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HHSC CONTRACT NO. HHS000264400001
AMENDMENT NO. 4

The **HEALTH AND HUMAN SERVICES COMMISSION** ("HHSC") and the **UNIVERSITY OF FLORIDA BOARD OF TRUSTEES, ON BEHALF OF THE INSTITUTE FOR CHILD HEALTH POLICY** ("Contractor"), who are collectively referred to herein as the "Parties," to that certain External Quality Review Organization ("EQRO") Vendor and Quality Vendor Contract effective September 1, 2019, and denominated HHSC Contract No. HHS000264400001 ("Contract"), now want to amend the Contract.

WHEREAS, the Parties want to add, revise the description of, and adjust the cost of certain deliverables to the Scope of Work ("SOW").

WHEREAS, the Parties want to describe, recognize the cost percentage of the total deliverable cost for, and the associated cost of each milestone in order to provide specificity and clarity.

WHEREAS, the Parties wish to add funds to the Contract.

NOW, THEREFORE, the Parties hereby amend and modify the Contract as follows:

I. **Article 4, Duration,** of the Contract is hereby amended to reflect a revised termination date of August 31, 2025.

II. **Article 5, Budget,** of the Contract is hereby amended by increasing the total amount of the Contract by $3,312,204.89, to a not to exceed amount of $78,169,844.45. All expenditures under the Contract will be in accordance with **Attachment B-4, Budget.**

III. **ATTACHMENT A-3** of the Contract, **SCOPE OF WORK**, is hereby amended and restated in its entirety with **ATTACHMENT A-4.** Changes from Attachment A-3 to A-4 include the following:

1. Adding Req 08-P8-04: "Contractor must, on a timeline and manner agreed upon with HHSC, design, implement, and report on a pilot program to test the delivery of long-term services and supports (LTSS) through the STAR+PLUS Medicaid managed care program."
2. Amending Req 15-ADTP-02 to add: "Immunization data of Medicaid members from the Department of Health Services (DSHS)"
3. Removing Req. 05-P4-06: "Contractor must send monthly MCO and Dental Contractor encounter data to the Department of State Health Services (DSHS) ImmTrac for immunization tracking in Texas within the formats and manner agreed upon by HHSC no later than 1 month after receipt of the encounter data.
4. Amending Section 2.1.4.7 to add Directed Payment Programs to section title.

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5. Amending Req 18-TW-01 to read, "Contractor must provide a DSRIP hospital level report in a format and timeline agreed upon with HHSC annually, to HHSC, by March 31. This report must include all PPEs using Medicaid and CHIP claims data in the format agreed upon with HHSC for each DSRIP hospital and uncompensated care hospital. HHSC will supply a provider list for use in creating this report."
6. Amending Req 18-TW-02 to read, "Contractor must provide a DSRIP regional healthcare partnership (RHP) level report for Medicaid and CHIP in a format and timeline agreed upon with HHSC annually. This report includes all PPEs. HHSC will provide RHP breakouts for use in creating this report."
7. Amending Req 18-TW-03 to read, "Contractor must provide reports in a format and timeline agreed upon with HHSC as outlined below related to the analysis of the Texas Healthcare Transformation Quality Improvement Program Waiver (1115 Waiver) DSRIP program initiatives for alignment with and integration into Medicaid managed care.
    1. HEDIS timeliness of prenatal care rate report: Contractor must provide semi-annual reports of HEDIS timeliness of prenatal care rates to HHSC. These reports will be for selected DSRIP performing providers as requested by HHSC. Reports must include provider-specific data on which cases are included in the rate.
    2. Statewide analysis report: Contractor must provide annually the statewide analysis report stratified by RHP, Medicaid population, uninsured and non-Medicaid population, age, and serious mental illness cohort annually to HHSC. This report must include the following:
        a. Summary PPA/PPV/PPR results for Medicaid and CHIP; and
        b. Summary PPR and PQI/PDI results for all-payer data.
        c. Texas PPR norm files report: This report must contain PPR norms for all-payer data and PPR norms for Medicaid and CHIP data.
    3. Statewide analysis report: Contractor must provide the statewide analysis report stratified by RHP, Medicaid population, uninsured and non-Medicaid population, age, and serious mental illness cohort annually to HHSC. This report must include the following:
        a. Summary results of outpatient and emergency department visits for Medicaid and CHIP;
        b. Summary results of certain PDI and PQI measures specified by HHSC for Medicaid and CHIP."
8. Adding Req 18-TW-04: "Contractor must provide targeted analysis or reports in a format and timeline agreed upon with HHSC related to the evaluation of Directed Payment Programs (DPPs) for each effective program year or related to areas of interest that include but are not limited to: PPEs, member surveys, HEDIS, or other

quality measures relevant to services provided under the Healthcare Transformation Waiver."

IV. **ATTACHMENT B-3** of the Contract, **BUDGET**, is hereby amended and restated in its entirety with **ATTACHMENT B-4**. Changes from Attachment B-3 to B-4 include the following:

1. Adding B-4 ID #82 and 83, Req 08-P8-04: "Contractor must, on a timeline and manner agreed upon with HHSC design, implement, and report on a pilot program to test the delivery of long-term services and supports (LTSS) through the STAR+PLUS Medicaid managed care program." For FY2022 and FY2023, a total cost of $2,922,359.35.

2. Removing B-4 ID # 46, Req. 05-P4-06: "Contractor must send monthly MCO and Dental Contractor encounter data to the Department of State Health Services (DSHS) ImmTrac for immunization tracking in Texas within the formats and manner agreed upon by HHSC no later than 1 month after receipt of the encounter data. This Amendment reduces the cost in FY2022-FY2025 by $532,609.20.

3. Amending B-4 ID # 33, Req 18-TW-01, B-4 ID #34, Req 18-TW-02. B-4 ID #35, 36, 37, and 54, Req 18-TW-03 and Adding B-4 ID #85, Req 18-TW-04. This Amendment will increase the cost FY 2022- FY 2025 by $651,077.37.

4. Reducing the cost of B-4 ID #16 Req 06-P5-02, 06-P5-03, Conduct and report results of member surveys including those for members with behavioral health. This Amendment will reduce the cost FY2022-FY2025 by $382,802.69.

   a. Increasing the cost of B-4 ID #17, Req 06-P5-05, 06-P5-06, Abbreviated survey of members for use in report cards. This Amendment will increase the cost for FY 2022-FY2023 by $362,541.

   b. Increasing the cost of B-4 ID # 20, Req 07-P6-06, Report core set measures to CMS. This Amendment will increase the cost for FY 2022-FY 2023 by $85,207.

5. Increasing the cost of B-4 ID #15, Req 05-P4-03, Encounter Data Validation: Dental and Medical Record Review. This Amendment will increase the cost for FY 2022-2025 by $84,647.03.

6. Increasing the cost of B-4 ID #50, Req 15-ADTP-02, 15-ADTP-04, Receive and store data on ADTP if Respondent is not required to use the DCS data center described in RFP Section 6.1. This Amendment increases the cost for FY 2022-FY 2025 by $29,177.46.

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7. Increasing the cost of B-4 ID #22, Req 10-TR-01, Create EQRO Summary of Activities report for FY 2022- FY 2025 by $80,403.72.

8. Increasing the cost of B-4 ID #48, Req 13-LC-02, 13-LC-04, 13-LC-05, Maintain THLC portal including loading data, updating with final Quality of Care results when available, and refreshing with PPE results each month if Respondent is not required to use the DCS data center described in RFP Section 6.1. This Amendment increases the cost for FY 2022-FY 2025 by $59,634.70.

9. Reducing the cost of B-4 ID #6, Req 02-P1-04, 02-P1-05, 02-P1-06, Onsite Administrative Interviews and Associated Reports. This Amendment will reduce the cost over FY2022-FY2025 by $44,471.

   a. Reducing the cost of B-4 ID #8, Req 04-P3-03, B-4 ID #9, Req 04-P3-04, B-4 ID #10, Req 04-P3-05 Evaluate PIP Plans, Progress Reports, and Final PIP Reports for all MCOs and Dental Contractors. This Amendment will reduce the cost for FY 2022- FY 2025 by $19,914.19.

   b. Reducing the cost of B-4 ID #4, 02-P1-02, Annual QAPI Reports. This Amendment will reduce the cost FY 2023-2025 by $19,207.18.

10. Reducing the cost of B-4 ID #25, Req 12-QF-01, 12-QF-02, Conduct Quality Forum. This Amendment reduces the cost for FY2021 by $30,137.83.

11. Reducing the cost of B-4 ID #52, Req 07-P6-10 "Contractor must provide periodic analysis reports on topics of special interest to HHSC produced on a timeline agreed upon based on each of HHSC's individual ad hoc request." This Amendment reduces the cost for FY2021 by $17,705.70.

12. Extending Req 19-QO-05 for FY 2022, B-4 ID #84 for a total cost for FY 2022 of $84,005.04.

V. This Amendment shall be effective on the date of the last signature below.

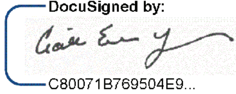
VI. Except as modified by this Amendment, all terms of the Contract shall remain in effect.

VII. Any further revisions to the Contract shall be by written agreement of the Parties.

SIGNATURE PAGE FOLLOWS

SIGNATURE PAGE FOR AMENDMENT NO. 4
HHSC CONTRACT NO. HHS000264400001

HEALTH AND HUMAN SERVICES COMMISSION

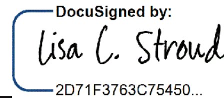


Name: Cecile Young

Title: Executive Commissioner

Date of execution: April 14, 2022

UNIVERSITY OF FLORIDA BOARD OF TRUSTEES



Name: Lisa C. Stroud

Title: Associate Director

Date of execution: April 13, 2022

THE FOLLOWING ATTACHMENTS ARE ATTACHED AND INCORPORATED AS PART OF THE CONTRACT:

Attachment A-4– Scope of Work
Attachment B-4– Budget

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ATTACHMENT A-4

STATEMENT OF WORK

HHSC CONTRACT NO. HHS000264400001

ARTICLE I – DEFINITIONS

Refer to **Attachment C, Uniform Terms and Conditions**, and **Attachment E, Special Conditions**, for additional definitions relevant to this Contract.

Unless the context clearly indicates otherwise, the following terms and conditions have the meanings assigned below:

"Accessible" means compliance with applicable laws and standards including, but not limited to, 29 U.S.C. § 794; 1 Tex. Admin.§§ 206.50 *et seq*.; 1 Tex. Admin. Code §§ 213.10 *et seq.;* and Texas Health and Human Services Electronic and Information Resources (EIR) Accessibility Standards.

"Administrative Interview" or "AI" means an assessment of MCO and Dental Contractor compliance with federal and state regulations in accordance with 42 C.F.R. § 438.358.

"All Programs" means the Texas Medicaid and CHIP managed care programs including STAR, STAR+PLUS, STAR Health, STAR Kids, Dental, and CHIP.

"Claims Administrator" means the organization responsible for processing claims and encounters submitted by MCOs and Dental Contractors. Currently, the Texas Medicaid & Healthcare Partnership (TMHP) performs this function.

"Dental Contractor" means a dental maintenance organization (DMO) that is under contract with HHSC for the delivery of dental services. Dental Contractors are prepaid ambulatory health plans.

"Dual Demonstration" means the Texas Dual Eligible Integrated Care Demonstration Project.

"External Quality Review" or "EQR" has the meaning as defined in 42 C.F.R. § 438.320.

"External Quality Review Organization" or "EQRO" has the meaning as defined in 42 C.F.R. § 438.320.

"Managed Care Organization" or "MCO" means an organization that delivers and manages managed care health services under a risk-based contract with HHSC.

"Medical Transportation Organization" or "MTO" means an organization that is under contract with HHSC for the delivery of non-emergency medical transportation services. MTOs are prepaid ambulatory health plans (PAHPs).

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"Medicare-Medicaid Plan" or "MMP" means the MCOs participating in the Texas Dual Eligible Integrated Care Demonstration Project.

"Medical Transportation Program" or "MTP" means transportation for eligible Medicaid members to and from medical providers for appointments or services that legitimately needed but do not put the health and life of the member at immediate serious risk.

"Operational Start Date" means the first day on which the Contractor is responsible for providing services under the operations phase of the Contract and occurs after the transition phase is completed.

"Potentially Preventable Events" or "PPEs" has the meaning provided in Texas Government Code Section 536.001.

"Quality" has the meaning as defined in 42 C.F.R. § 438.320.

"Quality of Care" means HHSC-specified measures that are selected on a regular basis.

"Technical Assistance" means providing information, consultation, or expertise via email, phone call, or meeting to HHSC, MCOs, Dental Contractors, or other stakeholders as needed.

"Validation" has the meaning as defined in 42 C.F.R. § 438.320.

ARTICLE II - SCOPE OF WORK

2.1 SCOPE OF WORK

The Sections below comprise the Scope of Work (SOW). HHSC reserves the option to decouple business functions and/or the functionality in the SOW at any time during the Contract. This may include removal of discrete components from the SOW. The Contractor must be willing to commence the transition of any business or technology components at the request of HHSC.

2.1.1 Contractor and Subcontractor Qualifications

Contractor may use Subcontractors. Contractor is accountable for, and must oversee, all Subcontractor functions.

Contractor must, at a minimum, meet the requirements of 42 C.F.R. § 438.354(b) and (c). Contractor must have competent staff and, as applicable, competent Subcontractor staff to perform research, evaluation, and analysis as requested by HHSC. This includes the Contractor staff and Subcontractor staff having appropriate skillsets and experience to compile, analyze, monitor, and evaluate information on Quality of Care, timeliness and access to care, member satisfaction, and the effectiveness and outcomes of the health care services furnished by fee-for-service (FFS) providers, MCOs, Dental Contractors, and providers or their contractors to Medicaid and members under All Programs as well as MTP, and Dual Demonstration.

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Req ID	Requirement
01-BG-01	Contractor must meet and maintain the competence requirements of 42 C.F.R. § 438.354 for qualifications of an of external quality review organization. Contractor must have, at a minimum, the following: 1. Staff with demonstrated experience and knowledge of: a. Medicaid and CHIP members, policies, data systems, and processes; b. FFS and managed care program delivery systems, organizations, and financing; c. Quality assessment and improvement methods; and d. Research design and methodology, including statistical and financial analysis; 2. Sufficient physical, technological, and financial resources to conduct EQR and EQR-related activities; and 3. Other clinical and non-clinical skills necessary to carry out the duties of the Contractor and other activities under the scope of this Contract, including the EQR and EQR-related activities and to oversee the work of any Subcontractors.
01-BG-02	Contractor must meet the independence requirement of 42 C.F.R. § 438.354.
01-BG-03	Contractor must have skilled staff or have access to staff with expertise in medical record review, survey implementation and techniques, and statistics and economics to support HHSC quality and performance analysis and rate setting activities.
01-BG-04	Contractor must have the requisite resources and staff to research and analyze the clinical aspects of health care delivery which affect populations of special concern to Medicaid and CHIP as directed by HHSC, including: 1. Persons 20 years of age and younger, including those eligible for the Children with Special Health Care Needs (CSHCN) program and the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) Comprehensive Care program services, known collectively in Texas as Texas Health Steps (THSteps); 2. Individuals needing long-term services and supports (LTSS), including individuals with physical disabilities, intellectual or developmental disabilities, and the elderly; 3. Persons with the behavioral health conditions of mental illness or substance use disorders; and 4. Pregnant women and newborns.
01-BG-06	Contractor must have staff with a wide variety of clinical skills for both medical and dental disciplines, as well as experience in: 1. Statistics; 2. Economics; 3. Encounter data analysis, including the use of the following case-mix adjustment systems: a. Chronic Illness and Disability Payment System; b. Adjusted Clinical Groups; c. Diagnostic Cost Groups;

Req ID	Requirement
	d. Clinical Risk Groups; e. Global Risk Assessment Model; and f. All Patients Refined Diagnosis Related Groups (APR DRG) classification system and grouping software; 4. Encounter data validation: data certification and medical record review (MRR)/dental record review (DRR) to ensure that data are sufficiently complete and accurate to support quality management and rate setting premium payments analysis and calculations; 5. Health care issues research and writing for publication; and 6. Clinical evaluation competence or direct contract access to such competence in, but not limited to, the following areas: a. Pediatrics; b. Long-term services and supports; c. Acute care; d. Behavioral health; e. Chronic illness and disability; f. Complex special health care needs; g. Women's health; and h. Pharmacy.
01-BG-07	Contractor staff must have expertise in data systems, statistics, data analysis, and economics, experienced in using or analyzing data, and performance in the following performance measurement systems and software: 1. Healthcare Effectiveness Data Information Set (HEDIS); 2. Chronic Illness and Disability Payment System (CDPS); 3. Consumer Assessment of Healthcare Providers and Systems (CAHPS); 4. Dental Quality Alliance (DQA); 5. National Core Indicators for Aging and Disability (NCI-AD); 6. Centers for Medicare and Medicaid Services Adult and Child Core Measures; 7. 3M PPEs; and 8. Other measures or systems recommended by the Contractor.
01-BG-08	CMS issues protocols that specify how EQROs are to perform their duties. Contractor is required to follow these CMS protocols, available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html.
01-BG-09	Neither Contractor nor any delegated survey Subcontractor is required to be certified by the National Committee for Quality Assurance (NCQA) as a NCQA CAHPS vendor. However, HHSC requires both entities to have experience and proficiency in administering surveys to Medicaid and CHIP members and providers in both English and Spanish.

2.1.2 CMS Required Activities Related to External Quality Review

The Centers for Medicare and Medicaid Services (CMS) addresses mandatory and optional EQR-related activities in 42 C.F.R. § 438.358 and provides additional information on its

website at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html related to federal protocols required under 42 C.F.R. § 438.352. The Contractor is required to perform all activities described below in accordance with the CMS regulations and protocols.

2.1.2.1 Protocol 1 - MCO and Dental Contractor Compliance Review

Consistent with 42 C.F.R. § 438.358(b)(1)(iii), this section discusses the Contractor's obligations to review compliance of MCOs and Dental Contractors standards against (1) federal regulations; (2) state regulations; and (3) the MCOs or Dental Contractors contract with HHSC, including standards regarding access to care, structure and operations, and quality measurement and improvement.

Req ID	Requirement
02-P1-01	Contractor must establish MCO and Dental Contractor compliance thresholds for HHSC approval and perform a preliminary review of MCO and Dental Contractor compliance with 42 C.F.R. Part 438, including, but not limited to: information requirements, enrollment/disenrollment, member rights, member advisory committee, emergency and post stabilization services, availability of services, continuity and coordination of care, coverage and authorization of services, provider selection, health information systems, timely and adequate notice of adverse benefit determination, handling and resolution of grievances and appeals, recordkeeping, and fair hearings.
02-P1-02	Contractor must provide annual Quality Assessment and Performance Improvement (QAPI) Reports for All Programs and Dual Demonstration within the formats, timeframes and manner agreed upon by HHSC.
02-P1-03	Contractor must provide an annual Administrative Interview Questionnaire Tool (AI Questionnaire Tool) for physical health, dental health, and behavioral health for each MCO and Dental Contractor for All Programs and Dual Demonstration within the formats, timeframes, and manner agreed upon by HHSC.
02-P1-04	Contractor must conduct an onsite Administrative Interview, every three years, with each MCO and Dental Contractor for All Programs and Dual Demonstration and provide an Administrative Interview Report for the onsite administrative interviews to HHSC within the formats, timeframes, and manner agreed upon by HHSC.
02-P1-05	Contractor must assess MCO and Dental Contractor compliance with HHSC-specified standards for quality operations including validation of required performance improvement activities and associated measures through the Administrative Interview.
02-P1-06	Contractor must provide findings, within the formats, timeframes, and manner agreed upon by HHSC, on the evaluation of MCO and Dental Contractor responses on the AI Questionnaire Tool to assess compliance with state and federal regulations. Contractor must provide tables that summarize MCO and Dental Contractor responses on the AI Questionnaire Tool regarding programs in place that address member's needs.

2.1.2.2 Protocol 2 - Validation of Performance Measures Reported by the MCOs

Consistent with 42 C.F.R. § 438.358(b)(1)(ii), the requirements in this section relate to the validation of performance measures reported by the MCO. Contractor must provide Technical Assistance for HEDIS hybrid reporting.

Req ID	Requirement
03-P2-01	Contractor must assist HHSC with identifying healthcare quality measures critical to the population served in All Programs and must assist in setting performance standards.
03-P2-02	Contractor must evaluate if the MCO followed the requirements of their managed care contracts with HHSC for calculating measures and, at a minimum, must: 1. Annually verify that MCO-provided HEDIS hybrid measure rates are certified by a NCQA auditor; and 2. Provide a compilation of annual HEDIS hybrid rates for each MCO, for each program listed below within the formats, timeframes and manner agreed upon by HHSC: a. STAR; b. STAR Kids; c. STAR+PLUS; d. CHIP; e. STAR Health; and f. MDCP

2.1.2.3 Protocol 3 - Performance Improvement Project Validation

Consistent with 42 C.F.R. § 438.358(b)(1)(i), the requirements in this section relate to the validation of Performance Improvement Projects (PIPs).

Req ID	Requirement
04-P3-01	Contractor must assist HHSC in developing PIPs topics for each MCO and Dental Contractor for All Programs.
04-P3-02	Contractor must conduct an annual PIPs Workshop for MCOs and Dental Contractors and must provide prompt Technical Assistance to the MCOs and Dental Contractors in the development, evaluation, and revision of PIPs. This will be done within the format, timeframes and manner agreed upon by HHSC.
04-P3-03	Contractor must perform annual evaluation of half of the PIPs plans for all MCOs and Dental Contractors for All Programs. Every PIPs plan should be evaluated at least once every two years. Such evaluation must include an assessment of the

Req ID	Requirement
	study methodology within the formats, timeframes and manner agreed upon by HHSC.
04-P3-04	Contractor must provide annual evaluation of PIPs progress reports for all MCOs and Dental Contractors for All Programs within 60 calendar days of Contractor's receipt of PIP progress reports from each MCO or Dental Contractor within the formats, and manner agreed upon by HHSC.
04-P3-05	Contractor must perform annual evaluation of half of the PIPs final reports for all MCOs and Dental Contractors for All Programs. Each PIPs final report must be evaluated at least once every two years. Such evaluation must include a verification of PIPs report findings and an assessment of the overall validity and reliability of the PIPs results within the formats, timeframes and manner agreed upon by HHSC.
04-P3-06	Contractor must provide MCOs with Technical Assistance and evaluations of the 2019 statewide PIPs addressing members with complex needs ("super utilizers") to assist MCOs in creating impactful interventions that will improve health outcomes and reduce inappropriate utilization of health services. This PIP targets members who, because of their health or social conditions may experience high levels of costly, but preventable service utilization.

2.1.2.4 Protocol 4 - Encounter Data Validation

Consistent with 42 C.F. R. § 438.358(c)(1), the requirements in this section relate to validation of encounter data reported by the MCO and Dental Contractor. Contractor must provide Technical Assistance and support related to the provision of deliverables and related data requests.

Req ID	Requirement
05-P4-01	Contractor must use data available, including the Medicaid Master Provider Filer, for mailing address and other information to generate correspondence and mail outs for purposes of data validation. Contractor must track compliance with requests and accuracy of address information to improve the validation process.
05-P4-03	Contractor must design and implement biennial encounter data validation medical and dental record reviews. These reviews include validation that electronic data accurately represent care documented by participating providers; verification that the provider of the medical or dental record is the provider of service; verification the medical or dental record is complete in relation to the encounter data submitted; and providing ongoing assessment of potential data quality issues. Contractor must perform the medical or dental record review every other year and review dental records in the years medical record reviews are not performed.
05-P4-04	Contractor must provide monthly data loads and maintenance of Analysis DTP as well as a monthly report on such actions performed within the formats, timeframes and manner agreed upon by HHSC.

05-P4-05	Contractor must perform and submit, no later than May 15 each year, a mid-year analysis of MCO and Dental Contractor encounter data received from the Claims Administrator for All Programs including CHIP Perinatal and Dual Demonstration within the formats, and manner agreed upon by HHSC.
05-P4-07	Contractor must provide a compliance report (National Institute of Standards and Technology (NIST) 800) that the data infrastructure meets contract standards for claims, encounters, and other data to maintain comprehensive Analysis and Data Transfer Platform (ADTP). The report must be provided annually by August 31.
05-P4-08	Contractor must design and implement a process to certify the integrity and completeness of the annual encounter data submissions, including submission of results for All Programs, CHIP Perinatal, and Dual Demonstration data in accordance with the CMS Encounter Data Toolkit, located on the CMS website and consistent with the requirements of Texas Government Code § 533.0131. The results must include, at a minimum, the percentage of missing encounter data, types of missing data, and overall data quality issues.

2.1.2.5 Protocol 5 - Consumer and Provider Surveys

Consistent with 42 C.F.R. § 438.358(c)(2), the requirements in this section cover the administration or validation of consumer or provider surveys of quality care.

Req ID	Requirement
06-P5-01	Contractor must document a purpose statement and objectives, develop or modify survey instruments, develop sampling strategies, develop a strategy to maximize the response rate, and develop a quality assurance plan, in order to, conduct the member surveys described in this section. Member surveys must include, at a minimum, CAHPS questions and integrate other questions as identified by the Contractor and HHSC pertinent to the target population.
06-P5-02	Contractor must implement HHSC-approved biennial member surveys of members in all programs including Children's Medicaid Dental Services, CHIP, CHIP Dental, STAR, STAR Health, STAR Kids, and STAR+PLUS. Surveys will interview adult members and caregivers of child members as appropriate and may include separate segments for special populations, such as Adoption Assistance (AA), Permanency Care Assistance (PCA), Medicaid for Breast and Cervical Cancer (MBCC), or others as required by HHSC.
06-P5-03	Contractor must implement a biennial survey of members with behavioral health conditions in STAR (with two separate surveys, one for members age 18 and over, and one for members age 17 and younger) and STAR+PLUS within the timeframes and manner agreed upon by HHSC.
06-P5-04	Contractor must implement a biennial, in-person survey of members in STAR+PLUS to measure outcomes in LTSS and community integration within the timeframes and manner agreed upon by HHSC.
06-P5-05	Contractor must implement an HHSC-approved abbreviated annual survey of members in STAR, STAR+PLUS, STAR Kids, and CHIP for use in report cards. The survey must capture a statistically significant portion of members in each

	service area. The survey must include CAHPS survey items determined to be relevant to the population in each program.
06-P5-06	Contractor must provide detailed survey results to HHSC as the surveys are completed, including preparing and analyzing the data obtained from the survey, documenting the survey process and results, and providing summaries and analyses in the annual summary of activities report as described in 10-TR-01. The results must be provided within the formats, timeframes and manner agreed upon by HHSC.
06-P5-07	Contractor must either develop or modify survey instruments and develop sampling strategies in order to conduct an annual satisfaction survey for the MTP program. The survey tool or tools must be adequate to gain feedback from transportation providers, medical providers, and members participating in the program. Contractor must provide a detailed, Accessible report of the results within the formats, timeframes and manner agreed upon by HHSC.
06-P5-08	Contractor must implement a biennial survey of members in the Medically Dependent Children Program in STAR Kids. This survey will use the same tool as the STAR Kids member survey (as described in 06-P5-02) and will be performed in the alternate years that the STAR Kids member survey (as described in 06-P5-02) is **not** performed.
06-P5-09	Contractor must design and implement a member survey to assess members with unmet transportation needs as described in Rider 12 of the General Appropriations Act.
06-P5-10	Contractor must implement a biennial, Child Family Survey (NCI-CFS) of members in STAR Kids to measure family outcomes within the timeframes and manner agreed upon by HHSC.

2.1.2.6 Protocol 6 - Calculation of Performance Measures

Consistent with 42 C.F.R. § 438.358(c)(3), the requirements in this section relate to the calculation of performance measures for MCOs and Dental Contractors.

Req ID	Requirement
07-P6-01	Contractor must implement and assess managed care performance measures, including evaluating and comparing MCO and Dental Contractor performance to state and national benchmarks, as well as to other plans' performance within Texas. These assessments must be within the formats, timeframes and manner agreed upon by HHSC.
07-P6-02	In preparing for, calculating, and reporting the results of performance measures, Contractor must follow the activities described in 42 C.F.R. § 438.358(c)(3).
07-P6-03	Contractor must consult with HHSC to evaluate and periodically propose new performance measures to improve MCO and Dental Contractor oversight or to meet new state mandates and objectives. Contractor must, as needed, provide technical expertise to HHSC in identifying and evaluating potential data analysis tools and software.

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Req ID	Requirement
07-P6-04	Contractor must perform analysis and develop reports of hospital level State Fiscal Year (SFY) PPRs and PPCs or other PPEs as identified by HHSC. The Contractor must at a minimum provide the following: hospital-level reports, underlying data, technical notes, statewide data files, and state norm files. The analysis and reports must occur on an annual and mid-year SFY cycle, or any other time frame specified by HHSC. Existing PPE reports can be found at https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events
07-P6-05	Contractor must provide monthly and annual summary and registry PPE data by MCO with the content, format, timeframe, and manner agreed upon by HHSC.
07-P6-06	Contractor must perform annual core set measure reporting to CMS.
07-P6-07	Contractor must provide preliminary Quality of Care data on an annual basis by each program listed below within the formats, timeframes and manner agreed upon by HHSC: 1. STAR 2. STAR Kids 3. STAR+PLUS 4. STAR Health 5. CHIP 6. CHIP Dental Services 7. Children's Medicaid Dental Services 8. MDCP 9. HTW
07-P6-08	Contractor must provide annual final Quality of Care data by each program listed below within the formats, timeframes and manner agreed upon by HHSC: 1. STAR 2. STAR Kids 3. STAR+PLUS 4. STAR Health 5. CHIP 6. CHIP Dental Services 7. Children's Medicaid Dental Services 8. MDCP 9. HTW
07-P6-09	In consultation with and as required by HHSC, the Contractor must propose detailed quality improvement strategies when Quality of Care shortcomings are identified for a particular MCO, Dental Contractor, program, or categorically across programs.
07-P6-10	Contractor must provide periodic analysis reports on topics of special interest to HHSC produced on a timeline agreed upon based on each of HHSC's individual ad hoc request.
07-P6-11	Contractor must provide an annual Quality of Care measures report specific to members with serious mental illness diagnoses within the formats, timeframes and manner agreed on by HHSC.

Req ID	Requirement
07-P6-12	Contractor must provide an annual Quality of Care measures report specific to maternal health within the formats, timeframes and manner agreed on by HHSC.
07-P6-13	Contractor must provide annual 3M Potentially Preventable events reports specific to members with serious mental illness diagnoses within the formats, timeframes and manner agreed on by HHSC.
07-P6-14	Contractor must provide an annual pregnancy-associated measures report within the formats, timeframes and manner agreed on by HHSC.
07-P6-15	Contractor must provide annual analysis of STAR Kids Screening and Assessment Instrument and Individual Service Plan data including ICHP developed SK-SAI based quality measures. The report must be within the formats, timeframes and manner agreed upon by HHSC.
07-P6-16	Contractor must make recommendations to add or remove measures in terms of health plan performance, state or national initiative/mandates, and impacts of measure specification changes, and calculate the minimum and high standards using the most current available results and national percentiles for STAR, STAR+PLUS, STAR Kids, CHIP and STAR Health.
07-P6-17	Contractor must run the P4Q calculation in parallel to validate results for both medical and dental plans.

2.1.2.7 Protocol 8 - Focused Studies

Consistent with 42 C.F.R. § 438.358(c)(5), the Contractor must conduct studies on quality that focus on a particular aspect of clinical or non-clinical services at a point in time. These focused studies are projects identified and defined by HHSC and are to be conducted with a minimum amount of administrative burden on the Medicaid and CHIP MCOs and Dental Contractors. Focused studies can be clinical, financial, or administrative studies that relate to patterns of care or operational issues that impact Quality of Care, financial performance, or service delivery in managed care.

Req ID	Requirement
08-P8-01	Contractor must design and implement an annual focused study on HHSC-specified topics that follows the procedures described in 42 C.F.R. § 438.358(c)(5) within the formats, timeframes, and manner agreed upon by HHSC.
08-P8-02	Contractor must provide Accessible quarterly topic reports on HHSC-specified topics focused on the quality of health care for child or adult members of Medicaid or CHIP, combining background research with analysis of claims data, survey data, or medical/dental records. These reports must be within the formats, timeframes and manner agreed upon by HHSC.
08-P8-03	Contractor must design, implement, and report on biennial focus groups of adult guardians of STAR Kids members. These reports must be within the formats, timeframes and manner agreed upon by HHSC.
08-P8-04	Contractor must, on a timeline and manner agreed upon with HHSC, design, implement, and report on a pilot program to test the delivery of long-term services and supports (LTSS) through the STAR+PLUS Medicaid managed care program.

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2.1.3 Non-protocol Requirements

This section contains items that are required federal requirements under 42 C.F.R Part 438 Subpart E; but do not fit within the CMS Mandatory EQR-Related Activity Protocols. CMS doesn't require that states use an EQRO to perform all activities in this section but HHSC has chosen to require Contractor to perform these activities.

2.1.3.1 MCO Quality Rating

Consistent with 42 C.F.R. § 438.358(c)(6), Contractor must develop performance measures and methodology to assist HHSC with the quality rating of MCOs.

Req ID	Requirement
09-QR-01	The Contractor must, in conjunction with HHSC and in compliance with 42 C.F.R. § 438.334, propose and develop methodology, tools, reports, and a final, Accessible deliverable, in print and electronic format, for annual MCO report cards for STAR (with two separate surveys, one for members age 18 and over, and one for members age 17 and younger), CHIP, STAR Kids, and STAR+PLUS, each broken down by service area. Report cards are designed to provide newly enrolled Medicaid and CHIP members and their caregivers, as appropriate, with consumer-oriented quality and member satisfaction information that helps support the selection of a managed care health plan. Report cards must be provided in English and Spanish and must be completed within the formats, timeframes and manner agreed upon by HHSC.
09-QR-02	Contractor must report findings of annual MCO report card surveys using the format, timeframes and manner agreed upon by HHSC.
09-QR-03	Contractor must provide Accessible annual MCO report card consumer product and instruction sheets within the formats, timeframes and manner agreed upon by HHSC.

2.1.3.2 Required Technical Reports

Consistent with 42 C.F.R. § 438.364, the Contractor must produce annual detailed technical reports to HHSC and CMS.

Req ID	Requirement
10-TR-01	Contractor must provide an Annual EQRO Summary of Activities report describing activities performed to meet all CMS requirements on a timeline and in a format approved by HHSC. At a minimum, the report must be Accessible and include: 1. A description of all methodologies used in EQRO-related conducted activities for aggregation and analysis; and the methodologies for drawing conclusions as to the timeliness, quality, and access to the care provided by MCOs and Dental Contractors; 2. For each activity conducted, the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data;

	3. An assessment, by MCO, Dental Contractor and program of strengths and weaknesses with respect to quality, timeliness, and access to health and dental care services furnished to Medicaid and CHIP members; 4. Recommendations, by MCO, Dental Contractor and program for improving the quality of health and dental care services; 5. Methodologically appropriate, comparative information about All Programs, Dual Demonstration, MTP, FFS, and MCOs, MMP, and Dental Contractors; 6. An assessment of the degree to which each MCO or Dental Contractor has addressed effectively the quality improvement recommendations made by the Contractor during the prior year's review; and 7. Detailed information about how each CMS protocol was addressed during the year.
10-TR-02	For areas of concern identified in the Annual EQRO Summary of Activities report, the Contractor must provide additional information to HHSC in Accessible reports called "summary of activities issues briefs" within the formats, timeframes, and manner agreed upon by HHSC.

2.1.3.3 Validation of MCO Network Adequacy

Consistent with 42 C.F.R. § 438.358(b)(1)(iv), the requirements in this section relate to the validation of MCOs' and Dental Contractors' network adequacy.

Req ID	Requirement
11-NA-01	Contractor must annually propose and develop, for HHSC approval, an appointment accessibility study, including the methodology, survey tools, and report for the direct monitoring of the length of time a Medicaid member must wait between scheduling an appointment with a provider and receiving treatment from the provider. The study must evaluate provider compliance with appointment availability standards for primary care, behavioral health, vision, and prenatal care providers.
11-NA-02	Contractor must perform the appointment accessibility study, which includes sub studies for primary care, behavioral health, vision and prenatal care, within the format, timeframes and manner agreed upon by HHSC.
11-NA-03	Contractor must report appointment accessibility study and sub study results within the format, timeframes and manner agreed upon by HHSC. This report must be Accessible.
11-NA-04	Contractor must propose and develop, for HHSC approval, a Biennial PCP Referral Study including a methodology, survey tools, and reporting for a biennial study that examines primary care physician (PCP) experiences when making referrals for specialty care for members in Medicaid managed care. At a minimum, the study must identify the key barriers physicians face when making specialty referrals and recommend strategies for improving access to specialty care for Medicaid and CHIP members.
11-NA-05	Contractor must perform the PCP Referral Study within the format, timeframes and manner agreed upon by HHSC.

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11-NA-06	Contractor must report the PCP Referral Study results within format, timeframes and manner agreed upon by HHSC. This report must be Accessible.
11-NA-07	Contractor must provide Technical Assistance to HHSC for the activities described in this table.

2.1.4 Additional HHSC Requirements

This section contains additional requirements that are not required by CMS but that HHSC will require the Contractor to perform.

2.1.4.1 Quality Forum

Req ID	Requirement
12-QF-01	In consultation with and subject to the approval of HHSC, the Contractor must organize and execute all aspects of conference planning for HHSC's annual quality forum. The annual quality forum must be held for all MCOs, Dental Contractors, and HHSC staff. Topics must include at a minimum: 1. MCO and Dental Contractor best practices; 2. Quality improvement strategies and interventions; and 3. Discussion and development of future directions for performance improvement.
12-QF-02	Contractor must facilitate a planning committee for the quality forum that includes HHSC, MCO, and Dental Contractor staff.

2.1.4.2 Texas Healthcare Learning Collaborative Portal

The Texas Healthcare Learning Collaborative (THLC) portal provides HHSC, contractors, providers, and other stakeholders up-to-date MCO, Dental Contractor, and statewide performance data on key quality of care measures, including PPEs, HEDIS, CAHPS and other quality of care information.

Req ID	Requirement
13-LC-01	Contractor must maintain the THLC portal, including data and visualizations at various levels of specificity for: 1. Medical Quality of Care; 2. Dental Quality of Care; 3. PPAs; 4. PPRs; 5. PPVs; 6. PPCs; 7. Performance indicator dashboards;

Req ID	Requirement
	8. CMS Core Measures; 9. Population-based Utilization; 10. Survey Data; and 11. Super-utilizers. The portal must be Accessible. Contractor must provide at least the level of detail and functionality currently available on the THLC portal, including the ability to download data, accessible at: https://thlcportal.com/home.
13-LC-02	Contractor must provide enhancements to the THLC portal as requested by HHSC.
13-LC-03	Contractor must provide loading and processing for the DSHS all-payer data for use in statewide data collection, analysis and posting on the THLC portal. Analysis may include data summary; ratio of actual to expected rates of potentially preventable complications (PPCs) and readmissions (PPRs); trending; demographic, geographic, provider and reason code segmentation.
13-LC-04	Contractor must update the THLC portal annually with Quality of Care results for FFS, STAR, STAR Kids, STAR+PLUS, CHIP, and STAR Health; and PPE results for STAR, STAR+PLUS, STAR Health, and CHIP, CHIP Dental Services and Children's Medicaid Dental Services.
13-LC-05	Contractor must perform a monthly refresh of MCO level PPE results to the THLC portal for STAR, STAR Kids, STAR+PLUS, STAR Health, and CHIP.
13-LC-06	Contractor must update the THLC portal annually with the hospital quality-based PPR and PPC results, or other hospital-level PPEs as identified by HHSC.
13-LC-07	Contractor must provide training and Technical Assistance to MCOs, Dental Contractors, HHSC staff, and HHSC-requested stakeholders on use of the THLC portal.
13-LC-08	Contractor must update the THLC portal annually with the Population-based Utilization Report, CMS Core Measure results, Performance indicator dashboard results, and survey data.

2.1.4.3 Additional Technical Assistance

Req ID	Requirement
14-TA-01	Contractor must provide ongoing technical expertise to HHSC to support medical and dental pay-for-quality programs. This expertise may include advising HHSC on appropriate measures and methodological changes or providing other recommendations to improve pay-for-quality programs.

2.1.4.4 Analysis and Data Transfer Platform (ADTP) Requirements

15-ADTP-01	The Contractor must establish and fully operationalize the ADTP no later than 3 months before the Operational Start Date.
15-ADTP-02	In addition to the files created from the Texas Encounter Data Warehouse maintained by the Claims Administrator, the Contractor must receive and store

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	data on the ADTP from the following primary data sources for Medicaid and CHIP: 1. Medicaid FFS claims and managed care encounters data from HHSC's Claims Administrator contractor; 2. Eligibility and enrollment data from HHSC's integrated eligibility and enrollment (IEE) broker for Medicaid and CHIP; 3. Medicaid and CHIP provider data; 4. Capitation file from the IEE broker via TMHP; 5. Premiums payable system data from the IEE broker via TMHP; 6. Drug claim data from HHSC's vendor drug program (VDP) contractor; and 7. Immunization data of Medicaid members from the Department of Health Services (DSHS) Contractor's management of the ADTP must include: 1. Receiving data; 2. Performing quality assurance checks against the data received; and 3. Loading, warehousing, analysis, and creation of data files for MCOs and Dental Contractors.
15-ADTP-03	The Contractor must submit the following plans for HHSC approval at least 60 calendar days prior to the Operational Start Date and at least 60 calendar days prior to implementing any substantial changes to the plans during the Contract's term: 1. Joint Interface Plan (JIP); 2. Disaster Recovery Plan (DRP); 3. Business Continuity Plan (BCP); 4. Risk Management Plan (RMP); and 5. Systems Quality Assurance Plan (SQAP).
15-ADTP-04	Contractor must submit monthly data logs detailing data file, date received, quality, ADTP load date, problems or issues identified by the Contractor, and other notations determined necessary by the Contractor and HHSC for Medicaid FFS, CHIP Perinatal, All Programs, as well as Medicare data required for MMP.

2.1.4.5 Business Plan

16-BP-01	Contractor must provide administrative oversight and financial management activities for Contract deliverable schedules and on-going provision of deliverable related budget estimates as requested by HHSC.
16-BP-02	Within 30 calendar days of the beginning of each SFY, the Contractor must create a business plan that identifies a detailed SOW including deliverables, milestones, lead staff, and timelines. Contractor must accomplish this via an HHSC-approved online project management tool.
16-BP-03	Contractor must track the status of the business plan on a weekly basis.
16-BP-04	Contractor must participate in 36 one-hour phone meetings with HHSC staff to review the status of deliverables and discuss questions and issues relevant to the

	SOW. Weekly meetings will not occur during the week that a monthly meeting takes place. The Contractor must provide the meeting agendas and minutes on a timeline approved by HHSC.
16-BP-05	Contractor must participate in monthly, three-hour meetings with HHSC staff to review the status of deliverables and discuss questions and issues relevant to the SOW. At least six of the meetings should, to the extent allowed by applicable law, travel restrictions, and state and local public health guidelines due to COVID-19, be conducted in-person. In the absence of in-person meetings, video conferences will be satisfactory to satisfy the in-person requirement.
16-BP-06	Contractor must participate, as directed by HHSC, in ad-hoc meetings with HHSC to review and discuss milestones, develop work plans, timelines for deliverables, discuss contract audit and audit findings, and develop performance improvement goals. These meetings may include advocates, members, or stakeholders as requested by HHSC.

2.1.4.6 Actuarial Analysis Related Activities

17-AA-01	Contractor must confirm HHSC fiscal year specifications, due dates for risk ratios and encounter data sets for All Programs, Dual Demonstration, and CHIP Perinatal.
17-AA-02	Contractor must provide risk ratio tables plus the weights along with technical specifications developed using CDPS to HHSC for STAR, STAR Kids, STAR+PLUS, CHIP and CHIP Perinatal. The Contractor must provide this information annually by March 15.
17-AA-03	Contractor must review CDPS specifications with HHSC yearly and provide for any changes, such as plan changes and population additions, in compliance with timeframes established by HHSC.
17-AA-04	Contractor must respond to questions submitted by MCOs, HHSC, and other stakeholders about CDPS methodology or specific acuity results; host a CDPS seminar with HHSC, MCOs, and others designated by HHSC; and work on related ad hoc activities as needed or requested by HHS.
17-AA-05	Contractor must provide CDPS risk adjustment model output so that HHSC can validate the MCOs and SA case mix results. Contractor must provide the member level data produced by the CDPS risk adjustment model, used to produce the final MCOs case mix scores reports, for STAR, STAR+PLUS, STAR Kids, CHIP and CHIP Perinatal.
17-AA-06	Contractor must submit a report of quality assurance analysis to determine the degree to which encounter data quality is within HHSC-specified standards for accuracy, a summary of amounts paid by services type and month of services, and a comparison of amounts paid in the Contractor's data to financial summary reports provided by each MCO and Dental Contractor for All Programs as well as Dual Demonstration and CHIP Perinatal. HHSC requires one encounter data file per program for actuarial analysis activities.
17-AA-07	Contractor must provide SFY certified encounter data sets for All Programs, Dual Demonstration, and CHIP Perinatal to HHSC annually no later than March 1.

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2.1.4.7 1115 Transformation Waiver Delivery System Reform Incentive Payment (DSRIP) Program and Directed Payment Programs (DPP)

18-TW-01	Contractor must provide a DSRIP hospital level report in a format and timeline agreed upon with HHSC annually, to HHSC. This report must include all PPEs using Medicaid and CHIP claims data in the format agreed upon with HHSC for each DSRIP hospital and uncompensated care hospital. HHSC will supply a provider list for use in creating this report.
18-TW-02	Contractor must provide a DSRIP regional healthcare partnership (RHP) level report for Medicaid and CHIP in a format and timeline agreed upon with HHSC annually. This report includes all PPEs. HHSC will provide RHP breakouts for use in creating this report.
18-TW-03	Contractor must provide reports in a format and timeline agreed upon with HHSC as outlined below related to the analysis of the Texas Healthcare Transformation Quality Improvement Program Waiver (1115 Waiver) DSRIP program initiatives for alignment with and integration into Medicaid managed care. 1. HEDIS timeliness of prenatal care rate report: Contractor must provide biannual reports of HEDIS timeliness of prenatal care rates to HHSC. These reports will be for selected DSRIP performing providers as requested by HHSC. Reports must include provider-specific data on which cases are included in the rate. 2. Statewide analysis report: Contractor must provide annually the statewide analysis report stratified by RHP, Medicaid population, uninsured and non-Medicaid population, age, and serious mental illness cohort to HHSC. This report must include the following: a. Summary PPA/PPV/PPR results for Medicaid and CHIP; and b. Summary PPR and PQI/PDI results for all-payer data. c. Texas PPR norm files report: This report must contain PPR norms for all-payer data and PPR norms for Medicaid and CHIP data. 3. Statewide analysis report: Contractor must provide the statewide analysis report stratified by RHP, Medicaid population, uninsured and non-Medicaid population, age, and serious mental illness cohort annually to HHSC. This report must include the following: a. Summary results of outpatient and emergency department visits for Medicaid and CHIP; b. Summary results of certain PDI and PQI measures specified by HHSC for Medicaid and CHIP.
18-TW-04	Contractor must provide targeted analysis or reports in a format and timeline agreed upon with HHSC related to the evaluation of Directed Payment Programs (DPPs) for each effective program year or related to areas of interest that include but are not limited to: PPEs, member surveys, HEDIS, or other quality measures relevant to services provided under the Healthcare Transformation Waiver.

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2.1.4.8 Quality Oversight Related Requirements

19-QO-01	Contractor must use Medicaid FFS claims, and Dental Contractor and MCO encounter data to evaluate value-based payment models identified by HHSC. These evaluations or comparison models may be in relation to cost of care, quality of care, utilization of services, and may include PPEs or other quality metrics as defined by HHSC. Contractor must provide up to three evaluations or comparisons per year. If HHSC does not use these evaluations or comparison, then these three requirements will be added to 19-QO-03, as targeted analyses or data extractions, increasing the total number of target analyses or data extractions to eight.
19-QO-02	Contractor must provide Technical Assistance and support related to requests by HHSC's Quality Oversight to participate in conference calls or to respond to inquiries related to the hospital quality-based PPR and PPC program. The Technical Assistance and support may be related but not limited to the deliverables of this program, webinars, PPE software questions, PPE logic, or data requests and may be done on an ad hoc basis.
19-QO-03	Contractor must provide up to five targeted analyses or data extractions per fiscal year based on HHSC's areas of interest that include, but not limited to: utilization analyses based on clinical conditions, more in depth analysis on PPE utilization by provider, Dental Contractor, MTO, MCO, or utilization analyses by demographic or risk group.
19-QO-04	Contractor must provide up to three targeted analyses or data extractions of Medicaid FFS claims and MCO encounter data to evaluate ways to improve birth outcomes in Medicaid per fiscal year. These studies involve work with Medicaid data linked to Texas vital statistics data, and may include risk adjustment calculations, regional variation analyses, and the incorporation of outcome and other quality measures. HHSC areas of interest include but are not limited to: neonatal intensive care unit and overall newborn care, neonatal abstinence syndrome, and maternal mortality and morbidity. Components of these studies, including regional disaggregation and maps, must be posted on the THLC public reporting portal. Contractor must provide related underlying data to MCOs and hospitals. Contractor must also provide Technical Assistance related to these targeted analyses.
19-QO-05	Contractor must provide monthly claims/encounter data extraction based on criteria identified by HHSC to all three grantees.

2.1.4.9 Other Requirements

20-O-01	Contractor must, annually, per MCO, calculate the number and percent of timely THSteps medical checkups for new and existing members in STAR, STAR Kids, STAR+PLUS, and STAR Health. MCOs will report this using Uniform Managed Care Manual Chapter 12.4 for the Medicaid Managed Care (MMC) THSteps Report Instructions and Chapter 12.5 for MMC THSteps Annual Report Template. The Contractor must develop and maintain a technical specification document describing the methods used in its calculations. Additionally, the Contractor must provide data and respond to MCO questions regarding the calculations.
20-O-02	Comply with the security controls set forth in **Attachment F, Texas Health and Human Services Information Security and Privacy Requirements.**
20-O-03	Contractor must hold up to three quality assurance training webinars per year on topics approved by HHSC for MCOs or Dental Contractors. These will be done within the format, timeframes and manner agreed upon by HHSC.
20-O-04	Contractor must notify HHSC at least 90 calendar days before the effective date of any change in Contractor's ownership, excluding minor stock transactions that have no individual, aggregate, or cumulative impact on the majority ownership. For purposes of this Contract, a change in control means any of the following: (1) a sale of Contractor's stock such that the effective ability to replace the CEO and/or Chairman or a majority of the Board members of the entity changes to another party; (2) a sale of substantially all of Contractor's assets; (3) a change in a majority of Contractor's board members; (4) consummation of a merger or consolidation of Contractor with any other entity; (5) a change in majority ownership through a transaction or series of transactions; or (6) the board (or the stockholders) approves a plan of complete liquidation. In the event of a change of control, Contractor must require the successor to assume this Contract and all of its obligations under this Contract. However, HHSC shall retain the right to terminate the Contract in the event of a change in control.

2.1.5 Key Measures and Liquidated Damages

The amounts below represent the liquidated damage that may be assessed for each calendar day the key measure (KM) is late, inaccurate, or incomplete. In instances where an hourly measure is used, the assessment will be for each hour the KM is not met.

ID	Measure	Frequency	Amount
KM-1	Submit hospital-level PPR and PPC reports as described in 07-P6-04 on the timeline approved by HHSC.	Twice Yearly	$500/day if the submission is late, inaccurate, or incomplete.
KM-2	Provide annual PPE data and reports described in 07-P6-04 by the due date approved by HHSC.	Annual	$500/day if the submission is late, inaccurate, or incomplete.

KM-3	Submit final Quality of Care data described in 07-P6-07 within 62 calendar days of the receipt of complete and accurate data from all MCOs and Dental Contractors.	Annual	$1,000/day if the submission is late, inaccurate, or incomplete.
KM-4	Provide annual MCO report card consumer product and instruction sheets described in 09-QR-03 by the due date approved by HHSC.	Annual	$500/day if the submission is late, inaccurate, or incomplete.
KM-5	Submit annual EQRO summary of activities report as described in 10-TR-01 on the timeline approved by HHSC.	Annual	$500/day if the submission is late, inaccurate, or incomplete.
KM-6	Perform and report on the appointment availability study described in 11-NA-03 by the due date approved by HHSC.	Annual	$500/day if the submission is late, inaccurate, or incomplete.
KM-7	Maintain 99% uptime, not including scheduled maintenance agreed to in advance by HHSC, for the THLC portal described in 2.1.4.2.	Monthly	$50/hour if uptime is not maintained at the required 99%.
KM-8	Provide monthly data updates to the THLC portal described in 13-LC-05	Monthly	$100/day if the data is late, inaccurate, or incomplete.
KM-9	Maintain 99% uptime, not including scheduled maintenance agreed to in advance by HHSC, for the ADTP described in 2.1.4.4.	Monthly	$50/hour if the system is down in excess of 1% per month.
KM-10	Follow the HHSC-approved plans described in 15-ADTP-03.	Daily	$1,000/day if the submission is late, inaccurate, or incomplete.
KM-11	Confirm HHSC fiscal year specifications, due dates for risk ratios and encounter data sets as described in 17-AA-01 no later than October 31	Annual	$100/day if the confirmation is late, inaccurate, or incomplete.
KM-12	Provide the risk ratio tables, weights, technical specifications, and cost estimates as described in 17-AA-02 no later than March 15 each year.	Annual	$1000/day if the submission is late, inaccurate, or incomplete.
KM-13	Review CDPS specifications and provide for changes as described in 17-AA-03, in the timeframe specified therein.	Annual	$500/day if the submission is late, inaccurate, or incomplete.
KM-14	Provide fiscal year certified encounter data sets as described in 17-AA-07 by March 1 each year.	Annual	$1000/day if the submission is late,

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			inaccurate, or incomplete.
KM-15	Provide the hospital level report described in 18-TW-01 no later than March 31 each year.	Annual	$500/day if the submission is late, inaccurate, or incomplete.
KM-16	Provide the RHP level report described in 18-TW-02 no later than March 31 each year.	Annual	$500/day if the submission is late, inaccurate, or incomplete.

2.2 FINANCIAL REQUIREMENTS

Payment is strictly conditioned on HHSC approval and acceptance of the Contractor services and deliverables. All expenses (including travel and travel-related expenses) incurred by the Contractor will be the sole responsibility of, and paid by, the Contractor. Such expenses will not be reimbursed by HHSC. Invoices must be submitted to the HHSC Medicaid and CHIP department contract management with a list of specific deliverables completed and approved by HHSC, per the Pricing Proposal (*see* Section 6.1 and **Attachment B, Budget**). Payments will be made according to the per-deliverable prices submitted in **Attachment B, Budget**. There is no reimbursement of incurred costs. HHSC will work with Contractor to develop milestones and corresponding progress payments for certain deliverables, as specified by HHSC; not all deliverables must be completed in full prior to any payment. HHSC Medicaid and CHIP department contract management must approve invoice formats for all services and deliverables.

2.3 FRAUD, WASTE, AND ABUSE

The Contractor is subject to all state and federal laws and regulations relating to fraud, waste, and abuse in health care and the Medicaid and CHIP programs. The Contractor 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 fraud, waste, or abuse.

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

1. The Contractor must designate one primary and one secondary contact person for all records requests from HHSC. HHSC will send records requests to the designated contact person(s) in writing by e-mail, fax, or mail, and will provide the specifics of the information being requested.
2. The Contractor must respond within the timeframe designated in the request. If the Contractor is unable to provide all of the requested information within the designated

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timeframe, the Contractor may request an extension in writing (e-mail) to the requestor no less than two business days prior to the due date.

3. The Contractor's response must include 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 Contractor 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 the record request.

2.4 DATA USE AGREEMENT

By entering into a Contract, or purchase order with the System Agency Contractor agrees to be bound by the terms of the Data Use Agreement attached as **Attachment G, Data Use Agreement** and **Attachment 2 to Attachment G, Security and Privacy Inquiry**.