Redlined Attachments

- Attachment A, STAR Kids Contract Terms and Condition
- Attachment B-1, Sec 6, Premium Payment Incentives and Disincentives
- Attachment B-1, Sec 8, Operations Phase Requirements
- Attachment B-2, STAR Kids Covered Services
- Attachment B-3, Liquidated Damages Matrix

Section-by-Section

Attachment A, STAR Kids Contract Terms and Condition

- **4.08. Subcontractors and Agreement with Third Parties -** The amendment to this provision requires that MCOs have a subcontract with all material subcontractors and all PBMs. It would also require that MCOs include in subcontracts a requirement that:
    - Employees of subcontractors who have a reasonable cause to believe that fraud, waste, or abuse has occurred must report the activity to the HHSC Office of Inspector General; and
    - Subcontractors, including all subcontractors of subcontractors, that enter into contracts with subcontractors provide HHSC the right to examine the Subcontract and complete and unredacted originals or copies of all Subcontractor records and information relating to the Contract and the Subcontract.

Attachment B-1, Sec 6, Premium Payment Incentives and Disincentives

- **6.2.3. Medicaid Managed Care Aligning Technology by Linking Interoperable Systems (ATLIS) -** This new section adds language related to the ATLIS program. It caps the total percentage paid to an MCO under the ATLIS and P4Q to 5% Failure to provide HHSC with the necessary data will result in a 0% performance rate during the measurement period. However, if the MCO provides the necessary data within the same program year, HHSC will reassign a satisfactory performance rate and make any payment associated with the milestone at the last semi-annual payment in the program year. HHSC may modify the payment methodologies and performance measures as frequently as necessary, but no less than annually.

Attachment B-1, Sec 8, Operations Phase Requirements

- **Section 8.1.3.4. Telemedicine, Telehealth, and Telemonitoring Services -** This provision is modified to clarify that telemedicine and telehealth are a means to deliver Covered Services, rather than distinct Covered Services
- **Section 8.1.3.4.1. School-based Telemedicine Medical Services -** This amendment clarifies that services are only available in primary or secondary school-based settings. The amendments also made other non-substantive changes.
- **Section 8.1.4.6.9. Directed Payment Program (DPP) Payments -** This provision requires MCOs to separate DPP payments from other payments in all electronic and hard copy provider explanations of payments. MCOs must also separate DPP payments and base payments on all applicable encounter data submissions.
- **Section 8.1.4.10.1. Primary Care Providers -** This provision is modified to clarify the current requirements that PCPs have admitting privileges to hospitals or to make referral arrangements.
- **Section 8.1.5.1. Member Materials -** This provision expands the ways in which an MCO can provide a member ID card. Currently, it must be mailed. This amendment would allow mail, email, notifying the member that it is available on the website, and any other method that could be reasonably expected to result in the member receiving the information.
- **Section 8.1.5.2. Member ID Cards -** Conforming amendments.
- **Section 8.1.5.3. Member Handbook -** Conforming amendments.
- **Section 8.1.5.7.1. Member Education on Abuse, Neglect, or Exploitation -** This provision is modified to comply with H.B. 4696, 88th Legislative Session, requiring the reporting of abuse, neglect and exploitation (ANE) and critical incidents to HHSC rather than DFPS or DADS.
- **Section 8.1.7.1. Quality Assessment and Performance Improvement Program Overview -** Requires MCOs to obtain either NCQA's Medicaid module or URAC's Medicaid Health Plan Accreditation when seeking reaccreditation.
- **Section 8.1.9. Utilization Management -** This provision requires MCOs to, before a denial, offer the requesting physician an opportunity to discuss the decision with a physician in the same or similar specialty. This aligns the UMCC with Tex. Gov't Code Sec. 533.00282 and Tex. Gov't Code Sec. 533.002821. However, the proposed provision would add a new requirement that, if a patient is not hospitalized, the peer-to-peer consultation must be offered no less than one business day prior to issuing the adverse determination.

- **Section 8.1.16. Behavioral Health Services and Network -** Updates CFR references.
- **Section 8.1.16.4. Follow-up after Hospitalization for Behavioral Health Services -** Conforming amendments.
- **Section 8.1.16.10. Mental Health Parity -** Updates CFR references.
- **Section 8.1.17.1. Formulary and Preferred Drug List -** This provision is modified as required by Texas Government Code Section 531.0691, as added by H.B. 3286, 88th Legislative Session. The amendments clarify that the agency will maintain separate provisional formularies for Medicaid and CHIP. Currently, MCOs are required to administer the PDL in a way that allows access to all non-preferred drugs through a structured PA process. This amendment would require that the structured PA process be "automated." The amendments would also require MCOs to educate network providers about where to find the VDP PDL Criteria Guide, in addition to the formularies and PDL, which are already required.
- **Section 8.1.22.2. Reports -** Conforming amendments for MSHCN service coordination.
- **Section 8.1.29. Member Complaint and Appeal System -** This provision is modified as a result of H.B. 44, 88th Legislative Session. It requires MCOs to refer any member alleging provider discrimination based on immunization status to the HHS Office of the Ombudsman.
- **Section 8.1.38.10. Discharge Planning -** Conforming amendments.
- **Section 8.1.39.4. Nonmedical Health Related Needs Screening for Pregnant Members -** This provision is added to comply with H.B. 1575, 88th Legislative Session, 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. The MCO would be required to make a best effort to screen within 30 days of enrollment. The MCO must try to contact the member three times, and if they are unable to, must mail written correspondence to the member. The screening may be conducted with the initial health needs screening or the perinatal risks assessment. The MCO must use the screening to determine whether the member is eligible for service coordination, case management, or non-covered services like value-added services. The MCO must submit data collected during the screening to HHSC, and upon requests to the member or the member's PCP.
- **Section 8.1.47.1. Member Education on Abuse, Neglect, or Exploitation -** This provision is modified to comply with H.B. 4696, 88th Legislative Session,

requiring the reporting of abuse, neglect and exploitation (ANE) and critical incidents to HHSC rather than DFPS or DADS.

- **Section 8.2.1. Medicaid Wrap-Around Services -** This provision is modified to comply with the 88th Legislative Session General Appropriations Act, H.B. 1, Art. II, Rider 32, which mandates HHSC to transition Medicaid-only services for dually eligible people enrolled in managed care from a fee-for-service delivery system to a managed care service delivery system, without imposing cost-sharing on dually eligible people

Attachment B-2, STAR Kids Covered Services - The STAR Kids Covered Services list is modified to clarify that telemedicine and telehealth are a means to deliver covered services, rather than distinct covered services.

Attachment B-3, Liquidated Damages Matrix - This attachment is amended to add the inclusion of HHSC's non-preferred and generic equivalents formularies on the point-of-care web-based application as a performance standard that could lead to liquidated damages. The amendments also make clarifying and non-substantive changes.