STAR/CHIP Contract Comments

Attachment A, Sec 4, Contract Administration & Management

4.08. Subcontractors and Agreement with Third Parties. We encourage the agency to provide clarity by changing the language to "their PBM," as MCOs will not have contracts with "all PBMs." Additionally, it should be clarified throughout (o) that HHSC will have the right to review contracts "upon request."

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

6.3.2.3. Medicaid Managed Care Aligning Technology by Linking Interoperable Systems (ATLIS). Draft changes to UMCM Chapter 6 to include ATLIS have not been issued for review and comment by MCOs, so HHSC should issue those proposed changes and extend the comment period for this section. Also, the mechanisms to earn payout, as well as timing of payments, are different for ATLIS and P4Q. The agency should clarify how these two programs will be measured together, as well as the total maximum payout for ATLIS.

Attachment B-1, Sec 8, Scope of Works

Section 8.1.4.8.11. Directed Payment Program (DPP) Payments. Implementing these requirements by September 1 will be unachievable. Plans will need to request system development, and any non-standard use of encounter agreement will take significant development time. We ask that the agency provide a six-month grace period to make necessary system changes. Plans will also need guidance on timelines, testing plans, and UMCM chapter updates to facilitate a structured implementation. In addition, there are still a number of outstanding questions on the Q&A log for this project; the plans need those questions answered and to receive final specifications from HHSC before they can start on implementation activities such as system builds and provider training.

Section 8.1.7.1. Quality Assessment and Performance Improvement Program Overview. This proposed amendment would add significant administrative and financial burden. The Medicaid module does not replace accreditation, and it does not happen upon renewal. This new requirement would therefore require both accreditation and the Medicaid module, which was not directed by the legislature. Section 533.0031, Texas

Government Code, merely requires accreditation. It does not require completion of the Medicaid module upon each reaccreditation. This would require a costly, time-consuming administrative interview duplicating the existing EQRO interview. HHSC should remove this requirement.

Section 8.1.8. Utilization Review. It is unclear how, if at all, this would apply to pharmacy determinations. Pharmacy determinations must be adjudicated in 24 hours, and these rules require offering a peer-to-peer more than one business day in advance. In other words, an MCO would be in the impossible situation of having to offer a peer-to-peer consultation before even receiving the authorization request. Rather than impose this new requirement that is not based on state law, HHSC should remove the timeline related to non-hospital determinations and instead, simply require the offer prior to the determination for all services.

Section 8.1.12.4. Service Plan for MSHCN. The underlying principle behind managed care is to hold MCOs accountable for outcomes but not dictate how to achieve them so that MCOs have the flexibility to be innovative. These requirements are overly prescriptive, and they would create significant unnecessary costs without any evidence that it will improve outcomes. Without legislative direction, the agency should continue holding MCOs accountable for outcomes rather than imposing new prescriptive requirements.

Section 8.1.13.3. Nonmedical Health Related Needs Screening for Pregnant Members. This section should be about the screening tool, not the effort made to engage with the members. Mail is expensive, and it has been shown to be one of the least effective options for communication, with a less than 3% response rate. This is not a good use of taxpayer dollars, and it violates the instruction from Rider 27 to "reduce unnecessary administrative and operational costs." HHSC should leave the decision of how to operationalize the screening tool with the MCOs.

STAR Kids Contract Comments

Attachment A, STAR Kids Contract Terms and Conditions

Section 4.08. Subcontractors and Agreement with Third Parties. Same as STAR/CHIP Section 4.08.

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

Section 6.2.3. Medicaid Managed Care Aligning Technology by Linking Interoperable Systems (ATLIS). Same as STAR/CHIP Section 6.3.2.3.

Attachment B-1, Sec 8, Operations Phase Requirements

Section 8.1.4.6.9. Directed Payment Program (DPP) Payments. Same as STAR/CHIP Section 8.1.4.8.11.

Section 8.1.7.1. Quality Assessment and Performance Improvement Program Overview. Same as STAR/CHIP Section 8.1.7.1.

Section 8.1.9. Utilization Management. Same as STAR/CHIP Section 8.1.8.

Section 8.1.39.4. Nonmedical Health Related Needs Screening for Pregnant Members. Same as STAR/CHIP Section 8.1.13.3.