS to provide services under the Home and Community-based Services (HCS) or Texas Home Living (TxHmL) waiver programs.

Medicaid STP requirements applied or continue to apply in the following manner.

Provider Type	Medicaid Program Service Area		Expiration Date
	STAR	STAR+PLUS	
Substance Use Disorders (SUD) providers	Statewide	statewide	See 8.1.4. Provider Network
Nursing Facilities	Statewide	statewide	February 28, 2018
LMHAs/LBHAs	Statewide	statewide	See 8.1.4 Provider Network
CFC Providers	Not applicable	statewide	May 31, 2018
Case Management for Children and Pregnant Women Providers	Statewide	Statewide	September 1, 2025

The MCO must give STPs the opportunity to participate in its Network for at least three years from the start of the STP requirement. However, the STP must:

1. agree to accept the MCO's Provider reimbursement rate for the provider type; and
2. meet the standard credentialing requirements of the MCO, provided that lack of board certification or accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) is not the sole grounds for exclusion from the Provider Network.

The MCO may terminate a Provider Contract with an STP after demonstrating, to the satisfaction of HHSC, good cause for the termination. Good cause may include evidence of provider Fraud, Waste, or Abuse.

8.2.4 MCO Internal Provider Complaints and Appeals Process

This section applies to NEMT Services providers unless stated otherwise.

8.2.4.1 Provider Complaints

MCOs must develop, implement, and maintain a system for tracking and resolving all Medicaid Provider complaints. Within this process, the MCO must respond fully and completely to each complaint and establish a tracking mechanism to document the status and final disposition of each Provider complaint. The MCO must provide information about the complaint and internal MCO appeal system to all providers and subcontractors at the time they enter into a contract. The MCO must resolve Provider complaints within 30 Days from the date the complaint is received. The HMO is subject to remedies, including liquidated damages, if at least 98 percent of Provider Complaints are not resolved within 30 Days of receipt of the Complaint by the HMO. Please see the **Attachment A** "Uniform Managed Care Contract Terms & Conditions" and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix."

MCOs must also resolve Provider complaints received by HHSC and referred to the MCOs no later than the due date indicated on HHSC's notification form. HHSC will generally provide MCOs ten Business Days to resolve such complaints. If an MCO cannot resolve a complaint by the due date indicated on the notification form, it may submit a request to extend the deadline. HHSC may, in its reasonable discretion, grant a written extension if the MCO demonstrates good cause.

Unless HHSC has granted a written extension as described above, the MCO is subject to contractual remedies, including liquidated damages if Provider complaints are not resolved by the timeframes indicated herein.

8.2.4.2 Provider Appeal of MCO Claims Determinations

MCOs must develop, implement, and maintain a system for tracking and resolving all Medicaid Provider appeals related to claims payment, as required by Texas Government Code § 533.005(a)(15). Within this process, the MCO must respond fully and completely to each Medicaid Provider's claims payment appeal and establish a tracking mechanism to document the status and final disposition of each appeal. The MCO must allow Community-based Long Term Services and Supports providers to appeal claims that the MCO has not paid or denied by the 31st Day following receipt.

In addition, the MCO's process must comply with Texas Government Code § 533.005(a)(19). The MCO and Dental Contractor must provide information specified in 42 C.F.R. § 438.10(g)(2)(xi) about the grievance and MCO appeal system to all Providers and subcontractors at the time they enter into a contract.

The MCO is subject to liquidated damages if at least 98 percent of Provider Appeals are not resolved within 30 Days of the MCO's receipt.

MCOs must contract with non-network physicians to resolve claims disputes related to denial on the basis of Medical Necessity that remain unresolved subsequent to a provider appeal. The physician resolving the dispute must not be an employee of the MCO's Medicaid or CHIP business but may be an employee in the MCO's Medicare or commercial lines of business. The determination of the physician resolving the dispute must be binding on the MCO and a Network Provider. The physician resolving the dispute must be licensed in the State of Texas and hold the same specialty or a related specialty as the appealing provider. HHSC reserves the right to amend this process to include an independent review process established by HHSC for final determination on these disputes.

8.2.5 Member Rights and Responsibilities

In accordance with 42 C.F.R. §438.100, MCOs must maintain written policies and procedures for informing Members of their rights and responsibilities and must notify Members of their right to request a copy of these rights and responsibilities. The Member Handbook must include a notice that complies with UMCM Chapter 3.

The use of seclusion is not permitted for Members receiving services in HCBS settings in the STAR+PLUS. Program.Seclusion is the involuntary placement of an individual alone in an area from which the individual is prevented from leaving. STAR+PLUS MCOs are required to report the use of unauthorized seclusion of its Members to HHSC as a Critical Event or Incident through the process outlined in UMCM Chapter 5. MCOs must also report unauthorized seclusion to the Department of Family and Protective Services.

Members have additional rights and responsibilities that apply specifically to utilization of NEMT Services, which are outlined in UMCM Section 3.4 Attachment FF.

8.2.6 Medicaid Member Complaint and Appeal System

The MCO must develop, implement, and maintain a Member Complaint and Appeal system that complies with the requirements in applicable federal and state laws and regulations, including 42 C.F.R. §431.200; 42 C.F.R. Part 438, Subpart F, "Grievance System"; and the provisions of 1 Tex. Admin. Code Chapter 357, relating to Medicaid managed care organizations.

The Complaint and Appeal system must include a Complaint process, an Appeal process, and access to HHSC's State Fair Hearing System. The procedures must be the same for all Members and must be reviewed and approved in writing by HHSC or its designee. Modifications and amendments to the Member Complaint and Appeal system must be submitted for HHSC's approval at least 30 Days prior to the implementation.

For purposes of this section an "authorized representative" is any person or entity acting on behalf of the Member in compliance with State law and 42 C.F.R. §438.402. A Provider may be an authorized representative.

The MCO must refer any Member alleging provider noncompliance with Government Code §531.02119(a) to the HHS Office of the Ombudsman.

8.2.6.1 MCO Internal Member Complaint Process

The MCO must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting and resolving Complaints by Members or their authorized representatives.

MCOs also must resolve Member Complaints received by HHSC and referred to the MCOs no later than the due date indicated on HHSC's notification form. HHSC will provide MCOs up to ten Business Days to resolve such Complaints, depending on the severity and/or urgency of the Complaint. HHSC may, in its reasonable discretion, grant a written extension if the MCO demonstrates good cause.

Unless the HHSC has granted a written extension as described above, the MCO is subject to contractual remedies, including liquidated damages, if Member Complaints are not resolved by the timeframes indicated herein.

The MCO must resolve Complaints within 30 Days from the date the Complaint is received. The MCO is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints are not resolved within 30 Days of receipt of the Complaint by the MCO. Please see the **Attachment A**, "Uniform Managed Care Contract Terms and Conditions," and **Attachment B-3,** "Deliverables/Liquidated Damages Matrix." The Complaint procedure must be the same for all Members. The Member or Member's authorized representative may file a Complaint either orally or in writing. The MCO must also inform Members how to file a Complaint directly with HHSC, once the Member has exhausted the MCO's Complaint process.

The MCO must designate an officer of the MCO who has primary responsibility for ensuring that Complaints are resolved in compliance with written policy and within the required timeframe. For purposes of **Section 8.2.6.1**, an "officer" of the MCO means a president, vice president, secretary, treasurer, or chairperson of the board for a corporation, the sole proprietor, the managing general partner of a partnership; or a person having similar executive authority in the organization.

The MCO must have a routine process to detect patterns of Complaints. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Complaints.

The MCO's Complaint procedures must be provided to Members in writing and through oral interpretive services. A written description of the MCO's Complaint procedures must be available in Prevalent Languages for Major Population Groups identified by HHSC, at no more than a 6th grade reading level.

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

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

1. a description of the reason for the internal MCO Complaint;
2. the date received;
3. the date of each reviewer, if applicable, review meeting;
4. resolution at each level of the internal Complaint, if applicable;
5. date of resolution at each level, if applicable); and
6. name of the covered person for whom the internal MCO Complaint was filed.

The records must be accurately maintained in a manner accessible to the state and available upon request to CMS. The MCO must acknowledge the Member's Complaint, in writing, within five Business Days after the MCO receives the Complaint unless the complaint is an Initial Contact Complaint.

For Complaints that are received In-Person or by telephone, the MCO must provide Members or their representatives with written notice of resolution if the Complaint cannot be resolved within one working day of receipt. As the Texas Department of Insurance does not require the reporting of those issues to TDI (see 28 Tex. Admin. Code § 3.9202(2)), the MCOs shall report this subcategory of Complaints to HHSC as "Initial Contact Complaints."

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making a Complaint.

If the Member makes a request for disenrollment from the MCO and wants to select a different MCO, or if the Member is voluntarily enrolled in the Managed Care model and would like to disenroll, the MCO must give the Member information on the disenrollment process and direct the Member to the HHSC Administrative Services Contractor. If the Member is enrolled in the Managed Care program on a mandatory basis and requests disenrollment from Managed Care, the MCO must direct the Member to HHSC. If the request for disenrollment includes a Complaint by the Member, the Complaint will be processed separately from the disenrollment request, through the Complaint process.

The MCO will cooperate with HHSC or its designee to resolve all Member Complaints. Such cooperation may include, but is not limited to, providing information or assistance to HHSC Complaint team members.

The MCO must provide designated Member Advocates, as described in **Section 8.2.6.9,** to assist Members in understanding and using the MCO's Complaint system. The MCO's

Member Advocates must assist Members in writing or filing a Complaint and monitoring the Complaint through the MCO's Complaint process until the issue is resolved.

8.2.6.2 Medicaid Member MCO Internal Appeal Process

The MCO must develop, implement and maintain an Appeal procedure that complies with state and federal laws and regulations, including 42 C.F.R. § 431.200 and 42 C.F.R. Part 438, Subpart F, "Grievance System." An Appeal is a disagreement with an MCO Adverse Benefit Determination as defined in **Attachment A**, "Uniform Managed Care Contract Terms and Conditions." The Appeal procedure must be the same for all Members. When a Member or his or her authorized representative expresses orally or in writing any dissatisfaction or disagreement with an Adverse Benefit Determination, the MCO must regard the expression of dissatisfaction as a request to Appeal an Adverse Benefit Determination.

The provisions of Chapter 4201, Texas Insurance Code, relating to an appeal to an independent review organization, do not apply to a Medicaid recipient. Texas Medicaid is using the External Medical Review process provided in 42 C.F.R. 438.408(f)(1)(ii). Medicaid MCOs are still expected to comply with the other applicable requirements of the Texas Insurance Code, including Chapter 4201.

The MCO must have policies and procedures in place outlining the Medical Director's role in an Appeal of an Adverse Benefit Determination. The Medical Director must have a significant role in monitoring, investigating and hearing Appeals. In accordance with 42 C.F.R.§ 438.406, the MCO's policies and procedures must require that individuals who make decisions on Appeals are not involved in any previous level of review or decision-making and are health care professionals who have the appropriate clinical expertise in treating the Member's condition or disease.

The MCO must provide designated Member Advocates, as described in **Section 8.2.6.9**, to assist Members in understanding and using the Appeal process. The MCO's Member Advocates must assist Members in writing or filing an Appeal and monitoring the Appeal through the MCO's Appeal process until the issue is resolved.

The MCO must have a routine process to detect patterns of Appeals. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Appeals.

The MCO's Appeal procedures must be provided to Members in writing and through oral interpretive services. A written description of the Appeal procedures must be available in Prevalent Languages identified by HHSC, at no more than a 6th grade reading level. The MCO must include a written description of the Appeals process in the Member Handbook. The MCO must maintain and publish in the Member Handbook at least one toll-free telephone number with TTY/TDD and interpreter capabilities for requesting an Appeal of an Adverse Benefit Determination. The MCO must provide such oral interpretive service to callers free of charge.

The MCO's process must treat every oral request for an MCO Internal Appeal in the same manner as a written request. The date of the oral request should be treated as the filing date of the request. All MCO Appeals must be recorded in a written record and logged with the following details:

1. A general description of the reason for the MCO appeals or grievance.
2. The date received.
3. The date of each review or, if applicable, review meeting.
4. Resolution at each level of the MCO appeal or grievance, if applicable.
5. Date of resolution at each level, if applicable.
6. Name of the covered person form whom the MCO appeal or grievance was filed.

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

A Member must file a request for an MCO Appeal within 60 Days from the date of the notice of the Adverse Benefit Determination. To ensure continuation of currently authorized services, the Member must file the Appeal on or before the later of: (1) ten Days following the MCO's sending of the notice of the Adverse Benefit Determination, or (2) the intended effective date of the proposed Adverse Benefit Determination. The MCO must send a letter to the Member within five Business Days acknowledging receipt of the Appeal request. Except for the resolution of an Expedited MCO Internal Appeal as provided in **Section 8.2.6.3**, the MCO must complete the entire standard Appeal process within 30 Days after receipt of the initial written or oral request for Appeal. The timeframe for an Appeal may be extended up to 14 Days if the Member or his or her representative requests an extension, or the MCO shows that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, the MCO must give the Member written notice of the reason for delay if the Member had not requested the delay. The MCO must designate an officer who has primary responsibility for ensuring that Appeals are resolved within these timeframes and in accordance with the MCO's written policies.

During the Appeal process, the MCO must provide the Member a reasonable opportunity to present evidence and any allegations of fact or law In-Person as well as in writing. The MCO must inform the Member of the time available for providing this information and that, in the case of an expedited resolution, limited time will be available.

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

In accordance with 42 C.F.R. § 438.420, the Medicaid MCO must continue the Member's benefits currently being received by the Member, including the benefit that is the subject of the Appeal, if all of the following criteria are met:

1. the Member or his or her representative files the Appeal timely as defined in this Contract:
2. the Appeal involves the termination, suspension, or reduction of a previously authorized services;
3. the services were ordered by an authorized provider;
4. the period covered by the original authorization has not expired; and
5. the Member or his or her representative timely requests an extension of the benefits.

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

1. the Member withdraws the Appeal or request for State Fair Hearing;
2. ten Days pass after the MCO mails the notice resolving the Appeal against the Member, unless the Member, within the ten-Day timeframe, has requested a State Fair Hearing with continuation of benefits; or
3. a State Fair Hearing Officer issues a hearing decision adverse to the Member.

In accordance with state and federal regulations, if the final resolution of the Appeal is adverse to the Member and upholds the MCO's Adverse Benefit Determination, then to the extent that the services were furnished to comply with the Contract, the MCO must not recover such costs from the Member without written permission form HHSC.

If the MCO, Independent Review Organization (IRO), or State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the MCO Appeal was pending, the MCO must authorize or provide the disputed services as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

If the MCO, IRO, or State Fair Hearing Officer reverses a decision to deny authorization of services and the Member received the disputed services while the Appeal was pending, the MCO is responsible for the payment of services.

If the IRO or a State Fair Hearing Officer reverses an MCO's denial of a prior authorization for a DME service/equipment after the Member has enrolled with a second MCO, the original MCO must pay for the DME service/equipment from the date it denied the authorization until the date the Member enrolled with the second MCO. In the case of custom DME, the original MCO must pay for the custom DME if the denial is reversed.

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making an Appeal.

8.2.6.3 Expedited MCO Internal Appeals

In accordance with 42 C.F.R. §438.410, the MCO must establish and maintain an expedited review process for Appeals. Such expedited process will apply when the MCO determines (for a request from a Member) or the provider indicates (in making the

request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain or regain maximum function. The MCO must follow all Appeal requirements for standard Member Appeals as set forth in **Section 8.2.6.2**, except where differences are specifically noted. The MCO must accept oral or written requests for Expedited MCO Internal Appeals.

Members must exhaust the expedited MCO Internal Appeal process before making a request for an expedited State Fair Hearing/EMR. After the MCO receives the request for an Expedited MCO Internal Appeal, it must hear an approved request for a Member to have an Expedited MCO Internal Appeal and notify the Member of the outcome of the Expedited MCO Internal Appeal within 72 hours except that the MCO must complete investigation and resolution of an Appeal relating to an ongoing emergency or denial of continued Hospitalization: (1) in accordance with the medical or dental immediacy of the case; and (2) not later than one Business Day after receiving the Member's request for Expedited MCO Internal Appeal.

Except for an Appeal relating to an ongoing emergency or denial of continued hospitalization, the timeframe for notifying the Member of the outcome of the Expedited MCO Internal Appeal may be extended up to 14 Days if the Member requests an extension or the MCO shows (to the satisfaction of HHSC, upon HHSC's request) that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, the MCO must give the Member written notice of the reason for delay if the Member had not requested the delay.

If the decision is adverse to the Member, the MCO must follow the procedures relating to the notice in **Section 8.2.6.5**. The MCO is responsible for notifying the Member of his or her right to access an EMR and/or an expedited State Fair Hearing from HHSC. The MCO will be responsible for providing documentation to HHSC and the Member, indicating how the decision was made, prior to HHSC's expedited State Fair Hearing.

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for requesting an Expedited MCO Internal Appeal. The MCO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a Member's request.

If the MCO denies a request for expedited resolution of an Appeal, it must:

1. transfer the Appeal to the timeframe for standard resolution, and
2. make a reasonable effort to give the Member prompt oral notice of the denial and follow up within two Days with a written notice.

8.2.6.4 Access to State Fair Hearing and External Medical Review (EMR) for Medicaid Members

The MCO must inform Members that they have the right to access the State Fair Hearing process, with or without an External Medical Review, only after exhausting the MCO Internal Appeal System provided by the MCO. The Member may request an EMR

and/or State Fair Hearing if the MCO fails to respond to the Member's Appeal within the timeframe in 42 C.F.R. § 438.408. The MCO must notify Members that they may be represented by an authorized representative in the State Fair Hearing process. The EMR is an optional, extra step a Member may request to further review the MCO's adverse benefit determination. The EMR will not consider new evidence. The MCO must provide the IRO the same set of records the MCO reviewed to determine service denial. EMRs will be conducted by IROs contracted by HHSC. The role of the IRO is to act as an objective arbiter and decide whether the MCO's original adverse benefit determination must be reversed or affirmed. The EMR will take place between the MCO Internal Appeal and the State Fair Hearing. The MCO is responsible for implementing the IRO EMR decisions of "overturned" or "partially overturned" within 72 hours of receiving the EMR decision from the IRO.

If a Member requests a State Fair Hearing, the MCO will complete and submit the request via TIERS to the appropriate State Fair Hearings office, within five Days of the Member's request for a State Fair Hearing. If the Member requests an EMR, the MCO will enter the request into TIERS, along with MCO Internal Appeal decision supporting documentation, and submit the request via TIERS to the HHSC Intake Team within three Days of the Member's request for an EMR.

Within five Days of notification that the State Fair Hearing is set, the MCO will prepare an evidence packet for submission to the HHSC State Fair Hearings staff and send a copy of the packet to the Member. The evidence packet must comply with HHSC's State Fair Hearings requirements.

The MCO must ensure that the appropriate staff members who have firsthand knowledge of the Member's appeal in order to be able to speak and provide relevant information on the case attend all State Fair Hearings as scheduled.

8.2.6.4.1 Independent Review Organization (IRO) Reimbursement for External Medical Reviews (EMRs)

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

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

MCO will pay the IRO $300.00 if the Member withdraws a non-expedited EMR request within five Calendar Days from the date the IRO receives notice of the EMR request, provided the IRO has not rendered an EMR decision.

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

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

8.2.6.6 Timeframe for Notice of Adverse Benefit Determination

In accordance with 42 C.F.R. § 438.404(c), the MCO must mail a notice of Adverse Benefit Determination within the following timeframes:

1. for termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 15 Business Days before the termination, suspension, or reduction of previously authorized services, or within the timeframes specified in 42 C.F.R.§§ 431.213 and 431.214;
2. for denial of payment, at the time of any Adverse Benefit Determination affecting the claim;
3. for standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R.§ 438.210(d)(1);
4. if the MCO extends the timeframe in accordance with 42 C.F.R. § 438.210(d)(1), it must:
    a. give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Complaint if he or she disagrees with that decision; and
    b. issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires;
5. for service authorization decisions not reached within the timeframes specified in 42 C.F.R.§ 438.210(d) (which constitutes a denial and is thus an Adverse Action), on the date that the timeframes expire;
6. for expedited service authorization decisions, within the timeframes specified in 42 C.F.R. § 438.210(d); and
7. all timeframes required in UMCM Chapter 3.

8.2.6.7 Notice of Disposition of Appeal

In accordance with 42 C.F.R. § 438.408(e), the MCO must provide written notice of disposition of all Appeals including Expedited MCO Internal Appeals to the affected parties. The written resolution notice (e.g., approval, denial, etc.) must be sent to the Member and must also be sent to a person acting on behalf of the Member to ensure the Member has an adequate opportunity to request a State Fair Hearing/EMR within ten Days if they choose to do so. The notice must include the results and date of the Appeal resolution. For decisions not wholly in the Member's favor, the notice must contain:

1. the right to request a State Fair Hearing/EMR;
2. how to request a State Fair Hearing/EMR;

3. The circumstances under which the Member may continue to receive benefits pending a State Fair Hearing/EMR;
4. how to request the continuation of benefits;
5. if the MCO's Adverse Benefit Determination is upheld in a State Fair Hearing, the Member may be liable for the cost of any services furnished to the Member while the Appeal is pending; and
6. any other information required by 1 Tex. Admin. Code Chapter 357 that relates to a managed care organization's notice of disposition of an Appeal.

8.2.6.8 Timeframe for Notice of Resolution of Appeals

In accordance with 42 C.F.R.§ 438.408, the MCO must provide written notice of resolution of Appeals, including Expedited MCO Internal Appeals, as expeditiously as the Member's health condition requires, but the notice must not exceed the timeframes provided in this Section for MCO Internal Appeals or Expedited MCO Internal Appeals. For expedited resolution of Appeals, the MCO must make reasonable efforts to give the Member prompt oral notice of resolution of the Appeal and follow up with a written notice within the timeframes set forth in this Section. If the MCO denies a request for expedited resolution of an Appeal, the MCO must transfer the Appeal to the timeframe for resolution as provided in this Section, make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two Days with a written notice.

8.2.6.9 Medicaid Member Advocates

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

1. their rights and responsibilities,
2. the Complaint process,
3. the Appeal process,
4. Covered Services available to them, including preventive services, and
5. Non-capitated Services available to them.

Member Advocates must assist Members in writing Complaints and are responsible for monitoring the Complaint through the MCO's Complaint process.

Member Advocates are responsible for making recommendations to the MCO's management on any changes needed to improve either the care provided, or the way care is delivered. Member Advocates are also responsible for helping or referring Members to community resources that are available to meet Members' needs if services are not available from the MCO as Covered Services.

8.2.6.10 NEMT Services Complaints and Appeals

All of the requirements found in this section 8.2.6, including its subsections, apply to NEMT Services, with the following exceptions:

1. The MCO Medical Director is not required to review Appeals related to NEMT Services in accordance with 8.2.6.2, unless the MCO action being appealed is related to a medical issue.
2. No specific clinical expertise is required in accordance with 8.2.6.2 for reviewers of Appeals related to NEMT Services.

8.2.7 Additional Medicaid Behavioral Health Provisions

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8.2.7.2 Substance Use Disorder Benefit

8.2.7.2.1 Substance Use Disorder and Dependency Treatment Services

Substance Use Disorder includes Substance Use Disorder and dependence as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

8.2.7.2.2 Providers and Referrals

MCOs must follow provider requirements at Sections 8.1.3.2, and 8.1.4 for Substance Use Disorder outpatient and residential services, respectively.

MCOs must maintain a provider education process to inform Substance Use Disorder treatment Providers in the MCO's Network on how to refer Members for treatment.

8.2.7.2.3 Care Coordination

MCOs must ensure care coordination is provided to Members with a Substance Use Disorder. MCOs must work with Providers, facilities, and Members to coordinate care for Members with a Substance Use Disorder and to ensure Members have access to the full continuum of Covered Services (including without limitation assessment, detoxification, residential treatment, outpatient services, and medication therapy) as Medically Necessary and appropriate. MCOs must also coordinate services with the appropriate state agencies, including HHSC and DFPS, and their designees for Members requiring Non-Capitated Services. Non-Capitated Services includes, without limitation, services that are not available for coverage under the Contract, State Plan or Waiver that are available under the Federal Substance Abuse and Prevention and Treatment block grant when provided by a HHSC-funded provider or covered by DFPS under direct contract with a treatment provider. MCOs must work with state agencies including HHSC and, DFPS, and providers to ensure payment for Covered Services is available to Out-of-Network providers who also provide related Non-capitated Services when the Covered Services are not available through Network Providers.

In accordance with UMCM Chapter 16 the MCO must share and integrate care coordination and service authorization data internally and, if applicable, between the

MCO and the third party or subsidiary contracted with the MCO to manage Behavioral Health Services. MCOs must implement joint rounds for physical health and Behavioral Health Services Network Providers or implement another effective means for sharing clinical information. MCOs must, to the extent feasible, co-locate physical health and Behavioral Health care coordination staff and ensure warm call transfers between physical health and Behavioral Health care coordination staff.

8.2.7.2.4 Member Education and Self-Referral for Substance Use Disorder and Dependency Treatment Services

MCOs must maintain a Member education process (including hotlines, manuals, policies and other Member Materials) to inform Members of the availability of and access to Substance Use Disorder treatment services, including information on self-referral.

8.2.7.2.5 Requirements for Medication Assisted Treatment

The MCO must comply with Texas Human Resources Code § 32.03115.

8.2.7.3 Mental Health Rehabilitative Services and Targeted Case Management Services

Mental Health Rehabilitative Services and Mental Health Targeted Case Management must be available to eligible STAR and STAR+PLUS Members who require these services based on the appropriate standardized assessment – the Adult Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS). The MCO must maintain a qualified Network of entities, such as Local Mental Health Authorities (LMHAs), multi-specialty groups, and clinic/group practices that employ providers of these services.

Mental Health Rehabilitative Services include training and services that help the Member maintain independence in the home and community, such as the following.

1. **Medication training and support** – curriculum-based training and guidance that serves as an initial orientation for the Member in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community.
2. **Psychosocial rehabilitative services** – social, educational, vocational, behavioral, or cognitive interventions to improve the Member's potential for social relationships, occupational or educational achievement, and living skills development.
3. **Skills training and development** – skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers.
4. **Crisis intervention** – intensive community-based one-to-one service provided to Members who require services in order to control acute symptoms that place the Member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting.

5. **Day program for acute needs** – short-term, intensive, site-based treatment in a group modality provided to a Member who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting.

The MCO must provide Mental Health Rehabilitative Services and Mental Health Targeted Case Management in accordance with UMCM Chapter 15, including ensuring providers meet all training requirements and the use of the DSHS Resiliency and Recovery Utilization Management Guidelines (RRUMG). The MCO must also ensure that a provider reviews a Member's plan of care for Mental Health Rehabilitative Services in accordance with the RRUMG to determine whether a change in the Member's condition or needs warrants a reassessment or change in service. If the Member's condition warrants a change in service, the provider must submit a new plan of care to the MCO for authorization. Additionally, the MCO must ensure that providers of Mental Health Rehabilitative Services and Mental Health Targeted Case Management use, and are trained and certified to use, the Adult Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) tools for assessing a Member's needs.

The MCO must ensure that STAR Service Coordination units and STAR+PLUS Service Coordinators coordinate with providers of TCM to ensure integration of behavioral and physical health needs of Members. Additionally, the MCO must ensure that if a Member loses Medicaid eligibility, STAR Service Coordination t units and STAR+PLUS Service Coordinators refer the Member to community resources such as Local Mental Health Authorities.

8.2.8 Third Party Liability and Recovery and Coordination of Benefits

Medicaid is the payer of last resort for Covered Services when coordinating benefits with all other insurance coverage, unless an exception applies under federal law. Coverage provided under Medicaid will pay benefits for Covered Services that remain unpaid after all other insurance coverage has been paid. For Network Providers and Out-of-Network providers with written reimbursement arrangements with the MCO, the MCO must pay the unpaid balance for Covered Services up to the agreed rates. For Out-of-Network providers with no written reimbursement arrangement, the MCO must pay the unpaid balance for Covered Services in accordance with 1 Tex. Admin. Code § 353.4 regarding Out-of-Network payment.

MCOs are responsible for establishing and documenting a plan and process, referred to as the Third Party Liability Managed Care Organization Action Plan (TPL MCO Action Plan), in accordance with UMCM Chapter 5 for avoiding and recovering costs for services that should have been paid through a third party [including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974)], service benefit plans, Managed Care Organizations, Pharmacy Benefit Managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

The TPL MCO Action Plan and process must be in accordance with state and federal law and regulations, including Sections 1902(a)(25)(E) and (F) of the Social Security Act, which require MCOs to first pay and later seek recovery from liable third parties for (1) preventive pediatric care, and (2) services provided to an individual on whose behalf child support enforcement is being carried out by the State agency under Part D of title IV of the Social Security Act.

Each MCO must submit the TPL MCO Action Plan to the Office of Inspector General-Third Party Recoveries (OIG-TPR), in accordance with UMCM Chapter 5, no later than September 1 for the upcoming state fiscal year for review and approval. MCOs must submit any change requests to the TPL MCO Action plan for review and approval no later than 90 Days prior to the date of the proposed changes. The projected amount of TPR that the MCO is expected to recover may be factored into the rate setting process.

HHSC will provide the MCO, by plan code, a daily Member file (also known as a TPR Client Insurance File). The file is an extract of those Medicaid Members who are known to have other insurance. The file contains any TPR data that HHSC's claims administrator has on file for individual Members, organized by name and Member number, and adding additional relevant information where available, such as the insured's name and contact information, type of coverage, the insurance carrier, and the effective dates. HHSC's TPR Client Insurance File will be considered the system of record. The MCOs are required to share other insurance information for its enrolled Members with HHSC that differs or is not included on the TPR Client Insurance File, in accordance with UMCM Chapter 5.

The MCO must provide financial reports to HHSC, as stated in **Section 8.1.17.1(d), "**Financial Reporting Requirements, Third Party Liability and Recovery (TPL/TPR) Reports" in accordance with UMCM Chapter 5.

The MCO must provide all TPR reports to OIG-TPR at the frequency stated in and in accordance with UMCM, Chapter 5.

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

1. responding to an MCO inquiry within 60 Days regarding a claim for payment for Covered Services submitted to the liable third party no later than the third anniversary after the date the Covered Services were provided;

2. except as provided in §32.0424(b-2), accepting authorization from the MCO for Covered Services that require prior authorization and were previously paid by the MCO as if the MCO's authorization is a prior authorization made by the liable third party for Covered Services; and

3. the prohibition of denying a claim submitted by the MCO for which payment was made solely on the basis of:

    a. the date of submission of the claim;

b. the type or format of the claim form;

c. a failure to present proper documentation at the point of service that is the basis of the claim; or

d. except as provided in §32.0424(b-2), a failure to obtain prior authorization for Covered Services.

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

The MCO has 120 Days from the date of adjudication of a claim that is subject to TPR to attempt recovery of the costs for services that should have been paid through a third party. The MCO must obtain recovery of payment from a liable third party and not from the provider unless the provider received payment from both the MCO and the liable third party. The MCO shall provide to HHSC, on a monthly basis by the tenth Day of each month, a report indicating the claims where the MCO has billed and/or made a recovery up to the 120th Day from adjudication of a claim that is subject to TPR. After 120 Days, HHSC will attempt recovery for any claims in which the MCO did not attempt recovery and will retain, in full, all funds received as a result of any HHSC-initiated TPR. The MCO is precluded from attempting to bill for any recovery after 120 Days from claim adjudication date. Any collections by the MCO billed after 120 Days from the claim adjudication date must be sent to OIG-TPR in the format prescribed in UMCM Chapter 5. The MCOs are to continue to cost avoid and cost recover where applicable.

After 365 Days from adjudication of a claim, the MCO loses all rights to pursue or collect any recoveries subject to TPR. HHSC has sole authority for recoveries of any claim subject to TPR after 365 Days from the date of adjudication of a claim. Should the MCO receive payment on a HHSC-initiated recovery, the MCO must send the payment to OIG-TPR in the format prescribed in UMCM Chapter 5.

HHSC retains the responsibility to pursue, collect, and retain recoveries of all resources and insurances other than health insurance wherein payments have been made on behalf of a Member. These resources and other insurances include, but are not limited to: casualty insurance, liability insurance, estates, child support, and personal injury claims. The MCO must pay valid claims for Covered Services provided to MCO Members who have, or may have, resources and insurances other than health insurance. Since HHSC retains the right of recovery for such resources and insurances other than health insurance, the MCO is not permitted to cost avoid or seek recovery for such items . Should the MCO receive payment on a claim in which resources or insurances other than health insurance are utilized, the MCO must send the payment to OIG-TPR in the format prescribed in UMCM Chapter 5. Members with these other resources shall remain enrolled in the MCO.

8.2.9 Coordination with Public Health Entities

8.2.9.1 Reimbursed Arrangements with Public Health Entities

The MCO must make a good faith effort to enter into a Provider Contract for Covered Services with health service regional office in a Public Health Region administered by a regional director under Section 121.007, Health and Safety Code and a Hospital District providing Covered Services to Medicaid and CHIP Members. The MCO must offer Provider Contracts for Covered Services with Medicaid and CHIP enrolled Local Health Departments established under Subchapter D, Chapter 121, Health and Safety Code and Public Health Districts established under Subchapter E, Chapter 121 Health and Safety Code.

These Provider Contracts must be available for review by HHSC on the same basis as all other MCO Provider Contracts. If the MCO is unable to enter into a Provider Contract with Public Health Entities, the MCO must document efforts to contract with Public Health Entities and make such documentation available to HHSC upon request.

The MCO's Provider Contracts with Public Health Entities must specify the scope of responsibilities of both parties, the methodology and agreements regarding billing and reimbursements, reporting responsibilities, Member and Provider educational responsibilities, and the methodology and agreements regarding sharing of confidential medical record information between the Public Health Entity and the MCO or PCP.

8.2.9.2 Non-Reimbursed Arrangements with Local Public Health Entities

The MCO must coordinate with Public Health Entities in each Service Area (SA) regarding the provision of essential public health care services. The MCO must:

1. Report to Public Health Entities regarding communicable diseases or diseases that are preventable by immunization as defined by state law;

2. Notify the local Public Health Entity of communicable disease outbreaks, as defined by state law, involving Members;

3. Educate Members and Providers regarding Women, Infants, and Children (WIC) services available to Members; and

4. Ensure through Provider Contracts that Providers coordinate with local Public Health Entities that have a child lead program, or with the DSHS Texas Childhood Lead Poisoning Prevention Program when the local Public Health Entity does not have a child lead program, when following up on suspected or confirmed cases of childhood lead exposure.

In addition, the MCO must establish and maintain an effective working relationship with all state and local Public Health Entities in its SAs to identify issues and promote initiatives addressing public health concerns.

8.2.10 Coordination with Other State Health and Human Services (HHS) Programs

The MCO must coordinate with other state HHS Programs in each Service Area regarding the provision of essential public Health Care Services. The MCO must meet the following requirements:

1. require Providers to use the DSHS Bureau of Laboratories for specimens obtained as part of a Texas Health Steps medical checkup, as indicated in **Section 8.1.4** under Laboratory Services;
2. notify Providers of the availability of vaccines through the Texas Vaccines for Children Program;
3. work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac2 registry;
4. participate, to the extent practicable, in the community-based coalitions with the Medicaid-funded case management programs in the Department of Assistive and Rehabilitative Services (DARS), the Department of Aging and Disability Services (DADS), and DSHS;
5. cooperate with activities required of state and local public health authorities necessary to conduct the annual population and community based needs assessment;
6. require Providers to, in accordance with Texas Health & Safety Code Chapter 88 and related rules at 25 Tex. Admin. Code Chapter 37, Subchapter Q, (1) report all blood lead results to the Childhood Lead Poisoning Program (if not performed at the DSHS state laboratory) and (2) follow-up on suspected or confirmed cases of childhood lead exposure with the Childhood Lead Poisoning Prevention Program, and follow the Centers for Disease Control and Prevention guidelines for testing children for lead and follow-up actions for children with elevated lead levels located on the DSHS website, “Texas Childhood Lead Poisoning Prevention”, “Screening”;
7. coordinate with Texas Health Steps Outreach and Informing Unit;
8. coordinate care protocols for working with Dental Contractors, as well as protocols for reciprocal referral and communication of data and clinical information regarding the Member’s Medically Necessary dental Covered Services, including coordination to provide NEMT Services for Members accessing dental Covered Services;
9. develop a coordination plan to share with local entities regarding clients identified as requiring special needs or assistance during a disaster; and
10. for STAR MCOs, educate Providers and Members about primary and family planning services available through the Healthy Texas Women Program; including Healthy Texas Women Plus services; the HHSC Healthy Texas Family Planning Program; and the HHSC Primary Health Care Program.

8.2.11 Advance Directives

Federal and state laws require MCOs and providers to maintain written policies and procedures for informing all adult Members 18 years of age and older about their rights to refuse, withhold or withdraw medical treatment and mental health treatment through advance directives (see Social Security Act §1902(a)(57) and §1903(m)(1)(A)). The MCO's policies and procedures must include written notification to Members and comply with provisions contained in 42 C.F.R. § 489, Subpart I, relating to advance directives for all Hospitals, critical access Hospitals, skilled nursing facilities, home health agencies, providers of home health care, providers of personal care services and hospices. The MCO's policies and procedures must comply with state laws and rules regarding:

1. a Member's right to self-determination in making health care decisions;
2. the Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:
    a. a Member's right to execute an advance written directive to physicians and family or surrogates, or to make a non-written directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition;
    b. a Member's right to make written and non-written out-of-Hospital do-not-resuscitate (DNR) orders;
    c. a Member's right to execute a Medical Power of Attorney to appoint an agent to make health care decisions on the Member's behalf if the Member becomes incompetent; and
3. Chapter 137, Texas Civil Practice and Remedies Code, which includes a Member's right to execute a Declaration for Mental Health Treatment in a document making a declaration of preferences or instructions regarding mental health treatment.

The MCO must maintain written policies for implementing a Member's advance directive. Those policies must include a clear and precise statement of limitation if a Provider cannot or will not implement a Member's advance directive.

The MCO cannot require a Member to execute or issue an advance directive as a condition of receiving Health Care Services. The MCO cannot discriminate against a Member based on whether or not the Member has executed or issued an advance directive.

The MCO's policies and procedures must require the MCO and Subcontractors to comply with the requirements of state and federal law relating to advance directives. The MCO must provide education and training to employees and Members on issues concerning advance directives.

All materials provided to Members regarding advance directives must be written at a 6th grade reading comprehension level, except where a provision is required by state or federal law and the provision cannot be reduced or modified to a 6th grade reading level because it is a reference to the law or is required to be included "as written" in the state or federal law.

The MCO must notify Members of any changes in state or federal laws relating to advance directives within 90 Days from the effective date of the change, unless the law or regulation contains a specific time requirement for notification.

8.2.12 SSI Members

A Member's SSI status is effective the date the State's eligibility system identifies the Member as Type Program 13 (TP13). The State is responsible for updating the State's eligibility system within 45 Days of official notice of the Member's Federal SSI eligibility by the Social Security Administration (SSA).

8.2.13 Medicaid Wrap-Around Services

STAR+PLUS MCOs must supplement Medicare coverage for STAR+PLUS Dual Eligible Members by covering Medicaid Wrap-Around Services, which include services as described below.

STAR+PLUS MCOs must cover:

1. Medicaid Wrap-Around Services for outpatient drugs and biological products as described in Section 8.2.13.1:
2. Nursing Facility Medicare Coinsurance for Members in a Nursing Facility as described in Section 8.2.13.2: and
3. other capitated long-term care and Community-Based Long-Term Services and Supports as described in Section 8.2.13.3.

When an authorization request for a Medicaid Wrap-Around Service that is not covered by Medicare is submitted to a STAR+PLUS MCO, the MCO must not require a Provider to submit a Medicare denial or explanation of benefits. Refer to **UMCM Chapter 2,** Uniform Managed Care Claims Manual, for additional information regarding the claims processing requirements for these Medicaid Wrap-Around Services.

STAR+PLUS MCOs must inform Providers and Members that all other Medicaid Wrap-Around Services than described herein are adjudicated and reimbursed by HHSC's claims administrator and provide information about that process.

HHSC will provide advance written notice to the STAR+PLUS MCOs identifying other types of Medicaid Wrap-Around Services that will become Covered Services, and the effective date of coverage.

8.2.13.1 Medicaid Wrap-Around Services for Outpatient Drugs and Biological Products

STAR+PLUS MCOs must provide Medicaid Wrap-Around Services for outpatient drugs, biological products, certain limited home health supplies (LHHS), and vitamins and minerals as identified on the HHSC drug exception file to STAR+PLUS Members under a non-risk, cost settlement basis, as described in **Attachment A, Section 10.16**, "Supplemental Payments for Medicaid Wrap-Around Services for Outpatient Drugs and

Biological Products." Refer to HHSC's **UMCM, Chapter 2** for additional information regarding the claims processing requirements for these Medicaid Wrap-Around Services.

8.2.13.2 Nursing Facility Medicare Coinsurance

STAR+PLUS MCOs must pay the State's Medicare coinsurance obligation for a qualified Dual Eligible Member's Medicare-covered stay in a Nursing Facility. STAR+PLUS MCOs are not responsible for the State's Medicare cost-sharing obligation for a Dual Eligible Member's Medicare-covered Nursing Facility Add-on Services, which are adjudicated by either the State's fee-for-service claims administrator or the Dual Eligible Member's Medicare plan, as applicable to the Member.

8.2.13.3 Long-Term Care and Long-Term Services and Supports

The STAR+PLUS MCO must provide capitated long-term care not covered by Medicare as Medicaid Wrap-Around Services, including:

1. Nursing Facility Unit Rate Services; and
2. Nursing Facility Add-on Services, as described in **UMCM Chapter 2**, Uniform Managed Care Claims Manual and **UMCM 3.31**, MMC Nursing Facility Provider Manual, Attachment A. However, the STAR+PLUS MCO is not responsible for covering physical therapy, speech therapy, and occupational therapy Nursing Facility add-on services for Dual Eligible Members.

The STAR+PLUS MCO must provide capitated Community-based LTSS not covered by Medicare as Medicaid Wrap-Around Services. These services are described further in the STAR+PLUS Handbook and include:

1. Community First Choice (CFC) services for qualified members, as specified in **Section 8.1.37.1.**, Community First Choice Services;
2. STAR+PLUS Home and Community Based Services (HCBS);
3. Personal Assistance Services (PAS); and
4. Day Activity and Health Services (DAHS)

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8.2.15 Abuse, Neglect, or Exploitation

8.2.15.1 Member Education on Abuse, Neglect, or Exploitation

At the time of assessment but no later than when the Medicaid Member is approved for LTSS, the MCO must ensure that the Member is informed orally and in the Member Handbook of the processes for reporting allegations of Abuse, Neglect, or Exploitation. The toll-free numbers for ~~DADS and DFPS~~ HHSC must be provided.

8.2.15.2 Abuse, Neglect, and Exploitation Email Notifications

The MCO must provide HHSC with an email address to receive and respond to Adult Protective Services notifications involving Abuse, Neglect, or Exploitation notifications. The MCO must respond to emails received by this email address by providing the information requested by APS within 24 hours of delivery seven Days a week to the MCO's email address.

8.2.15.3 MCO Training on Abuse, Neglect, and Exploitation, and Unexplained Death

By September 30, 2016, the STAR and STAR+PLUS MCOs must provide Abuse, Neglect, and Exploitation, and Unexplained Death training to all MCO staff who have direct contact with a Member. Direct contact includes In-Person and telephone contact. MCOs must use the approved training materials provided by HHSC as set forth in the UMCM Chapter 16 regarding policy guidance. All newly-hired staff who have direct contact with a Member must be trained no later than 30 Days from the date of hire. All employees that receive the required training must sign, upon completion of the training, an acknowledgement of their understanding of their duty to report. The MCOs must retain records of the training (including copies of all training materials) during the employment of the staff member and for three years thereafter. For Service Coordinators working with Members receiving Community-Based Long Term Services and Supports (LTSS), this training must be provided before contact with Members served, but no later than 30 Days from the date of hire and annually thereafter.

8.2.16 Supplemental Payments for Qualified Providers

In accordance with PPACA as amended by Section 1202 of the Health Care and Education Reconciliation Act and corresponding federal regulations at 42 C.F.R §§ 438.6 and 438.804, the MCO will make supplemental payments to qualified Medicaid providers for dates of service beginning on January 1, 2013, and ending on December 31, 2014. The UMCM will identify the types of providers and services that qualify for the supplemental payments.

HHSC or its Administrative Services Contractor will conduct the provider self-attestation process, and determine which providers and services are eligible for supplemental payments. HHSC will use encounter and other data provided by the MCO to calculate supplemental payments and will provide the MCO with detailed reports identifying qualified providers, claims, and supplemental payment amounts. The MCO will use this information to respond to provider inquiries and complaints regarding supplemental payments and will refer all cases for resolution as directed by HHSC.

The MCO will pay claims from qualified Network Providers at the MCO's contracted rates, and out-of-network providers in accordance with 1 Tex. Admin. Code § 353.4. The MCO's encounter data should reflect the actual amount paid to providers and should not be adjusted to include supplemental payment amounts.

As described in Attachment A, Section 10.17, "Pass-through Payments for Provider Rate Increases," the MCO must pay the full amount of supplemental payments to qualified providers no later than 30 Days after receipt of HHSC's supplemental payment report, contingent upon MCO's receipt of payment of the allocation. The MCO must submit a report and certification, in the form and manner identified in the UMCM, to validate that payments have been made to qualified providers in accordance with HHSC's calculations. In addition, the MCO must provide reports, in the manner and frequency prescribed in the UMCM, documenting all claims adjustments that alter the supplemental payment amounts, including documentation of recoupments of overpaid amounts. The MCO must collect and refund all overpayments of supplemental payments to HHSC in the format and manner prescribed in the UMCM. In cases where a third party is responsible for all or part of a Covered Service and the MCO recovers only part of the amount paid by the MCO, then the amount recovered must be applied first to the supplemental payment and returned to HHSC. If the amount recovered is less than the supplemental payment, then the MCO will return the full amount of the recovery to HHSC.

8.2.17 Electronic Visit Verification

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

The MCO must require Providers, CDS employers, and Financial Management Services Agencies (FMSAs) to use an Electronic Visit Verification (EVV) System in accordance with the EVV requirements described in Title 1, Chapter 354, Subchapter O of the Texas Administrative Code.

The MCO must require Providers, CDS employers, and FMSAs to use EVV for home health care services in accordance with UMCM 8.7.1 Section VII.

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8.2.19 STAR Members Enrolled in DADS Medicaid Hospice Program

Once a STAR Member enrolls in the DADS Medicaid Hospice Program, the Member is disenrolled from managed care and will receive Medicaid services through Fee-for-Service. HHSC will notify MCOs when a Member is enrolled in the DADS Medicaid Hospice Program and initiate prospective disenrollment from managed care and will transition the Member to Fee-for-Service.

8.2.20 Carve-in Readiness

MCOs must participate in Readiness Review dictated by HHSC for the expansion of Medicaid managed care to populations currently served by the fee-for-service system.

8.3 Additional STAR+PLUS Scope of Work

8.3.1 Covered Community-Based Long-Term Services and Supports

The MCO must ensure that STAR+PLUS Members needing Community Long-term Services and Supports are identified, and that services are referred and authorized in a timely manner. The MCO must ensure that Providers of Community Long-term Services and Supports are licensed or certified to deliver the services they provide. The inclusion of Community Long-term Services and Supports in a managed care model presents challenges, opportunities and responsibilities.

Community Long-term Services and Supports may be necessary as a preventive service to avoid more expensive hospitalizations, emergency room visits, or institutionalization. Community Long-term Services and Supports should also be made available to Members to assure maintenance of the highest level of functioning possible in the least restrictive setting. Community Long-term Services and Supports to assist with the activities of daily living must be considered as important as needs related to a medical condition. MCOs must provide both Medically Necessary and Functionally Necessary Covered Services to Community Long-term Services and Supports Members.

8.3.1.1 Community Based Long-Term Services and Supports Available to All Members

The MCO must contract with Providers of Personal Assistance Services (PAS) and Day Activity and Health Services (DAHS) to ensure access to these services for all STAR+PLUS Members. At a minimum, these Providers must meet all of the following state licensure and certification requirements for providing the services in **Attachment B-2.2**, "STAR+PLUS Covered Services."

Community-based Long-Term Services and Supports Available to All Members	
Service	**Licensure and Certification Requirements**
Primary Home Care	The Provider must be licensed by DADS as a Home and Community Support Services Agency (HCSSA). The level of licensure required depends on the type of service delivered. For primary home care and client managed attendant care, the agency may have only the Personal Assistance Services level of licensure.

Community-based Long-Term Services and Supports Available to All Members	
Service	**Licensure and Certification Requirements**
Day Activity and Health Services (DAHS)	The Provider must be licensed by the DADS Regulatory Division as an adult day care provider. To provide DAHS, the Provider must provide the range of services required for DAHS.

8.3.1.2 HCBS STAR+PLUS Waiver Services Available to Qualified Members

The HCBS STAR+PLUS Waivers provides Community Long-term Services and Supports to Medicaid Eligibles who are elderly and to adults with disabilities as a cost-effective alternative to living in a nursing facility. These Members must be age 21 or older, be a Medicaid recipient or be otherwise financially eligible for waiver services. HCBS STAR+PLUS Waiver services must be provided in home and community based settings and comply with 42 C.F.R. § 441.301(c)(4). To be eligible for HCBS STAR+PLUS Waiver Services, a Member must meet income and resource requirements for Medicaid nursing facility care and receive a determination from HHSC on the medical necessity/level of care of the nursing facility care. The MCO must make available to STAR+PLUS Members who meet these eligibility requirements the array of services allowable through HHSC's CMS-approved HCBS STAR+PLUS Waiver (see **Attachment B-2.2**, "STAR+PLUS Covered Services").

Community-based Long-Term Services and Supports under the HCBS STAR+PLUS Waiver	
Service	**Licensure, Certification, and Other Minimum Qualification Requirements**
Personal Assistance Services	The Provider must be licensed by HHSC as a Home and Community Support Services Agency (HCSSA). The level of licensure required depends on the type of service delivered. For Primary Home Care and Client Managed Attendant Care, the agency may have only the Personal Assistance Services level of licensure.
Employment Assistance	The Provider must meet all of the criteria in one of these three options. **Option 1:** • a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and • six months of documented experience providing services to people with disabilities in a professional or personal setting. **Option 2:**

Community-based Long-Term Services and Supports under the HCBS STAR+PLUS Waiver	
Service	**Licensure, Certification, and Other Minimum Qualification Requirements**
	• an associate's degree in rehabilitation, business, marketing, or a related human services field; and • one year of documented experience providing services to people with disabilities in a professional or personal setting. **Option 3:** • a high school diploma or GED; and • two years of documented experience providing services to people with disabilities in a professional or personal setting.
Supported Employment	The Provider must meet all of the criteria in one of these three options. **Option 1:** • a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and • six months of documented experience providing services to people with disabilities in a professional or personal setting. **Option 2:** • an associate's degree in rehabilitation, business, marketing, or a related human services field; and • one year of documented experience providing services to people with disabilities in a professional or personal setting. **Option 3:** • a high school diploma or GED; and • two years of documented experience providing services to people with disabilities in a professional or personal setting.
Assisted Living Services	The Provider must be licensed byHHSC, Long Term Care Regulatory Division in accordance with 26 Tex. Admin. Code, Chapter 553. The type of licensure determines what services may be provided.
Emergency Response Service Provider	Licensed by the Texas Department of State Health Services as a Personal Emergency Response Services Agency under 25 Tex. Admin.Code, Chapter 140, Subchapter B.

Community-based Long-Term Services and Supports under the HCBS STAR+PLUS Waiver	
Service	**Licensure, Certification, and Other Minimum Qualification Requirements**
Nursing Services	Licensed Registered Nurse by the Texas Board of Nursing under 22 Tex. Admin. Code Chapter 217. The registered nurse must comply with the requirements for delivery of nursing services, which include requirements such as compliance with the Texas Nurse Practice Act and delegation of nursing tasks. The licensed vocational nurse must practice under the supervision of a registered nurse, licensed to practice in the State.
Cognitive Rehabilitation Therapy	Psychologist must be licensed under Texas Occupations Code Chapter 501. Speech and language pathologists must be licensed under Texas Occupations Code Chapter 401. Occupational Therapist must be licensed under Texas Occupations Code Chapter 454.
Adult Foster Care	Adult Foster Care (AFC) homes must meet the minimum standards described in the STAR+PLUS Handbook Section 7100 found on the HHSC website under “laws-regulation,” “handbooks,” ”STAR+PLUS Handbook.” AFC homes including the Member's home must either have been determined qualified based on the minimum standards or licensed by DADS under 26 Tex. Admin. Code Chapter 553 (for homes serving four or more residents). The MCO must demonstrate the ability to recruit, train and certify AFC providers based on minimum standards described above either in-house or through an AFC-agency provider.
Dental	Licensed by the Texas State Board of Dental Examiners as a Dentist under 22 Tex. Admin. Code, Chapter 101.
Respite Care	Licensed by DADS as a Home and Community Support Services Agency (HCSSA) under 26 Tex. Admin. Code, Chapter 558; licensed as a Nursing Facility provider under 40 Texas Admin. Code, Chapter 19; licensed by DADS as an Assisted Living provider under 26 Tex. Admin. Code, Chapter 553; Adult Foster Care provider licensed by DADS under 26 Tex. Admin. Code, Chapter 553Unlicensed Adult Foster Care providers must meet the qualifications described in the STAR+PLUS Handbook Appendix XXIV found on the HHSC website under “laws-regulation,” “handbooks,” “STAR+PLUS Handbook.”

Community-based Long-Term Services and Supports under the HCBS STAR+PLUS Waiver	
Service	**Licensure, Certification, and Other Minimum Qualification Requirements**
	Adult Foster Care homes serving four or more participants must be licensed by DADS under 26 Tex. Admin. Code, Chapter 553.
Home Delivered Meals	Providers must comply with requirement of 40 Tex. Admin. Code, Chapter 55 for providing home delivered meal services, which include requirements such as dietary requirements, food temperature, delivery times, and training of volunteers and others who deliver meals.
Physical Therapy (PT) Services	Licensed Physical Therapist through the Texas Board of Physical Therapy Examiners, Chapter 453 of the Texas Occupations Code.
Occupational Therapy (OT) Services	Licensed Occupational Therapist through the Texas Board of Occupational Therapy Examiners, Chapter 454 of the Texas Occupations Code.
Speech, Hearing, and Language Therapy Services	Licensed Speech Therapist through the Department of State Health Services.
Financial Management Services	The Providers must complete DADS' required training. Current FMSAs contracted by DADS are assumed to have completed the training.
Support Consultation	Providers must be certified by the Department of Aging and Disability Services.
Transition Assistance Services (TAS)	The Provider must comply with the requirements for delivery of TAS, which include requirements such as allowable purchases, cost limits, and timeframes for delivery. TAS providers must demonstrate knowledge of, and experience in, successfully serving individuals who require home and community-based services
Minor Home Modification	No licensure or certification requirements.
Adaptive Aids and Medical Equipment	No licensure or certification requirements.

Community-based Long-Term Services and Supports under the HCBS STAR+PLUS Waiver	
Service	**Licensure, Certification, and Other Minimum Qualification Requirements**
Medical Supplies	No licensure or certification requirements.

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8.3.1.4 Community First Choice Services Available to Qualified Members

Community First Choice (CFC) provides Community Long-term Services and Supports to eligible Members who are elderly and to individuals with physical Disabilities, intellectual or developmental Disabilities, SED or SPMI as an alternative to living in an institution. To be eligible for CFC services, a Member must meet income and resource requirements for Medicaid under the State Plan and receive a determination from HHSC that the Member meets institutional level of care requirements for Nursing Facility care, an Intermediate Care Facility, an institution providing psychiatric services for individuals under age 21, or an Institution for Mental Diseases for individuals age 65 or over per 42 C.F.R. §441.510. The MCO must make available the full array of CFC services available to eligible STAR+PLUS Members in accordance with 1 Tex. Admin. Code pt. 15, ch. 354, subch. A, div. 27. (See Attachment B-2.2, "STAR+PLUS Covered Services").

The MCO must contract with Providers of CFC services to ensure access to these services for all qualified STAR+PLUS Members. CFC services must be provided in home and community based settings and comply with 42 C.F.R. § 441.301(c)(4). The administration of CFC in managed care is governed by Tex. Admin. Code, Chapter 354, Subchapter A, Division 27. At a minimum, these Providers must meet all of the following state licensure and certification requirements for providing the services in **Attachment B-2.2**, "STAR+PLUS Covered Services."

Community First Choice (CFC) Services Available to Qualified Members	
Service	**Licensure and Certification Requirements**
CFC Services--with the exception of Emergency Response Service-CFC	The Provider must be licensed by DADS as a Home and Community Support Services Agency (HCSSA) or certified as a Home and Community-based Services or Texas Home Living agency. The level of licensure required depends on the type of service delivered. For Personal Assistance Services - CFC, the agency may have only the Personal Assistance Services level of licensure.

Community First Choice (CFC) Services Available to Qualified Members	
Service	**Licensure and Certification Requirements**
Emergency Response Service - CFC	The Provider must: (1) be licensed: (A) by the Public Security Bureau of the Texas Department of Public Safety as an alarm systems company; or (B) by the Department of State Health Services as a personal emergency response system provider.

8.3.1.5 Home and Community Based Services Settings

The MCO must ensure that a setting in which any of the following STAR+PLUS home and community-based services are provided complies with 42 C.F.R §441.301(c)(4)(i)-(v) and §441.530, as applicable:

1. Personal assistance services
2. CFC personal assistance services
3. CFC Habilitation
4. Respite
5. Nursing
6. Physical therapy
7. Occupational therapy
8. Cognitive Rehabilitation Therapy
9. Speech Therapy
10. Supported Employment
11. Employment Assistance
12. Support consultation
13. Assisted living
14. Adult Foster Care

The MCO must ensure that a setting in which Assisted Living or Adult Foster Care is provided complies with 42 C.F.R §441.301(c)(4)(vi).

8.3.2 Service Coordination

8.3.2.1 Service Coordination Plan Requirements

The MCO must implement an HHSC-approved Service Coordination plan that must address:

- how outreach to Members will be conducted;
- how Members are assessed, and their service plans developed (the initial identification of Members' needed services and supports);
- how Members will be identified as needing an assessment when changes in their health or life circumstances occur;
- the Member's needs and preferences;
- the minimum number of Service Coordination contacts a Member will receive per year;
- how Service Coordination will be provided (Face-to-face, telephone contact, etc.); and
- how these Service Coordination services will be tracked by the MCO.

The Service Coordination plan must address service planning for Members in the following categories.

Level 1 Members: Highest level of utilization

- Includes HCBS SPW, Nursing Facility (except for Nursing Facility Members listed under Level 3), individuals with SPMI, and other Members with complex medical needs.
- MCOs must provide Level 1 Members with a single identified person as their assigned Service Coordinator. All Members within a Nursing Facility must have the same assigned Service Coordinator. HHSC must provide written approval for any exceptions.
- At a minimum, Level 1 Members in a Nursing Facility must receive quarterly Face-to-face visits, including Nursing Facility care planning meetings or other interdisciplinary team meetings. Required quarterly Face-to-face visits must be made at least 2 months apart, but no more than 3 months may elapse between visits. The MCO must maintain and make available upon request documentation verifying the occurrence of required Face-to-face Service Coordination visits, which may include participation in care planning or other interdisciplinary team meetings. In accordance with requirements for services by Telecommunication located in UMCM Chapter 16, a Service Coordinator of the STAR+PLUS MCO may determine it is appropriate to offer Level 1 Members in a Nursing Facility an Audio-visual Service Coordination visit in place of an In-Person visit. STAR+PLUS MCOs must conduct at least one Face-to-Face Service Coordination visit In-Person annually. Additionally, STAR+PLUS MCOs must conduct Nursing Facility discharge planning visits In-Person, including when a Member is transitioning to STAR+PLUS HCBS.

    - The MCO must have an internal escalation process in place to address when the MCO Service Coordinator is unable to visit a Nursing Facility Member on their Member caseload because the Member no longer resides at the Nursing Facility. This excludes Members on a three day (72-hour) therapeutic home visit away from the facility as defined in 26 Tex. Admin. Code § 554.2603. The MCO must track any discrepancy between its Nursing Facility Member caseload and that of the Nursing

Facility Provider. The MCO must report this information upon request from HHSC.

- All other Level 1 Members must receive a minimum of two Face-to-face Service Coordination contacts visits annually. For STAR+PLUS HCBS Members, one of the two Face-to-face visits can be the annual reassessment. The other, semi-annual Face-to-face visit must occur 4-6 months after the ISP start date. It is permissible for an MCO to schedule a Face-to-face visit outside of the 4-6 month timeframe at the Member's request. This request by the Member must be documented by the MCO. In accordance with requirements for services by Telecommunication located in in UMCM Chapter 16, a Service Coordinator of the STAR+PLUS MCO may determine it is appropriate to offer these Level 1 Members Audio-visual Service Coordination in place of an In-Person visit, if no assessment or reassessment is being conducted. STAR+PLUS MCOs must conduct at least one Service Coordination visit In-Person annually. An initial assessment or reassessment conducted In-Person satisfies the annual In-Person Service Coordination visit requirement.

  Members with SPMI must receive one telephonic Service Coordination contact annually in addition to the minimum of two annual Face-to-face Service Coordination visits. The required telephonic contact may not be made in the same month as the Face-to-face visit. One of the two Face-to-face visits can be the annual reassessment. For STAR+PLUS HCBS Members with SPMI, the other, semi-annual Face-to-face visit must occur 4-6 months after the ISP start date. For Members with SPMI without an ISP, the other semi-annual Face-to-face visit must occur 4-6 months after the Service Plan start date. It is permissible for an MCO to schedule a Face-to-face visit outside of the 4-6 month timeframe at the Member's request. This request by the Member must be documented by the MCO.

Level 2 Members: Lower risk/utilization MCOs must provide Level 2 Members with a single identified person as their assigned Service Coordinator. Members and required assessments are as follows.

- Members receiving LTSS for Personal Assistance Services, CFC Services, or Day Activity and Health Services must receive a minimum of one In-Person and one telephonic Service Coordination contact annually.
- Members with non-SPMI Behavioral Health issues and MBCC Members must receive a minimum of one In-Person and one telephonic Service Coordination contact annually.
- Dual Eligibles who do not meet Level 1 requirements must receive a minimum of two telephonic Service Coordination contacts annually.
- MBCC Members may receive In Person assistance with the six month recertification process as part of the required In-Person visit.
- In accordance with requirements for services by Telecommunication located in UMCM Chapter 16, a Service Coordinator of the STAR+PLUS MCO may determine it is appropriate to offer Level 2 Members Audio-visual Service Coordination in place of an In-Person visit, if no assessment or reassessment is

being conducted. STAR+PLUS MCOs must conduct at least one Service Coordination visit In-Person annually. An initial assessment or reassessment conducted In-Person satisfies the annual In-Person Service Coordination visit requirement.

Level 3 Members: Members who do not qualify as Level 1 or Level 2. Level 3 Members include Nursing Facility residents receiving hospice services or residing in a Nursing Facility outside the MCO's Service Area.

- MCO must make at least two telephonic Service Coordination outreach contacts yearly.
- Level 3 Members are not required to have a named Service Coordinator, unless
  - they request Service Coordination services; or
  - they are Nursing Facility residents receiving hospice services; or
  - they are residents in a Nursing Facility outside the MCO's Service Area.

HHSC may, on a case-by-case basis, require an MCO to discontinue Service Coordination or assessments using Telecommunications if HHSC determines that the discontinuation is in the best interest of the recipient.

Members who have intellectual or developmental disabilities (IDD), who live in a community-based intermediate care facility for individuals with an intellectual disability or related conditions (ICF-IID), or who are receiving LTSS through an IDD Waiver must have a named Service Coordinator, regardless of Service Coordination level. The number of required Service Coordination contacts and level of Service Coordination shall vary based on the Member's acuity, and individual needs and preferences of the Member or their authorized representative (AR). MCO Service Coordinators must document in the member record the recommended number and types of contact needed to support the Member, along with the Member's preferences for Service Coordination.

When reaching out to Members to make the required contacts for each level, the MCO must document in the Member case file:

- if Medically Necessary services and goods have been delivered and received, or if there has been any interruption in services since the last contact,
- If there has been any change in the health status of the Member including:
  - New diagnoses,
  - New medications,
  - Hospitalizations/visits to ER/doctor visits/institutionalization and
  - Change in Condition.
- If there have been any significant life stressors since the last contact including:

- Pending eviction,
- Death of spouse or other loved ones,
- Change in caregivers, and
- Natural disasters.

- If the Member requires any assistance from the MCO.

If the MCO fails to meet the Service Coordination performance standards in Attachment B-3, HHSC may impose liquidated damages as provided in that matrix.
MCOs must provide written notice to all STAR+PLUS Members (including Level 3 Members who do not have a named Service Coordinator) that includes:

- A description of Service Coordination;
- The MCO's Service Coordination phone number; and
- The availability of an annual wellness exam as a covered benefit.

Unless the Member/authorized representative specifies another preference of communication, the MCO must notify in writing all STAR+PLUS Members receiving Service Coordination of:

- The name of their Service Coordinator;
- The phone number of their Service Coordinator;
- The minimum number of contacts they will receive every year; and
- The types of contacts they will receive.

8.3.2.2 Service Coordination Structure

Members receiving Level 1 or Level 2 Service Coordination must have a single, identified person as their assigned Service Coordinator and the MCO must notify Members within five Business Days in writing unless the Member or Member's authorized representative specified another preference of communication of the name and phone number of their new Service Coordinator, if their Service Coordinator changes. The MCO must also post the new Service Coordinator's information on the portal within the same time period.

As described in Attachment A, Section 4.04.1, an integrated Health Home may perform Service Coordination functions, and serve as an identified Service Coordinator.

Service coordination teams must be led by at least one Service Coordinator. Team members must have the following expertise or access within the MCO to identified subject matter experts in the following areas:

- Behavioral Health, including outpatient services and Mental Health Rehabilitative Services
- Substance Use Disorder
- Local resources (such as basic needs like housing, food, utility assistance)

- Pediatrics
- LTSS
- Durable Medical Equipment (DME)
- End of life/advanced illness
- Acute care
- Preventive care
- Cultural competency based on National Standards for Culturally and Linguistically Appropriate Services (CLAS)
- Pharmacology
- Nutrition
- Texas Promoting Independence strategies
- Financial management services
- Person-directed planning
- Employment Assistance and Supported Employment
- PASRR requirements
- Trauma-informed care and trauma-informed practices
- Working with individuals with Intellectual or Development Disabilities (IDD)
- LTSS and medical services that may be necessary for individuals with IDD
- NEMT Services

All STAR+PLUS MCOs must provide dedicated toll-free Service Coordination phone numbers. These numbers, if not regional, must have the capabilities of warm transferring to the MCO's regional office. These numbers must have the capability for a Member, their family, or a Provider to leave a message between 5 p.m. and 8 a.m. Central Time on weekdays and on weekends. Any messages must be returned within two Business Days. If the number transfers to another MCO hotline after normal business hours, the caller must be able to leave a message for the Service Coordination team and the message must be returned within two Business Days.

The MCO must furnish a Service Coordinator to all STAR+PLUS Members who request one. The MCO should also furnish a Service Coordinator to a STAR+PLUS Member when the MCO determines one is required through an assessment of the Member's health and support needs. If the Member refuses Service Coordination, the MCO should document the refusal in the Member's case file.

At a minimum, the MCO will have three tiers of Service Coordination for all Members.

The MCO must ensure that each STAR+PLUS Member has a qualified PCP who is responsible for overall clinical direction and, in conjunction with the Service Coordinator, serves as a central point of integration and coordination of Covered Services, including primary, Acute Care, Long-term Services and Supports, and Behavioral Health Services.

The Service Coordinator must work with the Member's PCP to coordinate all STAR+PLUS Covered Services and any applicable Non-capitated Services. This requirement applies regardless of whether the PCP is in the MCO's Network particularly for Dual Eligible Members. In order to integrate the Member's care while remaining informed of the Member's needs and condition, the Service Coordinator must actively

involve the Member's primary and specialty care Providers, including Behavioral Health Service Providers, Providers of Non-capitated Services, as well as traditional Medicare and Medicare Advantage health plans for qualified Dual Eligible Members. For STAR+PLUS members eligible for LTSS services, including Nursing Facilities, Assisted Living Facilities, and adult foster care, the MCO Service Coordinator must ensure a Member's mental health and Substance Use Disorder treatment needs are identified and services coordinated. When considering whether to refer a Member to a nursing facility or other long-term care facility, the MCO must consider the availability of the Program of All-Inclusive Care for the Elderly (PACE) for that Member.

Dual Eligible Members receive most Acute Care services through Medicare, rather than Medicaid.

The MCO must identify and train Members or their families to coordinate their own care, to the extent of the Member's or the family's capability and willingness to coordinate care.

8.3.2.3 Service Coordinators

The MCO must employ as Service Coordinators persons experienced in meeting the needs of vulnerable populations who have Chronic or Complex Conditions. Service Coordinators are Key MCO Personnel as described in **Attachment A**, "Uniform Managed Care Contract Terms and Conditions," Section 4.02, and must meet the requirements set forth in Section 4.04.1 of **Attachment A**.

Service Coordinators must meet the following minimum requirements:

- A Service Coordinator for a **Level 1** Member must be a registered nurse (RN) or nurse practitioner (NP). Licensed vocational nurses (LVNs) employed as Service Coordinators before March 1, 2013 will be allowed to continue in that role. Level 1 Members with SPMI may receive Service Coordination from a Masters-level Social Worker or Professional Counselor, Licensed Bachelor of Social Work (LBSW), *Provisionally Licensed Psychologist (PLP), or Licensed Psychological Associate (LPA)* licensed to practice in Texas.
- A Service Coordinator for a **Level 2** or **3** Member must have an undergraduate or graduate degree in social work or a related field or be an LVN, RN, NP, or physician's assistant (PA); or have a minimum of a high school diploma or GED and direct experience with the ABD/SSI population in three of the last five years.
- Service Coordinators for **Level 3** Members must have experience in meeting the needs of the Member population served (for example, people with disabilities).
- Service Coordinators must possess knowledge of the principles of most integrated settings, including federal and state requirements.
- Service Coordinators must complete a minimum of 20 hours of Service Coordination training every two years, unless otherwise specified. MCOs must administer the training, which must include:
  - information related to the population served;
  - how to assess Member's medical, Behavioral Health, and social needs and concerns;

- how to assess and provide information to Members related to Employment Assistance and Supported Employment;
- how to provide Mental Health Targeted Case Management for Members receiving Mental Health Rehabilitative Services;
- PASRR requirements;
- identifying and reporting Critical Events or Incidents such as Abuse, Neglect, or Exploitation and Unexplained Deaths and educating Members regarding protections.

- For Service Coordinators working with Members receiving Community-Based Long Term Services and Supports (LTSS), including CFC and HCBS services, this training must be provided before contact with Members served, but no later than 30 Days of the date of hire and annually thereafter;
  - refresher of available local and statewide resources;
  - respect for cultural, spiritual, racial, and ethnic beliefs of others.
  - refresher of the, standards of documentation, and licensure requirements per Texas Occupational Code, Texas Administrative Code, and scope of practice requirements as applicable to the LTSS setting;
  - how to complete the nursing facility level of care assessment designated by HHSC per form instructions;
  - how to perform a thorough investigation of third-party resources before utilizing STAR+PLUS Waiver; and
  - education for service coordinators regarding how to determine Medicare versus Medicaid coverage and how to access internal MCO resources to assist service coordinators with determining coverage.
- All Service Coordinators must participate in trainings required by HHSC.
- Service Coordinators working with Members receiving home and Community-based Long-Term Services and Supports, including CFC and HCBS services, must complete an HHSC-approved training on Person-Centered Practices and Person-Centered Plan Facilitation to meet federal requirements on person-centered planning for home and Community-based Long-Term Services and Supports. This training must be completed within six months of the Service Coordinator's hire date using a trainer certified by the Learning Community for Person-Centered Practices or an HHSC-approved curriculum and trainer. This training is in addition to other Service Coordinator training requirements. Service Coordinators must also receive an HHSC-approved or HHSC-offered Person Centered training refresher course every two years.

8.3.2.4 Referral to Community Organizations

The MCO must provide information about and referral to community organizations that may not be providing STAR+PLUS Covered Services, but are otherwise important to the health and wellbeing of Members. These organizations include, but are not limited to:

1. state/federal agencies (e.g., those agencies with jurisdiction over aging, public health, Substance Use Disorder, mental health, intellectual or developmental

disabilities, rehabilitation, income support, nutritional assistance, family support agencies, etc.);
2. social service agencies (e.g., area agencies on aging, residential support agencies, independent living centers, supported employment agencies, etc.);
3. city and county agencies (e.g., welfare departments, housing programs, etc.);
4. civic and religious organizations; and
5. consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning, etc.).
6. affordable housing programs (e.g. Section 811, local housing authorities, agencies that operate affordable housing, homeless service agencies).

8.3.2.5 Discharge Planning

The MCO must provide discharge planning, transition care, and other education programs to Network Providers regarding all available long-term care settings and options. The MCO must have a protocol for quickly assessing the needs of Members discharged from a Hospital, Nursing Facility, or other care or treatment facility, including inpatient psychiatric facilities. The MCO must ensure that both physical and Behavioral Health needs, including Substance Use Disorder treatment, are assessed.

The MCO's Service Coordinator must work with the Member's PCP, the Hospital, inpatient psychiatric facility, or Nursing Facility discharge planner(s), the attending physician, the Member, and the Member's family to assess and plan for the Member's discharge. Upon receipt of notice of a Member's discharge from a hospital or an inpatient psychiatric facility, the Service Coordinator or member of the Service Coordination team must contact the Member within one Business Day. When Long-term Services and Supports are needed, the MCO must ensure that the Member's discharge plan includes arrangements for receiving community-based care whenever possible. The MCO must ensure that the Member, the Member's family, and the Member's PCP are all well informed of all service options available to meet the Member's needs in the community.

8.3.2.6 Transition Plan for New STAR+PLUS Members

The MCO must provide a transition plan for Members enrolled in the STAR+PLUS Program. HHSC, or the previous STAR+PLUS MCO contractor, will provide the MCO with information such as detailed care plans and names of current providers, for newly enrolled Members already receiving Long-term Services and Supports, including Nursing Facility Services, and Behavioral Health Services, including Substance Use Disorder treatment options, opiate addiction treatment, and SBIRT at the time of enrollment in the MCO. The MCO must ensure that current providers are paid for Medically Necessary and Functionally Necessary Covered Services that are delivered in accordance with the Member's existing care plan after the Member is enrolled in the MCO and until the transition plan is developed.

The transition planning process must include the following:

1. review of existing care plans prepared by DADS or another STAR+PLUS MCO;
2. preparation of a transition plan that ensures continuous care under the Member's existing Care Plan during the transfer into the MCO's Network while the MCO conducts an appropriate assessment and development of a new plan, if needed;
3. if durable medical equipment or supplies had been ordered prior to enrollment but have not been received by the time of enrollment, coordination, and follow-through to ensure that the Member receives the necessary supportive equipment and supplies without undue delay; and
4. payment to the existing provider of service under the existing authorization for up to six months, until the MCO has completed the assessment and Service Plans and issued new authorizations.

Except as provided below, the MCO must review any existing care plan and develop a transition plan within 30 Days of receiving notice of the Member's enrollment. For all existing care plans received prior to the Operational Start Date, the MCO will have additional time to complete this process, not-to-exceed 120 Days after the Member's enrollment. The transition plan will remain in place until the MCO contacts the Member or the Member's representative and coordinates modifications to the Member's current plan. The MCO must ensure that the existing services continue and that there are no breaks in services. For initial implementation of the STAR+PLUS program in a Service Area, the MCO must honor existing LTSS authorizations for up to six months following the Operational Start Date, or until the MCO has evaluated and assessed the Member and issued new authorizations. For the carve-in of Nursing Facility services, the MCO must honor existing authorizations for the earliest of (1) six months after the carve-in of Nursing Facility services, (2) until the expiration date of the prior authorization, or (3) until the MCO has evaluated and assessed the Member and issued or denied a new authorization.

The transition plan must include:

1. the Member's history;
2. summary of current medical, Behavioral Health, and social needs and concerns;
3. short-term and long term needs and goals;
4. a list of services required, their frequency, and
5. a description of who will provide these services.

The transition plan may include information for services outside the scope of covered benefits such as how to access affordable, integrated housing.

The MCO must ensure that the Member or the Member's representative is involved in the assessment process and fully informed about options, is included in the development of the transition plan, and is in agreement with the plan when completed.

8.3.2.7 Centralized Medical Record and Confidentiality

The Service Coordinator must be responsible for maintaining a centralized record related to Member contacts, assessments and service authorizations. The MCO must ensure that the organization of and documentation included in the centralized Member

record meets all applicable professional standards ensuring confidentiality of Member records, referrals, and documentation of information.

The MCO must have a systematic process for generating or receiving referrals and sharing confidential medical, treatment, and planning information across providers.

8.3.2.8 Section 811 Project Rental Assistance

The MCO Service Coordinator must coordinate with the Section 811 Project Rental Assistance (PRA) Program point of contact on an ongoing basis, as needed, in accordance with their role as the 811 Service Coordinator for Members with disabilities exiting a Nursing Facility and receiving services from the Section 811 PRA program.

8.3.2.9 ICD 10 Z Codes

The MCO must request that PCPs, emergency room providers and Behavioral Health providers submit claims, as appropriate, for STAR+PLUS Members that include the ICD 10 Z codes regarding socioeconomic and psychosocial circumstances and their related subcategories, as described in UMCM Chapter 16. When the MCO receives a claim that includes one of these codes, the MCO must communicate this information to the MCO's Service Coordinator to ensure appropriate delivery of services.

8.3.2.10 Prioritization Plan

Prior to the 3/1/2012 Operational Start Date of the STAR+PLUS Program in the Expansion Service Areas, HHSC and DADS will provide the MCO a plan that outlines a priority of populations and special handling procedures that the MCO must implement to help ensure timely assessments for potential enrollees and incoming Members as well as continuity of care for incoming Members. The populations that will be part of the priority list will include but are not limited to Money Follows the Person (MFP); Medically Dependent Children Program (MDCP), Comprehensive Care Program -Personal Care Services (CCP-PCS) and Comprehensive Care Program-Private Duty Nursing (CCP-PDN) aging out consumers; 217-Like Group Interest List consumers; and Supplemental Security Income (SSI) consumer. HHSC and/or DADS will also provide the MCO with information concerning Members who will be enrolled through manual processes and will need expedited access to services.

8.3.2.11 Service Coordination Using Telecommunication

MCOs must adhere to provisions for services by Telecommunication located in UMCM Chapter 16, and Subchapter R of 1 Tex. Admin. Code, Chapter 353.

8.3.3 STAR+PLUS Assessment Instruments

The MCO must have and use functional assessment instruments to identify Members with significant health problems, Members requiring immediate attention, and Members who need or are at risk of needing Long-Term Services and Supports. The MCO, a

Subcontractor, a Local IDD Authority, or a Provider may complete assessment instruments, but the MCO remains responsible for the data recorded.

The MCO must complete HHSC's Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, including any applicable addendums, to assess or reassess a Member's need for or a change in Functionally Necessary State Plan Personal Attendant Services, State Plan Day Activity and Health Services, or HCBS STAR+PLUS Waiver Services. If the Member is being assessed for or receiving Community First Choice services and the Form H6516, Community First Choice Assessment, is or has been completed, the MCO may use the H6516 in lieu of the Form H2060. The MCO may adapt the forms to reflect the MCO's name or distribution instructions, but the elements must be the same and instructions for completion must be followed without amendment. The MCO must not add, delete, or modify questions from the STAR+PLUS form. The MCO must use Form H2060 or Form H6516 any time there is an assessment of the need for or a change in services, including the initial contact with the Member, the Member's annual reassessment, the Member's request for services or a change in services, and the MCO's determination that there is a need for a change in the Member's services.

Upon notice of a Change in Condition by a STAR+PLUS Member, the Member's authorized representative, Member's caregiver, Provider, or Service Coordinator, the MCO must reassess the Member and authorize appropriate services no later than 21 Days from notification. The MCO must document the dates and source of notification and any action taken. The MCO must then notify the Member and the Provider delivering the impacted service(s) within two Business Days of any determination, including a change in service(s) or denial of service(s) following the reassessment and determination. If the MCO is unable to locate the Member or the Member prefers a later date, the MCO must document the attempts to locate the Member or the Member's preference in the Member's case file. If the Member's Change in Condition jeopardizes the Member's ability to remain safely in the community, the MCO must reassess and authorize necessary services no later than seven Days following notification. The MCO must document the date and source of notification and any action taken. The MCO must then notify the Member and the Provider delivering the impacted service(s) within two Business Days of any determination, including a change in service(s) or denial of service(s) following the reassessment and determination. If the MCO is unable to locate the Member or the Member prefers a later date, the MCO must document the attempts to locate the Member or the Member's preference in the Member's case file. If the Change in Condition relates to the Member's functional ability, the MCO must complete the appropriate functional assessments specified in the STAR+PLUS Handbook. If the Change in Condition relates to a Member's caregiver support, and does not impact the result of the original assessment, the MCO must authorize appropriate services and note the change in the Member's case file. The MCO must then notify the Member and the Provider delivering the impacted service(s) within two Business Days of any determination, including a change in service(s) or denial of service(s) following the reassessment and determination.

For Members needing Nursing Facility Unit Rate Services, the MCO's Provider Contract must require that the Nursing Facility use the state and federally-required assessment

instrument, as amended or modified, to assess Members and to supply current medical information for Medical Necessity determinations. The MCO's Provider Contract must require the Nursing Facility to supply these assessments to the MCO.

8.3.3.1 Community First Choice Services

For Members with a physical disability or who are elderly seeking or needing Community First Choice services, the MCO must use the Community Medical Necessity and Level of Care Assessment Instrument, as amended, or modified, to provide a comprehensive nursing assessment of applicants and Members and to supply current medical information for Medical Necessity determinations and service planning. The MCO must also use Form H6516 Community First Choice Assessment and all applicable Form H2060 addendums, to assess Members for all services provided through Community First Choice. After the initial service plan is established, it must be completed on an annual basis. These forms (Community Medical Necessity and Level of Care Assessment Instrument, Form H6516 and Form H2060 addendums, as applicable) must be completed annually at reassessment. The MCO is responsible for tracking the renewal dates to ensure all Member reassessment activities have been completed and posted on the LTC online portal 45 Days prior to the expiration date of the Community Medical Necessity and Level of Care Assessment Instrument for Members who are physically disabled or elderly. An initial Community Medical Necessity and Level of Care (MNLOC) determination will expire 120 Days from the MNLOC assessment date if the MNLOC is not approved by the HHSC Administrative Services Contractor, and CFC services have not been authorized. For the annual reassessment, the MCO cannot initiate or submit the Community Medical Necessity and Level of Care Assessment Instrument earlier than 90 Days prior to the end date of the previous assessment. The annual reassessment will expire 90 Days from the MNLOC assessment date, if the MNLOC is not approved by the HHSC Administrative Services Contractor, and CFC services have not been authorized.

For Members with an intellectual or developmental disability or who may potentially have an intellectual or developmental disability seeking or needing Community First Choice services for which the Local IDD Authority is responsible for completing the Level of Care assessment and developing the service plan, the MCO must review and consider the assessment and service plan the Local IDD Authority submits. After the initial service plan is established, the service plan must be completed on an annual basis. These forms (Intellectual Disability/Related Condition Assessment, Form H6516 and Form H2060 addendums, as applicable) must be completed annually at reassessment. The MCO is responsible for tracking the renewal dates to ensure all Member reassessment activities for Members with intellectual or developmental disabilities have been completed prior to the end of the 12th month after the previous assessment was completed.

For Members under age 21 and age 65 or older with a severe and persistent mental illness or a severe emotional disturbance who may meet an institution of mental diseases (IMD) level of care, the MCO must coordinate with a provider of mental health rehabilitation and mental health targeted case management services to obtain the level of care determination. IMD level of care is determined by the CANS or ANSA LOC 4.

The MCO is responsible for developing the service plan and must use Form H6516 and all applicable Form H2060 addendums to assess Members for all services provided through Community First Choice. After the initial service plan is established, it must be completed on an annual basis. The IMD LOC assessment and service plan (Form H6516 and Form H2060 addendums, as applicable) must be completed at least annually at reassessment.

MCOs must use the Texas Medicaid Personal Care Assessment Form (PCAF Form) in lieu of Form H2060 or H6516 for children under the age of 21 when assessing the Member's need for Functional Necessary Personal Attendant Services or Community First Choice services. MCOs may adapt the PCAF Form to reflect the MCO's name or distribution instructions, but the elements, including Addendum P, Community First Choice Addendum, must be the same and instructions for completion must be followed without amendment. Reassessments using the PCAF Form must be completed every 12 months and as requested by the Member's parent or other legal guardian. The PCAF Form must also be completed at any time the MCO determines the Member may require a change in the number of hours authorized or the type of services provided through Community First Choice.

8.3.3.2 HCBS STAR+PLUS Waiver

For Members and applicants seeking or needing the HCBS STAR+PLUS Waiver services, the MCOs must use the Community Medical Necessity and Level of Care Assessment Instrument, as amended, or modified, to provide a comprehensive nursing assessment of applicants and Members and to supply current medical information for Medical Necessity determinations and individual service planning. The MCO must also complete the Individual Service Plan (ISP), Form H1700, including all H1700 series addendums, for each Member prior to receiving HCBS STAR+PLUS Waiver Services. The ISP is established for a one-year period. After the initial ISP is established, the ISP must be completed on an annual basis, unless otherwise approved by HHSC, and the end date or expiration date does not change. For each STAR+PLUS HCBS Member and no less than twice per year, a Service Coordinator must review the Member's ISP to determine if updates are required.

The Service Coordinator or a member of the Service Coordination team must contact the Member no later than four weeks following the ISP start date, either Face-to-face or telephonically, to ensure all necessary services are in place. The MCO must maintain documentation of the contact and the result. At the time of that contact, if services that should be in place are not in place, the Service Coordinator or a member of the Service Coordination team must help the Member arrange care and document the result. If, during the contact with the Member, the Member requests assistance that may only be performed by a registered nurse, the Service Coordinator must address the Member's needs. The Service Coordinator must research and resolve any services on the ISP with no claims data within six months from the ISP start date. For each STAR+PLUS HCBS Member and no less than twice per year, a Service Coordinator must review the Member's ISP to determine if updates are required.

These forms (Community Medical Necessity and Level of Care Assessment Instrument, Forms H6516 or H2060 and addendums, and Form H1700 series and addendums) must be completed annually at reassessment. The MCO is responsible for tracking the end dates of the ISP to ensure all Member reassessment activities have been completed and posted on the LTC online portal 30 Days prior to the expiration date of the ISP. An initial Community Medical Necessity and Level of Care (MNLOC) determination will expire 120 Days from the MNLOC assessment date if the MNLOC is not approved by the HHSC Administrative Services Contractor, and HCBS STAR+PLUS Waiver services have not been authorized. For the annual reassessment, the MCO cannot initiate or submit the Community Medical Necessity and Level of Care Assessment Instrument earlier than 90 Days prior to the expiration date of the current ISP. The annual reassessment will expire 90 Days from the MNLOC assessment date if the MNLOC is not approved by the HHSC Administrative Services Contractor, and HCBS STAR+PLUS Waiver services have not been authorized.

8.3.4 HCBS STAR+PLUS Waiver Service Eligibility

To be eligible for HCBS STAR+PLUS Waiver, individuals must meet Nursing Facility level of care criteria determined by the Community Medical Necessity Level of Care Assessment for participation in the waiver and must have a plan of care at initial determination of eligibility, at annual reassessment, and for assessments related to change in condition in which the plan's annualized cost is equal to or less than 202% of the annualized cost of care if the individual were to enter a nursing facility. The MCO must be able to demonstrate the recipient has a minimum of one unmet need for at least one HCBS STAR+PLUS Waiver service.

If the MCO determines the individual's cost of care will exceed the 202% limit, the MCO will submit individual service planning documents to HHSC Utilization Review (UR). HHSC UR may conduct a clinical review of the case to consider the use of State general revenue funds (GR) to cover costs over the 202% allowance, in accordance with HHSC's policy and procedures, or authorize the MCO to exceed the cost limit under HHSC's medically fragile policy. If HHSC approves the use of GR, or an exception to exceed the cost limit under HHSC's medically fragile policy, the MCO will be allowed to provide STAR+PLUS Home and Community-Based Services (HCBS) in excess of the 202% allowance. Non-HCBS services are not Medicaid Allowable Expenses, and may not be reported as such on the FSRs.

8.3.4.1 Members Eligible for HCBS STAR+PLUS Waiver

Members can request to be tested for eligibility into the HCBS STAR+PLUS Waiver. The MCO can also initiate HCBS STAR+PLUS Waiver eligibility testing on a STAR+PLUS Member if the MCO determines that the Member would benefit from the HCBS STAR+PLUS Waiver services.

The MCO must complete the Community Medical Necessity and Level of Care Assessment Instrument for Medical Necessity/Level of Care determination and submit the form to HHSC's Administrative Services Contractor. The MCO is also responsible for completing the assessment documentation and all required forms and addendums

identified in **Section 8.3.3.2**, HCBS STAR+PLUS Waiver. The MCO must complete these activities within 45 Days of the identified need for or request for HCBS STAR+PLUS Waiver services. The MCO must authorize all HCBS STAR+PLUS Waiver services by the start date of the ISP and services must be initiated per **Section 8.1.3.1**, Waiting Times for Appointments.

HHSC will notify the Member and the MCO of the eligibility determination, which will be based on results of the assessments and the information provided by the MCO. If the STAR+PLUS Member is eligible for HCBS STAR+PLUS Waiver services, HHSC will notify the Member of the effective date of eligibility. If the Member is not eligible for HCBS STAR+PLUS Waiver services, HHSC will provide the Member information on right to Appeal the eligibility determination. The MCO is responsible for preparing any requested documentation regarding its assessments and ISPs, and if requested by HHSC, attending the State Fair Hearing. Regardless of the HCBS STAR+PLUS Waiver eligibility determination, HHSC will send a copy of the Member notice to the MCO.

8.3.4.2 Non-Member Applicants Eligibility for HCBS STAR+PLUS Waiver

Non-members who are not eligible for Medicaid in the community may apply for participation in the HCBS STAR+PLUS Waiver under the financial and functional eligibility requirements for the 217-Like Group (this group is described in the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver). HHSC will inform the non-member applicant that services are provided through an MCO and allow the applicant to select the MCO. HHSC will provide the selected MCO an authorization form to initiate pre-enrollment assessment services required under the HCBS STAR+PLUS Waiver for the applicant. The MCO's initial home visit with the applicant must occur within 14 Days of the receipt of the referral from HHSC. To be eligible for HCBS STAR+PLUS Waiver, the applicant must meet financial eligibility and eligibility criteria set forth in **Section 8.3.4**, HCBS STAR+PLUS Waiver Service Eligibility.

The MCO must complete the Community Medical Necessity and Level of Care Assessment Instrument for Medical Necessity/Level of Care determination, and submit the form to HHSC's Administrative Services Contractor. The MCO is also responsible for completing the assessment documentation and all required forms and addendums identified in **Section 8.3.3.2**, HCBS STAR+PLUS Waiver. The MCO must complete these activities within 45 Days of receiving the State's authorization form for eligibility testing. The MCO must authorize all HCBS STAR+PLUS Waiver services by the start date of the ISP and services must be initiated per **Section 8.1.3.1**, Waiting Times for Appointments.

HHSC will notify the applicant and the MCO of the results of its eligibility determination. If the applicant is eligible, HHSC will notify the applicant and the MCO will be notified of the effective date of eligibility, which will be the first Day of the month following the determination of eligibility.

If the applicant is not eligible, HHSC will notify the applicant and the MCO will be notified of the applicant's ineligibility. The notice to the applicant will provide information on the applicant's right to Appeal the determination. The MCO is responsible for preparing any

requested documentation regarding its assessments and service plans, and if requested by HHSC, attending the State Fair Hearing.

8.3.4.3 Annual Reassessment

Thirty Days before the end date of the annual ISP, the MCO must complete the same activities detailed in Section 8.3.3.2 HCBS STAR+PLUS Waiver for each reassessment to determine and validate continued eligibility for STAR+PLUS HCBS services for each Member receiving these services and submit the Member's Individual Service Plan (ISP) to HHSC. If the previous ISP was approved to exceed the cost limit under HHS's medically fragile policy or through the use of GR, the MCO must submit the complete documentation packet specified in the STAR+PLUS Handbook to HHSC at least 45 Days before the end date of the Member's ISP. As part of the assessment, the MCO must inform the Member about available service delivery options. Unlike the initial submission of the Community Medical Necessity and Level of Care Assessment, a physician signature is not required for reassessments.

8.3.4.3.1 Reassessment Following a Change in Condition

Upon notice by a Member, the Member's authorized representative, Member's caregiver, Provider, or Service Coordinator of a Change in Condition, the MCO must reassess the Member and authorize appropriate services as soon as possible but no later than 21 Days from notification. The MCO must document the date and source of notification and any action taken. The MCO must then notify the Member and the Provider delivering the impacted service(s) within two Business Days of any determination, including a change in service(s) or denial of service(s) following the reassessment and determination. If the MCO is unable to reach the Member or the Member prefers a later date, the MCO must document the attempts to contact the Member or the Member's preference in the Member's case file. If the Member's Change in Condition jeopardizes the Member's ability to remain safely in the community, the MCO must reassess and authorize necessary services as soon as possible but no later than seven Days following notification. The MCO must document the date and source of notification and any action taken. The MCO must then notify the Member and the Provider delivering the impacted service(s) within two Business Days of any determination, including a change in service(s) or denial of service(s) following the reassessment and determination. If the MCO is unable to reach the Member or the Member prefers a later date, the MCO must document the attempts to contact the Member or the Member's preference in the Member's case file. If the Member's Change In Condition relates to a medical condition, the MCO may complete the Community Medical Necessity and Level of Care Assessment Instrument and functional assessments specified in the STAR+PLUS Handbook. If the Change in Condition relates to the Member's functional ability, the MCO must complete the appropriate functional assessments specified in the STAR+PLUS Handbook. If the Change in Condition relates to a Member's caregiver support and does not impact the result of the original assessment, the MCO must authorize appropriate services and note the change in the Member's case file. The MCO must then notify the Member and the Provider delivering the impacted service(s) of any determination, including a change in service(s) or denial of service(s) within two Business Days following the reassessment and determination.

8.3.4.4 STAR+PLUS Utilization Reviews

HHSC will conduct STAR+PLUS utilization reviews, as described in Texas Government Code § 533.00281. The reviews will include the MCO's assessment processes used to determine HCBS waiver eligibility. If HHSC recoups money from the MCO as a result of a utilization review conducted under this section, the MCO cannot hold a Network service provider liable for the good faith provision of services based on the MCO's authorization.

8.3.5 Service Delivery Options

There are three service delivery options available to STAR+PLUS Members for the delivery of certain community-based Long Term Services and Supports (LTSS). These service delivery options are:

1. Consumer Directed Services (CDS) option;
2. Service responsibility option (SRO) ; and
3. Agency option.

The MCO must provide information about the service delivery options in the Member handbook, and the MCO Service Coordinator must present information about the three service delivery options to Members at the following times:

1. at initial assessment;

2. at annual reassessment or annual contact with the STAR+PLUS Member; and

3. at the Member's request.

The MCO must contract with Home and Community Support Services agencies (HCSSAs), certified Home and Community-based (HCS) or Texas Home Living (TxHmL) providers, and Financial Management Services Agencies (FMSAs) to ensure availability of all service delivery options. Network Providers must meet licensure and certification requirements as indicated in Attachment B-1, Sections 8.3.1.1 and 8.3.1.2 of the Uniform Managed Care Contract.

Regardless of which service delivery option(s) the Member selects, the Service Coordinator and the Member work together to develop the Individual Service Plan.

8.3.5.1 Consumer Directed Services (CDS) Option

In the CDS option, the Member or the Member's LAR is the employer of record and retains control over the hiring, management, and termination of service providers. The Member or Member's LAR is responsible for ensuring that the employee or contracted service provider meets all applicable eligibility qualifications and requirements. The Member is required to receive Financial Management Services provided by a FMSA.

The FMSA performs functions including processing payroll, withholding taxes and filing tax-related reports to the Internal Revenue Services and the Texas Workforce Commission for services delivered through the CDS option. The FMSA is also responsible for providing training to the Member or Member's LAR on being an employer, verifying provider qualifications (including criminal history and registry checks), and approving the CDS budget.

The MCO must ensure the FMSA meets necessary qualifications to provide financial management services, including completing the mandatory FMSA enrollment training provided by HHSC and meeting eligibility requirements for an HHSC FMSA contract.

The MCO must ensure that the CDS budget is calculated using HHSC rates for CDS services.

The MCO must offer the CDS option and make it available for eligible program covered services, including Medicaid state plan personal assistance services and respite.

The MCO must offer the CDS option and make it available for the following STAR+PLUS and STAR+PLUS HCBS covered services:

- CFC Personal Assistance Services
- CFC Habilitation
- Personal Assistance Services
- Respite
- Nursing
- Physical Therapy
- Occupational Therapy
- Cognitive Rehabilitation Therapy
- Speech Therapy
- Supported Employment
- Employment Assistance
- Support Consultation

8.3.5.2 Service Responsibility Option

In the service responsibility option (SRO), the Home and Community Support Services agency (HCSSA) or certified Home and Community-based Services (HCS) or Texas Home Living (TxHmL) Provider is the employer of record for the service provider. The Member or the Member's legal guardian is actively involved in choosing and overseeing the service provider but is not the employer of record.

The Member selects their service provider from the HCSSA or certified HCS or TxHmL Provider's employees. The Member retains the right to supervise and train the service provider, and to establish the schedule for service delivery. The Member may request a different personal attendant and the HCSSA or certified HCS or TxHmL Provider must honor the request as long as the new attendant is an employee of the agency. The HCSSA establishes the service provider's payment rate, benefits, and conducts all administrative functions.

The MCO must offer SRO and make it available for the following STAR+PLUS and STAR+PLUS HCBS Covered Services:

1. CFC Personal Assistance Services,
2. CFC Habilitation,
3. Personal Assistance Services, and
4. Respite.

8.3.5.3 Agency Option

In the agency option, the MCO contracts with a Home and Community Support Services agency (HCSSA) or a certified Home and Community-based Services (HCS) or Texas Home Living (TxHmL) Provider for the delivery of services. The HCSSA is the employer of record for the service provider. The HCSSA or certified HCS or TxHmL Provider establishes the payment rate and benefits for the service providers and conducts all administrative functions. The agency option is the default service delivery option for all community-based Long Term Services and Supports (LTSS).

The MCO must offer the agency option and make it available for all STAR+PLUS and STAR+PLUS HCBS Covered Services.

8.3.6 Community Based Long-term Services and Supports Providers

8.3.6.1 Training

The MCO must comply with Section 8.1.4.6 regarding Provider Manual and Provider training specific to the STAR+PLUS Program. The MCO must train all Community Long-term Services and Supports Providers regarding the requirements of the Contract and special needs of STAR+PLUS Members. The MCO must establish ongoing STAR+PLUS Provider training addressing the following issues at a minimum:

1. Covered Services and the Provider's responsibilities for providing such services to STAR+PLUS Members and billing the MCO. The MCO must place special emphasis on Community Long-term Services and Supports and STAR+PLUS requirements, policies, and procedures that vary from Medicaid Fee-for-Service and commercial coverage rules, including payment policies and procedures;
2. relevant requirements of the STAR+PLUS Contract, including the role of the Service Coordinator;
3. processes for making referrals and coordinating Non-capitated Services;
4. the MCO's quality assurance and performance improvement program and the Provider's role in such programs; and
5. the MCO's STAR+PLUS policies and procedures, including those relating to Network and Out-of-Network referrals.

8.3.6.2 LTSS Provider Billing

Long-term Services and Supports providers serving clients in the traditional Fee-for-Service Medicaid program have not been required to utilize the billing systems that most medical facilities use on a regular basis. For this reason, the MCO must make accommodations to the claims processing system for such providers to allow for a smooth transition from traditional Medicaid to STAR+PLUS.

HHSC has developed a standardized method for Long-term Services and Supports billing. All STAR+PLUS MCOs are required to utilize the standardized method, as found in the **STAR+PLUS Handbook**.

8.3.6.3 Rate Enhancement Payments for Agencies Providing Attendant Care

All MCOs participating in the STAR+PLUS Program must allow their Long-term Services and Supports Providers to participate in the STAR+PLUS Attendant Care Enhancement Program.

UMCM Chapter 2 includes a form the STAR+PLUS MCO may use to document their methodology to implement and pay the enhanced payments. The STAR+PLUS MCO must apply vendor holds to participating Providers in accordance with 1 Tex. Admin. Code § 355.101 and must recoup any enhancement payments that are made to Providers but do not comply with the MCO's enhanced payment methodology. Additionally, on HHSC's request, the MCO must provide HHSC with the MCO's methodology and a current list of Network Providers of the following attendant services: Day Activity Health Care Services (DAHS), Primary Home Care (PHC), Personal Assistance Services (PAS), and Texas Health Steps Personal Care Services (PCS), and Personal Assistance Services and acquisition, maintenance, and enhancement of skills in CFC.

8.3.6.4 STAR+PLUS Handbook

The STAR+PLUS Handbook contains HHSC-approved policies and procedures related to the STAR+PLUS Program, including policies and procedures relating to the Texas

Healthcare Transformation and Quality Improvement Program 1115 waiver. The STAR+PLUS Handbook includes additional requirements regarding the STAR+PLUS Program and guidance for the MCOs, the Program Support Units, and HHSC staff for administrating and managing STAR+PLUS Program operations. The STAR+PLUS Handbook is incorporated by reference into the Contract.

8.3.6.5 This Section is Intentionally Left

8.3.6.6 Cost Reporting for LTSS Providers

MCOs must require that LTSS Providers submit periodic cost reports and supplemental reports to HHSC in accordance with 1 Tex. Admin. Code Chapter 355, including Subchapter A (Cost Determination Process) and 1 Tex. Admin. Code § 355.403 (Vendor Hold). If an LTSS Provider fails to comply with these requirements, HHSC will notify the MCO to hold payments to the LTSS provider until HHSC instructs the MCO to release the payments.

8.3.7 Additional Requirements Regarding Dual Eligibles

8.3.7.1 Coordination of Services for Dual Eligibles

The STAR+PLUS MCOs must coordinate Medicare and Medicaid services for Dual Eligible recipients. To facilitate such coordination, the MCO must be contracted with the CMS and operating as a MA Dual SNP in the most populous counties in the Service Area(s), as identified by HHSC, no later than January 1, 2013, or as a Dual Eligible Medicare-Medicaid Plan (MMP) in the designated demonstration counties no later than January 1, 2015. After these dates, the MCO must maintain its status as an MA DUAL SNP or an MMP contractor throughout the term of the Contract. Failure to do so may result in HHSC's assessment of contractual remedies, including Contract termination.

8.3.7.2 MA Dual SNP Agreement

As part of the integrated care initiative for Dual Eligible STAR+PLUS Members, the MCO may maintain a separate capitation agreement with HHSC whereby the MCO's MA Dual SNP plan reimburses Medicare providers for the cost-sharing obligations that the State would otherwise be required to pay on behalf of qualified STAR+PLUS Dual Eligible Members. The final Texas MA Dual SNP Agreement, as amended or modified, will be incorporated by reference into the STAR+PLUS Contract. The MCO will be required to provide all enrolled STAR+PLUS Dual Eligible Members with the coordinated care and other services described in the Texas MA Dual SNP Agreement, and any violations of the Texas MA Dual SNP Agreement with respect to STAR+PLUS Members will also be a violation of the STAR+PLUS Contract. For STAR+PLUS Members who are also enrolled in the MA Dual SNP's Medicare plan, the Parties may develop alternative methods for verifying Member eligibility and submitting encounter data. Any modifications to these processes or other requirements identified in the Texas MA Dual SNP Agreement will be included in the Texas MA Dual SNP Agreement.

8.3.8 Minimum Wage Requirements for STAR+PLUS Attendants in Community Settings

The MCO must require its contracted providers to pay a base wage in accordance with 1 Tex. Admin. Code, § 355.7051(e) and (f) for any personal attendant who provides:

- Day Activity Health Care Services (DAHS);
- Primary Home Care (PHC);
- Personal Assistance Services (PAS);
- Personal Assistance Services - CFC;
- Acquisition, maintenance and enhancement of skills in CFC;
- Texas Health Steps Personal Care Services (PCS);
- Assisted living; and
- Residential care (RC).

This requirement applies to personal attendants providing services to Members in the CDS option.

The MCO must ensure that attendants are paid no less than $8.00 per hour for dates of service on or after September 1, 2015.

8.3.9 Nursing Facility Services

STAR+PLUS MCOs must provide reimbursement for Nursing Facility Services to qualified Medicaid recipients with the following exceptions: Individuals who are under the age of 21 or who reside in either the Truman W. Smith Children's Care Center or a state veteran's home will remain in FFS. Additionally, Nursing Facility residents who are federally recognized tribal members age 21 and older or who receive services through the Program of All-Inclusive Care for the Elderly (PACE) may optionally enroll in STAR+PLUS. As required in 1 Tex. Admin. Code § 19.2320(a), the Nursing Facility is responsible for providing transportation to medical services outside the facility. NEMT Services are available to Members in a Nursing Facility for transportation to dialysis treatment centers.

MCOs must provide access to Nursing Facility services for all qualified STAR+PLUS Members. Nursing Facility Providers must meet all of the state licensure, certification, and Medicaid contracting requirements, as well as the NF credentialing standards in UMCM Chapter 8. for providing the services in **Attachment B-2.2**, "STAR+PLUS Covered Services." An MCO may refuse to contract with a NF if the NF does not meet the minimum performance standards in UMCM Chapter 8.

Nursing Facility Services Available to All Members	
Service	**Licensure and Certification Requirements**
Nursing Facility	The MCOs must use the state-identified credentialing standards for Nursing Facilities set forth in UMCM Chapter 8. Credentialing documentation must be submitted to HHSC upon request.

8.3.9.1 Preadmission Screening and Resident Review (PASRR)

The MCO must fulfill PASRR requirements when providing services for STAR+PLUS Members as required by 26 Tex. Admin. Code § 303.101- 303.401. MCO participation includes coordinating with the Local Mental Health or Intellectual or Developmental Disability Authority, NF, Member, and interdisciplinary team to develop the Member's service plan and ensure PASRR specialized services are provided in compliance with the Member's service plan.

8.3.9.2 Participation in Texas Promoting Independence Initiative

The STAR+PLUS MCO must participate in the Texas Promoting Independence (PI) initiative.

The Nursing Facility MCO Service Coordinator must review MDS Section Q 3.0 responses. The MCO must designate a point of contact if not the Nursing Facility Service Coordinator to receive referrals for Nursing Facility Members who want to return to the community through the use of STAR+PLUS HCBS services. The MCO Service Coordinator must assess the individual to determine service and transition needs, including mental health and Substance Use Disorder services. The MCO must follow the timeframes prescribed in the STAR+PLUS Handbook. The MCO Service Coordinator or designated point of contact must assess the individual to determine if the individual can be safely served in the community with available resources. If determined eligible, the MCO must assess for service and transition needs within timeframes in the STAR+PLUS Handbook. The MCO Service Coordinator or point of contact must work with the individual and his/her family, the individual's primary care physician, the nursing facility discharge planner, and other community partners, as needed, to ensure timely and coordinated access to an array of providers and other Non-capitated Services as necessary and appropriate, including referrals to community organizations. If needed, the MCO must coordinate Transition Assistance Services as part of the STAR+PLUS HCBS Program and must refer for additional community resources including 811 Project Rental Assistance. The MCO must distribute supplemental funds, using non-Medicaid funds or other resources, as one-time financial assistance for essential household or transition expenses not covered by Transition Assistance Services (TAS), as defined in Attachment B-2.2, for all Members with an identified need.

If the initial review does not support a return to the community, the Service Coordinator must conduct a second assessment 90 Days after the initial assessment, and quarterly thereafter, to evaluate if the individual's condition or circumstances changed and support a return to the community. If a return to the community is possible and appropriate, the

Service Coordinator must develop and implement a transition plan with the individual and his/her supports.

Prior to discharge date the MCO must ensure all necessary services, including transition assistance services items, as well as, mental health or Substance Use Disorder treatment, are in place on the discharge date. The MCO service coordinator or point of contact must be present at the relocation site on the day and time of the Member's transition. Following discharge, the MCO must maintain contact with persons relocated from nursing facilities in the time intervals on the STAR+PLUS Handbook.

The MCO must maintain documentation of the assessments completed as part of this initiative and make them available for state review at any time.

8.3.9.3 Nursing Facilities Training

In addition to **Section 8.1.4.6**, the MCO must train all Nursing Facility Providers regarding the requirements of the Contract and special needs of STAR+PLUS Members. The MCO must establish ongoing Provider training addressing the following issues at a minimum.

1. Covered Services and the Provider's responsibilities for providing services to Members and billing the MCO for the services. The MCO must place special emphasis on Nursing Facility Services and STAR+PLUS requirements, policies, and procedures that vary from Medicaid Fee-for-Service and commercial coverage rules, including payment policies and procedures.
2. Relevant requirements of the Contract, including the role of the Service Coordinator;
3. Processes for making referrals and coordinating Non-capitated Services;
4. The MCO's quality assurance and performance improvement program and the Provider's role in these programs; and
5. The MCO's STAR+PLUS policies and procedures, including those relating to Network and Out-of-Network referrals.

8.3.9.4 Nursing Facility Claims Adjudication, Payment, and File Processing

The MCO must process claims in accordance with UMCM Chapter 2. The MCO must pay clean claims no later than ten Days after submission of the clean claim. For purposes of this section only, clean claim is defined in Texas Gov't. Code § 533.00251(a)(2).

The MCO must use the Initial and Daily Service Authorization System (SAS) Provider and rate data in the adjudication of claims for Nursing Facility Unit Rate and Nursing Facility Medicare Coinsurance.

The MCO must ensure that Network Nursing Facility Providers are paid Nursing Facility Unit Rates at or above the minimum rates established by HHSC for the dates of service. HHSC will post this information on the HHSC website. If HHSC makes a retroactive rate adjustment to a Nursing Facility Unit Rate, the MCO must retroactively automatically

adjust payment to a Nursing Facility no later than 30 Days after receipt of HHSC notification and meet the auto-adjustment benchmark outlined in UMCM Chapter 2.3, Section VIII.A.

The MCO must ensure that all enrollment and eligibility files in the Joint Interface Plan are loaded into the claims adjudication system before the first Day of the month following receipt.

8.3.9.5 Nursing Facility Direct Care Rate Enhancement

All MCOs participating in the STAR+PLUS Program must allow their Nursing Facility Providers to participate in the STAR+PLUS Direct Care Staff Rate Enhancement Program in accordance with 1 Tex. Admin. Code § 355.308. HHSC will determine enhancement payments, which will be included in the Nursing Facility Unit Rates. HHSC will post information regarding Nursing Facility enhanced payments on the HHSC website.

The rate methodology submitted for approval by the MCO to set a staff rate enhancement shall result in a staff rate enhancement that is no less than the rate that would be developed under the methodology existing at HHSC on August 31, 2015. HHSC will determine Nursing Facility compliance with Direct Care Rate Enhancement spending and staffing requirements. If HHSC makes a retroactive rate adjustment to a Nursing Facility's Unit Rate due to non-compliance with Direct Care Rate Enhancement spending or staffing requirements, the MCO must retroactively automatically adjust payment to a Nursing Facility no later than 30 Days after receipt of HHSC notification in accordance with **Section 8.3.9.4** and meet the auto-adjustment benchmark outlined in UMCM Chapter 2.3, Section VIII.A.

8.3.10 Acute Care Services for Recipients of ICF-IID Program and IDD Waiver Services

Individuals with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID Program or an IDD Waiver are eligible for Acute Care services through STAR+PLUS. These individuals will not be eligible for the HCBS STAR+PLUS Waiver Services while enrolled in the ICF-IID Program or an IDD Waiver.

8.3.11 Cognitive Rehabilitation Therapy

The MCO may only authorize Cognitive Rehabilitation Therapy if one of the following Texas Medicaid-covered assessment tests, as listed in the Texas Medicaid Provider Procedures Manual, shows that the therapy can benefit the Member and is Medically Necessary:

- Neurobehavioral Test; or
- Neuropsychological Test

8.3.12 This Section Intentionally Left Blank

8.3.13 Community First Choice Eligibility

Recipients of Community First Choice services must meet level of care criteria for participation and must have a plan of care at initial determination of eligibility. Members needing services provided through Community First Choice must be tested for eligibility before those services are provided through other STAR+PLUS Community Long-term Services and Supports.

8.3.13.1 For Members Who Are Elderly or Have Physical Disabilities

To be eligible for the Community First Choice services, the Member must be eligible for Medicaid, with the exception of Members who receive Medicaid as a result of being a HCBS STAR+PLUS waiver recipient under the 217-Like Group provision and meet Medical Necessity/Level of Care.

The MCO must complete the Community Medical Necessity and Level of Care Assessment Instrument for Medical Necessity/Level of Care determination and submit the form to HHSC's Administrative Services Contractor. The MCO is also responsible for completing the assessment documentation and preparing a service plan identifying the needed Community First Choice services, as well as any additional services the Member may benefit from, including the HCBS STAR+PLUS waiver. The MCO must complete these activities within the timeframe specified by HHSC in the STAR+PLUS Handbook.

8.3.13.2 For Members with an Intellectual or Developmental Disability

To be eligible for Community First Choice services, the Member must be eligible for Medicaid and meet an institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF-IID). The MCO must review and consider the assessment and service plan completed by the Local IDD Authority when determining eligibility and finalizing the service plan. The MCO must complete these activities within the timeframe specified by HHSC in the STAR+PLUS Handbook.

8.3.13.3 For Members with Severe and Persistent Mental Illness or Severe Emotional Disturbance

To be eligible for the Community First Choice services, the Member must be eligible for Medicaid and meet an IMD level of care, which is determined by CANS or ANSA LOC 4.

The MCO must coordinate with a provider of mental health rehabilitation and mental health targeted case management to determine whether the Member meets an IMD level of care. The MCO is also responsible for preparing a service plan identifying the needed Community First Choice services, as well as any additional services the Member may benefit from, including the HCBS STAR+PLUS waiver. The MCO must complete these activities within the timeframe specified by HHSC in the STAR+PLUS Handbook.

8.3.13.4 Eligibility

The MCO will notify the Member of the eligibility determination, which will be based on results of the assessments. If the STAR+PLUS Member is eligible for Community First Choice services, the MCO will notify the Member of the effective date of eligibility. If the Member is not eligible for Community First Choice services, the MCO will provide the Member information on the right to appeal the determination, including access to HHSC's State Fair Hearing process. The MCO is responsible for preparing any requested documentation regarding its assessments and service plans and attending the State Fair Hearing.

8.3.13.5 Annual Reassessment

The MCO is responsible for tracking the renewal dates to ensure all Member reassessment activities are completed. Before the end date of the annual Community Medical Necessary and Level of Care Assessment; before the end of the 12th month after the previous assessment was completed for Members with intellectual or developmental disabilities; or Members with severe and persistent mental illness or severe emotional disturbance, the MCO must initiate an annual reassessment to determine and validate continued eligibility for Community First Choice services for each Member receiving these services. As part of the assessment, the MCO must inform the Member about Consumer Directed Services options. The MCO will be expected to complete the same activities for each annual reassessment as required for the initial eligibility determination.

8.4 Additional CHIP Scope of Work

The following provisions only apply to MCOs participating in CHIP.

The MCO must not avoid costs for Covered Services by referring Members to publicly funded health care resources.

8.4.1 CHIP Provider Complaint and Appeals

CHIP Provider complaints and claims payment appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. The MCO must resolve Provider complaints and claims payment appeals within 30 Days from the date of receipt.

The MCO must refer any Member alleging provider noncompliance with Government Code §531.02119(a) to the HHS Office of the Ombudsman.

8.4.2 CHIP Member Complaint and Appeal Process

CHIP Member Complaints and Appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. HHSC will require the MCO to resolve Member Complaints and Appeals that are not elevated to TDI within 30 Days

from the date the Member Complaint or Appeal is received unless the MCO can document that the Member requested an extension, or the MCO shows there is a need for additional information and the delay is in the Member's interest. Any person, including those dissatisfied with a MCO's resolution of a Member Complaint or Appeal, may report an alleged violation to TDI.

HHSC is not required by federal law to pay for Covered Services provided to a CHIP Member pending an Appeal. The MCO cannot include costs for these services in Encounter Data submitted to HHSC or seek any other reimbursement from HHSC.

8.4.3 Third Party Liability and Recovery, and Coordination of Benefits

CHIP is the payer of last resort for Covered Services when coordinating benefits with all other insurance coverage, unless an exception applies under federal law. Coverage provided under CHIP will pay benefits for Covered Services that remain unpaid after all other insurance coverage has been paid. For Network Providers and Out-of- Network providers with written reimbursement arrangements with the MCO, the MCO must pay the unpaid balance for Covered Services up to the agreed rates. For Out-of-Network providers with no written reimbursement arrangement, the MCO must pay the unpaid balance for Covered Services in accordance with 1 Tex. Admin. Code § 370.604 regarding Out-of-Network payment and TDI's rules regarding usual and customary payment.

MCOs are responsible for establishing and documenting a plan and process, referred to as the Third Party Liability Managed Care Organization Action Plan (TPL MCO Action Plan), in accordance with UMCM Chapter 5, for avoiding and recovering costs for services that should have been paid through a third party [including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974)], service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

The TPL MCO Action Plan and process must be in accordance with state and federal law and regulations, including Section 1902(a)(25)(E) and (F) of the Social Security Act, which require MCOs to first pay and later seek recovery from liable third parties for (1) preventive pediatric care, and (2) services provided to an individual on whose behalf child support enforcement is being carried out by the State agency under Part D of Title IV of the Social Security Act.

Each MCO must submit the TPL MCO Action Plan to the Office of Inspector General – Third Party Recoveries (OIG-TPR) accordance with UMCM Chapter 5 no later than September 1 for the upcoming state fiscal year for review and approval. MCOs must submit any change requests to the TPL MCO Action Plan for review and approval no later than 90 Days prior to the date of the proposed changes. The projected amount of TPR that the MCO is expected to recover may be factored into the rate setting process.

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

1. responding to an MCO inquiry within 60 Days regarding a claim for payment for Covered Services submitted to the liable third party no later than the third anniversary after the date the Covered Services were provided;
2. except as provided in §32.0424(b-2), accepting authorization from the MCO for Covered Services that require prior authorization and were previously paid by the MCO as if the MCO's authorization is a prior authorization made by the liable third party for Covered Services; and
3. the prohibition of denying a claim submitted by the MCO for which payment was made solely on the basis of:
    a. the date of submission of the claim;
    b. the type or format of the claim form;
    c. a failure to present proper documentation at the point of service that is the basis of the claim; or
    d. except as provided in §32.0424(b-2), a failure to obtain prior authorization for Covered Services.

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

The MCO must provide all TPR reports to OIG-TPR at the frequency and in accordance with UMCM Chapter 5.

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

The MCO shall provide to HHSC, on a monthly basis by the tenth Day of each month, a report indicating the claims where the MCO has billed and/or made a recovery up to the 120th Day from adjudication of a claim that is subject to TPR. After 120 Days, HHSC will attempt recovery for any claims in which the MCO did not attempt recovery and will retain, in full, all funds received as a result of any state-initiated TPR. The MCO is precluded from attempting to bill for any recovery after 120 Days from claim adjudication date. Any collections by MCO billed after 120 Days from the claim adjudication date must be sent to OIG-TPR in the format prescribed in UMCM Chapter 5. The MCOs are to continue to cost avoid and cost recover where applicable.

After 365 Days from adjudication of a claim, the MCO loses all rights to pursue or collect any recoveries subject to TPR. HHSC has the sole authority for recoveries of any claim subject to TPR after 365 Days from the date of adjudication of the claim. Should the MCO receive payment on a HHSC-initiated recovery, the MCO must send the payment to OIG-TPR in the format prescribed in UMCM Chapter 5.

HHSC retains the responsibility to pursue, collect, and retain recoveries of all resources and insurances other than health insurance wherein payments have been made on behalf of a Member. These resources and other insurances include but are not limited to: casualty insurance, liability insurance, estates, child support, and personal injury claims. MCOs must pay valid claims for Covered Services provided to MCO Members who have, or may have, resources and insurances other than health insurance. Since HHSC retains the right of recovery for such resources and insurances other than health insurance, the MCO is not permitted to cost avoid or seek recovery for such items. Should the MCO receive payment on a claim in which resources or insurances other than health insurance are utilized, the MCO must send the payment to OIG-TPR in the format prescribed in UMCM Chapter 5. Members with these other resources shall remain enrolled in the MCO.

8.4.4 Perinatal Services for Traditional CHIP Members

The MCO's perinatal Health Care Services must ensure appropriate care is provided to women and infant Members of the MCO from the preconception period through the infant's first year of life. The MCO's perinatal health care system must comply with the requirements of the Texas Health and Safety Code, Chapter 32 (the Maternal and Infant Health Improvement Act), and administrative rules codified at 25 Tex. Admin. Code Chapter 37, Subchapter M.

The MCO must have a perinatal health care system in place that, at a minimum, provides the following services:

1. pregnancy planning and perinatal health promotion and education for reproductive-age women;
2. perinatal risk assessment of non-pregnant women, pregnant and postpartum women, and infants up to one year of age;
3. access to appropriate levels of care based on risk assessment, including emergency care;
4. transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary;
5. availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; and
6. availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems.

The MCO must have a process to expedite scheduling a prenatal appointment for an obstetrical exam for a Member with a confirmed diagnosis indicating pregnancy.

The MCO must have procedures in place to contact and assist a pregnant/delivering Member in selecting a PCP for her baby either before the birth or as soon as the baby is born.

Except as provided in **Attachment A, Section 5.06**, the MCO must provide inpatient care and professional services relating to labor and delivery for its pregnant/delivering Members for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated caesarian delivery. The MCO must provide neonatal care for its newborn Members until the time of discharge.

The MCO must notify providers involved in the care of pregnant/delivering women and newborns (including Out-of-Network providers and Hospitals) of the MCO's prior authorization requirements. The MCO cannot require a prior authorization for services provided to a pregnant/delivering Member or newborn Member for a medical condition that requires Emergency Services, regardless of when the emergency condition arises.

8.4.5 Continuity of Care and Out-of-Network Providers

The MCO must ensure that the care of newly enrolled Members is not disrupted or interrupted. The MCO must take special care to provide continuity in the care of newly enrolled Members whose health or Behavioral Health condition has been treated by specialty care providers or whose health could be placed in jeopardy if Medically Necessary Covered Services are disrupted or interrupted.

Upon notification from a Member or Provider of the existence of a prior authorization, the new MCO must ensure Members receiving services through a prior authorization from another CHIP MCO, Medicaid MCO, or fee-for-service receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following:

(1) 90 Days after the transition to a new MCO,

(2) until the end of the current authorization period, or

(3) until the MCO has evaluated and assessed the Member and issued or denied a new authorization.

See Section **8.1.14**, "Disease Management (DM)." for specific requirements for new Members transferring to the MCO's Disease Management (DM) Program.

For instances in which a newly enrolled Member was receiving a service that did not require a prior authorization in FFS or the previous MCO, but does require one by the new MCO, the MCO must ensure Members receive services for the same amount, duration, and scope for the shortest period of one of the following: (1) 90 Days after the transition to a new MCO, or (2) until the MCO has evaluated and assessed the Member and issued or denied a new authorization.

The MCO is also required to ensure that clients being transferred to a new MCO as part of an HHSC initiative, receiving acute care services through a prior authorization as of the Operational Start Date receive continued authorization of those services for the shorter period of one of the following: 90 Days after Operational Start Date, or (2) until the expiration date of the prior authorization. During transition, an HHSC's Administrative Services Contractor or an HHS Agency will provide the MCO with files identifying Members with prior authorizations for acute care services. The MCO must describe the process it will use to ensure continuation of these services in its Transition/Implementation Plan as noted in **Section 7.2.1** Contract Start-Up and Planning. The MCO is also required to ensure that Providers in the Service Areas are educated about and trained regarding the process for continuing these services prior to the Operational Start Date (see Section **8.3.6.1** Training).

As described in **Section 8.1.3.2**, the MCO must allow pregnant Members past the 24th week of pregnancy to remain under the care of the Member's current OB/GYN through the Member's postpartum checkup, even if the provider is Out-of-Network. If a Member wants to change her OB/GYN to one who is in the Network, she must be allowed to do so if the Provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

The MCO must pay a Member's existing Out-of-Network providers for Medically Necessary Covered Services until the Member's records, clinical information and care can be transferred to a Network Provider, or until such time as the Member is no longer enrolled in that MCO, whichever is shorter. Payment to Out-of-Network providers must be made within the time period required for Network Providers. The MCO must comply with Out-of-Network rules as described in 1Tex. Admin. Code § 370.604.

With the exception of pregnant Members who are past the 24th week of pregnancy, this Article does not extend the obligation of the MCO to reimburse the Member's existing Out-of-Network providers for ongoing care for more than 90 Days after a Member enrolls in the MCO's Program, or

The MCO's obligation to reimburse the Member's existing Out-of-Network provider for services provided to a pregnant Member past the 24th week of pregnancy extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six (6) weeks of delivery.

If a Member moves out of a Service Area, the MCO must provide or pay Out-of-Network providers in the new Service Area who provide Medically Necessary Covered Services to Members through the end of the period for which the MCO received a Capitation Payment for the Member.

If Covered Services are not available within the MCO's Network, the MCO must provide Members with timely and adequate access to Out-of-Network services for as long as those services are necessary and not available in the Network, in accordance with 42 C.F.R. § 438.206(b)(4). The MCO will not be obligated to provide a Member with access to Out-of-Network services if such services become available and within acceptable appointment availability timeframes described in this Contract from a Network Provider.

The MCO must ensure that each Member has access to a second opinion regarding the use of any Medically Necessary Covered Service. A Member must be allowed access to a second opinion from a Network Provider or Out-of-Network provider if a Network Provider is not available, at no cost to the Member, in accordance with 42 C.F.R. § 438.206(b)(3), applicable to CHIP through 42 C.F.R § 457.1230. The MCO may use single case agreements with Out-of-Network providers to facilitate a Member's access to a second opinion.

The MCO is not required to include Members seeking a second opinion as part of its "Out-of-Network Utilization Reporting" requirements under UMCM Chapter 5.

8.4.6 Education for CHIP Members and Providers

The MCO must provide education to the parent or Member's LAR about any other state programs or resources. The MCO must also have procedures in place to educate the following Members about family planning programs as follows:

- Members in CHIP who are aging out of the program should receive education about Healthy Texas Women Program services, including Health Texas Women Plus services;

- All CHIP Members of child-bearing age should receive education about HHSC Family Planning Program services; and

- All CHIP Members should receive education about HHSC Primary Health Care Program services.

The MCO must also have procedures in place to educate Providers about eligibility criteria and services available under the Healthy Texas Women Program, including Healthy Texas Women Plus services; the HHSC Family Planning Program; and the HHSC Primary Health Care Program.

8.4.7 Compliance with State and Federal Prior Authorization Requirements

For CHIP, the MCO must comply with Texas Human Resources Code § 32.073 and Texas Insurance Code §§ 1217.004 and 1369.304, which require MCOs to use national standards for electronic prior authorization of prescription drug and health care benefits no later than two years after adoption, and accept PA requests submitted using in the Texas Department of Insurance's (TDI's) standard form.

8.4.8 CHIP Perinatal Services

The MCO must provide CHIP Perinatal Covered Services, including postpartum visits, to the mother of a CHIP Perinatal unborn child beginning on the Member's date of enrollment up to 60 Days after the end of pregnancy.

If provided within 60 Days after the end of pregnancy, the MCO cannot deny a Provider's claims for Covered Services provided to the mother of a CHIP Perinatal Newborn or former CHIP Perinatal unborn child on the basis that the mother's CHIP Perinatal ID number has expired in accordance with HHSC's claims processing requirements in UMCM Chapter 2. The MCO may Adjudicate claims using a proxy ID number, newborn's State-issued Medicaid ID number, or newborn's CHIP Perinatal ID number.

The MCO must have a procedure to prevent duplication of payment to Providers submitting bundled payment claims for CHIP Perinatal Covered Services, including postpartum visits.