

DOCUMENT HISTORY LOG

STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
Baseline	n/a	October 1, 2015	Initial version of Attachment B-1, RFP Sections 1 – 5, “Introduction; Procurement Strategy; General Instructions & Requirements; Submission Requirements; and Evaluation Process & Criteria” that includes all modifications negotiated by the Parties.

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represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions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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1 Introduction

1.1 Scope

The State of Texas, by and through the Health and Human Services Commission (HHSC), announces the release of request for proposal (RFP) # 529-13-0071 for establishment of the STAR Kids Medicaid managed care program.

Public comments concerning the RFP are subject to public disclosure under the Public Information Act, [Texas Government Code Chapter 552](#).

1.2 Point-of-Contact

The sole point-of-contact for inquiries concerning this RFP is the following.

Rick Blincoe, CTPM
Procurement and Contract Services
Health and Human Services Commission
4405 North Lamar Blvd.
Austin, Texas 78756
Phone: (512) 206-5468
Fax: (512) 206-5552
richard.blincoe@hhsc.state.tx.us

Respondents must direct all communications relating to this RFP to the HHSC point-of-contact named above. All other communications between a Respondent and HHSC and the HHS agencies, their agents, employees, or contractors concerning this RFP are prohibited. The Respondent may not discuss cost information contained in a proposal with the HHSC point-of-contact or any other staff under any circumstances. Failure to comply with these requirements may result in HHSC's disqualification of the proposal.

Only the HHSC point-of-contact can clarify issues and render any opinion regarding this RFP. No other individual HHSC employee or state employee is empowered to make binding statements regarding this RFP. No statements, clarifications, or opinions regarding this RFP are valid or binding except those issued in writing by the HHSC point-of-contact and posted on HHSC's website at http://www.hhsc.state.tx.us/about_hhsc/BusOpp/BO_opportunities.asp.

1.3 Procurement Schedule

The anticipated schedule for this procurement is as follows. HHSC reserves the right to revise this schedule. Any revisions will be posted on the HHSC website at http://www.hhsc.state.tx.us/about_hhsc/BusOpp/BO_opportunities.asp.

Procurement Schedule	
Draft RFP Release Date	March 19, 2014
Draft RFP Respondent Comments Due	April 18, 2014
RFP Release Date	July 18, 2014
Vendor Conference	July 31, 2014
Respondent Questions Due	August 5, 2014
Letters Claiming Mandatory Contract Status Due	September 2, 2014
HHSC Posts Responses to Respondent Questions	September 16, 2014
Proposals Due	October 30, 2014
Deadline for Proposal Withdrawal	October 30, 2014
Tentative Award Announcement	To be Announced
Anticipated Contract Effective Date	September 1, 2015
Operational Start Date	September 1, 2016

1.4 Purpose

The purpose of this procurement is to contract with multiple Managed Care Organizations (MCOs) to establish the STAR Kids Medicaid managed care program for children and young adults with disabilities.

1.5 Mission Statement

HHSC's mission is to provide individually appropriate Medicaid managed care services to children and young adults with disabilities to enable them to live and thrive in a setting that maximizes their health, safety, and overall well-being. To achieve HHSC's mission, the STAR Kids program is established to:

1. Coordinate care across service arrays;
2. Improve quality, continuity, and customization of care;
3. Improve access to care and provide person-centered Health Homes;
4. Improve ease of program participation for Members, MCOs, and Providers;
5. Improve Provider collaboration and integration of different services;
6. Improve Member outcomes to the greatest extent achievable;

7. Prepare young adults for the transition to adulthood;
8. Foster program innovation; and
9. Achieve cost efficiency and cost containment.

1.6 Mission Objectives

To accomplish HHSC's mission, HHSC will prioritize desired outcomes and benefits for the STAR Kids population and will focus its monitoring efforts on the MCO's ability to provide satisfactory results for these Mission Objectives.

1.6.1 Network Adequacy and Access to Care

HHSC intends that all Members have timely access to quality care through a Provider Network designed to meet the needs of the STAR Kids population. The MCO will be accountable for creating and maintaining a Network capable of delivering all Covered Services to Members throughout the State of Texas. The MCO must provide Members with access to qualified Network Providers within the travel distance and waiting time for appointment standards defined in this RFP. HHSC will especially focus on Members' access to a Health Home, qualified Specialists, and if appropriate, Behavioral Health Services and Community-Based Services.

1.6.2 Continuity of Care

The MCO must ensure minimal impact to established Member/Provider relationships, existing treatment protocols, and ongoing care plans. Transition to the managed care model must be as seamless as possible for Members and their Providers.

1.6.3 Health Home

HHSC is committed to providing a consistent and integrated source of healthcare for the STAR Kids population through a person-centered Health Home. The MCO must develop and uphold the Health Home model through the management and coordination of Healthcare Services.

1.6.4 Behavioral Health Services

The MCO must focus on access to, and delivery of, Behavioral Health Services. The MCO must provide Members with timely access to Medically Necessary Behavioral Health Services, such as mental health and substance abuse treatment and counseling, as well as timely and appropriate follow-up care. Contract requirements emphasize the importance of integration of care and formal, regular communication between Providers for Members who need assessment and evaluation for behavioral health concerns, or who are receiving both primary physical health and Behavioral Health Services. The Provider Network must include Providers experienced in working with children and young adults with Intellectual and Developmental Disabilities.

1.6.5 Service Coordination

The integration and coordination of all Covered Services are essential features of STAR Kids. The MCO must demonstrate sufficient levels of qualified and competent personnel devoted to

Service Coordination to meet the everyday and unique needs of STAR Kids Members, including Dual Eligibles.

1.6.6 Timeliness of Initial Texas Health Steps Visit

STAR Kids MCOs must ensure timely, age-appropriate medical check-ups with Providers in accordance with the Texas Health Steps periodicity schedule.

1.6.7 Timeliness of Claims Payments

A key element of an MCO's success is the ability to ensure that Network Providers receive timely and fair payment for services rendered. MCOs must pay Clean Claims and appealed claims on a timely basis, as well as resolve Pended Claims in a timely manner. HHSC will require strict adherence to basic claims processing standards.

1.6.8 Quality

HHSC is accountable to Texans for ensuring that all Members receive quality services in the most efficient and effective manner possible. Accordingly, the MCO will be responsible for providing high quality services in a professional, ethical, and cost-effective manner. HHSC expects the MCO to implement new and creative approaches that ensure quality services, cost-effective service delivery, and careful stewardship of public resources.

1.6.9 Delivery of healthcare to diverse populations

Member populations in Texas are diverse. Healthcare Services must be delivered without regard to racial or ethnic factors. HHSC expects the MCO to implement intervention strategies to avoid disparities in the delivery of Healthcare Services to diverse populations and provide services in a culturally competent manner as described in **Section 8.1.5.8**.

1.6.10 Disease management requirements

The MCO must provide a comprehensive disease management program or coverage for Disease Management (DM) services for asthma, diabetes, and other chronic diseases identified by the MCO, based upon an evaluation of the prevalence of the diseases within the MCO's membership. Please refer to the **Uniform Managed Care Manual (UMCM)**, Chapter 9.1 "Disease Management," for additional DM requirements.

1.6.11 Individualized Service Planning

Service Coordination strategies and services received through the MCO must be tailored to the unique needs of each Member. Through the STAR Kids Assessment Process and other strategies designed by the MCO to identify Member needs and preferences, the MCO must design and adhere to an Individual Service Plan (ISP) that is thoughtfully crafted, regularly monitored, and altered appropriately over time.

1.7 STAR Kids Overview

Senate Bill 7¹ directs the Health and Human Services Commission to establish a mandatory, capitated STAR Kids managed care program tailored to provide Medicaid benefits to children and young adults with disabilities. Through the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 Waiver, STAR Kids will serve children and young adults under the age of 21 who receive social security income (SSI) and SSI-related Medicaid. For eligible Members, STAR Kids will also provide the full service array for the Medically Dependent Children Program (MDCP).

Children and young adults who qualify for STAR Kids have diverse strengths and challenges. The service and support needs for the STAR Kids population varies based on broad differences in diagnoses, conditions, prior treatments, development, environment, age, family dynamics, and access to care. By working with Members and their families, STAR Kids MCOs will customize and coordinate acute, behavioral, and long-term services and supports (LTSS) through an individualized planning and service design process. Through comprehensive service coordination, STAR Kids Members will receive services and supports tailored to their individual needs.

Refer to the **Procurement Library** for enrollment information by Service Area.

1.8 Eligible Populations for STAR Kids

The following groups will be required to enroll in STAR Kids: (1) children and young adults under the age of 21 who receive Social Security Income (SSI) or (2) children and young adults who receive services through Home and Community-Based Services (HCBS) Waiver programs operated by HHSC, the Department of Aging and Disability Services (DADS), and the Department of State Health Services (DSHS). These programs include the following.

1. Medically Dependent Children Program (MDCP)
2. Home and Community-based Services (HCS)
3. Community Living Assistance and Supports Services (CLASS)
4. Deaf Blind with Multiple Disabilities (DBMD)
5. Texas Home Living (TxHmL)
6. Youth Empowerment Services (YES)

Children and young adults enrolled in MDCP will receive all of their services through STAR Kids, including LTSS currently provided through MDCP. Children and young adults enrolled in the other listed HCBS Waiver programs will receive Medicaid State Plan services (sometimes known as “acute care” services) and Service Coordination through their STAR Kids MCO, but will receive LTSS specific to their HCBS Waiver through their waiver service providers.

¹ 83rd Legislature, Regular Session, 2013

1.9 Authorization

The Texas Legislature has designated HHSC as the single state agency to administer the Medicaid Program in the State of Texas. HHSC has authority to contract with MCOs to carry out the duties and functions of the Medicaid Managed Care Program under [Title XIX of the Social Security Act](#); [Texas Health and Safety Code §§ 12.011, 12.017, and 12.021](#); and [Texas Government Code, Chapter 533](#). Contracts awarded under this RFP are subject to all necessary federal and state approvals, including Centers for Medicare and Medicaid Services' (CMS) approval.

1.10 Eligible Respondents

Except as provided in this document, eligible Respondents include insurers that are licensed by the Texas Department of Insurance (TDI) as MCOs in accordance with Chapter 843 of the Texas Insurance Code, a certified Approved Non-Profit Health Corporation (ANHC) formed in compliance with Chapter 844 of the Texas Insurance Code, and Exclusive Provider Organizations (EPO) with TDI-approved exclusive provider benefit plans.

Throughout this RFP, the term MCO includes HMOs, ANHCs, and EPOs. A Respondent that has submitted its application for licensure as an HMO, for certification as an ANHC, or for approval of an EPP prior to the Proposal due date is also eligible to respond to this RFP; however, the Respondent must receive TDI approval no later than 60 days after HHSC executes the Contract (see **Section 1.3**, "Procurement Schedule"). Failure to receive the required approval within 60 days after HHSC executes the Contract will result in the cancellation of the award.

Failure to timely submit proof of TDI licensure, certification, or approval will result in HHSC's termination of the Contract. The MCO will be at risk for all costs incurred by HHSC or its authorized representatives through the date of termination, as well as all costs HHSC incurs to replace the MCO.

For more information on the reasons for HHSC's disqualification of Respondents, see **Section 3.3.2**, "Conflicts of Interest," and **Section 3.3.3**, "Former Employees of a State Agency."

1.11 Contract Term

The Contract will begin on the Contract's Effective Date and will continue through, August 31, 2019 (Initial Contract Period). HHSC may, at its option, extend the Contract for an additional period or periods, not to exceed a total of eight operational years. All reserved Contract extensions beyond the Initial Contract Period will be subject to good faith negotiation between the parties.

As discussed in other sections of the RFP, the MCO must begin serving Members on the Operational Start Date, which HHSC anticipates will be September 1, 2016.

1.12 Development of Contracts

HHSC intends to execute one Contract per MCO, which will include all awarded MCO Service Areas.

2. Procurement Strategy and Approach

HHSC seeks to contract with multiple MCOs to give all Members a choice of at least two MCOs. HHSC reserves the right to enter into Contracts with more than two MCOs in any Service Area based on:

- the number of managed care Eligibles in the Service Area compared to the combined capacity of qualified MCO Respondents; and
- statutory requirements.

HHSC conducts this procurement as a competitive negotiation in accordance with [1 Tex. Admin. Code Ch. 391](#).

Texas Government Code § 2155.144 obligates HHSC to purchase goods and services on the basis of best value. HHSC rules define “best value” as the optimum combination of economy and quality that is the result of fair, efficient, and practical procurement decision-making and that achieves health and human services procurement objectives (see [1 Tex. Admin. Code § 391.31](#)). As stated in [1 Tex. Admin. Code § 391.121](#), HHSC may consider any of the following factors in determining best value:

- (1) Any installation costs;
- (2) The delivery terms;
- (3) The quality and reliability of the vendor's goods or services;
- (4) The extent to which the goods or services meet the agency's needs;
- (5) Indicators of probable vendor performance under the contract such as past vendor performance, the vendor's financial resources and ability to perform, the vendor's experience and responsibility, and the vendor's ability to provide reliable maintenance agreements;
- (6) The impact on the ability of the agency to comply with laws and rules relating to historically underutilized businesses or relating to the procurement of goods and services from persons with disabilities;
- (7) The total long-term cost to the agency of acquiring the vendor's goods or services;
- (8) The cost of any employee training associated with the acquisition;
- (9) The effect of an acquisition on agency productivity;
- (10) The acquisition price;
- (11) The extent to which the goods or services meet the needs of the client(s) for whom the goods or services are being purchased; and
- (12) Any other factor relevant to determining the best value for the agency in the context of a particular acquisition that is sufficiently described in a solicitation instrument.

HHSC will evaluate proposals using the criteria developed from these best value factors as set forth in **Section 5**.

2.1. Risk-Based Contract

In making the award of the Contract, HHSC will rely on the MCO's assurances of the following.

1. The MCO is an established HMO, ANHC, or EPO that arranges for the delivery of Healthcare Services, and will be fully authorized by TDI to conduct business in the Service Area no later than 60 days after the Contract's Effective Date.
2. The MCO and the MCO's Administrative Services Subcontractors have the skills, qualifications, expertise, financial resources, and experience necessary to provide the Services and Deliverables described in this RFP, the Respondent's Proposal, and the Contract in an efficient, cost-effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities.
3. The MCO has thoroughly reviewed, analyzed, and understood this RFP, has timely raised all questions or objections to this RFP, and has had the opportunity to review and fully understand HHSC's current program and operating environment for the activities that are the subject of the Contract and the needs and requirements of HHSC during the Contract term.
4. The MCO has had the opportunity to review and understands HHSC's stated objectives in entering into the Contract and, based on this review and understanding, the MCO currently has the capability to perform in accordance with the terms and conditions of the Contract.
5. The MCO is at risk for expenses that may be necessary or incurred in order to deliver contractually required services and deliverables, even if these expenses are in excess of the Capitation Payments received.

2.2. HHSC Model Management Strategy

HHSC has identified performance measures and objectives that it expects the MCO to address during the term of the Contract (see **Section 1.6**, "Mission Objectives" and **Section 8**, "Operations Phase Requirements.")

HHSC will use two "Performance Indicator Dashboards" (one for administrative and financial measures and another for quality measures). The two **Performance Indicator Dashboards** will be determined within a year of the Operational Start Date. The Performance Indicator Dashboards are not all-inclusive sets of performance measures; HHSC will measure other aspects of MCO performance as well. Rather, the Performance Indicator Dashboards assemble performance indicators that assess many of the most important aspects of MCO performance, and include measures that, when publicly shared, will also serve to hold MCOs accountable to measurable benchmarks.

HHSC will seek to accelerate improvement efforts in areas of high priority, including those identified in **Section 1.6**. As described in **Section 8.1.1.1**, HHSC's method for accelerating improvement is to establish with the MCO a series of performance improvement projects. The MCO will be committed to making its best efforts to achieve the established projects. HHSC may establish some or all of the performance improvement projects. HHSC and each MCO will

negotiate any remaining projects. These projects will be highly specified and measurable. The projects will reflect areas that present significant opportunities for performance improvement. Once finalized and approved by HHSC, the projects will become part of each MCO's plan for its Quality Assurance and Performance Improvement (QAPI) Program, as defined in **Section 8.1.7**, "Quality Assessment and Performance Improvement," and will be incorporated by reference into the Contract.

As described in **Section 8.1.1.3** HHSC will develop MCO report cards to help STAR Kids enrollees identify and select an MCO.

HHSC recognizes the importance of applying a variety of financial and non-financial incentives and disincentives for demonstrated MCO performance. It is HHSC's objective to recognize and reward both excellence in MCO performance and improvement in performance, within existing state and federal financial constraints. It is likely that HHSC will modify this approach over time based on several variables, including accumulated experience by HHSC and the MCO, changes in the status of state finances, and changes in MCO performance levels. **Section 6.2** "Performance Incentives and Disincentives," describes the incentive and disincentive approach in additional detail.

HHSC anticipates that incentives and disincentives will be linked to some of the measures in the Performance Indicator Dashboards, as found in the **UMCM**. HHSC may use MCO performance relative to the performance improvement projects (PIPs) to identify and reward excellence and improvement by the MCO in subsequent years.

Finally, HHSC plans to improve methods for sharing policy information with the MCO through HHSC-sponsored work groups and other initiatives.

2.3. Performance Measures and Associated Remedies

The MCO must provide all services and deliverables under the Contract at an acceptable quality level and in a manner consistent with acceptable industry standard, custom, and practice. Failure to do so may result in HHSC's assessment of contractual remedies, including liquidated damages, as set forth in **Attachment B-3**, "Deliverables/Liquidated Damages Matrix."

3. General Instructions and Requirements

3.1. Strategic Elements

3.1.1. Contract Elements

The term “Contract” means the contract awarded as a result of this RFP and all attachments. At a minimum, the following documents will be incorporated into the contract: this RFP and all attachments; any modifications, addendum, or amendments issued in conjunction with this RFP; HHSC’s STAR Kids Contract Terms; and the successful Respondent’s proposal.

Respondents are responsible for reviewing all parts of the Contract, including the STAR Kids Contract Terms, and noting any exceptions, reservations, and limitations on the Respondent Information and Disclosures form.

3.1.2. HHSC’s Basic Philosophy: Contracting for Results

HHSC’s fundamental commitment is to contract for results. A successful result is defined as the generation of defined, measurable, and beneficial outcomes that support HHSC’s Missions and Objectives and satisfy the Contract requirements. This RFP describes what is required of the MCO in terms of performance measures and outcomes, and places the responsibility for meeting objectives on the MCO.

3.2. External Factors

External factors such as budgetary and resource constraints may affect the project. Any contract resulting from this RFP is subject to the availability of state and federal funds. As of the issuance of this RFP, HHSC anticipates that funds are available to reasonably fulfill the RFP requirements. However, if funds become unavailable, HHSC reserves the right to withdraw the RFP or terminate the resulting contract without penalty.

3.3. Legal and Regulatory Constraints

3.3.1. Delegation of Authority

State and federal laws generally limit HHSC’s ability to delegate certain decisions and functions to a vendor, including: (1) policy-making authority and (2) final decision-making authority on the acceptance or rejection of contracted services.

3.3.2. Conflicts of Interest

A conflict of interest is a set of facts or circumstances in which either a Respondent or anyone acting on its behalf in connection with this procurement has past, present, or currently planned personal, professional, or financial interests or obligations that, in HHSC’s determination, would

actually or apparently conflict or interfere with the Respondent's contractual obligations to HHSC. A conflict of interest would include circumstances in which a party's personal, professional, or financial interests or obligations may directly or indirectly:

- Make it difficult or impossible to fulfill its contractual obligations to HHSC in a manner that is consistent with the best interests of the State of Texas;
- Impair, diminish, or interfere with that party's ability to render impartial or objective assistance or advice to HHSC; or
- Provide the party with an unfair competitive advantage in future HHSC procurements.

Neither the Respondent nor any other person or entity acting on its behalf, including subcontractors, employees, agents, and representatives, may have a conflict of interest with respect to this procurement. Before submitting a proposal, Respondents should carefully review **Attachment A**, "STAR Kids Contract Terms," for additional information concerning conflicts of interest.

A Respondent must certify that it does not have personal or business interests that present a conflict of interest with respect to this RFP and resulting contract (see the [Required Certifications form](#)). Additionally, if applicable, the Respondent must disclose all potential conflicts of interest. The Respondent must describe the measures it will take to ensure that there will be no actual conflict of interest and that it will maintain fairness, independence, and objectivity (see the [Respondent Information and Disclosures form](#)). HHSC will determine to what extent, if any, a potential conflict of interest can be mitigated and managed during the term of the Contract. **Failure to identify potential conflicts of interest may result in HHSC's disqualification of a proposal or termination of the Contract.**

3.3.3. Former Employees of a State Agency

Respondents must comply with state and federal laws and regulations relating to the hiring of former state employees, such as [Texas Government Code § 572.054](#), [Texas Government Code § 669.003](#), and [45 C.F.R. § 74.43](#). "Revolving door" provisions generally restrict former agency heads from communicating with or appearing before the agency on certain matters for two years after leaving the agency, or from contracting with the agency four years after leaving the agency. The "revolving door" provisions also restrict some former employees from representing clients on or receiving compensation for services rendered on behalf of any person regarding matters that the employee participated in during state service or matters that were in the employees' official responsibility.

As a result of these and similar laws and regulations, a Respondent must certify that it has complied with all applicable laws and regulations regarding all former state employees (see the Required Certifications Forms). Furthermore, a Respondent must disclose any relevant past state employment of the Respondent's or its subcontractors' employees and agents in the Respondent Information and Disclosure form.

3.4. HHSC Amendments and Announcements Regarding this RFP

HHSC will post all official communication regarding this RFP on its website, including the notice of tentative award. HHSC reserves the right to revise the RFP at any time. HHSC will issue any changes, clarifications, amendments, addendum, or written responses to Respondents' questions on HHSC's website. Respondents should check the website frequently for notice of matters affecting the RFP. To access the website, go to the "[HHSC Contract Opportunities](#)" page and enter a search for this procurement. Also, Respondents can find announcements regarding this RFP on the ESBD website at: <http://esbd.cpa.state.tx.us/>.

3.5. RFP Cancellation/Partial Award/Non-Award

HHSC reserves the right to cancel this RFP, to make a partial award, or to make no award if it determines that action is in the best interest of the State of Texas.

3.6. Right to Reject Proposals or Portions of Proposals

HHSC may, in its discretion, reject any proposal or portion of the proposal.

3.7. Costs Incurred

Respondents understand that issuance of this RFP in no way constitutes a commitment by HHSC to award a contract or to pay any costs incurred by a Respondent in the preparation of a response to this RFP. HHSC is not liable for any costs incurred by a Respondent prior to issuance of or entering into a formal agreement, contract, or purchase order. Costs of developing proposals, preparing for or participating in oral presentations and site visits, or any other similar expenses incurred by a Respondent are entirely the Respondent's responsibility, and HHSC will not reimburse the Respondent in any manner.

3.8. Protest Procedures

[1 Tex. Admin. Code Ch. 392, Subchapter C](#) outlines HHSC's Respondent protest procedures.

3.9. Vendor Conference

HHSC will hold a vendor conference according to the date in **Section 1.3** (Procurement Schedule) beginning at 1:00 pm in Room K100, 1100 West 49th Street, Austin, Texas. Vendor conference attendance is strongly recommended, but is not required.

Respondents may e-mail questions for the conference to the HHSC Point-of-Contact (see **Section 1.2**) no later than five days before the conference. HHSC will also give Respondents

the opportunity to submit written questions at the conference. All questions should reference the appropriate RFP page and section number. HHSC will attempt to respond to questions at the vendor conference, but responses are not official until posted in final form on the HHSC website. HHSC reserves the right to amend answers prior to the proposal submission deadline.

3.10. Questions and Comments

All questions and comments regarding this RFP should be sent to the HHSC Point-of-Contact (see **Section 1.2**). Questions should reference the appropriate RFP page and section number, and must be submitted by the deadline set forth in **Section 1.3**. HHSC will not respond to questions received after the deadline. HHSC's responses to Respondent questions will be posted to the HHSC website. HHSC reserves the right to amend answers prior to the proposal submission deadline.

Respondents must notify HHSC of any ambiguity, conflict, discrepancy, exclusionary specification, omission, or other error in the RFP by the deadline for submitting questions and comments. If a Respondent fails to notify HHSC of these issues, it will submit a proposal at its own risk, and if awarded a contract: (1) will have waived any claim of error or ambiguity in the RFP or resulting contract, (2) must not contest HHSC's interpretation of such provision(s), and (3) is not entitled to additional compensation, relief, or time by reason of the asserted ambiguity, error, or its later correction.

3.11. Modification or Withdrawal of Proposal

Prior to the proposal submission deadline set forth in **Section 1.3**, a Respondent may: (1) withdraw its proposal by submitting a written request to the HHSC Point-of-Contact, or (2) modify its proposal by submitting a written amendment to the HHSC Point-of-Contact. HHSC may request proposal modifications at any time.

HHSC reserves the right to waive minor informalities in a proposal and award a contract that is in the best interest of the State of Texas. A "minor informality" is an omission or error that, in HHSC's determination, if waived or modified when evaluating proposals, would not give a Respondent an unfair advantage over other Respondents or result in a material change in the proposal or RFP requirements. When HHSC determines that a proposal contains a minor informality, it may, at its discretion, provide the Respondent with the opportunity to correct the minor informality.

3.12. News Releases

Prior to tentative award, a Respondent may not issue a press release or provide any information for public consumption regarding its participation in the procurement. After tentative award, a Respondent must receive prior written approval from HHSC before issuing a press release or providing information for public consumption regarding its participation in the procurement. Requests should be directed to the HHSC Point-of-Contact identified in **Section 1.2**.

Section 3.12 does not preclude business communications necessary for a Respondent to develop a proposal, or required reporting to shareholders or governmental authorities.

3.13. Incomplete Proposals

HHSC may reject without further consideration a proposal that does not include a complete, comprehensive, or total solution as requested by this RFP.

3.14. State Use of Ideas

HHSC reserves the right to use any and all ideas and information presented in a proposal. A Respondent may not object to HHSC's use of this information.

3.15. Property of HHSC

Except as otherwise provided in this RFP or the resulting Contract, all products produced by a Respondent, including without limitations the proposal, all plans, designs, software, and other contract deliverables, become the sole property of HHSC. See **Attachment A**, "STAR Kids Contract Terms," **Article 15** for additional information concerning intellectual property rights.

3.16. Copyright Restriction

HHSC will not consider any proposal that is copyrighted by the Respondent, in whole or part.

3.17. Additional Information

By submitting a proposal, the Respondent grants HHSC the right to obtain information from any lawful source, whether identified in Respondent's proposal or not, regarding the Respondent's and its directors', officers', and employees': (1) past business history, practices, and conduct, (2) ability to supply the goods and services, and (3) ability to comply with Contract requirements. By submitting a proposal, a Respondent generally releases from liability and waives all claims against any party providing HHSC information about the Respondent. HHSC may take this information into consideration in evaluating proposals.

3.18. Multiple Responses

A Respondent may only submit one proposal as a prime contractor. If a Respondent submits more than one proposal, HHSC may reject one or more of the submissions. This requirement does not limit a subcontractor's ability to collaborate with one or more Respondents submitting proposals.

A Respondent may not entice or require a subcontractor to enter into an exclusive subcontract for the purpose of this procurement. Any subcontract entered into by a Respondent with a third party to meet a requirement of this RFP must not include any provision that would prevent or

bar that subcontractor from entering into a comparable contractual relationship with another Respondent submitting a proposal under this procurement. This prohibition against exclusive subcontracts does not apply to professional services that solely pertain to development of the proposal, including gathering of competitive intelligence.

3.19. No Joint Proposals

HHSC will not consider joint or collaborative proposals that require it to contract with more than one Respondent.

3.20. Use of Subcontractors

Subcontractors providing services under the Contract must meet the same requirements and level of experience as required of the Respondent. No subcontract under the Contract must relieve the Respondent of the responsibility for ensuring the requested services are provided. Respondents planning to subcontract all or a portion of the work to be performed must identify the proposed subcontractors and describe the subcontracted functions in their proposals.

3.21. Texas Public Information Act

Proposals will be subject to the Texas Public Information Act (the Act), located in [Texas Government Code Chapter 552](#), and may be disclosed to the public upon request. By submitting a proposal, the Respondent acknowledges that all information and ideas presented in the proposal are public information and subject to disclosure under the Texas Public Information Act, with the limited exception of Social Security Numbers and certain non-public financial reports or information submitted in response to **Sections 4.2.3.3 and 4.2.3.4**.

If the Respondent asserts that financial reports or information provided in response to **Sections 4.2.3.3 and 4.2.3.4** contain trade secret or other confidential information as specified under the provisions of the Act, the Respondent must clearly mark that information in boldface type and include the words “confidential” or “trade secret” at the top of the page. Furthermore, the Respondent must identify by specific page numbers the financial reports or information, and provide an explanation of why the reports or information are excepted from public disclosure under the provisions of the Act, on the Respondent Information and Disclosures form.

HHSC will process any request from a member of the public in accordance with the procedures outlined in the Act. Respondents should consult the Texas Attorney General’s website (www.oag.state.tx.us) for information concerning the Act’s application to applications and potential exceptions to disclosure.

3.22. Inducements

HHSC submits this RFP setting forth certain information regarding the objectives of the Contract and HHSC’s desire to mitigate risk throughout the life of the Contract by use of expert MCO services.

Therefore, HHSC will consider all representations contained in a Respondent's proposal, oral or written presentations, correspondence, discussions, and negotiations as representations of the Respondent's expertise. HHSC accepts these representations as inducements to contract.

3.23. Definition of Terms

Defined terms have the meaning described in **Attachment A**, "STAR Kids Contract Terms," unless the context clearly indicates otherwise. Defined terms are capitalized throughout this RFP.

4 Submission Requirements

To be considered for award, the Respondent must address all RFP specifications to HHSC's satisfaction. If requested by HHSC, the Respondent must provide HHSC with information necessary to validate any statements made in its Proposal. This includes granting permission or access for HHSC to verify information with third parties, whether identified by the Respondent or HHSC. If any requested information is not provided within the timeframe allotted, HHSC may reject the Proposal.

Respondents must prepare and submit proposals in accordance with the provisions of this section. Proposals received that do not follow these instructions may be evaluated as non-responsive and may not be considered for award.

If a Respondent believes that parts of a Proposal are excepted from required public disclosure under the Texas Public Information Act, the Respondent must specify those parts and the exception(s) that it believes apply, with specific detailed reasons. See **Section 3.21** (Texas Public Information Act) for more information.

4.1 Part 1 – General Instructions

A Proposal must include the following two components:

- Business Proposal; and
- Programmatic Proposal.

All Proposal information must be submitted on 8½" x 11", white bond paper, three-hole punched, and placed in sturdy three-ring binders. Text must be no smaller than 11-point font, single-spaced. Figures may not incorporate text smaller than 8-point font. All pages must have one-inch margins and page numbering must be sequential per section. Where practical, pages should be double-sided. Each binder must be labeled clearly with the title of this RFP, the Respondent's legal name, and the title of the document contained in the binder, e.g., Business Proposal or Programmatic Proposal.

Proposals must be organized and numbered in a manner that facilitates reference to this RFP and its requirements. Respondents must respond to each item in the order it appears in the RFP. The Respondent's response must include headings and numbering to match the corresponding section of the RFP. Respondents may place attachments in a separate section, if the attachments are not included in any page limits specified in the RFP.

4.1.1 Economy of Presentation

Unnecessarily elaborate Proposals beyond those sufficient to provide a complete and effective response to this RFP are not desired and may be construed as an indication of the Respondent's lack of ability to provide efficient work products.

The Respondent must adhere to page limits where specified. Page limits are listed in parentheses at the end of the title of the section to which the page limit applies. A three-page limit, for example, means that the response should not be in excess of three one-sided pages that meet the size, font, and margin requirements specified in the General Instructions in **Section 4.1**.

In other cases, additional pages may be provided based on certain aspects of the Respondent's Proposal or organization, such as the number of organizational charts submitted reflecting arrangements with Material Subcontractors, or the number of Key Contract Personnel included in the Proposal.

If the Respondent chooses to repeat the RFP question in its Proposal, the question text will be included in the page limit.

In responding to questions in **Section 4.2** ("Business Proposal") and **Section 4.3** ("Programmatic Proposal") for which the Respondent includes information about a Material Subcontractor or Action Plans, up to one page may be used to describe each Material Subcontractor arrangement, and up to one page may be used to describe each Action Plan. These pages are outside of the page limit instructions for the specific submission requirement.

HHSC reserves the right not to review information provided in excess of the page limits. Respondents need not feel compelled to submit unnecessary text in order to reach the page limits.

Attachments required by the RFP, such as certain policies and procedures, are not counted in calculating the Respondent's page limits. Respondents must not submit information or attachments not explicitly requested in the RFP. Elaborate artwork, expensive paper and bindings, and expensive visual or other presentation aids are neither necessary nor desired.

4.1.2 Number of Copies and Packaging

Respondents must submit one hardbound original and eight hardbound copies of the Proposal. The original must be clearly labeled "Original" on the outside of the binder. In addition to the hardbound original and copies, Respondents must submit 22 electronic copies of each Proposal component. The Respondent must clearly label the exterior of

the shipping package with proposal number 529-13-0071. At the Respondent's option, it may produce only electronic copies of certain attachments and appendices. This exception applies to attachments and appendices that exceed 10 pages, such as GeoAccess tables, Significant Traditional Provider (STP) files, TDI filings, and other financial documents. The exception does not apply to the attachments referenced in **Section 4.2**, "Part 2 - Business Proposal," **Section 4.2.5**, "Section 5 - HUB Subcontracting Plan," or **Section 4.2.6**, "Section 6 - Certifications and Other Required Forms," which must be included in both the hardbound and electronic copies of the Proposal. If the Respondent produces only an electronic copy of an attachment or appendix, the hardbound Proposals should refer the reader to the electronic Proposal for the required information.

For the electronic copies, the Proposal, attachments, financial documents, signed forms, pamphlets, and all other documents included in the proposal hardcopy must be submitted on-CDs compatible with Microsoft Office 2007 files. PDF files should be prepared in a format that is text searchable. **HHSC will not accept Proposals by facsimile or e-mail.**

4.1.3 Due Date, Time, and Location

Submit all copies of the Proposal to HHSC's Enterprise Contracts and Procurement Services (ECPS) no later than **2:00 p.m.** Central Time (CT) according to the timeline in **Section 1.3** ("Procurement Schedule"). All submissions will be date and time stamped when received by ECPS. The clock in the ECPS office is the official timepiece for determining compliance with the deadlines in this procurement. HHSC reserves the right to reject late submissions. It is the Respondent's responsibility to appropriately mark and deliver the Proposal to HHSC by the specified date and time. The sole point-of-contact for inquiries concerning this RFP is:

Rick Blincoe, CTPM
Procurement and Contracting Services
Health and Human Services Commission
4405 North Lamar Blvd
Austin, Texas 78756-3422
Phone: (512) 206-5468
Fax: (512) 206-5552
Richard.Blincoe@hhsc.state.tx.us

4.2 Part 2 – Business Proposal

The Business Proposal must include the following:

1. Section 1 – Executive Summary
2. Section 2 – Respondent Identification and Information
3. Section 3 – Corporate Background and Experience
4. Section 4 – Material Subcontractor Information
5. Section 5 – HUB Subcontracting Plan
6. Section 6 – Certifications and Other Required Forms

4.2.1 Section 1 – Executive Summary

(2 pages)

In this section, condense and highlight the content of the Business Proposal to provide HHSC with a broad understanding of the respondent's approach to meeting the RFP's business requirements. The summary must demonstrate an understanding of HHSC's goals and objectives for this procurement. Please identify the Service Areas in which the Respondent proposes to operate. Respondents must indicate the intent to provide statewide coverage. (The Service Areas are described in **Attachment B-4** and **B-4.1**. A Respondent may elect to bid on some or all of the Service Areas.)

4.2.2 Section 2 – Respondent Identification and Information

(No page limit)

Submit the following information:

1. Respondent identification and basic information.
 - a. The Respondent's legal name, trade name, d.b.a, acronym, and any other name under which the Respondent does business.
 - b. The physical address, mailing address, and telephone number of the Respondent's headquarters office.
2. TDI Authority. A copy of the MCO's licensure, certification, or approval to operate as an MCO, ANHC, or EPO/EPBP. If the Respondent has not received TDI approval, then submit a copy of the application filed with TDI. In accordance with **Section 7.3.9**, the Respondent must receive TDI approval no later than 60 days after HHSC executes the Contract.
3. Authorized Counties. Indicate whether the Respondent is currently authorized by TDI to operate as an MCO in each county in the proposed Service Area with a

“Yes,” “No,” or “Partial.” If the Respondent is not authorized to conduct business as an MCO in all or part of a county, it should list those areas in Column C. For each county listed in Column C, the Respondent must document that it applied to TDI for approval prior to the submission of a Proposal for this RFP. The Respondent must indicate the date that it applied for TDI approval and the status of its application to get TDI approval in the relevant counties in this section of its submission to HHSC.

Table 2: TDI Authority in Proposed Service Area

Column A	Column B	Column C
Service Area	TDI Authority/Status of Approval	Counties/Partial Counties without TDI Authority
Bexar		
Dallas		
El Paso		
Harris		
Hidalgo		
Jefferson		
Lubbock		
Medicaid RSA Central		
Medicaid RSA Northeast		
Medicaid RSA West		
Nueces		
Tarrant		
Travis		

4. Texas Comptroller Certificate. A current Certificate of Good Standing issued by the Texas Comptroller of Public Accounts, or an explanation for why this form is not applicable to the Respondent.
5. Respondent Legal Status and Ownership.
 - a. The type of ownership of the Respondent by its ultimate parent:
 - wholly-owned subsidiary of a publicly-traded corporation;
 - wholly-owned subsidiary of a private (closely-held) stock corporation;
 - subsidiary or component of a non-profit foundation;
 - subsidiary or component of a governmental entity such as a County Hospital District;
 - independently-owned member of an alliance or cooperative network;
 - joint venture (describe ultimate owners);

- stand-alone privately-owned corporation (no parents or subsidiaries); or
 - other (describe).
- b. The legal status of the Respondent and its parent (any/all that may apply):
- Respondent is a corporation, partnership, sole proprietor, or other (describe);
 - Respondent is for-profit, or non-profit;
 - the Respondent's ultimate parent is for-profit, or non-profit;
 - the Respondent's ultimate parent is privately-owned, listed on a stock exchange, a component of government, or other (describe).
- c. The legal name of the Respondent's ultimate parent (e.g., the name of a publicly-traded corporation, or a County Hospital District).
- d. The name and address of any other sponsoring corporation, or others (excluding the Respondent's parent) who provide financial support to the Respondent, and the type of support, e.g., guarantees, letters of credit. Indicate if there are maximum limits of the additional financial support.
6. Hospital District/Non-Profit Corporation. Section 5 of the RFP requires Respondents who believe they qualify for mandatory STAR Kids contracts under [Texas Government Code § 533.004](#) to submit a detailed, written notice to HHSC no later than indicated in the Procurement Schedule included in **Section 1.3**. Please indicate whether the Respondent provided this notice to HHSC in the manner described in Section 5.
7. The name and address of any health professional that has at least a 5% financial interest in the Respondent, and the type of financial interest.
8. The full names and titles of the Respondent's officers and directors.
9. The state in which the Respondent is incorporated and the state(s) in which the Respondent is licensed to do business as an MCO. The Respondent must also indicate the state where it is commercially domiciled, if outside Texas.
10. The Respondent's federal taxpayer identification number.
11. If any change of ownership of the Respondent's company or its parent is anticipated during the 12 months following the Proposal Due Date, the Respondent must describe the circumstances of such change and indicate when the change is likely to occur.
12. Whether the Respondent or its parent (including other managed care subsidiaries of the parent) had a managed care contract terminated or not renewed for any reason within the past five years. In such instance, the Respondent must describe the issues and the parties involved, and provide the address and telephone number of the principal terminating party. The

Respondent must also describe any corrective action taken to prevent any future occurrence of the problems that may have led to the termination or non-renewal.

13. Whether the Respondent has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status, and if it has or is, indicate:
 - its current NCQA or URAC accreditation status;
 - if NCQA or URAC accredited, its accreditation term effective dates; and
 - if not accredited, a statement describing whether and when NCQA or URAC accreditation status was ever denied the Contractor.
14. The website address (URL) for the homepage of any website operated, owned, or controlled by the Respondent, including any that the Respondent may have contracted to be run by another entity. If the Respondent has a parent, then also provide the same for the parent, and any parent of the parent. If none exists, provide a clear and definitive statement to that effect.

4.2.3 Section 3 – Corporate Background and Experience

(no page limit)

1. Provide the following information on all publicly-funded managed care contracts (if the Respondent does not have publicly-funded managed care contracts, it may include information on privately-funded managed care contracts). Include information for all current contracts, as well as work performed in the past three years:
 - a. client name and address;
 - b. name, telephone, and e-mail address of the person HHSC could contact as a reference that can speak to the Respondent's performance;
 - c. contract size: average monthly covered lives and annual revenues;
 - d. whether payments under the contract were capitated or non-capitated;
 - e. contract start date and duration;
 - f. whether work was performed as a prime contractor or subcontractor; and
 - g. a general and brief description of the scope of services provided by the Respondent; including the covered population and services (e.g., Medicaid, state-funded program).
2. With respect to the Respondent and its parent (and including other managed care subsidiaries of the parent), briefly describe any regulatory actions, sanctions, or fines imposed by any federal or Texas regulatory entity, or a regulatory entity in another state, within the last three years. Include a description of any letters of deficiencies, corrective actions, findings of non-compliance, or sanctions, and describe if and how any noted deficiencies or non-compliance issues were resolved. Please indicate

which of these actions or fines, if any, were related to the Medicaid program. HHSC may, at its option, contact these clients or regulatory agencies and any other individual or organization whether or not identified by the Respondent.

3. If the Respondent had a contract terminated or not renewed for nonperformance or poor performance within the past five years, the Respondent must describe the issues, the parties involved, and provide the address and telephone number of the principal terminating party. The Respondent must also describe any corrective action taken to prevent any future occurrence of the problem leading to the termination.

Respondents should not include letters of support or endorsement from any individual, organization, agency, interest group, or other identified entity in this section or other parts of the Proposal.

When evaluating proposals, HHSC may consider a current or past contractor's performance under an agreement with an HHS agency in Texas, including any corrective actions or damages imposed by HHSC or another HHS agency.

4.2.3.1 Organizational Chart

(1 page narrative for each organizational chart, excluding organizational chart itself)

Respondents should submit the following:

1. An organizational chart (**Chart A**), showing the corporate structure and lines of responsibility and authority in the administration of the Respondent's business as a health plan.
2. An organizational chart (**Chart B**) showing the Texas organizational structure and how it relates to the proposed Service Area(s), including staffing and functions performed at the local level. If Chart A represents the entire organizational structure, label the submission as Charts A and B.
3. An organizational chart (**Chart C**) that illustrates how administration of services to Members is integrated into the overall administrative structure of the Respondent's business as a managed care organization. Specifically show the organizational structure if the Respondent proposes to maintain offices in more than one city in Texas.
4. An organizational chart (**Chart D**) showing the Management Information System (MIS) staff organizational structure and how it relates to the proposed Service Area(s) including staffing and functions performed at the local level.
5. An organizational chart (**Chart E**) showing the Respondent's committee structure and committee lines of accountability. Indicate which committee(s) will participate

in establishing treatment guidelines and criteria for delivery of Covered Services to Members.

6. If the Respondent is proposing to use a Material Subcontractor, the Respondent must include an organizational chart (**Chart F**) demonstrating how the Material Subcontractors will be managed within the Respondent's Texas organizational structure, including the primary individuals at the Respondent's organization and at each Material Subcontractor organization responsible for overseeing such Material Subcontract. This information may be included in **Chart B**, or in a separate organizational chart.
7. Submit a brief narrative explaining the organizational charts submitted, and highlighting the key functional responsibilities and reporting requirements of each organizational unit relating to the Respondent's proposed management of the STAR Kids Program, including its management of any proposed Material Subcontractors.

4.2.3.2 Résumés

(1 page per Key Personnel, excluding résumés)

Identify and describe the respondent's and its subcontractor's proposed labor skill set, years of experience, and provide résumés of all proposed key personnel. Résumés must demonstrate experience germane to the position proposed. Résumés should include work on projects cited under the Respondent's corporate experience, and the specific functions performed on such projects. Each résumé should include at least three references from recent projects, if the projects were performed for unaffiliated parties. References may not be the Respondent's or subcontractor's employees.

For each of the Key MCO Personnel listed below, submit (a) a job description and qualifications; (b) a résumé of each individual expected to hold such position, if such person has already been identified by the Respondent; and (c) indicate the portion of each person's time the Respondent anticipates will be dedicated to STAR Kids:

1. Executive Director
2. Medical Director
3. Member Services Manager
4. Behavioral Health Services Manager
5. Manager of Transition Specialists
6. Vision Services Manager
7. Pharmacy Benefits Services Manager
8. Management Information Systems Manager
9. Claims Processing Manager
10. Provider Network Development and Management Manager
11. Benefit Administration and Utilization Review Manager

12. Service Coordinator Manager
13. Quality Improvement Manager
14. Financial Functions Manager
15. Reporting Manager

Service Coordinators. Please refer to **Section 8.1.38.7** for a description of Service Coordinator responsibilities. Please submit the following for each individual Service Coordinator:

1. a job description and qualifications; and
2. the anticipated maximum caseload for each Service Coordinator (number of Members per Service Coordinator) by assigned service level and the assumptions the Respondent used in developing the maximum caseload estimate.

4.2.3.3 Financial Capacity

(no page limit)

Submit the following financial documents to demonstrate the Respondent's financial solvency, and its capacity to comply with **Section 6**, "Premium Payment, Incentives, and Disincentives," and **Section 8**, "Operations Phase Requirements," and **Attachment A**, "STAR Kids Contract Terms":

1. Audited Financial Statements covering the two most recent years of the Respondent's financial results. These statements must include the independent auditor's report (audit opinion letter to the Board or shareholders), the notes to the financial statements, any written description of legal issues or contingencies, and any management discussion or analysis.

Make sure that the name and address of the firm that audits the Respondent is shown. State the date of the most-recent audit, and whether the Respondent is audited annually or otherwise. State definitively if there has, or has not, been any of the following:

1. a "going concern" statement was issued by any auditor in the last three years;
 2. a qualified opinion was issued by any auditor in the last three years;
 3. a change of audit firms in the last three years; and
 4. any significant delay (two months or more) in completing the current audit.
2. The most recent quarterly and annual financial statements filed with the TDI, and if the Respondent is domiciled in another state, the financial statements filed with the state insurance department in its state of domicile. The annual financial

statement must include all schedules, attachments, supplements, management discussion, analysis, and actuarial opinions.

3. The most recent financial examination report issued by TDI, and by any state insurance department in states where the Respondent operates a Medicaid or comparable managed care product. If any submitted financial examination report is 2 or more years old, or if Respondent has never had a financial examination report issued, submit the anticipated approximate date of the next issuance of a TDI or state department of insurance financial examination report.
4. The most recent Form B Registration Statement disclosure filed by Respondent with TDI, and any similar form filed with any state insurance department in other states where the Respondent operates a Medicaid or comparable managed care product. If Respondent is exempt from the TDI Form B filing requirement, demonstrate this and explain the nature of the exemption.
5. Other related documents, as applicable:
 - a. SEC Form 10-K and 10-Q. If Respondent is a publicly-traded (stock-exchange-listed) corporation, then submit the most recent United States Securities and Exchange Commission (SEC) Form 10-K Annual Report, and the most-recent 10-Q Quarterly report.
 - b. IRS Form 990. If the Respondent is a non-profit entity, then submit the most recent annual Internal Revenue Service (IRS) Form 990 filing, complete with all attachments or schedules. If Respondent is a non-profit entity that is exempt from the IRS 990 filing requirement, demonstrate this and explain the nature of the exemption.
 - c. If the Respondent is a non-profit entity that is a component or subsidiary of a County Hospital District, or otherwise an entity of a government, then submit the most recent annual financial statements as prepared under the relevant rules or statutes governing annual financial reporting and disclosure for Respondent, including all attachments, schedules, and supplements.
 - d. Bond or debt rating analysis. If Respondent has been, in the last three years, 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, submit the most-recent detailed report from each rating entity that has produced such a report.
 - e. Annual Report. If Respondent produces any written "annual report" or similar item that is in addition to the above-referenced documents, submit the most recent version. This might be a yearly report or letter to shareholders, the community, regulators, lenders, customers, employees, the Respondent's owner, or other constituents.

- f. If the Respondent has issued any press releases in the 12 months prior to the submission due date, and the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues, provide a copy of each press release. HHSC does not wish to receive other types of press releases that are primarily promotional in nature.

With respect to items 5(a) through 5(e), Respondent must also submit a schedule that shows for each of the five categories: whether there is any applicable filing or report; the name(s) of the entity that does the filing or report; and the regular or estimated filing/distribution date(s).

At a minimum, the financial statements and reports submitted must include:

1. balance sheet;
2. statement of income and expense;
3. statement of cash flows;
4. statement of changes in financial position (capital & surplus; equity);
5. independent auditor's letter of opinion;
6. description of organization and operation, including ownership, markets served, type of entity, number of locations and employees, and, dollar amount and type of any Respondent business outside of that with HHSC; and
7. disclosure of any material contingencies, and any current, recent past, or known potential material litigation, regulatory proceedings, legal matters, or similar issues.

The Respondent must include key non-financial metrics and descriptions, such as facilities, number of covered lives, area of geographic coverage, years in business, material changes in business situation, key risks, and prospective issues.

4.2.3.4 Financial Report of Parent Organization and Corporate Guarantee

(no page limit)

If another corporation or entity either substantially or wholly owns the Respondent, submit the most recent detailed financial reports (as required in **Section 4.2.3.3**) for the parent organization. If there are one or more intermediate owners between the Respondent and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

The Respondent must also include a statement, using the "Corporate Guarantee" form found in the Procurement Library, that the parent organization will unconditionally guarantee performance by the Respondent of each and every obligation, warranty, covenant, term and condition of the Contract. This guarantee is not required for Respondents owned by political subdivisions of the State (e.g., hospital districts).

If HHSC determines that an entity does not have sufficient financial resources to guarantee the Respondent's performance, HHSC may require the Respondent to obtain another acceptable financial instrument or resource from such entity, or to obtain an acceptable guarantee from another entity with sufficient financial resources to guarantee performance.

4.2.3.5 Bonding

The Respondent must submit a statement that, if selected as a Contractor, the Respondent agrees to:

1. secure and maintain throughout the life of the Contract, fidelity bonds required by the Texas Department of Insurance in compliance with [Texas Insurance Code § 843.402](#); and
2. secure and maintain throughout the life of the Contract, a performance bond in accordance with the **Attachment A**, "STAR Kids Contract Terms," of this RFP and [28 Tex. Admin. Code § 11.1805](#).

4.2.4 Section 4 – Material Subcontractor Information

(no page limit)

See **Attachment A**, "STAR Kids Contract Terms," for contractual definition of Material Subcontractor. Organize this information by Material Subcontractor, and list them in descending order of estimated annual payments. For *each* Material Subcontractor, the MCO must provide:

1. The Material Subcontractor's legal name, trade name, acronym, d.b.a., and any other name under which the Material Subcontractor does business.
2. The Respondent's estimated annual payments to the Material Subcontractor, by MCO Program.
3. The physical address, mailing address, and telephone number of the Material Subcontractor's headquarters office, and the name of its Chief Executive Officer.
4. Whether the Material Subcontractor is an Affiliate of the Respondent or an unrelated third party (see **Attachment A**, "STAR Kids Contract Terms," for the definition of "Affiliate.")
5. If the Material Subcontractor is an Affiliate, then provide:
 - a. the name of the Material Subcontractor's parent organization, and the Material Subcontractor's relationship to the Respondent;

- b. the proportion, if any, of the Material Subcontractor's total revenues that are received from non-Affiliates. If the Material Subcontractor has significant revenues from non-Affiliates, then also indicate the portion, if any, of those external (non-Affiliate) revenues that are for services similar to those that the Respondent would procure under the proposed Subcontract;
 - c. a description of the proposed method of pricing under the Subcontract;
 - d. indicate if the Respondent presently procures, or has ever procured, similar services from a non-Affiliate;
 - e. the number of employees (staff and management) who are dedicated full-time to the Affiliate's business;
 - f. whether the Affiliate's office facilities are completely separate from the Respondent and the Respondent's parent. If not, identify the approximate number of square feet of office space that are dedicated solely to the Affiliate's business;
 - g. attach an organization chart for the Affiliate, showing head count, Key Personnel names, titles, and locations; and
 - h. indicate if the staff and management of the Affiliate are directly employed by the Affiliate itself, or are they legally employed by a different legal entity (such as a parent corporation). The employee's W-2 form identifies the name of the corporation and is indicative of the actual employer.
6. A description of each Material Subcontractor's corporate background and experience, including its estimated annual revenues from unaffiliated parties, number of employees, location(s), and identification of three major clients.
7. A signed letter of commitment from each Material Subcontractor that states the Material Subcontractor's willingness to enter into a Subcontractor agreement with the Respondent, and a statement of work for subcontracted activities. Respondents must provide Letters of Commitment on the Material Subcontractor's official company letterhead, signed by an official with the authority to bind the company for the subcontracted work. The Letter of Commitment must state, if applicable, the company's certified HUB status.
8. The business entity structure of the Material Subcontractor and the Affiliate. [For example, wholly-owned subsidiary of a publicly-traded corporation; wholly-owned subsidiary of a private (closely-held) stock corporation; subsidiary or component of a non-profit foundation; subsidiary or component of a governmental entity such as a County Hospital District; independently-owned member of an alliance or cooperative network; joint venture (describe owners)] Indicate the name of the ultimate owner (e.g., the name of a publicly-traded corporation or a County Hospital District).

9. Indicate status (all that may apply): sole proprietor, partnership, corporation, for-profit, non-profit, privately owned, or listed on a stock exchange. If a Subsidiary or Affiliate, name of the direct and ultimate parent organization.
10. The name and address of any sponsoring corporation or others who provide financial support to the Material Subcontractor and the type of support, e.g., guarantees, letters of credit. Indicate if there are maximum limits of the additional financial support.
11. The name and address of any health professional that has at least a 5% financial interest in the Material Subcontractor and the type of financial interest.
12. The state in which the Material Subcontractor is incorporated, commercially domiciled, and the states in which the organization is licensed to do business.
13. The Material Subcontractor's federal taxpayer identification number.
14. Whether the Material Subcontractor had a managed care contract terminated or not renewed for any reason within the past five years. In such instance, the Respondent must describe the issues, the parties involved, and provide the address and telephone number of the principal terminating party. The Respondent must also describe any corrective action taken to prevent any future occurrence of the problem that may have led to the termination.
15. Whether the Material Subcontractor has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation or certification status, and if it has or is, indicate:
 - its current NCQA or URAC accreditation or certification status;
 - if NCQA or URAC accredited or certified, its accreditation or certification term effective dates; and
 - if not accredited, a statement describing whether and when NCQA or URAC accreditation status was ever denied the Material Subcontractor.
16. The website address (URL) for the homepage of any website operated, owned, or controlled by the Material Subcontractor, including any websites run by another entity on the Material Subcontractor's behalf. If the Material Subcontractor has a parent, then also provide the same for the parent organization, and any parent of the parent organization. If none exist, provide a clear and definitive statement to this effect.

4.2.5 Section 5 – Historically Underutilized Business (HUB) Participation

In accordance with [Texas Government Code § 2161.252](#), a proposal that does not contain a HUB Subcontracting Plan (HSP) is non-responsive and will be rejected

without further evaluation. In addition, if HHSC determines that the HSP was not developed in good faith, it will reject the proposal for failing to comply with material RFP specifications. Please see the Procurement Library for the HSP Template.

4.2.5.1 Introduction

HHSC is committed to promoting full and equal business opportunities for businesses in state contracting in accordance with the goals specified in the State of Texas Disparity Study. HHSC encourages the use of Historically Underutilized Businesses (HUBs) through race, ethnic and gender-neutral means. HHSC has adopted administrative rules relating to HUBs, and a [Policy on the Utilization of HUBs](#), which is located on HHSC's website.

Pursuant to [Texas Government Code § 2161.181](#) and [§ 2161.182](#), and HHSC's HUB policy and rules, HHSC is required to make a good faith effort to increase HUB participation in its contracts. HHSC may accomplish the goal of increased HUB participation by contracting directly with HUBs or indirectly through subcontracting opportunities.

4.2.5.2 HHSC's Administrative Rules

HHSC has adopted the Comptroller of Public Accounts' (CPA) HUB rules as its own. HHSC's rules are located in [15 Tex. Admin. Code Ch. 392, Subchapter J](#) of the Texas Administrative Code, and the CPA rules are located in [34 Tex. Admin. Code Ch. 20, Subchapter B](#). If there are any discrepancies between HHSC's administrative rules and this RFP, the rules will take priority.

4.2.5.3 HUB Participation Goal

The CPA has established statewide annual HUB utilization goals for different categories of contracts in [34 Tex. Admin. Code § 20.13](#) of the HUB Rules. In order to meet or exceed the statewide annual HUB utilization goals, HHSC encourages outreach to certified HUBs. Contractors must make a good faith effort to include certified HUBs in the procurement process.

This contract is classified as an "**All Other Services**" contract under the CPA rule, and therefore has a statewide annual HUB utilization goal of **24.6%** per fiscal year. This goal applies to MCO Administrative Services, as defined below.

4.2.5.4 Required HUB Subcontracting Plan

In accordance with Texas Government Code, Chapter 2161, Subchapter F, each state agency that considers entering into a contract with an expected value of \$100,000 or more over the life of the contract (including any renewals) shall, before the agency

solicits bids, proposals, offers, or other applicable expressions of interest, determine whether subcontracting opportunities are probable under the contract.

In accordance with [34 Tex. Admin. Code § 20.14\(a\) \(1\) \(C\)](#) of the HUB Rule, state agencies may determine that subcontracting is probable for only a subset of the work expected to be performed or the funds to be expended under the contract. If an agency determines that subcontracting is probable on only a portion of a contract, it shall document its reasons in writing for the procurement file.

HHSC has determined that subcontracting opportunities are probable for this RFP for MCO Administrative Services. MCO Administrative Services are those services or functions other than the direct delivery of medical Covered Services necessary to manage the delivery of and payment for such services. MCO Administrative Services include Network, utilization, clinical or quality management, service authorization, claims processing, Management Information System (MIS) operation, and reporting. The Respondent must submit an HSP (see the **Procurement Library**) with its proposal for these MCO Administrative Services. The HSP is required whether a Respondent intends to subcontract or not.

HSP requirements will not apply to subcontracts with Network Providers (providers who contract directly with the MCO to deliver medical Covered Services to STAR Kids). A Respondent therefore should not include Network Providers' participation in its HSP submissions.

In the HSP, a Respondent must indicate whether it is a Texas-certified HUB. Being a certified HUB does not exempt a respondent from completing the HSP requirement.

HHSC will review the documentation submitted by the respondent to determine if a good faith effort has been made in accordance with solicitation and HSP requirements. During the good faith effort evaluation, HHSC may, at its discretion, allow revisions necessary to clarify and enhance information submitted in the original HSP.

If HHSC determines that the respondent's HSP was not developed in good faith, the HSP will be considered non-responsive and will be rejected as a material failure to comply with advertised specifications. The reasons for rejection will be recorded in the procurement file.

4.2.5.5 CPA Centralized Master Bidders List

Respondents may search for HUB subcontractors in the CPA's Centralized Master Bidders List (CMBL) HUB Directory, which is located on the CPA's website at <http://www2.cpa.state.tx.us/cmb/cmbhub.html>. For this procurement, HHSC has identified the following class and item codes for potential subcontracting opportunities.

NIGP Class/Item Code:

- 948-07: Administration Services, Health;
- 958-56: Health Care Management Services (Including Managed Care Services); and
- 915-49: High Volume, Telephone Call Answering Services (See 915-05 for Low Volume Services)

Respondents are not required to use, nor limited to using, the class and item codes identified above, and may identify other areas for subcontracting.

HHSC does not endorse, recommend, or attest to the capabilities of any company or individual listed on the CPA's CMBL. The list of certified HUBs is subject to change, so Respondents are encouraged to refer to the CMBL often to find the most current listing of HUBs.

4.2.5.6 HUB Subcontracting Procedures – If a Respondent Intends to Subcontract

An HSP must demonstrate that the Respondent made a good faith effort to comply with HHSC's HUB policies and procedures. The following subparts outline the items that HHSC will review in determining whether an HSP meets the good faith effort standard. A Respondent that intends to subcontract must complete the HSP to document its good faith efforts.

4.2.5.6.1 Identify Subcontracting Areas and Divide Them into Reasonable Lots

A Respondent should first identify each area of the contract MCO Administrative Service work it intends to subcontract. Then, to maximize HUB participation, it should divide the contract MCO Administrative Service work into reasonable lots or portions, to the extent consistent with prudent industry practices.

4.2.5.6.2 Notify Potential HUB Subcontractors

The HSP must demonstrate that the respondent made a good faith effort to subcontract with HUBs. The Respondent's good faith efforts will be shown through utilization of all methods in conformance with the development and submission of the HSP and by complying with the following steps:

1. Divide the contract work into reasonable lots or portions to the extent consistent with prudent industry practices. The Respondent must determine which portions of work, including goods and services, will be subcontracted.
2. Use the appropriate method(s) to demonstrate good faith effort. The respondent can use method(s) 1, 2, 3, or 4:

Method 1: Respondent Intends to Subcontract with only HUBs:

The respondent must identify in the HSP the HUBs that will be utilized and submit written documentation that confirms 100% of all available subcontracting opportunities will be performed by one or more HUBs; or,

Method 2: Respondent Intends to Subcontract with HUB Protégé(s):

The respondent must identify in the HSP the HUB protégé(s) that will be utilized and should:

- Include a fully executed copy of the Mentor Protégé Agreement, which must be registered with the CPA prior to submission to HHSC; and
- Identify areas of the HSP that the protégé will perform.

HHSC will accept a Mentor Protégé Agreement that has been entered into by a respondent (mentor) and a certified HUB (protégé) in accordance with [Texas Government Code §2161.065](#). When a respondent proposes to subcontract with a protégé(s), it does not need to provide notice to 3 HUB vendors for that subcontracted area.

Participation in the Mentor Protégé Program, along with the submission of a protégé as a subcontractor in an HSP, constitutes a good faith effort for the particular area subcontracted to the protégé; or,

Method 3: Respondent Intends to Subcontract with HUBs and Non-HUBs (Meet or Exceed the Goal):

The Respondent must identify in the HSP and submit written documentation that one or more HUB subcontractors will be utilized; and that the aggregate expected percentage of subcontracts with HUBs will meet or exceed the goal specified in this solicitation. When utilizing this method, only HUB subcontractors with existing contracts with the Respondent for five years or less may be used to comply with the good faith effort requirements.

When the aggregate expected percentage of subcontracts with HUBs meets or exceeds the goal specified in this solicitation, respondents may also use non-HUB subcontractors; or,

Method 4: Respondent Intends to Subcontract with HUBs and Non-HUBs (Does Not Meet or Exceed the Goal):

The Respondent must identify in the HSP and submit documentation regarding both of the following requirements:

- written notification to minority or women trade organizations or development centers to assist in identifying potential HUBs of the subcontracting opportunities the respondent intends to subcontract.

Respondents must give minority or women trade organizations or development centers at least seven business days prior to submission of the Respondent's response for dissemination of the subcontracting opportunities to their members. A list of minority and women trade organizations is located on HHSC's website under the [Minority and Women Organization](#) link.

- written notification to at least three HUB businesses of the subcontracting opportunities that the Respondent intends to subcontract. The written notice must be sent to potential HUB subcontractors prior to submitting proposals and must include:
 - a description of the scope of work to be subcontracted;
 - information regarding the location to review project plans or specifications;
 - information about bonding and insurance requirements;
 - required qualifications and other contract requirements; and
 - a description of how the subcontractor can contact the respondent.

Respondents must give potential HUB subcontractors a reasonable amount of time to respond to the notice, at least seven business days prior to submission of the respondent's response unless circumstances require a different time period, which is determined by the agency and documented in the contract file.

Respondents must also use the CMBL, the HUB Directory, and Internet resources when searching for HUB subcontractors. Respondents may rely on the services of contractor groups; local, state, and federal business assistance offices; and other organizations that provide assistance in identifying qualified applicants for the HUB program.

4.2.5.6.3 Written Justification of the Selection Process

HHSC will make a determination if a good faith effort was made by the respondent in the development of the required HSP. One or more of the methods identified in the previous sections may be applicable to the respondent's good faith efforts in developing and submission of the HSP. HHSC may require the respondent to submit additional documentation explaining how the respondent made a good faith effort in accordance with the solicitation.

A Respondent must provide written justification of its selection process if it chooses a non-HUB subcontractor. The justification should demonstrate that the respondent

negotiated in good faith with qualified HUB bidders, and did not reject qualified HUBs who were the best value responsive bidders.

4.2.5.7 HUB Subcontracting Procedures – If a Respondent Does Not Intend to Subcontract

If the Respondent plans to complete all contract MCO Administrative Service requirements with its own equipment, supplies, materials, or employees, it is still required to complete an HSP.

The Respondent must complete the “Self Performance Justification” portion of the HSP, and attest that it does not intend to subcontract for any administrative goods or services, including the class and item codes identified in **Section 4.2.5.5**. In addition, the Respondent must identify the sections of the proposal that describe how it will complete the Scope of Work using its own resources or provide a statement explaining how it will complete the Scope of Work using its own resources. The Respondent must agree to comply with the following if requested by HHSC:

1. Provide evidence of sufficient respondent staffing to meet the RFP requirements;
2. Provide monthly payroll records showing the respondent staff fully dedicated to the contract;
3. Allow HHSC to conduct an on-site review of company headquarters or work site where services are to be performed; and
4. Provide documentation proving employment of qualified personnel holding the necessary licenses and certificates required to perform the Scope of Work.

4.2.5.8 Post-award HSP Requirements

The HSP will be reviewed and evaluated prior to contract award and, if accepted, the finalized HSP will become part of the contract with the successful respondent(s).

After contract award, HHSC will coordinate a post-award meeting with the successful Respondents to discuss HSP reporting requirements. The MCO must maintain business records documenting compliance with the HSP, and must submit monthly reports to HHSC by completing the HUB “[Prime Contractor Progress Assessment Report](#).” This monthly report is required as a condition for payment and tells the agency the identity and the amount paid to all subcontractors.

As a condition of award the Contractor is required to send notification to all selected subcontractors as identified in the accepted/approved HSP. In addition, a copy of the notification must be provided to the agency’s Contract Manager or HUB Program Office within 10 days of the contract award.

During the term of the contract, if the parties in the contract amend the contract to include a change to the scope of work or add additional funding, HHSC will evaluate to determine the probability of additional subcontracting opportunities. When applicable, the Contractor must submit an HSP change request for HHSC review. The requirements for an HSP change request will be covered in the post-award meeting.

The [UMCM](#) outlines the procedures for changing the HSP, as well as the HSP compliance and reporting requirements. When making a change to an HSP, the Contractor will obtain prior written approval from HHSC before making any changes to the HSP. Proposed changes must comply with the HUB Program good faith effort requirements relating to the development and submission of the HSP.

If the MCO decides to subcontract any part of the contract after the award, it must follow the good faith effort procedures outlined in **Section 4.2.5.6** (e.g., divide work into reasonable lots, notify at least three vendors per subcontracted area, provide written justification of the selection process, or participate in the Mentor Protégé Program).

For this reason, HHSC encourages Respondents to identify, as part of their HSP, multiple subcontractors who are able to perform the work in each area the Respondent plans to subcontract. Selecting additional subcontractors may help the selected MCO make changes to its original HSP, when needed, and will allow HHSC to approve any necessary changes expeditiously.

Failure to meet the HSP and post-award requirements will constitute a breach of contract, and will be subject to remedial actions. HHSC may also report noncompliance to the CPA in accordance with the provisions of the Vendor Performance and Debarment Program (see [34 Tex. Admin. Code § 20.108](#) and [34 Tex. Admin. Code § 20.105](#)).

4.2.6 Section 6 – Certifications and Other Required Forms

Respondents must submit the following required forms with their proposals:

1. Child Support Certification;
2. Debarment, Suspension, Ineligibility, and Voluntary Exclusion of Covered Contracts;
3. Federal Lobbying Certification;
4. Nondisclosure Statement;
5. Required Certifications; and
6. Respondent Information and Disclosures.
7. Anti-Trust Certification

The required forms are located on HHSC's website, under the "Business Opportunities" link. HHSC encourages Respondents to carefully review all of these forms and submit

questions regarding their completion prior to the deadline for submitting questions (see **Section 1.3**).

Respondents should note that the “[Respondent Information and Disclosures](#)” form asks Respondents to provide information on certain litigation matters. In addition to the information required on this form, Respondents must provide all of the information described in **UMCM** Chapter 5.8, “[Report of Legal and Other Proceedings and Related Events](#).” Respondents may include this supplemental information on the “Respondent Information and Disclosures” form, or under a separate submission.

4.3 Part 3 – Programmatic Proposal

Respondents must provide a detailed description of the proposed programmatic solution, which must support all business activities and requirements described in the RFP. The Programmatic Proposal must reflect a clear understanding of the nature of the work undertaken.

Respondents should carefully read the submission requirement instructions for specific questions in this section. For each applicable programmatic submission requirement, the Respondent must indicate, in addition to the information requested in each subsection, the following information if applicable to the Respondent and its Proposal:

Material Subcontractor: If the Respondent plans to provide the service or perform the function through a Material Subcontractor, the Respondent must detail the services or function to be subcontracted, and how the Respondent and the Material Subcontractor will coordinate the service or function. Describe the specific management tools and strategies the Respondent will use to provide oversight of the Material Subcontractor’s performance. Respondents should describe any prior working relationships with the Material Subcontractor.

Action Plan: This requirement applies to any Respondent who is not currently (1) providing services or performing functions relating to a specific RFP submission, or (2) meeting the Operations Phase Requirements in **Section 8** relating to a specific submission requirement for the STAR Kids Program. In the Action Plan, the Respondent must, for each submission requirement describe: (1) the services, functions, or requirements the Respondent is not currently performing, (2) its current comparable experience and abilities, if any, and (3) how the Respondent must meet the HHSC MCO Contract responsibilities, including assigned staffing and resources for completing the services, functions, or requirements and a timeline for completing each.

In responding to questions for which the Respondent includes information about a Material Subcontractor or Action Plans, up to one page may be used to describe each

Material Subcontractor arrangement and up to one page may be used to describe each Action Plan. These pages are outside of the page limit instructions for the specific submission requirement.

HHSC understands that some Respondents may not have current experience providing managed care services to STAR Kids Target Population. In responding to questions relating to experience, Respondents should clearly indicate if their experience is in Texas, and if their experience is with STAR+PLUS, STAR, STAR Health, or other comparable populations of managed care members.

The Programmatic Proposal must include a detailed description of the following program components, at a minimum:

- Section 1 – Service Area and Capacity
- Section 2 – Experience Providing Covered Services
- Section 3 – Value-added and Case-by-Case Added Services
- Section 4 – Access to Care
- Section 5 – Provider Network Provisions
- Section 6 – Member Services
- Section 7 – Quality Assurance and Performance Improvement
- Section 8 – Utilization Management
- Section 9 – Early Childhood Intervention (ECI)
- Section 10 – Flexible and Tailored Services
- Section 11 – Service Coordination
- Section 12 – Adult Transition Planning
- Section 13 – Texas Promoting Independence Initiative
- Section 14 – STAR Kids Screening and Assessment Process
- Section 15 – Comprehensive Care Program Community-Based Services
- Section 16 – Primary Care Providers and the Health Home
- Section 17 – Disease Management (DM)
- Section 18 – Behavioral Health Services and Network
- Section 19 – Telemedicine, Telehealth, and Telemonitoring Access
- Section 20 - Pharmacy Services
- Section 21 - Management Information System (MIS) Requirements
- Section 22 - Fraud, Waste, and Abuse
- Section 23 - MCO Transition Plan
- Section 24 - Additional Requirements Regarding Dual Eligibles

4.3.1 Section 1 – Service Area and Capacity

(3 pages, excluding tables)

The Respondent must:

1. Complete the STAR Kids Service Area and Capacity table found in the **Procurement Library**, which must include for each proposed Service Area an estimate of the number of HHSC MCO Members the Respondent has the capacity to

serve on the Operational Start Date;

2. Describe the calculations and assumptions used to arrive at these Service Area and capacity projections. In developing these projections, the Respondent should consider the capacity of its Network, including its PCP Network, its Behavioral Health Services Network, its specialty care Network, its Pharmacy Network, and its Community-based Services Network. Respondents should specify:
 - a) the anticipated STAR Kids Program enrollment;
 - b) the expected utilization of services, taking into consideration the characteristics and healthcare needs of specific populations represented in the STAR Kids Program;
 - c) the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the Covered Services;
 - d) the numbers of Network Providers and providers with signed contracts, LOAs, or LOIs who are not accepting new patients, by MCO Program;
 - e) the geographic location of providers and HHSC MCO members, considering travel time, the means of transportation ordinarily used by HHSC MCO members, and whether the location provides physical access for members with disabilities; and
 - f) generally describe anticipated Service Area capacity changes, if any, for each of the proposed Service Areas over the Initial Contract Period; and
 - g) generally describe methods that the MCO will use to ensure access to all Covered Services upon potential population growth due to changes in law, including growth resulting from the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010.

4.3.2 Section 2 – Experience Providing Covered Services

(7 pages)

Covered Services are described in **Section 8.1.2**, **Section 8.1.36** and **Attachment B-2**.

The Respondent must briefly review the Respondent's experience providing services equivalent or comparable to STAR Kids Covered Services described in **Attachment B-2**:

1. Indicate which STAR Kids Covered Service(s) (in whole or in part) the Respondent has and does not have experience providing to a comparable population.
2. Briefly describe the Respondent's proposal for providing Covered Services, including any plans for expansions of its Provider Network prior to a Readiness Review. If the Respondent proposes to use a Material Subcontractor to provide Covered Services,

the Respondent must describe its relationship with the Material Subcontractor, as required by **Section 4.2.4**.

3. Describe the Respondent's experience in using Service Coordination for the STAR Kids population or a comparable population to coordinate non-capitated services and community resources. If the Respondent does not have experience coordinating these services, indicate how the Respondent intends to meet this requirement.
4. Describe the Respondent's experience in providing Medicaid wrap-around services for Dual Eligibles entitled to these benefits. If the Respondent does not have experience in providing these services, indicate how the Respondent intends to meet this requirement.
5. Describe the Respondent's experience in providing Service Coordination for Dual Eligibles. Respondent should specifically describe the processes and procedures used to coordinate Medicare services with Medicaid Community-based Services and related services. If the Respondent does not have experience coordinating these services, indicate how the Respondent intends to meet this requirement.
6. Describe the Respondent's experience in providing Service Coordination for Medicaid Members with Third-Party Insurance from Medicare or a private health insurance carrier. Respondent should specifically describe the processes and procedures used to coordinate Third-Party Insurance, non-covered services and Medicaid Covered Services. If the Respondent does not have experience coordinating these services, indicate how the Respondent intends to meet this requirement.
7. Describe the Respondent's experience providing Covered Services in coordination with non-capitated HCBS waiver services.

4.3.3 Section 3 – Value-added and Case-by-Case Added Services (1 page per Value-added Service)

Respondents may propose to offer Value-added Services as described in **Section 8.1.2.3**. If offered, the Respondent will not receive additional compensation for Value-added Services, and may not report the costs of Value-added Services as allowable medical or administrative costs. The Respondent may propose different Value-added Services for each Service Area bid.

For each MCO Program and Value-added Service proposed, the Respondent must:

1. define and describe the Value-added Service and how it will benefit children and young adults with special healthcare needs;
2. specify the applicable Service Areas for the proposed Value-added Services;
3. describe how a Member may obtain or access the Value-added Service;

4. identify the category or group of Members eligible to receive the proposed Value-added Services if it is a type of service that is not appropriate for all Members;
5. if the Value-added Service is not a healthcare service or benefit, specify which staff will determine whether a Member is eligible to receive the Value-added Service;
6. note any limitations or restrictions that apply to the Value-added Services;
7. for each proposed Service Area, identify the types of Providers responsible for providing the Value-added Service, including any limitations on Provider capacity if applicable;
8. propose how and when Providers and Members will be notified about the availability of Value-added Services;
9. include a statement that the Respondent will provide any Value-added Service(s) that are approved by HHSC for at least 12 months after the Operational Start Date of the Contract; and
10. describe if, and how, the Respondent will identify the Value-added Service in administrative data (Encounter Data).

4.3.3.1 Case-by-Case Added Services

(1 page per Service)

Respondents must briefly describe any Case-by-Case Added Services which the Respondent proposes satisfy requirements described in **Section 8.1.2.4**. Describe an example in which such a service might be offered to the Member.

4.3.4 Section 4 – Access to Care

Access to Care standards are described in **Section 8.1.3**.

4.3.4.1 Travel Distances

(No page limit, should only submit applicable tables)

For each proposed Service Area, submit tables created using **UMCM Chapter 5.14.2** “STAR Kids Geo-Mapping Report” found in the Procurement Library and maps created using GeoAccess, or a comparable software program, to demonstrate the geographic adequacy of the Respondent’s proposed Provider Network compared to the projected population in each proposed Service Area. For purposes of Geo Mapping, the distribution method will be to place all members at the center of the county. If the software used does not support this methodology, describe the assumptions and approach used to determine the information reported in the “STAR Kids Geo-Mapping Report”.

Providers in the demonstrated Provider Network must have an executed contract with the Respondent, a letter of intent (LOI), or a letter of agreement (LOA) indicating the provider intends to contract with the Respondent if HHSC awards the Respondent a MCO Contract. Respondents do not need to submit the signed contracts, LOIs, or LOAs with the Proposal, but HHSC may request to review these documents during its evaluation of the Proposal. Providers who have not signed a Network Provider contract or LOI/LOAs may **not** be included in the Respondent's Network for purposes of responding to this RFP submission requirement.

Respondents should submit 1 set of the above tables and maps for each Service Area bid.

4.3.4.2 Assessing Access to Care

(10 pages)

1. Identify the processes by which the Respondent must measure and regularly verify:
 - a. Network compliance, including pharmacy, regarding travel distance access in **Section 8.1.3.2**;
 - b. Provider compliance regarding appointment access standards in **Section 8.1.3.1**, and
 - c. Compliance with after-hours coverage standards in **Section 8.1.3**.
2. Describe actions the Respondent will take if they are notified or become aware of inappropriate wait times before a Member is seen by a Provider.
3. Describe the steps the Respondent has taken in the past when it identified a deficiency in its compliance with plan or state travel distance access standards. The description should include how the Respondent will address deficiencies in the Network related to:
 - a. The lack of an age-appropriate PCP with an Open Panel within the required travel distance;
 - b. The lack of inpatient Behavioral Health Services within the required travel distance;
 - c. The lack of outpatient Behavioral Health Services from Providers, including child psychiatrists, within the required travel distance;
 - d. The lack of appropriate specialist with sufficient knowledge and training to treat the Member's diagnosis;
 - e. For female Members of childbearing age, the lack of an OB/GYN within the travel distance of the Member's residence; and
 - f. The lack of a Network pharmacy within the travel distance of the Member's residence.
4. Describe the steps the Respondent has taken in the past when it identified a deficiency in its compliance with:
 - a. A Provider that was not meeting plan or state appointment access standards; and

- b. A PCP that was not in compliance with the plan or state after-hours coverage requirements.

If the Respondent has not taken the steps listed in 3 and 4 above with regularity, describe how it proposes to take those steps in the future.

5. Describe the processes the Respondent will implement to accommodate additional Members and to ensure the access standards are met if actual enrollment exceeds projected enrollment;
6. Describe how the Respondent will provide training to ensure the Providers understand and respond to the STAR Kids population's physical and Behavioral Health needs;
7. Describe how the Respondent plans to provide Behavioral Health Emergency Services described in **Section 8.1.16.8** including emergency screening services, Emergency Services and short-term crisis stabilization services, and how the Respondent will address a Provider not meeting the Respondent's or state's appointment standards; and
8. Describe how the Respondent plans to address deficiencies in the availability of appropriately credentialed providers to provide Community-Based Services.

4.3.5 Section 5 – Provider Network Provisions

(3 pages)

Provider Network requirements are primarily described in **Section 8.1.4**. In addition, the Significant Traditional Provider (STP) requirements applicable to Medicaid MCOs are described in **Sections 8.1.25**. Respondents should review these RFP requirements when developing their responses to questions in this section.

The Respondent must provide a narrative overview in its proposal of the Respondent's Network. This narrative must include a description of the deficiencies in the Respondent's proposed Provider Network and a description of how the Respondent's Network addresses the needs of the STAR Kids population.

The Respondent must provide a Provider Network Development Plan in its proposal that details how the Respondent will address any Provider Network deficiencies before the Operational Start Date. The Respondent should describe the items below as part of the Provider Network Development Plan:

1. Timeframes for addressing deficiencies.
2. Types of providers that the Respondent will recruit, including STPs.
3. How the Respondent will recruit the providers, including STPs.
4. Who will be responsible for recruiting the providers.
5. How the Respondent will determine that the Provider Network is complete.

After the Contract Effective Date, the MCO must provide updates to the Provider Network Development Plan on a fixed schedule as determined by HHSC.

4.3.5.1 Provider Network

(1 page, excluding Provider listing and tables)

Network Providers must have an executed contract with the Respondent, a letter of intent (LOI) or a letter of agreement (LOA) indicating the Provider intends to contract with the Respondent should HHSC award the Respondent a contract for the applicable MCO Program. Network Providers must be licensed in the State of Texas to provide the contracted Covered Services. As described in **Section 8.1.4** Network Providers must be credentialed by selected Respondents prior to serving Members. Sample LOI/LOA agreements and sample Network Providers tables can be found in the **Procurement Library**.

1. For each Service Area in which the Respondent proposes to participate, the Respondent must submit a complete list of proposed Network Providers for each of the following provider types that would be responsible for providing Covered Services. The list must indicate for each provider type, the name, address, and NPI and TPIN, if applicable, of the Providers with signed contracts, LOIs, or LOAs. The Respondent must include in an Excel file at least the two nearest Providers meeting each of the following provider type descriptions. The Respondent must also include in the Excel file all Providers in the designated provider type within the Service Area. The list must include separate lists of each provider type in the order listed below and a separate worksheet for each proposed Service Area.

Acute Care Services

- a. Acute Care Hospitals, inpatient and outpatient services;
 - b. Hospitals providing Level 1 trauma care;
 - c. Hospitals providing Level 2 trauma care;
 - d. Hospitals designated as transplant centers;
 - e. Hospitals designated as Children's Hospitals by the CMS;
 - f. Other Hospitals with specialized pediatric services;
 - g. Psychiatric Hospitals providing mental health services, inpatient and outpatient;
 - h. Other facilities or clinics providing outpatient mental health services;
 - i. Hospitals providing substance abuse services, inpatient and outpatient; and
 - j. Other facilities or clinics providing outpatient substance abuse services.
2. For each Service Area in which the Respondent proposes to participate, identify a list of Community-based Service Providers with whom the Respondent has a signed contract, LOI, or LOA. These Providers should be listed by type, name, address, and

Department of Aging and Disability Services (DADS) contract number where applicable. Respondent should also list the array of Community-based Services each of these entities provides.

Community-based Services

- a. Personal Care Services (PCS);
 - b. Private Duty Nursing (PDN);
 - c. In-home skilled nursing care;
 - d. Adaptive aids
 - e. Durable medical equipment (DME) and medical supplies;
 - f. Assisted living and residential care services;
 - g. Emergency response services;
 - h. Supported Employment and Employment Assistance;
 - i. Minor home modifications;
 - j. Respite care;
 - k. Therapy – occupational;
 - l. Therapy – physical;
 - m. Therapy – speech or language pathology services;
 - n. Consumer-directed services;
 - o. Community Living Supports;
 - p. Family Supports;
 - q. Supportive Family-based Alternatives; and
 - r. Transition assistance services.
3. Identify the types of Providers the Respondent allows as PCPs for adults, PCPs for children, and outpatient Behavioral Health Service Providers. The Respondent must identify its contractual requirements for these Provider types and any exceptions. For example, Respondent should note under what circumstances, if any, an internist is allowed to serve as a PCP for children.

4.3.5.2 Significant Traditional Providers

(No page limit for STP tables, 1 page for narrative)

The STP requirements applicable to Medicaid MCOs are described in **Section 8.1.25**. HHSC-designated Medicaid Significant Traditional Providers (STPs) can be found in the Procurement Library. STPs also include Community-based Service Providers. For each STP provider type in the Respondent's proposed Service Area(s) complete the "STP Network Percentage Table" charts provided in the **Procurement Library**. The total number of STPs in each Service Area can be found in the Procurement Library by type of STP.

Respondent may provide a one-page narrative to explain STP status.

4.3.5.3 Provider Network Capacity

(5 pages)

HHSC has targeted continued access to existing Providers, improved Network capacity, and improved Member access to Covered Services as priorities for the Initial Contract Period.

1. Identify short-term and long-term strategies the Respondent will adopt to encourage participation among existing and new Providers;
2. Indicate which, if any, Covered Services are not available from a qualified Provider in the Respondent's proposed Network in each applicable Service Area and how the Respondent proposes to provide such Covered Services to Members in each proposed Service Area; and
3. Briefly describe how deficiencies will be addressed when the Provider Network is unable to provide a Member with appropriate access to Covered Services due to lack of a qualified, Network Providers within the travel distance of the Member's residence specified in **Section 8.1.3.2**. The description should include how the Respondent will address deficiencies in the Network related to:
 - a. the lack of a PCP with an Open-Panel within the required travel distance of the Member's residence;
 - b. the lack of a pediatric specialists and subspecialists within the travel distance of the Member's residence;
 - c. the lack of an OB/GYN within the travel distance of the Member's residence;
 - d. the lack of Hospitals with specialized children's services, Children's Hospitals or Special Hospitals within the travel distance of the Member's residence;
 - e. the lack of Psychiatric Hospitals within the travel distance of the Member's residence;
 - f. the lack of pediatric psychiatrists and Qualified Mental Health Professionals (QMHP) within the travel distance of the Member's residence; and
 - g. the lack of a Network pharmacy within the travel distance of the Member's residence.

4.3.5.4 Credentialing and Re-credentialing

(5 pages)

Provider credentialing and re-credentialing requirements are described in **Section 8.1.4.2**. For all of the following submission requirements the Respondent must provide a brief summary of its policies and procedures. Do not attach copies of the MCO's policies and procedures.

1. Describe the Respondent's minimum credentialing and licensure requirements and procedures for Providers of Acute Care by type of Provider, and demonstrate how the Respondent ensures, or proposes to ensure, that any Provider rendering Covered Services meets the minimum credentialing requirements. The description

must demonstrate compliance with **Section 8.1.4.2**. The Respondent should not attach relevant policies and procedures, but must summarize its policies and procedures within the page limit requirements.

2. Describe the re-credentialing process or process between re-credentialing cycles for Providers and how the Respondent will capture and assess the following information:
 - a. Member Pre-Appeals, Complaints and Appeals;
 - b. results from quality reviews and Provider quality profiling;
 - c. utilization management information; and
 - d. information from licensing and accreditation agencies.
3. Describe the Respondent's minimum credentialing and licensure requirements and procedures for Providers of Community-based Services by type of Provider, and how Respondent will ensure that any Provider rendering Covered Services meets the minimum credentialing and licensing requirements. Describe how the Respondent's credentialing process will ensure that Providers will meet the needs of a pediatric population. The Respondent should not attach relevant policies and procedures, but must summarize its policies and procedures within the page limit requirements.
4. A Respondent currently operating in Texas must separately report the following information. A Respondent not currently operating in Texas must separately report the same information for a managed care program it operates in another state similar to the STAR Kids Program or a similar program serving individuals under the age of 21 or with disabilities:
 - a. the percentage of providers in its Texas network re-credentialed in the past three years, for the following provider types: primary care physician, specialty care physician, and masters-level outpatient Behavioral Health Service providers; and
 - b. the number and percentage of providers in its Texas network who were subjected to the regularly scheduled re-credentialing process over the past 24 months that were denied continued network status.

4.3.5.5 Provider Manual, Materials, and Training

(4 pages)

Provider training requirements are described in **Section 8.1.4.4** and **Section 8.1.40.1**.

1. Outline the contents the Respondent intends to include in the Provider Manual.
2. Provide a brief description of proposed Provider training programs. Please distinguish between training programs for PCPs, other Acute Care, Behavioral Health and Community-based Services Providers. The description should include:

- a. the types of programs to be offered, including the modality of training;
 - b. what topics will be covered (such as billing, complaints and appeals, service coordination, health home, telemedicine and telehealth services);
 - c. how the Respondent will specifically train Providers on the requirements of the Contract and the unique needs of the STAR Kids population;
 - d. which Providers will be invited to attend in-person trainings;
 - e. how Provider training programs will be evaluated;
 - f. the frequency of Provider training;
 - g. how the Respondent proposes to maximize Provider participation in training programs, including how the Respondent proposes to use Internet and televideo capabilities to provide training;
 - h. how the Respondent will facilitate training programs for Providers to receive continuing education credits; and
 - i. how the Respondent will specifically train Providers to be attuned to the need for increased sensitivity and respect for confidentiality in dealing with the STAR Kids population.
3. Briefly describe two examples of recent Provider training programs conducted by the Respondent that may be relevant to the STAR Kids program. These examples must include:
- a. a description of the training program;
 - b. a summary of distributed materials (the actual materials are not to be submitted);
 - c. number and type of attendees; and
 - d. results of any evaluations from the training.

A Respondent currently participating in any of HHSC's Medicaid MCO Programs must submit the above Provider training examples for each such MCO Program.

A Respondent not currently participating in one or more of HHSC's Medicaid MCO Programs must submit the above provider training examples for a similar managed care program in another state. If the Respondent referenced a non-HHSC managed care program in another submission requirement, the Respondent must submit its provider education information in this submission requirement.

4.3.5.6 Provider Hotline

(3 pages; excluding hotline telephone reports)

Describe the proposed Provider Hotline function and how the Respondent would meet the requirements of **Section 8.1.4.5**. The description must include:

1. Normal hours of operation of the hotline;
2. Staffing for the hotline;
3. Training for the hotline staff on Covered Services and STAR Kids Program requirements;

4. The routing of calls among hotline staff to ensure timely and appropriate response to provider inquiries;
5. Responsibilities of hotline staff, if any, in addition to responding to HHSC Provider Hotline calls (e.g., responding to non-Network provider calls or HHSC Member Hotline calls);
6. After-hours procedures and available services;
7. Provider hotline telephone reports for the most recent four quarters with data that show:
 - a. the monthly call volume,
 - b. the monthly trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system), and
 - c. the monthly trends for the abandonment rate; and
8. Whether the Provider Hotline has the capability to administer automated surveys to callers at the end of calls.

A Respondent currently participating in any of HHSC's Medicaid MCO Programs must submit the information in Section 4.3.5.6(7) for each provider hotline operated, and identify any proposed changes to provider hotline functions that would occur under the STAR Kids Program.

A Respondent not currently participating in any of HHSC's Medicaid MCO Programs must submit the information in Section 4.3.5.6(7) for a similar managed care program that it operates in another state. If such a Respondent referenced a non-HHSC managed care program in another submission requirement, the Respondent must submit its provider hotline telephone report for the same managed care program.

4.3.5.7 Provider Incentives

(2 pages)

Provide a high-level description of the processes the Respondent will put in place to meet the requirements as described in **Section 8.1.4.6.2**, "MCO Value-Based Contracting (Expansion of Alternative Payment Structures for Providers)."

The Respondent must submit a plan with alternative payment structures to increase quality and efficiency through collaboration and innovation to improve access to comprehensive Health Homes. The plan should address methods for addressing the following goals:

1. Identified opportunities for shared savings;
2. Reductions in inappropriate utilization of services including inappropriate admissions and readmissions;
3. Mechanics by which the MCO will provide incentive payments to providers to improve quality of care;
4. Quality metrics that would be required for provider recruitment strategies, incentives, and shared savings; and

5. Strategies to increase availability of comprehensive Health Homes.

4.3.5.8 Clinical and Administrative Advisory Committees

(2 pages)

For requirements described in **Section 8.1.7.7**, the Respondent must:

1. Describe the role of the Clinical and Administrative Advisory Committee in establishing and monitoring clinical policies and procedures, and in developing and updating clinical practice guidelines.
2. Describe how the Respondent will outreach to a broad variety of Providers for the goal of including Acute Care, Community-based, Behavioral Health, therapies, DME and supplies, and pharmacy Providers in Clinical and Administrative Advisory Committee meetings.
3. Describe how the Respondent will encourage and provide an opportunity for its Providers to have access to peer-to-peer consultation and to consult with the MCO's physical health and Behavioral Health staff.

4.3.6 Section 6 – Member Services

4.3.6.1 Member Services Staffing

(5 pages; excluding organizational charts)

The MCO must maintain a Member Services Department to assist Members and Member's LAR in obtaining Covered Services as described in **Section 8.1.2**

1. Provide an organizational chart of the Member Services Department showing the placement of Member Services within the Respondent's organization and showing the key staff within the Member Services Department. Include a description for how Member services staff will interact with other departments or units within the Respondent's organization.
2. Explain the functions of the Member Services staff, including brief job descriptions and qualifications.
3. Describe the curriculum for training the MCO will provide to Member Services representatives, including when the training is conducted and how the training addresses:
 - a. Eligibility policy;
 - b. Access to Covered Services, including access to Texas Health Steps (THSteps) medical checkups and Behavioral Health Services and Community-based Services;
 - c. The STAR Kids Assessment Instrument and coordinating additional assessments and evaluations;
 - d. Understanding STAR Kids Program requirements;
 - e. Cultural Competency;

- f. Trauma-Informed Care;
 - g. Person-centered practices;
 - h. Providing assistance to Members with limited English proficiency, including developing Member Materials and providing language assistance to Members speaking languages of Major Population Groups making up 10 percent or more of the population;
 - i. The purpose and information included in the Individual Service Plan (ISP); and
 - j. Educating Members about Non-capitated Services and providing referrals to these services.
4. Identify the turnover rate for Member Services staff in the past two years. A Respondent operating any HHSC Medicaid MCO Program must provide the staff turnover rate of these Programs. A Respondent not currently operating an HHSC Medicaid MCO Program must provide its Member Services staff turnover rate for a comparable managed care program in another state and identify the managed care program.
 5. Identify the percentage of Member Services staff that will be physically located in the Service Area.
 6. Identify situations in which the Respondent will provide eligibility assistance to a Member.
 7. Explain plans to establish a STAR Kids Member website or mobile device application. Include example content that will be available on the website or application.

4.3.6.2 Nurse and Member Hotline

The Nurse and Member Hotline requirements are described in **Section 8.1.5.6**.

4.3.6.3 Nurse Hotline

(5 pages; excluding hotline telephone reports)

Describe the proposed Nurse Hotline function and how its purpose differs from the Member Hotline. Provide the following information on the Nurse Hotline:

1. normal hours of operation;
2. number of nurses designated to the STAR Kids Nurse Hotline, expressed in the number of full time employees (FTEs) per 1000 Members who are available 8:00 a.m. to 5:00 p.m., local time in all areas of the state, Monday through Friday, excluding state-approved holidays;
3. routing of calls to Nurse Hotline nurses, to ensure timely and accurate response to Member inquiries;

4. responsibilities of Nurse Hotline staff;
5. training for Nurse Hotline staff including responding to a behavioral health crisis;
6. after-hours procedures and available services, including those provided to non-English speaking Members and Members who are deaf or hard-of-hearing;
7. the number and percentage of FTE Nurse Hotline staff who are bilingual in English and Spanish;
8. the number and percentage of FTE Nurse Hotline staff who are multi-lingual for any additional language, by language spoken;
9. Nurse Hotline telephone reports for the most recent four quarters with data that show:
 - a. the monthly trends for call volume;
 - b. monthly trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system), and
 - c. monthly trends for the abandonment rate; and
10. whether the Nurse Hotline has the capability to administer automated surveys to callers at the end of calls.

A Respondent currently participating in any of HHSC's MCO Programs must submit the information in items 1 through 9 above for each Nurse Hotline operated, and identify any proposed changes to hotline functions for the STAR Kids Program.

If the Respondent is not currently participating in any of HHSC's MCO Programs, it should describe its experience and proposed approach in establishing and maintaining an accessible call center for members that is comparable to the Nurse Hotline described in **Section 8.1.5.6.1**. The description must include the information listed in items 1 to 9 above.

If a Respondent is proposes a single point of access, i.e., toll-free number, for multiple hotlines, e.g., Member Services, Behavioral Health, Nurse Hotline, and Provider Hotline, the Respondent must note in its proposal the differences in its staffing for each of these Hotlines, and must describe how calls to the Hotline(s) are triaged.

4.3.6.4 Nurse Hotline Scenarios

(6 pages)

Describe the procedures a Nurse Hotline representative will follow to deal with the following situations:

1. a Member or Member's LAR calls requesting advice regarding a missed medication dose;
2. a Member or Member's LAR is unable to reach her PCP after normal business hours;
3. a Member or Member's LAR is having difficulty filling a needed prescription after hours;

4. a Member or Member's LAR calls requesting an evaluation of whether or not to go to an Emergency Room for immediate care;
5. a Member is experiencing a Behavioral Health crisis;
6. a caregiver other than the Member's LAR calls to seek advice about a Member's medical situation; and
7. a Member or Member's LAR calls to report a problem or malfunction with critical adaptive equipment.

4.3.6.5 Member Hotline

(4 pages; excluding hotline telephone reports)

The Member Hotline requirements are described in **Section 8.1.5.6.2**.

Describe the proposed Member Hotline function, including:

1. Training for Member Services representatives to assure proficiency in the knowledge requirements established in **Section 8.1.5.6.2**;
2. Oversight of Member Services representatives including monitoring calls and customer satisfaction;
3. normal hours of operation;
4. number of Member Hotline staff dedicated to the STAR Kids Program, expressed in the number of full time employees (FTEs) per 1000 Members who are available 8:00 a.m. to 5:00 p.m., local time in all areas of the state, Monday through Friday, excluding state-approved holidays;
5. routing of calls among Member Hotline staff to ensure timely and accurate response to Member inquiries;
6. responsibilities of Member Hotline staff, if any, in addition to responding to STAR Kids Member Hotline calls, (e.g., responding to non-STAR Kids Member calls or Provider Hotline or Behavioral Health Hotline calls);
7. after-hours procedures and available services, including those provided to non-English speaking Members and Members who are deaf or hard-of-hearing;
8. the number and percentage of FTE Member Hotline staff who are bilingual in English and Spanish;
9. the number and percentage of FTE Member Hotline staff who are multi-lingual for any additional language, by language spoken;
10. If applicable, Member Hotline telephone reports for the most recent four quarters with data that show:
 - a. the monthly trends for call volume;
 - b. monthly trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system), and
 - c. monthly trends for the abandonment rate; and
 - d. whether the Member Hotline has the capability to administer automated surveys to callers at the end of calls.

A Respondent currently participating in any of HHSC's Medicaid MCO Programs must submit the information in items one through ten above for each Member Hotline operated, and identify any proposed changes to hotline functions for the STAR Kids Program.

If the Respondent is not currently participating in any of HHSC's Medicaid MCO Programs, it should describe its experience and proposed approach in establishing and maintaining an accessible call center for members that is comparable to the Member Hotline described in **Section 8.1.5.6.2**. The description must include the information listed in items one to ten above.

If a Respondent is proposing to use a single point of access, i.e., toll-free number, for multiple hotlines, e.g., Member Services, Behavioral Health, Nurse Hotline, and Provider Hotline, the Respondent must note in its proposal the differences, if any, in its staffing for each of these Hotlines, and must describe how calls to the Hotline(s) are triaged.

4.3.6.6 Member Service Scenarios

(10 pages)

Describe the procedures a Member Services representative will follow to handle these situations:

1. a Member or Member's LAR has received a bill for payment of Covered Services from a Network Provider and an Out-of-Network Provider;
2. a Member or Member's LAR is unable to reach her PCP after normal business hours;
3. a Member or Member's LAR is having difficulty scheduling an appointment for preventive care with her PCP;
4. a Member becomes ill while traveling outside of the state;
5. a Member or Member's LAR has a request for a specific medication that the pharmacy is unable to provide;
6. a Member or Caregiver does not speak English;
7. a Member is experiencing a behavioral health crisis;
8. a Caregiver or the Member's LAR calls after hours asking for assistance in managing the Member's acting out behavior;
9. a Member or the Member's LAR believes the Member is not receiving needed home and community-based services;
10. a Member or Member's LAR with a hearing impairment or another communicative disorder calls the Member Hotline and needs assistance;
11. a Member's PCP calls to report a suspicion that he/she is treating an adolescent with a substance abuse problem;
12. a Member or Member's LAR calls stating that the Member's current specialist is not meeting their needs;
13. a Member or Member's LAR requests a specialist Out-of-Network;

- 14. a request is made for a Member to receive applied behavior analysis therapy;
- 15. a Member or Member's LAR calls to complain that their Service Coordinator is not meeting their needs;
- 16. a Member or Member's LAR calls to complain that it is taking too long to be seen by a Specialist; and
- 17. a Member or Member's LAR calls requesting a review of their ISP or for a re-assessment.

4.3.6.7 Member Education

(5 pages)

Member education requirements are described in **Section 8.1.5.7**. Provide a description of Member education materials and other methods the Respondent will use to disseminate information to Members. The description must explain how the materials and methods will inform and educate Members and Member's LAR on each of the following topics:

1. How the STAR Kids MCO system operates including the role of the PCP, Health Home, ISP and Service Coordination;
2. The Member complaint, appeals and fair hearings process;
3. Covered Services, and limitations and any Value-added Services offered by the MCO; and
4. How to obtain Covered Services; and
5. Access to services delivered through the consumer directed services model.

The Respondent must also describe how Member Education will be personalized based on the different types of needs of Members.

4.3.6.8 Cultural Competency

(3 pages)

Provide a high-level description of the processes the Respondent will adopt to meet the requirements of the cultural competency requirements as described in **Section 8.1.5.8**, "Cultural Competency Plan."

1. Describe how the Respondent will ensure culturally competent services to people of all cultures, education levels, family composition, races, ethnic backgrounds, 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.
2. Describe how the Respondent will develop intervention strategies and work with Network Providers to avoid disparities in the delivery of healthcare to diverse populations.

4.3.6.9 Member Advisory Groups

(2 pages)

Provide a high-level description of the processes the Respondent will put in place to the meet the requirements as described in **Section 8.1.5.10**, “Member Advisory Groups.”

The Respondent must describe the process for implementing and maintaining the Member Advisory Groups including the identification and selection of participants and how the Respondent will ensure participation. The response must also include a description for how the Respondent will elevate concerns raised through the Member Advisory Group meetings to executive level staff and other decision-makers.

4.3.6.10 Continuity of Care

(4 pages)

Continuity of Care transition requirements for certain new Members with Out-of-Network providers are described **Section 8.1.23**. Requirements related to Conversation Plans for new STAR Kids Members are described in **Section 8.1.38.11**.

1. Describe the proposed Conversion Planning process for newly enrolled Members.
2. Describe how the Respondent will ensure continuity of prior authorized services when a Member transfers from the Fee-for-Service program to the STAR Kids program or from another Medicaid or CHIP MCO to the STAR Kids program. Also, describe how the Respondent will share information with the Fee-for-Service program or another Medicaid or CHIP MCO when the Member transfers out of the STAR Kids program. The Respondent’s description should include how the STAR Kids MCO will authorize the Member’s Out-of-Network providers to finish the treatment plan authorized by the Fee-for-Service program or another Medicaid or CHIP managed care organization.
3. Describe the proposed Conversion Plan for new Members whose current PCP, OB/GYN, specialty care, Behavioral Health, and Community-based Providers are not participants in the Respondent’s Provider Network.
4. Describe the MCO’s Provider recruitment process and timeframes (especially for recruiting STP providers) for outreaching to and enrolling Out-of-Network providers who have existing relationships with Members.
5. Describe the protocol the Respondent will follow to ensure services are not disrupted for Member’s receiving specialty services that were prior authorized previous to the Member’s enrollment with the MCO.
6. Describe how the Respondent will evaluate and make certain a change in Provider is appropriate for the Member’s unique healthcare needs.
7. Describe how the Respondent will identify and track new Members with high physical or behavioral health needs to assure continuity of care.
8. Describe how the Respondent will coordinate with other MCOs when a Member changes MCOs in order to ensure continuity of care. Include a description for how authorizations and data will be exchanged.

9. Describe how the Respondent will develop a plan to identify and reach out to Members with the most immediate service needs leading up and immediately after the Operational Start Date.

4.3.6.11 Objection to Providing Certain Services

(1 page)

In accordance with 42 C.F.R. § 438.102, the Respondent may file an objection to provide, reimburse for, or provide coverage of, counseling or referral service for a Covered Service based on moral or religious grounds, as described in **Section 8.1.24.7**. HHSC reserves the right to make downward adjustments to Capitation Rates for any Respondent that objects to providing certain services based on moral or religious grounds.

The Respondent must indicate objections, if any, to providing a Covered Service based on moral or religious grounds. Identify the specific services to which it objects and describe the basis for its objection.

4.3.6.12 Member Complaint and Appeal Processes

(4 pages, excluding flow chart)

Medicaid Member Complaint and Appeal Processes are described in **Section 8.1.5.9 and Section 8.1.29**. A Respondent's submission must reflect how it will meet the applicable Member Complaint and Appeal requirements. The submission must include details about automation that will be used to document, track and report on Complaints and Appeals. A Respondent should not submit detailed Complaint and Appeal policies and procedures as an attachment.

The Respondent must:

1. describe the process the Respondent will follow to review Member Complaints and Appeals, including which staff will be involved;
2. provide a flowchart that depicts the process the Respondent will follow to resolve Member complains, questions and appeals. The process must start from the receipt of a request and describe each phase of the review including notification of disposition. Include information on providing notice of access to HHSC Fair Hearings;
3. document the MCO's average time for resolution over the past twelve months for Member Complaints and Appeals (excluding expedited appeals), from date of receipt to date of notification of disposition;
4. describe the number and job descriptions of Member Advocates, how Members are informed of the availability of Member Advocates, and how Members access Advocates;

5. describe how and if named Service Coordinators will be involved in the complaint resolution process; and
6. describe any additional measures that will be used to assure transparency for all Complaints and Appeals.

4.3.6.13 Marketing Activities and Prohibited Practices

(no page limit)

If the Respondent has been sanctioned or placed under corrective action for prohibited Marketing practices related to managed care products by CMS, Texas, or by another state:

1. describe the basis for each sanction or corrective action, and;
2. explain how the Respondent would ensure that it would not commit any practices prohibited by CMS or HHSC in its Marketing activities.

The Respondent must report whether it has been sanctioned or been placed under corrective action by the federal government, Texas, or any other state in the past three years as part of its Business Specifications submission.

4.3.6.14 This Section Intentionally Left Blank

4.3.7 Section 7 – Quality Assurance and Performance Improvement

The Quality Assurance and Performance Improvement (QAPI) requirements of the RFP are described in **Section 8.1.7.1**.

4.3.7.1 Clinical Initiatives

(4 pages, excluding QA plan)

1. Describe data-driven clinical initiatives that the Respondent initiated within the past 24 months that have yielded improvement in clinical care for a managed care population comparable to the STAR Kids population.
2. Document two statistically significant improvements generated by the Respondent's clinical initiatives.
3. Describe challenges associated with establishing quality metrics and measuring outcomes for children and young adults with Complex Conditions and how the Respondent will tailor their QAPI Plan based on the individual traits of the STAR Kids population.
4. Describe two new or ongoing clinical initiatives that the Respondent proposes to pursue in the first year of the Contract. Document why each topic warrants Quality Improvement investment, and describe the Respondent's measurable goals for the initiative.

5. For Respondents that already participate in an HHSC MCO Program, provide a copy of the most recent QAPI Plan. For Respondents that do not participate in an HHSC MCO Program, provide a copy of a 2013 quality assurance plan that the Respondent developed for a Medicaid population, or if a Respondent did not operate a Medicaid managed care plan in 2013, the most recent quality assurance plan for a program operated by the Respondent and serving a population with similarities to the STAR Kids population, such as a CHIP plan.

4.3.7.2 Healthcare Effectiveness Data and Information Set (HEDIS) and Other Quality Data

(4 pages)

HHSC's External Quality Review Organization (EQRO) will perform HEDIS and Consumer Assessment of Health Plans Survey (CAHPS) calculations required by HHSC for MCO management. The following questions solicit information on a Respondent's proposed approach to generating its own clinical indicator information to identify and address opportunities for improvement, as well as the Respondent's approach to acting on clinical indicator data reported by HHSC's EQRO.

The Respondent must:

1. identify the MCO-level HEDIS and any other statistical clinical indicator measures the Respondent will generate to identify MCO opportunities for clinical quality improvement;
2. describe the challenges associated with using traditional measures like HEDIS for children and adolescents with special healthcare needs and what other types of measures the Respondent will use to gauge and measure quality for STAR Kids;
3. document examples of statistical clinical indicator measures previously generated by the Respondent within the last two years for the STAR Kids population or a managed care population comparable to the STAR Kids population;
4. describe efforts that the Respondent has made to assess Member satisfaction within the last two years for a managed care population comparable to the STAR Kids population and Member satisfaction methodologies the Respondent will collect for STAR Kids; and
5. describe management interventions implemented within the last two years based on member satisfaction measurement findings for the STAR Kids population or a managed care population comparable to the STAR Kids population, and whether these interventions resulted in measurable improvements in later member satisfaction findings.

4.3.7.3 Clinical Practice Guidelines

(2 pages)

Through strategic partnerships between HHSC, STAR Kids MCOs, and medical professionals, HHSC encourages increased adoption of evidence-based clinical practice guidelines.

1. Describe a clinical guideline that is relevant to the STAR Kids populations and that the Respondent believes requires improved adherence.
2. Describe what steps the Respondent will take to increase compliance with the clinical guideline noted in its response to number 1, including the roles of HHSC, the Respondent, and medical professionals.
3. Provide a general description of the Respondent's process for developing and updating clinical guidelines, and for disseminating them to participating Providers and Members.
4. Describe at least two tactics the Respondent will implement to assure Provider compliance with clinical practice guidelines.
5. Describe what steps the MCO will take to align clinical practice guidelines with other MCOs for the purpose of requiring Providers to adopt conflicting guidelines from different Medicaid MCOs.

4.3.7.4 Provider Profiling

(2 pages, excluding sample profile reports)

1. Describe the Respondent's practice of profiling the quality of care delivered by Network PCPs, and any other Acute Care Providers (e.g., high volume specialists, Hospitals), including the methodology for determining which and how many Providers will be profiled.
2. Submit sample quality profile reports used by the Respondent, or proposed for future use (identify which).
3. Describe the rationale for selecting the performance measures presented in the sample profile reports.
4. Describe the proposed frequency with which the Respondent will distribute the reports to Network Providers, and identify which Providers will receive the profile reports.

4.3.7.5 Network Management and Pay-for-Quality

(5 pages)

1. Describe how the Respondent will actively work with Network Providers to ensure accountability and improvement in the quality of care provided by the Providers. The description should include:
 - a. the steps the Respondent will take with each profiled Provider following the production of each profile report, including a description of how the

- Respondent will motivate and facilitate improvement in the performance of each profiled Provider;
- b. the process and timeline the Respondent proposes for periodically assessing Provider progress on its implementation of strategies to attain improvement goals;
 - c. how the Respondent will reward Providers who demonstrate continued excellence or significant performance improvement over time, through non-financial or financial means, including pay-for-performance;
 - d. how the Respondent will share “best practice” methods or programs with Providers of similar programs in its Network;
 - e. how the Respondent will take action with Providers who demonstrate continued unacceptable performance and performance that does not improve over time;
 - f. the steps the Respondent will take with a Provider that specifically is not meeting HHSC contractual access standards; and
 - g. the extent to which the Respondent currently operates a Network management program consistent with HHSC requirements in **Section 8.1.7.8**, and measurable results it has achieved from those Network management efforts.
 - h. strategies the MCO will adopt to simplify administrative procedures for Providers.
2. Based on pay-for-quality requirements in **Section 8.1.7.11** identify the Respondent's strategy for reducing potentially preventable events (PPEs); rewarding evidence-based practices; and promoting healthcare coordination in compliance with the P4Q program.

4.3.8 Section 8 – Utilization Management (6 pages)

Utilization Management (UM) requirements are described generally in **Section 8.1.9** and specifically for Behavioral Health Services in **Section 8.1.9**. A Respondent's response to this submission requirement should address UM for all Covered Services, including Behavioral Health Services unless otherwise indicated.

1. Describe the UM guidelines the Respondent plans to employ, including whether and how the guidelines comply with the standards in **Section 8.1.9**.
2. If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised.
3. Describe how the UM guidelines will generally be applied to authorize or retrospectively review services for the spectrum of Covered Services.

4.3.9 Section 9 – Early Childhood Intervention (ECI)

(2 pages)

ECI Services are described in **Section 8.1.10**.

1. Describe the Respondent's experience with, and general approach to, providing ECI services, including how the Respondent will identify such individuals.
2. Describe procedures and protocols for using the IFSP information in the development of the Member ISP and to authorize services.
3. Describe procedures and protocols for developing and including the interdisciplinary team in the assessment and care planning process.
4. Describe the process by which the Respondent will provide the IFSP information and other necessary information to the PCP.

4.3.10 Section 10 – Flexible and Tailored Services

(3 pages)

All STAR Kids Members are considered Members with Special Health Care Needs (MSHCN) as defined in the STAR Kids Contract Terms. Children and young adults with special healthcare needs vary greatly in terms of strengths, challenges and needs. STAR Kids MCOs are expected to provide services and supports that are tailored to the needs of individual Members as described in **Section 8.1.13** and **8.1.38.2**.

1. Describe the Respondent's experience with, and general approach to, providing services for children and young adults with special healthcare needs.
2. Describe procedures and protocols for including the Member or Member's LAR and key Providers in the care planning process.
3. Describe the process by which the Respondent will allow Members to have:
 - a. direct, timely access to a Specialist as appropriate for the Member's condition and identified needs, such as a standing referral to a specialty physician; and
 - b. timely access to non-primary care physician specialists as PCPs, as required by [28 Tex. Admin. Code § 11.900](#) and **Section 8.1.4.10.1**.

4.3.11 Section 11 – Service Coordination

(18 pages)

Service Coordination is described in **Section 8.1.38**.

1. Describe the duties and responsibilities of the Service Coordinator to authorize Community-based Services. The Respondent must describe in detail how the Service Coordinator will function in relation to the Member's PCP for:
 - a. Dual Eligible STAR Kids Members receiving both Medicaid and Medicare services from the MCO;
 - b. Dual Eligible STAR Kids Members receiving Medicare services through either fee-for-service Medicare or another Medicare MCO; and
 - c. Members with third-party insurance from a private health insurance carrier.
2. Submit detailed information, including protocols and procedures, for identifying Members requiring Service Coordination at Levels 1, 2, and 3 (as described in **Section 8.1.38.6**).
3. Describe the methods the MCO will use to determine Service Coordinator qualifications for all three Service Coordination levels.
4. Provide a description of the appropriate case mix and staffing ratio of Service Coordinators to Members and the Respondent's target ratio of Service Coordinators to Members for each Service Coordination level.
5. Describe the actions the MCO will take to establish relationships with community organizations and engage them in providing non-Covered Services to Members.
6. Describe the process for creating an ISP including parties to be consulted, what information will be incorporated, and how the Member and the Member's LAR will be involved in the process.
7. Describe procedures and protocols for using the information from the STAR Kids Assessment to inform and update the Member ISP and authorize services.
8. Describe under what types of circumstances the MCO will allow Members to receive Service Coordination through an integrated Health Home and how the MCO will compensate Health Home Providers who are designated to provide a Member's Service Coordination.
9. Describe how the Respondent will arrange to include clinical information and options for Medically Necessary Covered Services in the Member's ISP, and share this information with the PCP or Medical Home, as appropriate.
10. Describe how the MCO will evaluate and report Members' clinical progress in meeting goals identified in the ISP.
11. Describe how the ISP development process may be tailored to the specific needs of Members with the following health considerations:
 - a. Autism Spectrum Disorder (ASD);
 - b. Intellectual or Developmental Disability (IDD);
 - c. Cancer; and
 - d. Severe mental illness or behavioral health concerns.
12. Describe procedures and protocols for including the Member or Member's LAR in the care planning and ISP development process. Include a description of how the Member and the Member LAR will be educated about the Service Coordination process and how the Member and the Member's LAR will be informed of the name and contact information for his or her Service Coordinator.

13. Describe the criteria and processes for advising Members and Member's LARs about how to access the most appropriate, least restrictive home and community-based services as alternatives to institutional care. Additionally, describe how the Respondent will ensure that the Member or the Member's LAR receives the opportunity to make an informed choice about care options.
14. Describe the MCO's plan for a dedicated toll-free Service Coordination phone number or call option through the Member Services phone number.
15. Describe the MCO's plan for tracking Service Coordination provided to its Members, including numbers and types of contact, timeliness of contacts, and the qualifications of individuals making the contact.
16. Submit criteria for identifying and training certain Members and those in their immediate Support Network to coordinate and direct the Member's own care, to the extent reasonable and supported by the Member and the Member's LAR. Criteria should include those used to enable the Member and family to select, train, and supervise providers of Community-based Services.
17. Submit a list of the relevant community organizations in each proposed STAR Kids Service Area with which the Respondent will coordinate services for Members and to which it will refer Members for services.
18. Describe how the Respondent will identify Members who are at risk of an institutional placement and how the Service Coordination process will address those identified at risk.
19. Describe in detail the training provided to Service Coordinators, both initially and ongoing, to ensure they are knowledgeable about the STAR Kids population, and their responsibilities. Include information regarding who trains and his or her credentials, topics covered, frequency of training, and how a determination is made regarding the effectiveness of the training.
20. Describe how the MCO will reach Members for whom the MCO has lost contact.
21. Describe the Service Coordination process for STAR Kids Members who also receive non-capitated services through the following programs:
 - a. Intermediate Care Facility for Individuals with an Intellectual or Developmental Disability or Related Condition (ICF/IID);
 - b. Nursing Facility;
 - c. Community Living and Assistance Support Services (CLASS);
 - d. Home and Community-based Services (HCS);
 - e. Deaf Blind with Multiple Disabilities (DBMD);
 - f. Texas Home Living (TxHmL); and
 - g. Youth Empowerment Services (YES)

4.3.12 Section 12 – Adult Transition Planning (3 pages)

Adult Transition planning requirements are included in **Section 8.1.38.8**.

1. Describe the process for hiring and training Transition Specialists, including qualifications for the position and a job description.
2. Describe how the Respondent proposes to help Member's transition to adulthood including the role of Service Coordination, use of Transition Specialists, and additional resources for transition planning.
3. Describe how Transition Specialists will work with Members, individuals in the Member's Support System, and other individuals employed by the MCO to help prepare Members for the transition to adulthood.

4.3.13 Section 13 – Texas Promoting Independence Initiative

(1 page)

Requirements for the Texas Promoting Independence Initiative are provided in **Section 8.1.38.13**. Describe the steps the Respondent will take on behalf of a STAR Kids Member who moves from the community to an institutional setting. Explain the MCO's objective in this situation and who the MCO will work with to meet established goals.

4.3.14 Section 14 – STAR Kids Screening and Assessment Process

(5 pages)

Screening and assessment requirements for STAR Kids are described in **Section 8.1.39**

1. Leading up to and immediately after the Operational Start Date describe the process the MCO will use to identify which Members need to be assessed most quickly.
2. Describe strategies the MCO will adopt to assess all Members in a timely and thorough manner following the Operational Start Date.
3. Describe who will administer the STAR Kids Screening and Assessment Instrument (SAI) and what training they will receive.
4. Describe the process for initially and periodically screening and assessing Members' needs for services, including how the STAR Kids SAI will be incorporated into the process.
5. Submit any proposed functional assessment instruments to be used in addition to the STAR Kids SAI and describe how the assessment instruments will be employed to help inform the Member's service needs. Identify who will perform each assessment and specify his or her credentials.
6. Describe how the Respondent will engage Providers in the STAR Kids Screening and Assessment Process and how the MCO will attempt to resolve different plan of care recommendations between Provider orders and STAR Kids Screening and Assessment Process findings.

7. Describe the HIPAA-compliant process for sharing information between the individual that administers the STAR Kids Assessment Instrument and a subsequently named Service Coordinator.
8. Describe the process the Respondent will follow to determine which Members will be considered Priority 1, Priority 2, or Priority 3 after the Operational Start Date. and
9. Describe the steps the Respondent will take to ensure annual MDCP assessments to not lapse.

4.3.15 Section 15 – Comprehensive Care Program Community-Based Services (3 pages)

Personal Care Services and Nursing Services are Covered Services available to Members when Medically Necessary or Functionally Necessary.

Describe the Respondent's experience providing Personal Care Services (PCS) and PDN or any similar services. In the description, include strategies the MCO will employ to connect Members who receive PCS and PDN with appropriate Providers. Describe the processes and protocols for ensuring the continuity and provision of prior authorized PCS or PDN hours for Members who are new to the STAR Kids program. The description should include how the MCO will authorize the Member's providers to finish a previously authorized treatment plan.

4.3.16 Section 16 – Primary Care Providers and the Health Home (5 pages)

Primary Care Providers and the Health Home is described in **Section 8.1.4.10**

1. Describe the methods the Respondent will train Network PCPs on requirements described in **Section 8.1.4.10.1** and how the Respondent will monitor PCPs to ensure ongoing compliance.
2. Describe the Respondent's experience in implementing Health Home programs for populations comparable to the STAR Kids Program.
3. Identify the process by which the Respondent proposes to provide Members with Health Home services. Describe how the Respondent will work with medical practices to establish qualified Health Homes, the proposed outreach approach, and how services will be differentiated for Members of different risk levels.
4. Describe the process by which the Respondent will ensure continuity of care with the Member's previous health home services program(s), if any.

5. Identify innovative strategies the Respondent will implement to expand the number of Network Health Home Providers and to improve Health Home offerings for children and young adults with Complex Needs.
6. Describe how the MCO will work with PCPs and Health Homes to improve access to care for Members in rural or underserved areas including through the use of telemedicine or mobile clinics.
7. Describe proposed incentive programs to establish Network Providers that meet nationally recognized levels of accreditation, recognition, and certification for the development of a medical or Health Home model.

4.3.17 Section 17 – Disease Management (DM)

(5 pages)

Disease Management is described in **Section 8.1.14**.

1. Describe the Respondent's experience in implementing Disease Management programs for the STAR Kids population or populations comparable to the STAR Kids population.
2. Identify any measurable results in terms of clinical outcomes and program savings that have resulted from the Respondent's Disease Management initiatives, and briefly describe the analyses used to identify such outcomes and savings.
3. Identify the process by which the Respondent proposes to provide Members with Disease Management. Describe how the Respondent will identify Members in need of such Disease Management program, the proposed outreach approach, and the Disease Management program components for Members of different risk levels.

4.3.18 Section 18 – Behavioral Health Services and Network

The Behavioral Health Services and Network requirements are described in **Section 8.1.16**.

4.3.18.1 Behavioral Health Services Hotline

(3 pages; excluding telephone reports)

The Behavioral Health Services Hotline requirements are described in **Section 8.1.16.2**.

Describe the proposed Behavioral Health Services Hotline function, including:

1. verification that it is, or will be, staffed 24 hours per day, 365 days per year;
2. staffing of Behavioral Health Services Hotline staff, including clinical credentials;

3. routing of calls among Behavioral Health Services Hotline staff to ensure timely and accurate response to Member inquiries;
4. the curriculum for training to be provided to Behavioral Health Services Hotline representatives, including when the training will be conducted and how the training will address a) Covered Services; b) STAR Kids Program requirements; c) Cultural Competency; and d) providing assistance to Members with limited English proficiency.
5. responsibilities of Behavioral Health Services Hotline staff, if any, in addition to responding to STAR Kids Member Hotline calls, (e.g., responding to non-STAR Kids member calls or STAR Kids Provider Hotline or Member Hotline calls);
6. the number and percentage of FTE Behavioral Health Services Hotline staff who are bilingual in English and Spanish;
7. the number and percentage of FTE Behavioral Health Services Hotline staff who are multi-lingual for any additional language, by language spoken;
8. Behavioral Health Services telephone reports for the most recent four quarters with data that show the monthly trends for call volume, monthly trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system), and monthly trends for the abandonment rate; and
9. whether the Behavioral Health Services Hotline has the capability to administer automated surveys to callers at the end of calls.

A Respondent currently participating in any of the HHSC MCO Programs bid must submit the information above for each Behavioral Health Services Hotline it operates, and should provide the monthly call volume for each Service Area by MCO Program. Such a Respondent should also indicate any changes it proposes to its Behavioral Health Services Hotline.

If the Respondent is not currently participating in a HHSC MCO Program, describe its experience and proposed approach in establishing and maintaining an accessible call center for Members that is comparable to the Behavioral Health Services Hotline described in **Section 8.1.16.2**, such a description must include the information listed in items 1 to 9 above.

4.3.18.2 Behavioral Health Provider Network Expertise
(no page limit)

1. For each proposed Service Area, identify Behavioral Health Service Providers with expertise in providing services to each of the following populations, as applicable to the Respondent's Proposal:
 - a. Individuals with IDD;
 - b. Children and adolescents with Complex Needs;
 - c. Children and adolescents with Severe Emotional Disturbance (SED);

- d. persons with a dual diagnosis of mental health and substance abuse; and
 - e. services for linguistic and cultural minorities.
2. Indicate the criteria the Respondent will use to determine that the Behavioral Health Providers have the requisite expertise.

4.3.18.3 Coordination of Behavioral Health Care

(2 pages)

1. Describe the Respondent's approach to coordinating Behavioral Health Service delivery with other healthcare services delivered by a Member's PCP, and vice versa.
2. Describe or propose innovative programs and identify Network Providers contracted to serve special populations through integrated medical/Behavioral Health Service delivery models. Describe the program model services, treatment approach, special considerations, and expected outcomes for the special populations.
3. Describe the process the Respondent will use to ensure the delivery of outpatient Behavioral Health Services within seven days of inpatient discharge for Behavioral Health Services. Describe additional monitoring or coordination techniques the MCO will use following an inpatient Behavioral Health stay to prevent re-admission.

4.3.18.4 Behavioral Health Quality Management

(2 pages)

1. Identify the areas Respondent believes to be the greatest opportunities for clinical quality improvement in Behavioral Health in the STAR Kids Program and provide supporting information.
2. Discuss the approaches the Respondent will pursue to improve clinical Behavioral Health outcomes.
3. Describe how the Respondent proposes to integrate behavioral health into its quality assurance program, as described in **Section 8.1.7.5**.

4.3.18.5 Utilization Management for Behavioral Health Services

(2 pages)

1. Identify the source of the Respondent's Behavioral Health Services UM guidelines and include a copy of internally developed Behavioral Health Services UM guidelines, if any.
2. Describe how the Utilization Management guidelines, whether internally or externally developed, will generally be applied to authorize or retrospectively review inpatient, residential, and outpatient Behavioral Health Services.
3. Discuss any special issues in applying the Behavioral Health Services UM guidelines for:

- a. substance abuse services;
- b. Inpatient Behavioral Health Services.

4.3.18.6 Behavioral Health Emergency Services

(2 pages)

Describe the Respondent's experience with, and plans for, providing Behavioral Health Emergency Services, including:

- 1. Use of Mobile Crisis Teams;
- 2. Emergency screening services;
- 3. Training for Members and individuals in the Member's support network to help prevent and effectively respond to a behavioral health emergency; and
- 4. Short-term crisis stabilization for STAR Kids populations or for a comparable population.

4.3.19 Section 19 – Telemedicine, Telehealth, and Telemonitoring Access

(2 pages)

Describe the Respondent's vision for the use of Telemedicine, Telehealth, and Telemonitoring services including opportunities to use video conferencing to improve quality or access to care. The Respondent must describe the Respondent's Telemedicine, Telehealth, and Telemonitoring capabilities, how the Respondent will recruit providers with Telemedicine, Telehealth, and Telemonitoring capabilities, and how the Respondent will structure its Provider Network to use Telemedicine, Telehealth, and Telemonitoring to connect providers throughout Texas. The Respondent must describe how it will meet the Telemedicine, Telehealth, and Telemonitoring requirements in **Section 8.1.3.4**, including how it will determine the number and placement of telemedicine and telehealth endpoints.

4.3.20 Section 20 – Pharmacy Services

(8 pages)

The Pharmacy Services requirements are described in **Section 8.1.17**. For all of the following submission requirements, instead of attaching copies of the Respondent's policies and procedures, the Respondent should provide a brief summary of its policies and procedures.

- 1. The Respondent must describe the processes it will use to manage the pharmacy benefit under both of the following scenarios:
 - a. HHSC requires the MCO to implement the Medicaid formulary and preferred drug lists (PDLs); and
 - b. the MCO is allowed to establish its own formularies and PDLs.
- 2. The Respondent must describe the policies and procedures for how mail-order pharmacies will be available to Members.

3. The Respondent must identify the rationale for requiring prior authorizations, identify the types of drugs that normally require prior authorization, and describe the policies and procedures for the prior authorization process.
4. The Respondent must describe how rebates will be negotiated (if HHSC determines that the MCO will perform this service), identified, and reported.
5. The Respondent must describe the policies and procedures for drug utilization reviews, including ensuring prospective reviews take place at the dispensing pharmacy's point of sale (POS).
6. The Respondent must describe its policies and procedures for targeted interventions for Network Providers over-utilizing certain drugs.
7. The Respondent must describe monitoring policies and procedures to ensure prescriptions for psychotropic medications remain within established parameters.

4.3.21 Section 21 – Management Information System (MIS) Requirements

(10 pages – Page limit excludes system diagrams and process flow charts.)

The Respondent must:

1. Describe the Management Information System (MIS) the Respondent will implement, including how the MIS will comply with HIPAA as amended or modified. The response must address the requirements of **Section 8.1.20**. At a minimum, the description should address:
 - a. hardware and system architecture specifications;
 - b. data and process flows for all key business processes in **Section 8.1.20.3**; and
 - c. attest to the availability of the data elements required to produce required management reports.
2. If claims processing and payment functions are outsourced, provide the above information for the Material Subcontractor.
3. Describe how the Respondent would ensure accuracy, timeliness, and completeness of Encounter Data submissions for the MCO's proposed STAR Kids Program.
4. Describe the Respondent's ability and experience in performing coordination of benefits and Third Party Recovery (TPR).
5. Describe the Respondent's ability and experience in allowing providers to submit claims electronically and its ability and experience in processing electronic claims payments to providers:
 - a. if currently processing claims electronically, generally describe the type and volume of provider claims received electronically in the previous year versus paper claims for each claim type; and
 - b. if currently making claims payments to providers electronically, generally describe the type and volume of provider claims payment processed electronically.

6. Describe the Respondent's experience and capability to comply with the Internet website requirements and mobile application requirements of **Section 8.1.5.5**, and briefly describe any additional website and mobile application capabilities that the Respondent proposes to offer to Members or Providers.
7. Provide acknowledgment and verification that the Respondent's proposed systems are 5010 compliant by submitting a copy of the 5010 compliance plan.
8. Describe the Respondent's capability to pay providers via direct deposit and its experience in doing so, including the percentage, number, and types of providers paid via direct deposit in the most recent 12-month period for which the Respondent has those statistics. If the Respondent operates in Texas, the Respondent must provide this information related to its experience in Texas. If the Respondent does not currently operate in Texas, the Respondent must provide this information for a state in which the Respondent currently operates a managed care program similar to the STAR Kids Program.

4.3.22 Section 22 – Fraud, Waste, and Abuse

(3 pages)

The Fraud, Waste, and Abuse requirements of the RFP are described in **Section 8.1.21**. The Respondent must describe how it will implement a Fraud, Waste, and Abuse Plan that will comply with state and federal law and this RFP, including the requirements of [Texas Government Code § 531.113](#). The Respondent must:

1. Include detail about what parts of the organization and which key staff will have responsibilities in implementing and carrying out the Fraud, Waste, and Abuse program.
2. Identify the officer or director of the Respondent organization who will have overall responsibility and authority for carrying out the Fraud, Waste, and Abuse Program provisions.

4.3.23 Section 23 – MCO Transition Plan

(4 pages)

The Transition Plan Requirements for MCOs are described in **Section 7**.

1. Briefly describe the Respondent's experience establishing and maintaining electronic interfaces with other contractors responsible for portions of Medicaid operations. A Respondent with experience participating in one or more HHSC MCO Programs must clearly note its experience in establishing and maintaining these interfaces in Texas. A Respondent without experience establishing and maintaining electronic interfaces with other contractors responsible for Medicaid operations must note its experience in establishing and maintaining similar electronic interfaces with similar contractors.

2. Respondent must answer either (a) or (b) as it applies to Respondent.
 - a. A Respondent that is proposing to participate in STAR Kids for the first time must briefly describe its Transition Plan, including major activities related to the System Readiness Review and the Operational Readiness Review, including Network development, internal system testing, and proposed schedule to comply with the anticipated Operational Start Date and other requirements described in **Section 7**. The Respondent must clearly indicate in which Texas counties it currently does not operate as an MCO and any differences in its transition approach by county.
 - b. A Respondent that is currently a contractor for the STAR Kids program must briefly describe its Transition Plan, including major activities related to the System Readiness Review and the Operational Readiness Review, such as Network Development, internal system testing, and schedule to comply with the anticipated Operational Start Date and other requirements described in **Section 7**.

4.3.24 Section 24 – MCO Turnover Plan

(4 pages)

The Turnover Plan Requirements for MCOs are described in **Section 9**.

The Respondent must describe a high-level overview of how it will implement a Turnover Plan that will comply with this RFP, including how it will transfer data to HHSC or a successor contractor and how it will ensure the least disruptive delivery of services to Members.

In addition, the Respondent must:

1. Include detail about what parts of the organization and which key staff will have responsibilities in implementing and carrying out the Turnover Plan.
2. Identify the officer or director of the Respondent organization who will have overall responsibility and authority for carrying out the Turnover Plan provisions.

4.3.25 Section 25 – Additional Requirements Regarding Dual Eligibles

(4 pages)

The additional requirements regarding certain categories of Dual Eligibles are described in **Section 8.2**.

1. Briefly describe the Respondent's experience in managing the cost sharing obligations of Dual Eligibles, or, if the Respondent has no experience, describe the Respondent's proposed process for meeting this requirement. Include a

- description of the Respondent's methods to inform providers regarding the balance billing requirements of federal law with respect to Dual Eligible cost-sharing obligations.
2. Describe how the Respondent intends to coordinate care for Dual Eligible Members, including:
 - a. How the Respondent will identify Long-Term Services and Supports (LTSS) providers in the relevant Service Areas.
 - b. The processes and procedures Respondent will use to coordinate the delivery of Community-based Long-Term Care Services with Medicare benefits for Dual Eligible Members.
 - c. The training Respondent will provide to staff and providers regarding Community-based Long-Term Care Services and the coordination of those services with Medicare benefits.
 3. Describe the Respondent's process for providing Medicaid outpatient pharmacy services for Dual Eligibles.
 4. Describe how the Respondent will work with HHSC to share information regarding Medicare and Medicaid participating providers, Member complaints, and HEDIS data.

4.4 Part 4 – Additional Requirements Regarding MDCP STAR Kids

(8 pages)

1. Describe the process the Respondent will use to create an ISP for a Member receiving MDCP STAR Kids services. Include a description of the role of the named Service Coordinator in the process.
2. Describe how the Respondent will identify needs for home modifications and adaptive aides, determine the appropriate amount of services, and ensure the services are sufficiently provided.
3. Describe how the Respondent will work with Members, the Members' LARs, and Providers to create a plan of care for MDCP services that is within the MDCP Member's cost limit. Include a description of how the MCO will document and communicate service fluctuations that occur from month to month.
4. Describe the process the Respondent will use to coordinate services for Members who receive respite, flexible family supports, PCS, and Nursing Services. Describe how the Member and the Member's LAR will be involved in this process.
5. Provide a list of qualifications and training requirements for staff members who will help provide services to Members who receive MDCP STAR Kids services. Include specific requirements for named Service Coordinators working with MDCP Members.
6. Describe immediate steps the Respondent will take for Members who fail to meet Medical Necessity criteria upon annual reassessment.

7. Describe how the Respondent will work with families, HHSC, and the HHSC Administrative Services Contractor (ASC) to prevent gaps in service resulting from the annual redetermination process.

5. Evaluation Process and Criteria

5.1. Overview of Evaluation Process

HHSC will use a formal evaluation process to select the successful Respondent. HHSC will consider capabilities or advantages that are clearly described in the proposal, which may be confirmed by oral presentations, site visits, demonstrations, and references contacted by HHSC. HHSC reserves the right to contact individuals, entities, or organizations that have had dealings with the Respondent or proposed staff, whether or not identified in the proposal.

HHSC will more favorably evaluate proposals that offer no or few exceptions, reservations, or limitations to the terms and conditions of the RFP, including **Attachment A**, “STAR Kids Contract Terms.”

5.2. MCO Service Areas

MCOs may bid to serve one or multiple Medicaid Managed Care Service Areas. See the maps in **Attachment B-4 and B-4.1**.

5.3. Evaluation Criteria

HHSC will evaluate each proposal using the following criteria, in descending order of priority, developed from the best value factors listed in Section 2.

Evaluation Criteria	
1	<p>The extent to which the goods and services meets HHSC’s needs and the needs of the Members for whom the goods and services are being purchased, including:</p> <ul style="list-style-type: none"> a. The extent to which the proposal addresses HHSC’s priority objectives for the initial Contract Period, as defined in Section 1.6 (“Mission Objectives”); b. The extent to which the Respondent accepts without reservation or exception the RFP’s terms, including Attachment A, “STAR Kids Contract Terms”; c. The extent to which the proposal exhibits expertise in providing services to populations comparable to STAR Kids Members and ability to comply with the requirements of this RFP—particularly the requirements outlined in Section 4 and 8; d. The quality and reliability of the goods and services, including the ability to retain, recruit, and maintain Providers in Respondent’s network and to

Evaluation Criteria	
	<p>respond timely and adequately to Member questions and complaints;</p> <ul style="list-style-type: none"> e. The degree to which the proposal demonstrates flexibility based on individual Members' needs, the MCO's adaptability to the unique needs of this population, and exceptional customer service; f. The identification of a methodology to identify positive outcomes and a proposal to structure payments to incentivize and reward desired outcomes; and g. The extent to which the proposal ensures appropriate access to care in rural and medical shortage areas;
2	<p>Indicators of probable vendor performance, including:</p> <ul style="list-style-type: none"> a. Respondent's past performance in Texas or comparable experience in other states, including proven ability to integrate physical and behavioral health services and acute and long-term services and supports; b. Current financial solvency and the ability to remain financially solvent during the Initial Contract Period; c. Ability to deliver Community-Based Services and coordinate with HCBS Waiver programs; d. Capacity for Respondent's organizational structure to support operations; e. Ability to obtain and maintain TDI approval to operate and a status of Good Standing with the Comptroller; and f. The qualifications and experience of Respondent's key personnel to achieve program goals.
3	<p>Effect of the acquisition on agency productivity, including:</p> <ul style="list-style-type: none"> a. The level of effort and resources required by HHSC to monitor the Respondent's performance under the Contract; and b. The level of effort required by HHSC to maintain a good working relationship with Respondent.
4	<p>Delivery Terms, including:</p> <ul style="list-style-type: none"> a. The Respondent's ability to complete transition phase requirements in Section 7 and to fully implement services by the Operational Start Date; b. The Respondent's ability to maintain full service operations throughout the Initial Contract Period; c. The Respondent's ability to comply with turnover requirements in Section 9 upon termination of the Contract.

If all other considerations are equal, HHSC will give preference to:

1. proposals that include substantial participation by Network providers who are Significant Traditional Providers (STP). HHSC defines “substantial participation” as proposals that include at least 50 percent of the STPs in a Service Area. The Respondent must either have a Network Provider agreement in place with the STP, or a Letter of Intent/Letter of Agreement to participate in the Network. A listing of STPs for the new Service Areas can be found in the Procurement Library; and
2. proposals that ensure continuity of coverage for Medicaid Members for at least three months beyond the period of Medicaid eligibility. For purposes of this provision, HHSC defines “continuity of coverage” as providing the full set of Covered Services.

Respondents who are licensed as health maintenance organizations under [Texas Insurance Code Chapter 843](#) and believe they meet the requirements for mandatory contracting under [Texas Government Code § 533.004](#) must provide written notice to HHSC’s Point-of-Contact no later than the date provided in **Section 1.3**. The notice must provide a clear description of why the Respondent believes it is entitled to a mandatory contract under the Texas Government Code and the basis for that belief. The notice must include an in-depth analysis of how the Respondent meets the exact requirements of [Texas Government Code § 533.004](#).

5.4. Initial Compliance Screening

HHSC will perform an initial screening of all proposals received. Unsigned proposals and proposals that do not include all required forms and sections are subject to rejection without further evaluation.

In accordance with **Section 3.11** (Modification or Withdrawal of Proposal), HHSC reserves the right to waive minor informalities in a proposal and award contracts that are in the best interest of the State of Texas.

5.5. Competitive Field Determinations

HHSC may determine that certain proposals are within the field of competition for admission to discussions. The field of competition consists of the proposals that receive the highest or most satisfactory ratings. HHSC may, in the interest of administrative efficiency, place reasonable limits on the number of proposals admitted to the field of competition.

5.6. Oral Presentations and Site Visits

HHSC may, at its sole discretion, request oral presentations, site visits, or demonstrations from one or more Respondents admitted to the field of competition. HHSC will notify selected Respondents of the time and location for these activities, and may supply agendas or topics for discussion. HHSC reserves the right to ask additional questions during oral presentations, site visits, or demonstrations to clarify the scope and content of the written proposal.

The Respondent's oral presentation, site visit, or demonstration must substantially represent material included in the written proposal, and should not introduce new concepts or offers unless specifically requested by HHSC.

5.7. Best and Final Offer

Respondents will not submit cost proposals for this RFP. HHSC will establish the Capitation Rates for each Program and Service Area in accordance with the methodology described in **Attachment A**, "STAR Kids Contract Terms," **Article 10**, "Terms of Payment".

HHSC may, but is not required to, permit Respondents to prepare one or more revised offers. For this reason, Respondents are encouraged to treat their original proposals, and any revised offers requested by HHSC, as best and final offers of services.

5.8. Discussions with Respondents

HHSC may, but is not required to, conduct discussions with all, some, or none of the Respondents admitted to the field of competition for the purpose of obtaining the best value for the State of Texas. It may conduct discussions for the purpose of:

- obtaining clarification of proposal ambiguities;
- requesting modifications to a proposal; or
- obtaining a best and final offer.

HHSC may make an award prior to the completion of discussions with all Respondents admitted to the field of competition if HHSC determines that the award represents best value to the State of Texas.

5.9. Contract Awards

Respondents are allowed to select which Services Areas to include in their Proposals. It is possible that a Respondent submitting a Proposal for more than one Service Area could be awarded a Contract for some of its proposed Service Areas, but not necessarily all Service Areas. HHSC reserves the right to change the boundaries for, or otherwise modify, the Service Areas if it determines that doing so is in the best interest of the State.

DOCUMENT HISTORY LOG

STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
Baseline	n/a	October 1, 2015	Initial version of Attachment B-1, RFP Section 6, "Incentives & Disincentives" that includes all modifications negotiated by the Parties.

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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6 Premium Payments and Performance Incentives and Disincentives

This section describes capitation rate payments and performance incentives and disincentives related to HHSC’s value-based purchasing approach.

6.1 Capitation Rate Payments

Refer to **Attachment A**, “STAR Kids Contract Terms,” under Article 10, “Terms of Payment,” and **UMCM Chapter 6** for information concerning Capitation Rate development, financial payment structure and provisions, and capitation payments, including the time and manner of payment and adjustments to capitation payments.

6.2 Performance Incentives and Disincentives

Performance incentives and disincentives are subject to change by HHSC over the course of the Contract Period.

HHSC will refine the methodologies required to implement these strategies after collaboration with contracting MCOs through a new incentives workgroup that HHSC will establish.

MCO is prohibited from passing down financial disincentives or sanctions imposed on the MCO to healthcare providers, except on an individual basis and related to the individual provider’s inadequate performance.

Information about the data collection period to be used and performance indicators selected or developed will be found in **Section 8.1.7.11** and **Uniform Managed Care Manual (UMCM)** Chapter 6.2.11.

6.2.1 Performance Profiling

HHSC intends to distribute information on key performance indicators to MCOs on a regular basis, identifying an MCO’s performance, and comparing that performance HHSC standards or external Benchmarks. For example, HHSC may post performance results on its website, where they will be available to both stakeholders and members of the public. Likewise, HHSC may post its final determination regarding poor performance or MCO peer group performance comparisons on its website.

6.2.2 Pay for Quality (P4Q) Program

Under the P4Q Program, HHSC will place each MCO at risk for 4% of the Capitation Payment. HHSC retains the right to reduce the percentage of the Capitation Payment placed at risk in a given FSR Reporting Period.

HHSC will pay the MCO the full monthly Capitation Payments as described in **Section 6.2**. Then, at the end of the P4Q data collection period HHSC will evaluate the MCO's performance and assign points and dollar amounts using the methodology set out in UMCM Chapter 6.2.12, "Texas Medicaid and CHIP Pay for Quality (P4Q) Technical Specifications." HHSC's objective is that all MCOs achieve performance levels that enable them to retain the full at-risk amount.

Specific contractual requirements, including performance measures, and program details are set forth in UMCM Chapters 6.2.11, "Performance Measures for Pay for Quality," and 6.2.12, "Medicaid/CHIP Pay for Quality (P4Q) Technical Specifications."

Failure to timely provide HHSC with necessary data related to the calculation of the P4Q performance indicators will result in HHSC's assignment of a zero percent (0%) performance rate for each related performance indicator.

MCOs will report actual Capitation Payments received on the Financial Statistical Report (FSR) during the FSR Reporting Period that is at risk (i.e., the MCO will *not* report Revenues at a level equivalent to 96% of the payments received, leaving four percent (4%) as contingent). Any subsequent loss of the at-risk amount that may be realized will be reported below the income line as an informational item, and not as an offset to Revenues or as an Allowable Cost (as described in the Uniform Managed Care Manual, Chapter 5.3.1, "Financial Statistical Report and Instructions").

HHSC will evaluate the P4Q program methodology annually in consultation with MCOs. HHSC may then modify the methodology as it deems necessary and appropriate, in order to motivate, recognize, and reward MCOs for superior performance.

6.3 Auto-assignment Methodology for Medicaid MCOs

HHSC may revise its auto-assignment methodology during the Contract Period for enrollees who do not select an MCO. The new assignment methodology may reward those MCOs that demonstrate superior performance or improvement on one or more key dimensions of performance (see 1 Tex. Admin. Code § 353.403(d)(3)(B)).

6.4 Frew Incentives and Disincentives

This Contract includes a system of incentives and disincentives required by the *Frew v. Traylor* “Corrective Action Order: Managed Care” that apply to the MCO. The incentives and disincentives and corresponding methodology are set forth in the **UMCM Chapter 12**.

6.5 This Section Intentionally Left Blank

6.6 Remedies and Liquidated Damages

All areas of responsibility and all requirements of the MCO in the Contract will be subject to performance evaluation by HHSC. Any and all responsibilities or requirements not fulfilled may have remedies, and HHSC may assess damages, including liquidated damages. Refer to **Attachment A**, “STAR Kids Contract Terms,” and **Attachment B-3 2**, “Deliverables/Liquidated Damages Matrix,” for performance standards that carry liquidated damage values.

6.7 Additional Incentives and Disincentives

HHSC will evaluate all performance-based incentive and disincentive methodologies in consultation with the MCO. HHSC may then modify the methodologies as needed, or develop additional methodologies, as funds become available, or as mandated by court decree, statute, or rule in an effort to motivate, recognize, and reward the MCO for performance.

DOCUMENT HISTORY LOG

STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
Baseline	n/a	October 1, 2015	Initial version of Attachment B-1, RFP Section 7, "Transition Phase Requirements" that includes all modifications negotiated by the Parties.
<p>¹ Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions</p> <p>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.</p> <p>³ Brief description of the changes to the document made in the revision.</p>			

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7 Transition Phase Requirements

7.1 Introduction

This Section presents the scope of work for the Transition Phase of the Contract, which includes activities that must occur between the time of Contract award and the Operational Start Date.

The Transition Phase will include a Readiness Review of each MCO, which must be completed successfully prior to an MCO's Operational Start Date. HHSC may, at its discretion, terminate the Contract, postpone the Operational Start Date, or assess other contractual remedies if the MCO fails to timely correct all Transition Phase deficiencies within a reasonable cure period, as determined by HHSC.

If for any reason, an MCO does not fully meet the Readiness Review prior to the Operational Start Date, and HHSC has not approved a delay in the Operational Start Date or approved a delay in the MCO's compliance with the applicable Readiness Review requirement, then HHSC will impose remedies including actual or liquidated damages. Refer to **Attachment A**, "STAR Kids Contract Terms," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix," for additional information.

7.2 Transition Phase Scope

STAR Kids MCOs must meet the Readiness Review requirements established by HHSC no later than 90 days prior to the Operational Start Date. The MCO agrees to provide all materials required to complete the Readiness Review by the dates established by HHSC and its Contracted Readiness Review Vendor, if any.

7.3 Transition Phase Schedule and Tasks

The Transition Phase will begin after both Parties sign the Contract. The MCO must complete the Transition Phase no later than the Operational Start Date.

The MCO has overall responsibility for the timely and successful completion of each of the Transition Phase tasks. The MCO is responsible for clearly specifying and requesting information needed from HHSC, other HHSC contractors, and Providers in a manner that does not delay the schedule or work to be performed.

7.3.1 Contract Start-Up and Planning

HHSC and the MCO will work together during the initial Contract start-up phase to:

1. define project management and reporting standards;

2. establish communication protocols between HHSC and the MCO;
3. establish contacts with other HHSC contractors;
4. establish a schedule for key activities and milestones; and
5. clarify expectations for the content and format of Contract Deliverables.

The MCO will be responsible for developing a written work plan, referred to as the Transition/Implementation Plan, which will be used to monitor progress throughout the Transition Phase. The MCO must update the Transition/Implementation Plan provided with its proposal to HHSC no later than 30 calendar days after the Contract's Effective Date, then provide monthly implementation progress reports through the sixth month of MCO Program operations. HHSC may require more frequent reporting as it determines necessary.

The MCO's Transition/Implementation Plan must include a detailed description of the process it will use to ensure continued authorization of Community-based Services at the time of implementation. An HHS Agency will provide a file identifying clients who receive Community-based Services, including those enrolled in MDCP to the MCO for this purpose. The MCO's Transition/Implementation Plan must identify a designated MCO staff member responsible for the facilitation and oversight of this process. These requirements are further described in **Section 8.1.23** "Continuity of Care and Out-of-Network Providers."

7.3.2 Administration and Key MCO Personnel

No later than the Effective Date of the Contract, the MCO must designate and identify Key MCO Personnel that meet the requirements in **Attachment A**, "STAR Kids Contract Terms." The MCO will supply HHSC with résumés of each Key MCO Personnel as well as organizational information that has changed relative to the MCO's Proposal, such as updated job descriptions and updated organizational charts, if applicable. For Service Coordinators, the MCO must also provide information on the anticipated maximum caseload per Service Coordinator (i.e., number of Members per Service Coordinator). If the MCO is using Material Subcontractors, the MCO must also provide the organizational chart for these Material Subcontractors.

7.3.2.1 Material Subcontractors

The MCO or its designee will conduct, at a minimum, one annual site visit to each Material Subcontractor per Contract Year to ensure compliance with the performance of all delegated functions. The MCO must use a standard site visit tool. During the site visit the MCO will review the policies, procedures, and applicable files and also interview Material Subcontractor staff. The MCO will maintain a monitoring plan for each Material Subcontractor, which includes the following, at a minimum:

1. the requirements for performance of all delegated functions with which the entity must comply;

2. the MCO's responsibilities for the financial oversight of a Material Subcontractor who has an at-risk contract with the MCO for the provision of covered services;
3. required and periodic reporting and interfaces with Material Subcontractors required to perform an administrative function on behalf of the MCO;
4. a review of the entity's solvency status, financial operation, and amounts paid for Covered Services (if applicable); and
5. a review of the entity's contract compliance, logged complaints, and functional performance measurements.

The MCO must maintain quarterly and annual 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 will contractually require periodic reporting from each Material Subcontractor. The MCO will monitor each reporting entity to ensure accurate and timely deliverables. The MCO will meet with each Material Subcontractor on a regular basis to discuss any issues that may exist. These meetings will include key personnel and designated staff by functional area and their Material Subcontractor counterparts. All meetings will have agendas and documented minutes. The MCO must allow HHSC to attend meetings between the MCO and its Material Subcontractors and to receive the minutes from these meetings.

7.3.3 Organizational and Financial Readiness Review

In order to complete an organizational and financial Readiness Review and assess the most current corporate environment, the MCO must update the organizational and financial information submitted in its proposal for any awarded Contract. See **Section 4.2** ("Business Proposal") of the RFP for a list of Financial Statements, Corporate Background and Status, Corporate Experience, and Material Subcontractor Information the MCO must update for Readiness Review.

7.3.4 System Testing and Transfer of Data

The MCO must have hardware, software, network and communications systems with the capability and capacity to handle and operate all MIS systems and subsystems identified in **Section 8.1.20**. For example, the MCO's MIS system must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as indicated in **Section 8.1.20.4**.

During this Readiness Review task, the MCO will accept into its system any and all necessary data files and information available from HHSC or its contractors. The MCO will install and test all hardware, software, and telecommunications required to support

the Contract. The MCO will define and test modifications to the MCO's system(s) required to support the business functions of the Contract.

The MCO will produce data extracts and receive all electronic data transfers and transmissions.

If any errors or deficiencies are evident, the MCO will develop resolution procedures to address problems identified. The MCO will provide HHSC, or a designated vendor, with test data files for systems and interface testing for all external interfaces. The HHSC Administrative Services Contractor will provide enrollment test files to new MCOs that do not have previous HHSC enrollment files. The MCO will demonstrate its system capabilities and adherence to Contract specifications during readiness review.

7.3.5 System Readiness Review

The MCO must assure that systems services are not disrupted or interrupted during the Operations Phase of the Contract. The MCO must coordinate with HHSC and other contractors to ensure business and systems continuity for the processing of all health care claims and data as required under the Contract.

The MCO must submit descriptions of interface and data and process flow for each key business processes described in **Section 8.1.20.3** "System-wide Functions" to HHSC.

The MCO must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. The MCO must develop, and submit for State review and approval, the following information no later than 120 days prior to the Operational Start Date:

1. Disaster Recovery Plan*;
2. Business Continuity Plan*;
3. Security Plan;
4. Joint Interface Plan;
5. Risk Management Plan; and
6. Systems Quality Assurance Plan.

*The Business Continuity Plan and the Disaster Recovery Plan may be combined into one document.

7.3.6 Demonstration and Assessment of System Readiness

The MCO must provide documentation on systems and facility security and provide evidence or demonstrate that it is compliant with HIPAA and the HITECH Act. The MCO must also provide HHSC with a summary of all recent external audit reports, including

findings and corrective actions, relating to the MCO's proposed systems, including any SSAE16 audits that have been conducted in the past three years. The MCO must promptly make additional information on the detail of these system audits available to HHSC upon request.

In addition, HHSC will provide to the MCO a test plan that will outline the activities that the MCO needs to perform prior to the Operational Start Date of the Contract. The MCO must be prepared to assure and demonstrate system readiness. The MCO must execute system readiness test cycles to include all external data interfaces, including those with the MCO's Pharmacy Benefits Manager (PBM) and other Material Subcontractors.

HHSC, or its agents, may independently test whether the MCO's MIS has the capacity to administer the STAR Kids MCO business. This Readiness Review of a MCO's MIS may include a desk review or an onsite review. HHSC may request from the MCO additional documentation to support the provision of STAR Kids Services. Based in part on the MCO's assurances of systems readiness, information contained in the Proposal, additional documentation submitted by the MCO, and any review conducted by HHSC or its agents, HHSC will assess the MCO's understanding of its responsibilities and the MCO's capability to assume the MIS functions required under the Contract.

The MCO must provide a Corrective Action Plan in response to any Readiness Review deficiency no later than 10 calendar days after notification of any deficiency by HHSC. If the MCO documents to HHSC's satisfaction that the deficiency has been corrected within 10 calendar days of the deficiency notification by HHSC, no Corrective Action Plan is required.

7.3.7 Operations Readiness

The MCO must clearly define and document the policies and procedures that will be followed to support day-to-day business activities related to the provision of STAR Kids Services, including coordination with contractors. The MCO will be responsible for developing and documenting its approach to quality assurance.

HHSC or its designee will conduct a Readiness Review not later than the 15th day before the date on which HHSC plans to begin the enrollment process and again not later than the 15th day prior to the Operational Start Date. MCO is responsible for all reasonable travel costs incurred by HHSC or its authorized agent for onsite Readiness Reviews. For purposes of this section, "reasonable travel costs" 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. This provision does not limit HHSC's ability to collect other costs as damages in accordance with **Attachment A**, "STAR Kids Contract Terms," **Section 12.02(e)**, "Damages."

During Readiness Review, the MCO must, at a minimum:

1. Develop new, or revise existing, operations procedures and associated documentation to support the MCO's proposed approach to conducting operations activities in compliance with the contracted Scope of Work.
2. Submit a list of all contracted and credentialed Providers to HHSC, in an HHSC-approved format, including a description of additional contracting and credentialing activities scheduled to be completed before the Operational Start Date. The list must include a specific section on home health providers. The section must also include estimates of STAR Kids Members who may require Private Duty Nursing and attendant services and evidence of provider adequacy to serve the eligible population.
3. Prepare and implement a Member Services staff training curriculum and a Provider training curriculum, and provide documentation demonstrating compliance with training requirements (e.g., enrollment or attendance rosters dated and signed by each attendee or other written evidence of training.)
4. Prepare a Coordination Plan documenting how the MCO will coordinate its business activities with those activities performed by the Department of Aging and Disability Services (DADS), HHSC contractors, the MCO's PBM, and other Material Subcontractors, if any. The Coordination Plan will include identification of coordinated activities and protocols for the Transition Phase.
5. Develop and submit the draft Member Handbook, draft Provider Manual, draft Provider Directory, and draft Member Identification Card to HHSC for review and approval. The materials must at a minimum meet the requirements specified in **Section 8.1.5.1** and include the Critical Elements as defined in the **Uniform Managed Care Manual (UMCM)** Chapters 3.13, 3.14, 3.15, and 3.16.
6. Develop and submit all other Provider Materials relating to Medicaid to HHSC prior to use or mailing. If HHSC has not responded to MCO's request for review within 15 Business Days, the MCO may use the submitted materials. HHSC reserves the right to require discontinuation or correction of any Provider Materials that are not in compliance with state and federal laws or the Contract's requirements.
7. Develop and submit the MCO's proposed Member complaint and appeals processes to HHSC.
8. Provide sufficient copies of the final Provider Directory to the HHSC Administrative Services Contractor in sufficient time to meet the enrollment schedule.
9. Demonstrate toll-free telephone systems and reporting capabilities for the Nurse Hotline, Member Hotline, the Behavioral Health Hotline, and the Provider Hotline.
10. Submit a Service Coordination plan that addresses requirements provided in **Section 8.1.38.6**.
11. Submit a written Fraud, Waste, and Abuse Compliance Plan to HHSC for approval no later than 30 days after the Contract Effective Date. See **Section**

- 8.1.21**, Fraud, Waste, and Abuse, for the requirements of the plan, including new requirements for special investigation units. As part of the Fraud, Waste, and Abuse Compliance Plan, the MCO must:
- a. Designate executive and essential personnel to attend mandatory training in fraud and abuse detection, prevention and reporting. Executive and essential fraud and abuse personnel means MCO staff persons who supervise staff in the following areas: data collection, Provider enrollment or disenrollment, Encounter Data, claims processing, Utilization Review, appeals or grievances, quality assurance and marketing, and who are directly involved in the decision-making and administration of the Fraud, Abuse, and Waste detection program within the MCO. The training will be conducted by the Office of Inspector General, HHSC, and will be provided free of charge. The MCO must schedule and complete training no later than 90 days after the Effective Date.
 - b. Designate an officer or director within the organization responsible for carrying out the provisions of the Fraud, Waste, and Abuse Compliance Plan.
 - c. Ensure that, if the MCO subcontracts this function to another entity, the Subcontractor also meets all the requirements in this section and the Fraud, Waste, and Abuse section as stated in **Section 8.1.21**.
 - d. Complete hiring and training of STAR Kids Service Coordination staff no later than 45 days prior to the STAR Kids Operational Start Date.
12. Submit a written plan to HHSC for providing pharmacy services, including proposed policies and procedures for:
- a. routinely updating formulary data following receipt of HHSC's daily files (no less frequently than weekly, and off-cycle upon HHSC's request);
 - b. prior authorization of drugs, including how HHSC's preferred drug lists (PDLs) will be incorporated into prior authorization systems and processes. The MCO must adopt HHSC's prior authorization processes, criteria, and edits unless HHSC grants a written exception, and HHSC's approval is required for all Clinical Edit policies;
 - c. implementing drug utilization review;
 - d. monitoring the use of psychotropic medications;
 - e. overriding standard drug utilization review criteria and clinical edits when Medically Necessary based on the individual Member's circumstances (e.g., overriding quantity limitations, drug-drug interactions, refill too soon);
 - f. call center operations, including how the MCO will ensure that staff for all appropriate hotlines are trained to respond to prior authorization inquiries and other inquiries regarding pharmacy services; and

g. monitoring the PBM Subcontractor.

The plan must also include 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.

Additionally, the MCO must include a written attestation by the PBM Subcontractor in the plan stating, in the three years preceding the Contract's Effective Date, the PBM Subcontractor has not been: (1) convicted of an offense involving a material misrepresentation or any act of fraud or of another violation of state or federal criminal law; (2) adjudicated to have committed a breach of contract; or (3) assessed a penalty or fine of \$500,000 or more in a state or federal administrative proceeding. If the PBM Subcontractor cannot affirmatively attest to any of these items, then it must provide a comprehensive description of the matter and all related corrective actions.

During the Readiness Review, HHSC may request from the MCO certain operating procedures and updates to documentation to support the provision of STAR Kids Services. HHSC will assess the MCO's understanding of its responsibilities and the MCO's capability to assume the functions required under the Contract, based in part on the MCO's assurances of operational readiness, information contained in the Proposal, and in Transition Phase documentation submitted by the MCO.

The MCO is required to promptly provide a Corrective Action Plan or Risk Mitigation Plan as requested by HHSC in response to Operational Readiness Review deficiencies identified by the MCO or by HHSC or its agent. The MCO must promptly alert HHSC of deficiencies, and must correct a deficiency or provide a Corrective Action Plan or Risk Mitigation Plan no later than 10 calendar days after HHSC's notification of deficiencies. If the Contractor documents to HHSC's satisfaction that the deficiency has been corrected within 10 calendar days of such deficiency notification by HHSC, no Corrective Action Plan is required.

7.3.8 Assurance of System and Operational Readiness

In addition to successfully providing the Deliverables described in **Section 7.3** (Transition Phase Schedule and Tasks), the MCO must assure HHSC that all processes, MIS systems, and staffed functions are ready and able to successfully assume responsibilities for operations prior to the Operational Start Date. In particular, the MCO must assure that Key MCO Personnel, Member Services staff, Provider Services staff, and MIS staff are hired and trained, MIS systems and interfaces are in place and functioning properly, communications procedures are in place, Provider Manuals have been distributed, and that Provider training sessions have occurred according to the schedule approved by HHSC.

7.3.9 TDI and Centers for Medicare and Medicaid Services (CMS) Licensure, Certification, or Approval

The MCO must receive TDI licensure, certification, or approval (as applicable) for all zip codes in the awarded Service Areas no later than 60 days after the Contract's Effective Date.

7.3.10 Post-Transition

The MCO will work with HHSC, Providers, and Members to promptly identify and resolve problems identified after the Operational Start Date and to communicate to HHSC, Providers, and Members, as applicable, the steps the MCO is taking to resolve the problems.

The MCO must:

1. Meet with HHSC staff and discuss post-Transition Phase issues and problems.
2. Work proactively and collaboratively to resolve issues or problems identified by the Provider community, Members, Members' families, and other stakeholders.
3. Document the problems and their causes encountered during start-up and implementation in writing, and provide information regarding steps to correct the problem, including resources that will be used, the timeline for correcting the problem, and the steps that the MCO will take to prevent the issue or problem from recurring. The MCO will also document when the problem is resolved. The MCO will report this information to HHSC every 14 days, or as often as determined necessary by HHSC, during the first six months of operations, at which time HHSC will reassess the required frequency of providing this report.

If an MCO makes assurances to HHSC of its readiness to meet Contract requirements, including MIS and operational requirements, but fails to satisfy requirements set forth in this Section, or as otherwise required under the Contract, HHSC may, at its discretion, do any of the following in accordance with the severity of the non-compliance and the potential impact on Members and Providers:

1. impose contractual remedies, including liquidated damages; or
2. pursue other equitable, injunctive, or regulatory relief.

Refer to **Sections 8.1.1.2** and **8.1.17** for additional information regarding MCO Readiness Reviews during the Operations Phase.

DOCUMENT HISTORY LOG

STATUS¹	DOCUMENT REVISION²	EFFECTIVE DATE	DESCRIPTION³
Baseline	n/a	September 1, 2015	Initial version of Attachment B-1, RFP Section 8, "Operations Phase Requirements" that includes all modifications negotiated by the Parties.

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

HHSC will select multiple MCOs to provide Healthcare Services and Medically Dependent Children Program (MDCP) services to Members in every STAR Kids Service Area.

Section 8.1 describes the general administrative and operational requirements for serving all STAR Kids Members.

Section 8.2 includes additional requirements for serving qualified Dual Eligible Members.

Section 8.3 includes additional requirements for serving Members participating in MDCP STAR Kids.

This Section does not include all of the STAR Kids Program requirements, such as the time frames and formats for all reporting requirements. HHSC has included this information in the **Attachment A**, “STAR Kids Contract Terms,” and the **Uniform Managed Care Manual (UMCM)**. HHSC reserves the right to modify these documents using the procedures set forth in the **STAR Kids Contract Terms**.

8.1 General Scope of Work

The MCO must provide Covered Services to all Members who are enrolled in the MCO on or after the Operational Start Date.

The MCO must be licensed by the Texas Department of Insurance (TDI) as an HMO or an ANHC, or approved as an EPO, in all zip codes in the MCO’s Service Area(s).

8.1.1 Administration and Contract Management

The MCO must comply, to the satisfaction of HHSC, with all provisions set forth in this Contract, including all applicable provisions of state and federal laws, rules, regulations, and waiver agreements with CMS.

8.1.1.1 Performance Evaluation

HHSC will provide the MCO with two Performance Improvement Project (PIP) topics. The MCO must develop one PIP per topic. The MCO must conduct one PIP per program 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 the

NorthSTAR behavioral health organization (as appropriate) in the Service Area. The MCO must send PIP projects to HHSC no later than September 8 each year. Each MCO must also complete a mid-year review process as outlined in the **UMCM Chapter 10.2.9**.

PIPs will follow CMS protocol, as described below. The purpose of healthcare 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 10-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 10.2.4, “Performance Improvement Project Submission Instructions” and 10.2.5, “Performance Improvement Project Template”).

The MCO must participate in semi-annual contract status meetings (CSMs) with HHSC for the primary purpose of reviewing progress toward the achievement of PIPs and Contract requirements. HHSC may request additional CSMs, as it deems necessary to address areas of noncompliance and other issues. HHSC will provide the MCO with reasonable advance notice of additional CSMs, generally at least five Business Days.

The MCO must provide to HHSC, no later than 14 Business Days prior to each semi-annual CSM, one electronic copy of a written report detailing and documenting the MCO’s progress toward and any barriers in meeting the PIPs.

HHSC will track MCO performance on the PIPs. HHSC will also track other key facets of MCO performance through the use of the Performance Indicator Dashboards (see **UMCM** Chapters 10.1.3 and 10.1.8). 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 results with the MCO on a quarterly basis.

8.1.1.2 Additional Readiness Reviews and Monitoring Efforts

During the Operations Phase, HHSC may conduct desk or onsite reviews as part of its normal Contract monitoring efforts. Additionally, if the MCO chooses to make a change to any operational system or undergoes any major transition, it may be subject to an additional Readiness Review(s). HHSC will determine whether the proposed changes will require a desk review or an onsite review. The MCO is responsible for all reasonable 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, "reasonable travel costs" 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. This provision does not limit HHSC's ability to collect other costs as damages in accordance with **Attachment A, Section 12.02(e)**, "Damages."

Refer to **Section 7.3.7** and **Section 8.1.20** for additional information regarding MCO Readiness Reviews. Refer to **Attachment A, Section 4.08(c)** for information regarding Readiness Reviews of the MCO's Material Subcontractors.

8.1.1.3 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 provide annual MCO report cards. HHSC will also provide a separate report card for each Program Service Area to allow enrollees to easily compare the MCOs on specific 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.

8.1.2 Covered Services

The MCO is responsible for authorizing, arranging, coordinating, and providing Covered Services in accordance with the requirements of the Contract. The MCO must provide full coverage for necessary Covered Services beginning on the date of the Member's enrollment and without regard to the Member's:

1. Previous coverage, if any, or the reason for termination of that coverage;
2. Pre-existing conditions;
3. Prior diagnoses;
4. Receipt of any prior healthcare services;
5. Health status;

6. Confinement in a healthcare facility; or
7. For any other reason.

The MCO must not impose any pre-existing condition limitations or exclusions or require Evidence of Insurability to provide coverage to any Member.

The MCO is not responsible for providing payments to a Nursing Facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities or other related condition (ICF/IID), but must provide Acute Care and Service Coordination to a Member residing in a Nursing Facility or an ICF/IID if the services are not provided through the Nursing Facility or ICF/IID as part of the daily rate.

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 Members are listed in **Attachment B-2** (STAR Kids Covered Services). As noted in **Attachment B-2**, the MCO must provide Covered Services described in the **Texas Medicaid Provider Procedures Manual (TMPPM)** except for those services identified in **Section 8.1.24.8** as Medicaid Non-capitated Services. Covered Services are subject to change due to changes in federal and state law; changes in Medicaid Program policy; and changes in medical practice, clinical protocols, or technology.

8.1.2.1 Medicaid Covered Services for Recipients of Facility-Based Care and Certain HCBS Waiver Services

Members who receive services through a Nursing Facility, the ICF-IID Program, or an HCBS Waiver not integrated into STAR Kids must receive Medicaid Covered Services and Service Coordination through their STAR Kids MCO. The MCO will not pay the Nursing Facility or ICF-IID daily rate. The MCO will not provide HCBS Waiver services for the following programs: Home and Community-Based Services (HCS), Community Living Assistance and Support Services (CLASS), Texas Home Living (TxHmL), Deaf Blind with Multiple Disabilities (DBMD), and Youth Empowerment Services (YES).

Except as provided in **Section 8.1.2.2**, the STAR Kids MCO must help to coordinate all services for Members enrolled these HCBS Waivers, but will not contract with HCBS Waiver service providers for services provided through those HCBS Waivers. For STAR Kids Members who reside in a Nursing Facility or ICF-IID, the MCO is responsible for coordinating the Member's care with facility-based LTSS providers providing Non-capitated Services to the Member.

8.1.2.2 Additional STAR Kids Services Available to Qualified Members

The MCO must provide all Covered Services, including MDCP STAR Kids Covered Services, to Members that are eligible for and enrolled in MDCP STAR Kids, as

described in **Section 8.3.1**, Program Eligibility. MDCP STAR Kids services include Home and Community-Based LTSS and the services listed in **Section 8.3.2**, MDCP STAR Kids Covered Services. The MCO must contract with Providers that can provide MDCP STAR Kids Covered Services, including Providers listed in **Section 8.3.2**, MDCP STAR Kids Covered Services.

At a future date following the STAR Kids Operational Start Date, to be determined by HHSC, the YES waiver will be included in STAR Kids. At that future date, the MCO must provide YES STAR Kids services to Members who are eligible for and enrolled in YES STAR Kids.

8.1.2.3 Value-added Services

The MCO may propose additional services for coverage. These are referred to as “Value-added Services.” Value-added Services may be actual Healthcare Services, health-related benefits, Family Support Services, or positive incentives that HHSC agrees will promote wellness and improved health outcomes among Members. Value-added Services that promote wellness may include nutritional support services, home modifications, enhancements or additions to adaptive aids, improved access to telemedicine and telehealth services, exercise programs, or other programs approved by HHSC. Family and community support services may include respite care or trainings on managing challenging behaviors or care for a child with complex health needs. Value-added Services may also include services such as applied behavior analysis (ABA) or specialized therapies such as hippo therapy. Temporary phones, cell phones, additional transportation benefits, and extra home health services may also be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.

The MCO must offer approved Value-added Services for Acute Care or Behavioral Health services to all Members in a Service Area, but the MCO may offer additional Value-added Services to Members receiving MDCP STAR Kids services. Value-added Services that are approved by HHSC during the contracting process will be included in the Contract’s Scope of Work.

The MCO must provide Value-added Services 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 not pass on the cost of the Value-added Services to Members or Providers. 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 Transition Phase, HHSC will offer a one-time opportunity for the MCO to propose two additional Value-added Services to its list of current, approved Value-added Services. (See: **UMCM** Chapter 4.5 "Physical and Behavioral Health Value-Added Services Template."). HHSC will establish the requirements and the timeframes for submitting the two additional proposed Value-added Services.

During this HHSC-designated opportunity, the MCO may propose either to add new Value-added Services or to enhance its current, approved Value-added Services. HHSC will review the proposed additional services and, if appropriate, will approve the additional Value-added Services, which will be effective on the Operational Start Date. The MCO's Contract will be amended to reflect the additional, approved Value-added Services.

The MCO does not have to add Value-added Services during the HHSC-designated opportunity, but this will be the only time during the Transition Phase for the MCO to add Value-added Services. At no time during the Transition Phase will the MCO be allowed to delete, limit, or restrict any of its current, approved Value-added Services.

The MCO must use HHSC's template for submitting proposed Value-added Services. (See: **UMCM** Chapter 4.5) Once approved by HHSC, this document is incorporated by reference into the Contract.

During the Operations Phase, Value-added Services can be added or removed only by written amendment of the Contract. MCOs will be given the opportunity to add or enhance Value-added Services twice per State Fiscal Year, with changes to be effective September 1 and March 1. MCOs will also be given the opportunity to 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 State Fiscal Year. This approach allows HHSC to coordinate biannual revisions to HHSC's MCO Comparison Charts for Members. An MCO's request to add, enhance, delete, or reduce a Value-added Service must be submitted to HHSC by March 15 of each year to be effective September 1 for the following Contract Period. For the September 1, 2016 implementation date only, the MCO must submit a second request to add or enhance Value-added Services to HHSC by March 15, 2016. The MCOs cannot reduce or delete any Value-added Services until September 1 of the next State Fiscal Year. A second request to add or enhance Value-added Services must be submitted to HHSC by September 15 of each year to be effective March 1. When the MCO requests deletion of a Value-added Service, the MCO must include information regarding the processes by which the MCO will notify Members and revise materials. (See **UMCM** Chapter 4.5 "Physical and Behavioral Health Value-Added Services Template.")

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

Define and describe the proposed Value-added Service;

Specify the Service Areas for the proposed Value-added Service;

Identify the category or group of mandatory Members eligible to receive the Value-added Service if it is a type of service that is not appropriate for all mandatory Members;

If the Value-added Service is not a Healthcare Service or benefit, describe how the MCO will determine whether a Member is eligible to receive the Value-added Service and what criteria were used to arrive at that decision;

Note any limitations or restrictions that apply to the Value-added Service;

Identify the Providers or other entities responsible for providing the Value-added Service, including any limitation on Provider or other persons' capacity, if applicable.

Describe how the MCO will identify the Value-added Service in administrative data (including Encounter Data) and/or in its Financial Statistical Report (FSR), as applicable or will otherwise document delivery of the Value-added Service.;

Propose how and when the MCO will notify Providers and mandatory Members about the availability of the Value-added Service;

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

Include a statement that the MCO will provide the Value-added Service for at least 12 months from the Operational Start Date.

An MCO cannot include a Value-added Service in any material distributed to Members or prospective Members until the Parties have amended the Contract to include that Value-added Service. If a Value-added Service is deleted by amendment, the MCO must notify each Member that the service is no longer available 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.

8.1.2.4 Case-by-Case Added Services

Except as provided below, the MCO may offer additional benefits 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 Member's Legally Authorized Representative (LAR), the potential for improved health status of the Member, or Functional Necessity.

8.1.3 Access to Care

All Covered Services must be available to Members on a timely basis in accordance with medically appropriate guidelines generally accepted practice parameters, and the requirements in this Contract. 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 provide coverage for Emergency Services in compliance with 42 C.F.R. § 438.114, and as described in more detail in **Section 8.1.24.1**. 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 in the MCO's Network or Out-of-Network. An MCO is not responsible for payment for unauthorized non-emergency services provided to a Member by Out-of-Network Providers.

The MCO must also have an emergency and crisis Behavioral Health Services Hotline available 24 hours a day, 7 days a week, toll-free throughout the Service Area(s). The Behavioral Health Services Hotline must meet the requirements described in **Section 8.1.16.2**. The MCO may arrange Emergency Services and Crisis Behavioral Health Services through Mobile Crisis Teams.

The MCO must require, and make best efforts to ensure, that PCPs are accessible to Members 24 hours a day, 7 days a week and that Network Primary Care Providers (PCPs) have after-hours telephone availability consistent with **Section 8.1.5.6.2**. 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 patients.

If Medically Necessary Covered Services are not available through Network physicians or other Providers, the MCO must allow referral to an Out-of-Network physician or provider upon request of a Network Provider. The referral must occur within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed 5 business days after receipt of reasonably requested documentation. The MCO must fully reimburse the Out-of-Network Provider in accordance with the Out-of-Network methodology for Medicaid as defined by HHSC in 1 Tex. Admin. Code § 353.4. The MCO must provide these services within the timeframes specified in **Section 8.1.4.6** and within the time appropriate to the circumstances and Member's need.

The MCO must ensure the provision of Covered Services meet the specific preventive, Acute Care, Community-Based Services, Long-Term Services and Supports, and specialty healthcare needs appropriate for treatment of the individual Member's condition(s).

The MCO must provide access to PCPs and specialist physicians with experience serving children and adolescents with special healthcare needs, including behavioral health needs. The MCO must make best efforts to recruit and contract with PCPs and specialist physicians who are board-certified in their specialty. As described in **Section 8.1.38.2**, the MCO is responsible for working with Members, their LAR, and their Providers to develop a seamless package of care in which primary care, community-based care, behavioral health, and specialty care needs are met through an Individual Service Plan (ISP) that is culturally competent and understandable to the Member.

The MCO may not require the Member to pay for any Medically Necessary or Functionally Necessary Covered Services other than HHSC-specified copayments and applied income for Medicaid Members, where applicable (if HHSC implements Medicaid cost sharing after the Effective Date of the Contract).

8.1.3.1 Waiting Times for Appointments

Through its Provider Network composition and management, the MCO must ensure that the following standards are met. In all cases below, “day” is defined as a calendar day, and 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. Treatment for an Urgent Condition, including urgent specialty care, must be provided within 24 hours;
3. Routine primary care must be provided within 14 days;
4. Initial outpatient behavioral health visits must be provided within 14 days;
5. Initial outpatient behavioral health visits must be provided within seven days upon discharge from an inpatient psychiatric setting;
6. Community-Based Services for Non-MDCP STAR Kids Waiver Members must be initiated within 7 days from the date the MCO authorizes services unless the referring provider or Member states otherwise;
7. Prenatal care must be provided within 14 days of request, except for high-risk pregnancies or new Members in the third trimester, for whom an appointment must be offered within five days, or immediately, if an emergency exists;
8. PCPs must make referrals for specialty care on a timely basis, based on the urgency of the Member's medical condition, but no later than 30 days; and
9. Preventive health services for children, such as Texas Health Steps medical checkups, must be offered in accordance with the Texas Health Steps periodicity schedule. For a New Member birth through age 20, overdue or upcoming Texas Health Steps medical checkups, must 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. The Texas Health Steps annual medical checkup for an Existing Member age 36 months and older is due on the child's birthday. The annual medical checkup is considered timely if it occurs no later than 364 calendar days after the child's birthday. For purposes of this

requirement, the terms “New Member” and “Existing Member” are defined in **UMCM** Chapter 12.4.

8.1.3.2 Access to Network Providers

The MCO’s Network must include all of the provider types described in this section in sufficient numbers, and with sufficient capacity, to provide timely access to all Covered Services in accordance with the waiting times for appointments in **Section 8.1.3.1**. To the extent possible, Providers must have experience working with children or young adult populations. The MCO’s PCP Network must provide timely access to regular and preventive care to all Members, and Texas Health Steps services to all child Members.

This section includes distance standards for each Provider type. For each Provider type, the MCO must provide access to at least 90 percent of Members in each Service Area within the prescribed distance standard. This 90 percent benchmark does not apply to pharmacy providers (refer to the “Pharmacy Access” heading for applicable benchmarks).

HHSC will consider requests for exceptions to the distance standards for all provider types under limited circumstances. Each exception request must be supported by information and documentation as specified in HHSC’s exception request template.

PCP Access: At a minimum, the MCO must ensure that all adult Members have access to one age-appropriate PCP in the Provider Network with an Open Panel within 30 miles of the Member’s residence. Child Members must have access to two age-appropriate Network PCPs with an Open Panel within 30 miles of the Member’s residence. If the Member lives in a county with a minimum population of 800,000 individuals, the MCO must ensure the Member has access to at least one age-appropriate PCP in the Provider Network with an Open Panel within 20 miles of the Member’s residence. For the purposes of assessing compliance with this requirement, an internist who provides primary care to adults only is not considered an age-appropriate PCP choice STAR Kids Members.

As described above, the MCO can request a special exception if no appropriate provider types are located within the mileage standards.

OB/GYN Access: At a minimum, MCOs must ensure that all female Members have access to an OB/GYN in the Provider Network within 30 miles of the Member’s residence for Members in a county with more than 50,000 residents or within 75 miles of the Member’s residence if the Member’s residence for Members in a county with 50,000 or fewer residents. (If the OB/GYN is acting as the Member’s PCP, the MCO must follow the access requirements for the PCP.) The MCO must allow female Members or the Member’s LAR to select an OB/GYN within its Provider Network. A female Member who selects an OB/GYN must be allowed direct access to the OB/GYN’s health care services without a referral from the Member’s PCP or a prior authorization. A pregnant Member past the 24th week of pregnancy must be allowed to remain under the Member’s current

OB/GYN care though the Member's post-partum checkup, even if the OB/GYN Provider is, or becomes, Out-of-Network.

Outpatient Behavioral Health Service Provider Access:

At a minimum, the MCO must ensure that all Members have access to an outpatient Behavioral Health Service Provider in the Network within 30 miles of the Member's residence for Members in an Urban County or within 75 miles of the Member's residence for Members in a Rural County. The Behavioral Health Service Provider should be the appropriate Provider type to meet each individual Member's needs.

Outpatient Behavioral Health Service Providers must include psychiatrists and child psychiatrists; Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient Hospital departments; LCSWs; LMFTs; licensed professional counselors; licensed adolescent chemical dependency treatment facilities; and entities employing Qualified Mental Health Professionals for Community Services (QMHPs-CS).

The MCO must also ensure that a Member has Network access to an entity within 75 miles of the Member's residence that can provide Mental Health Rehabilitative Services through QMHP-CS. QMHPs-CS include Licensed Practitioners of the Healing Arts (LPHAs). QMHP-CS can also include Community Services Specialists (CSSP), Peer Providers, or Family Partners if acting under the supervision of an LPHA. In addition, day program providers who address pharmacology issues must be certified as Licensed Medical Personnel.

The MCO must also ensure that a Member has Network access to an entity within 75 miles of the Member's residence that can provide Targeted Case Management (TCM).

See also **UMCM Chapter 15.1**, "Mental Health Targeted Case Management and Mental Health Rehabilitative Services" and **UMCM Chapter 15.2**. "Mental Health Targeted Case Management and Mental Health Rehabilitative Services Request Form."

Other Specialist Provider Access: At a minimum, the MCO must ensure that all Members have access to a Network specialist provider within 75 miles of the Member's residence for common pediatric medical specialties for Members in a county with less than 800,000 residents, or within 30 miles for Members in a county with more than 800,000 residents. Common medical specialties must include general surgery, cardiology, orthopedics, urology, neurology, pulmonology, otolaryngology, and ophthalmology. 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 Healthcare Services from a Network specialist who is an ophthalmologist or therapeutic optometrist for non-surgical services. MCOs may request exceptions on a case-by-case basis.

Hospital Access: The MCO must ensure that all Members have access to an Acute Care Hospital with a staff or on-call pediatrician in the Provider Network within 30 miles of the Member's residence. MCOs may request exceptions on a case-by-case basis.

The MCO also must ensure that Members have access by transfer to an appropriate Network or Out-of-Network Hospital providing the needed level of care.

Pharmacy Access: For purposes of this requirement only, the terms urban, suburban, and rural counties have the following meaning:

Urban – Counties that have been designated as metropolitan by the Office of Management and Budget (OMB), and that contain the most populated city within a metropolitan area, also known as Metropolitan Statistical Area. HHSC Strategic Decision Support (SDS) classifies these counties as Metro Central City counties. A county meets the definition of metropolitan if it has a central city, or pair of twin cities in it, with a minimum population of 50,000.

Suburban – Counties that have been designated as metropolitan by the OMB, and that are adjacent (share a boundary) to a Metro Central City county. The SDS classifies these counties as Metro Suburban counties.

Rural – Non-metropolitan counties of the state, regardless of whether they are adjacent or non-adjacent to a metropolitan county.

The following standards apply to the Medicaid Rural Service Area:

1. In urban counties, at least 75 percent of Members must have access to a Network Pharmacy within 2 miles of the Members' residence;
2. In suburban counties, at least 55 percent of Members must have access to a Network Pharmacy within 5 miles of the Member's residence; and
3. In rural counties, at least 90 percent of Members must have access to a Network Pharmacy within 15 miles of the Member's residence.
4. In all counties, at least 90 percent of Members must have access to a 24-hour pharmacy within 75 miles of the Member's residence.

For all other counties:

1. In urban counties, at least 80 percent of Members must have access to a Network Pharmacy within 2 miles of the Member's residence;
2. In suburban counties, at least 75 percent of Members must have access to a Network Pharmacy within 5 miles of the Member's residence;
3. In rural counties, at least 90 percent of Members must have access to a Network Pharmacy within 15 miles of the Member's residence; and
4. In urban, suburban, and rural counties, at least 90 percent of Members must have access to a 24-hour pharmacy within 75 miles of the Member's residence.

Note: MCOs may request exceptions to these requirements on a case-by-case basis. Mail order pharmacies, including specialty pharmacies that only mail prescriptions, will not be included when calculating these percentages. However, MCOs will be required to

report on the number of prescriptions filled and number of clients served through mail order/specialty pharmacies by MCO Program and Service Area.

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 at least one Network Provider for each of the remaining Covered Services described in **Attachment B-2** within 75 miles of the Member's residence. This access requirement includes: specialists, hospitals with specialist children's services, children's hospitals and special Hospitals, psychiatric Hospitals, diagnostic and therapeutic services, and single or limited service healthcare physicians or Providers. MCOs may request exceptions on a case-by-case basis.

The MCO may make arrangements with physicians or providers outside the state for Members to receive a higher level of skill or specialty than the level available within the state, including treatment of cancer, burns, and cardiac diseases.

The MCO must make arrangements with physicians or Providers outside the MCO's Service Area if necessary for a Member to receive a higher level of skill or specialty than the level available within the Service Area.

HHSC may consider exceptions to the above access-related requirements when an MCO has established, through utilization data provided to HHSC, that a normal pattern for securing Healthcare Services within an area does not meet these standards, or when an MCO is providing care of a higher skill level or specialty than the level which is available within the Service Area.

8.1.3.3 Monitoring Access

The MCO is required to systematically and regularly verify that Covered Services are available and accessible to Members in compliance with the standards described in **Sections 8.1.3 and 8.1.3.2**. For Covered Services furnished by PCPs, the MCO must also comply with the standards described in **Section 8.1.2**.

The MCO is required to develop and implement a mandatory challenge survey to verify Provider information and monitor adherence to Provider requirements. The MCO must design the survey so that on a periodic, randomized basis, a Provider's input is required before accessing the MCO Provider portal functionalities. At a minimum, the challenge survey must include verification of the following elements:

- 1) Provider Name;
- 2) Address;
- 3) Phone Number;
- 4) Office Hours;
- 5) Days of Operation;
- 6) Practice Limitations;
- 7) Languages Spoken;

- 8) Provider Type / Provider Specialty;
- 9) Pediatric Services;
- 10) Wait Times for Appointment as defined in **Section 8.1.3.1**;
- 11) Closed or Open Panel (PCPs only); and
- 12) Texas Health Steps Provider (PCP only).

The MCO must collect, analyze, and submit survey results as specified in **UMCM** Chapter 5.4.1.10, "Provider Network Examination."

The MCO must enforce access and other Network standards required by the Contract and take appropriate action with Providers whose performance is determined by the MCO to be out of compliance.

8.1.3.4 Telemedicine, Telehealth, and Telemonitoring Access

The MCO must contract with Providers with Telemedicine, Telehealth, and Telemonitoring capabilities to increase access to specialty and behavioral healthcare. The MCO must include information in its Provider Directory on Providers with Telemedicine, Telehealth, and Telemonitoring capabilities. **Section 8.1.16**, Behavioral Health (BH) Services and Network, provides additional information regarding Telemedicine, Telehealth, and Telemonitoring.

The MCO must determine the exact number and locations of all Telemedicine, Telehealth, and Telemonitoring end points and the number of Providers who will commit to working with the MCO's Telemedicine, Telehealth, and Telemonitoring contractors. The MCO must outreach to its Telemedicine, Telehealth, and Telemonitoring Providers to encourage the increase and availability of end points in rural and medically underserved areas. The MCO must also outreach to pediatric specialty and behavioral health providers to assure engagement of qualified Telemedicine, Telehealth, and Telemonitoring contractors. In 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 Telemedicine, Telehealth, and Telemonitoring can provide.

8.1.4 Provider Network

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 also develop short- and long-term strategies to improve access to qualified providers.

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 or regulations related to the Contract. The Provider Network must be responsive to the linguistic, cultural, and other unique needs of the population in the Service Area(s) served by the MCO, including 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 Medicaid 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. HHSC may modify this requirement for Medicaid MCOs that demonstrate good cause for noncompliance, as set forth in 1 Tex. Admin. Code § 353.4(e)(3) (see **UMCM** Chapter 5.15, "Special Exception Request Template for Variance of Mileage or Out-of-Network Utilization Standards").

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 8.1.2**, all Providers must comply with State of Texas licensure requirements and all state and federal laws governing the provision of Covered Services. Network Providers cannot be under sanction or exclusion from the Medicaid program. All Providers serving Medicaid Members must be enrolled as Medicaid providers and have a Texas Provider Identification Number (TPIN). All Pharmacy Providers must be enrolled with HHSC's Vendor Drug Program. Long-Term Services and Supports (LTSS) Providers are not required to have a TPIN but must have an LTSS Provider number. All Providers must also have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D. This also includes Atypical Provider Identification Numbers (APIs).

Inpatient hospital and medical services: The MCO must ensure that Acute Care Hospitals and specialty Hospitals are available and accessible 24 hours per day, 7 days per week, within the MCO's Network to provide Covered Services to Members throughout the Service Area(s). The MCO must enter into a Network Provider Agreement 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 Member 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, so that these services are available and accessible 24

hours per day, 7 days per week, to provide Covered Services to Members throughout the Service Area. The MCO must enter into written arrangements with Out-of-Network designated Children's Hospitals or hospital with specialized pediatric services in proximity to the Member's residence if the MCO does not include these hospitals in its Provider Network. Provider Directories, 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 Member access to 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 the Service Area. The MCO must make a written reimbursement arrangement with an Out-of-Network 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 Provider Network. For additional information on the EMS Trauma System in Texas, click on this link:
<http://www.dshs.state.tx.us/emstraumasystems/default.shtm>.

Transplant centers: The MCO must ensure Member access to HHSC-designated transplant centers meeting equivalent levels of care. A list of HHSC-designated transplant facilities can be found in the **Procurement Library**. HHSC-designated transplant centers also include members of the United Network for Organ Sharing (UNOS), which can be accessed at <http://optn.transplant.hrsa.gov/members/search.asp>. 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). A list of these hemophilia centers can be found at <http://www.cdc.gov/ncbddd/hemophilia/HTC.html>. The MCO must make written reimbursement arrangements with an Out-of-Network CDC-supported hemophilia center if the MCO does not include such a center in its Provider Network.

Outpatient Behavioral Health Service Providers: The MCO must ensure Member access to outpatient Behavioral Health Service Providers in the Network, including psychiatrists and child psychiatrists; Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient Hospital departments; licensed social workers (LCSWs); licensed marriage and family therapists (LMFTs); licensed professional counselors; licensed adolescent chemical dependency treatment facilities; licensed chemical dependency counselors (LCDCs) with experience treating adults and adolescents; and entities employing Qualified Mental Health Professionals for Community Services (QMHPs-CS). QMHPs-CS include Licensed Practitioners of the Healing Arts (LPHAs). QMHPs can also include Community Services Specialists (CSSP), Peer Providers, or Family Partners if acting under the supervision of an LPHA. The Provider Network can include both LMHAs employing QMHPs-CS as well as other entities employing QMHPs-CS. In addition, day

program providers who address pharmacology issues must be certified as Licensed Medical Personnel.

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 the access requirements throughout **Section 8.1.3** and meet the needs of Members 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 specialist 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 patients 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; and Pap Smear, gonorrhea, and chlamydia screening processed at the Women's Health Laboratories in San Antonio. 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. The MCO must refer Providers to the Texas Health Steps Online Provider Training Modules referencing specimen collection on the DSHS website and the Texas Medicaid Provider Procedures Manual, Children Services Handbook for the most current information and any updates.

Pharmacy Providers: The MCO must ensure that all Pharmacy Network Providers are licensed with the Texas State Board of Pharmacy and meet all other requirements under 1 Tex. Admin. Code § 353.909. Providers must not be under sanction or exclusion from

the Medicaid, Medicare, or CHIP Programs. The MCO must enter into a Network Provider Agreement with any willing pharmacy provider that meets the MCO's credentialing requirements and agrees to the MCO's contract rates and terms. However, the MCO may enter into selective contracts for specialty pharmacy services with one or more pharmacy provider, subject to the following conditions. These arrangements must comply with Texas Government Code § 533.005(a)(23)(G) and 1 Tex. Admin. Code §§ 353.905, 354.1853, and 370.701.

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.

Community-Based Service Providers: The MCO must ensure that all Members have access to at least two Providers of each category of Community-Based Services, not including MDCP STAR Kids service Providers referenced in this Section. If the MCO determines it is unable to provide Member access to more than one Provider of Community-Based Services, the MCO must submit and receive an exception as noted in this Section.

MDCP STAR Kids: The MCO must have a sufficient number of contracts with MDCP STAR Kids service Providers so that all Members who receive MDCP STAR Kids have access to Medically Necessary and Functionally Necessary Covered Services.

Ambulance providers: The MCO must enter into a Network Provider Agreement with any willing ambulance provider 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.

Durable Medical Equipment (DME) and Medical Supplies: The MCO must ensure Members have access to DME and Medical Supplies.

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 participation in its Provider Network.

The MCO's contract with Providers must be in writing, must be in compliance with applicable federal and state laws and regulations, and must include the minimum requirements specified in the **Attachment A**, "STAR Kids Contract Terms," and **HHSC's UMCM** Chapter 8.1, "Provider Contract Checklist."

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 the STAR Kids Contract or Program requirements.

8.1.4.2 Provider Credentialing and Re-credentialing

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 Provider 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, and, as an additional requirement for Medicaid MCOs, 42 C.F.R. §§ 438.12 and 438.214(b). 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 calendar 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 5 Business Days after receipt.

The MCO must complete the initial credentialing process, and its claim systems must be able to recognize the provider as a Network Provider, no later than 30 calendar days after receiving a complete application requiring expedited credentialing, and no later than 90 calendar days after receiving all other complete applications. 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. For new providers, the MCO must complete the credentialing process prior to the effective date of the Network Provider agreement. The re-credentialing process must occur at least every three years.

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.

8.1.4.2.1 Expedited Credentialing Process

MCOs 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. Additionally, the MCO must comply with the Subchapters' hold harmless requirements for Members.

If a provider qualifies for expedited credentialing, the MCO's claims system must be able to process claims from the provider as if the Provider was a Network Provider no later than 30 calendar days after receipt of a complete application, even if the MCO has not yet completed the credentialing process.

8.1.4.2.2 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:
 - [HHS-OIG Exclusion](#); and
 - [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 or Neglect (CPS) and Abuse, Neglect, or Exploitation (APS) of a Member;
5. is instructed on and understands how to report suspected Abuse or Neglect (CPS) and Abuse, Neglect, or Exploitation (APS);
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.

8.1.4.3 Board Certification Status

The MCO must maintain a policy with respect to board certification for PCPs and specialist physicians that encourages participation of board-certified PCPs and specialist

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 specialist physicians, by specialty, available to HHSC upon request.

8.1.4.4 Provider Relations Including Manual, Materials, and Training

The MCO must maintain a provider relations presence in each Service Area. MCO provider relations staff must have a physical address in each Service Area so that the staff can meet face-to-face with providers as necessary.

The MCO must maintain a Provider Manual, including any necessary specialty manuals (e.g., behavioral health) for all existing Network Providers. The MCO must notify newly contracted Providers about the Provider Manual and how to access it within five business days from inclusion of the Provider into the Network. The Provider Manual must contain the critical elements defined in **UMCM** Chapter 3, "Critical Elements," including sections relating to describe the special requirements of the STAR Kids Program and Members.

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 unique needs of Members. The MCO's training must be completed within 30 days of placing a newly contracted Provider on active status. The MCO must provide on-going training to new and existing Providers as required by the MCO or 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 their staff.

MCO training for PCPs must include the use of valid screening and assessment instruments as well as the use of the Texas Health Steps Forms. The MCO must provide training to Network PCPs on identifying and referring Members three years of age and older suspected of having a developmental delay or developmental disability, Severe Emotional Disturbance (SED), mental illness, or chemical dependency. The MCO must ensure that PCPs have valid screening and assessment instruments to identify and refer children to Providers specializing in evaluations to determine whether a child or young adult has a developmental disability, or is at risk for or has SED or another type of mental illness. The MCO must also ensure that Members who may need access to IDD supports and HCBS Waiver services receive the appropriate evaluation and psychometric testing required for approval of services.

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

1. Covered Services and the Provider's responsibilities for providing or coordinating those services.
 - a) Special emphasis must be placed on areas that vary from commercial coverage rules (e.g., Early Childhood Intervention services, Private Duty Nursing, Personal Care Services, MDCP STAR Kids 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) The MCO should also place special emphasis on Mental Health Rehabilitative Services and the availability of Mental Health Targeted Case Management for Members for qualified Members, and the process for making referrals for and coordination with Non-capitated Services;
2. Relevant requirements of the Contract;
3. Specific training related to Utilization Management reviews, Fraud, Waste, and Abuse, including oversight activities such as pre-payment reviews, audits, and monitoring;
4. Information regarding Service Coordination including how and when to contact the Member's Service Coordinator;
5. The MCO's policy and procedures for prior authorization;
6. The MCO's quality assurance and performance improvement program and the Provider's role in the program;
7. The MCO's policies and procedures, especially regarding Network and Out-of-Network referrals;
8. Member cost-sharing obligations, benefit limitations, Value-added Services, and prohibitions on balance-billing Members for Covered Services;
9. Cultural Competency Training based on National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS);
10. Texas Health Steps benefits, periodicity, and required elements of a checkup;
11. Medical Transportation Program services available to Medicaid Members such as rides to services by bus, taxi, van, airfare, gas money, mileage reimbursement, and meals and lodging when away from home;
12. The importance of updating contact information to ensure accurate Provider Directories and the Medicaid Online Provider Lookup;
13. Information about the MCO's process for acceleration of Texas Health Steps services for Children of Migrant Farmworkers;
14. Partial settlement agreements in *Alberto N., et al. v. Traylor, et al.*;
15. Missed appointment referrals and assistance provided by the Texas Health Steps Outreach and Informing Unit;
16. The role of the MCO Service Coordinators;
17. Information on discharge planning and transitional care related to long-term care settings;
18. Administrative issues such as detailed claims filing (including the processes regarding claims appeals and recoupments) and how to receive assistance with claims;
19. Services available to Members;

20. Information about maintaining and developing a Health Home, including best practices, as referenced in **Section 8.1.4.10.2**, Health Home;
21. Requirements of the *Frew v. Taylor* Consent Decree and Corrective Action Orders;
22. Specific information in training materials (such as in 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; and
23. 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 Kids program.

Provider Materials must comply with state and federal laws governing the STAR Kids Program and requirements of the **Attachment A**, "STAR Kids Contract Terms," and **UMCM** Chapter 3, "Critical Elements."

As described above, HHSC must approve the MCO's Provider Manual and all substantive revisions. Additionally, the MCO must submit, for HHSC's review, all other Provider Materials relating to STAR Kids prior to publication or distribution. If HHSC has not responded to MCO's request for review within 15 Business Days, the MCO may use the submitted materials provided the MCO first notifies HHSC of its intended use. HHSC reserves the right to require discontinuation or correction of any Provider Materials, including those previously approved by HHSC, that are not in compliance with state and federal laws or the Contract's requirements.

8.1.4.5 Provider Hotline

The MCO must operate a toll-free telephone line for Provider inquiries from 8 a.m. to 5 p.m. local time for the Service Area(s), Monday through Friday, except for state-approved holidays. The State-approved holiday schedule is updated annually and can be found at <http://sao.hr.state.tx.us/compensation/holidays.html>. The Provider Hotline must be staffed with personnel who are knowledgeable about the STAR Kids Program, Covered Services, and Non-capitated Services.

The MCO must ensure that, after regular business hours, the Provider Hotline 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 verification prior to providing Emergency Services.

The MCO must ensure that the Provider Hotline meets the following minimum performance requirements for all Service Areas:

1. 99 percent of calls are answered by the fourth ring or an automated call pick-up system is used;
2. No more than 1 percent of incoming calls receive a busy signal;
3. The average hold time is 2 minutes or less; and
4. The call abandonment rate is 7 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 or Service Areas if Hotline staff is knowledgeable about all of the MCO's Programs and Service Areas, including the Provider Network in each Service Area.

The MCO must monitor its Provider Hotline performance and submit performance reports summarizing call center performance for the Hotline as indicated in **Section 8.1.22.2**. 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 8.1.16.2**.

If HHSC determines that it is necessary to conduct onsite monitoring of the MCO's Provider Hotline functions, the MCO is responsible for all reasonable travel costs incurred by HHSC or its authorized agent(s) relating to that monitoring. For purposes of this section, "reasonable travel costs" 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. The MCO is encouraged to inform and arrange for access to training programs to provide continuing education credits for Providers. The MCO may coordinate with national and local provider associations to deliver continuing education training. Continuing education training must focus on enhancing Provider understanding of the complex and special physical and behavioral healthcare needs of the STAR Kids Population. To improve Provider access to these continuing education training programs, the MCO must make every effort to allow Providers to complete training programs through the Internet.

8.1.4.6 Provider Reimbursement

The MCO must pay for all Medically Necessary and Functionally Necessary Covered Services provided to Members. The MCO's Network Provider Agreement must include a complete description of the payment methodology or amount, as described in **UMCM Chapter 8.1**.

The MCO must pay Out-of-Network providers using the Medicaid methodology as defined by HHSC in 1 Tex. Admin. Code § 353.4 and ensure that claims payment is timely and accurate as described in **Section 8.1.20.5**, "Claims Processing Requirements," and **UMCM Chapter 2.0**. 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

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.

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 across-the-board 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. The MCO must submit a written request for an across-the-board rate reduction to HHSC’s Director of Program Operations and provide a copy to the 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 no later than 60 days after the Medicaid fee schedule change, and any retroactive claim adjustments must be completed within 60 days after HHSC retroactively adjusts the Medicaid fee schedule.

8.1.4.6.1 Provider Preventable Conditions

STAR Kids MCOs must identify Present on Admission (POA) indicators as required in the **UMCM** Chapter 2.0, “Claims Manual,” and must reduce or deny payments for Provider Preventable Conditions that were not POA. This includes any hospital-acquired conditions or healthcare acquired conditions identified in the Texas Medicaid Provider Procedures Manual.

8.1.4.6.2 This Section Intentionally Left Blank

8.1.4.6.3 Advanced Payments

MCOs are required to develop a process by which providers may request advanced payments for authorized services that have not yet been delivered. The MCO will develop an agreement with the provider to determine what portion of funds for claims payments will apply towards the balance of the advanced payments until that balance is reduced to zero. The MCO may not charge the provider interest on the balance of the advanced payments.

8.1.4.7 Termination of Provider Contracts

The MCO must notify HHSC within five days after termination of a Network Provider contract that (1) impacts more than ten percent of its Members or (2) impacts more than ten percent of its Network for that provider type for that Service Area and Program. The MCO must also notify HHSC of Provider terminations in accordance with UMCM Chapter 5.4.1.1, "Provider Termination Report."

Additionally, unless prohibited or limited by applicable law, the MCO must make a good faith effort to give written notice of termination of a Network Provider, within 15 calendar days after receipt or issuance of the termination notice, to each Member who receives his or her primary care from, or who is seen on a regular basis by, the Network Provider. The MCO must send notice to: (1) all Members in a PCP's panel, and (2) all Members who have had two or more visits with the Network Provider for home-based or office-based care in the past 12 months.

8.1.4.8 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 Network 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 Network under the circumstances described in Texas Government Code § 531.066.

8.1.4.9 Provider Protection Plan

The MCO must comply with the HHSC's provider protection plan requirements for reducing the administrative burdens placed on Network Providers, and ensuring efficiency in Network enrollment and reimbursement. At a minimum, the plan must comply with the requirements of Texas Government Code § 533.0055, and:

1. Provide for timely and accurate claims adjudication and proper claims payment in accordance with **UMCM** Chapter 2.0.

2. Include Network Provider training and education on the requirements for claims submission and appeals, including the MCO's policies and procedures (see also **Section 8.1.4.4**, "Provider Relations Including Manual, Materials and Training.")
3. Ensure Member access to care, in accordance with **Section 8.1.3**, "Access to Care," and the UMCM's Geo-Mapping requirements (see **UMCM** Chapters 5.14.1 through 5.14.4.)
4. Ensure prompt credentialing, as required by **Section 8.1.4.2**, "Provider Credentialing and Re-credentialing."
5. Ensure compliance with state and federal standards regarding prior authorizations, as described in **Sections 8.1.9**, "Utilization Management," and **8.1.17.2**, "Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies."
6. 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.
7. Include other measures developed by HHSC or a provider protection plan workgroup, or measures developed by the MCO and approved by HHSC.

Additionally, the MCO must participate in HHSC's work group, which will develop recommendations and proposed timelines for other components of the provider protection plan.

8.1.4.10 Primary Care Providers and the Health Home

8.1.4.10.1 Primary Care Providers

The MCO's PCP Network may include Providers from any of the following practice areas:

1. General Practice;
2. Family Practice;
3. Internal Medicine;
4. Pediatrics;
5. Obstetrics/Gynecology (OB/GYN);
6. Advanced Practice Registered Nurses (APRNs);
7. Physician Assistants (PAs)
8. Federally Qualified Health Centers (FQHCs);
9. Rural Health Clinics (RHCs), and similar community clinics; and
10. Specialist physicians who are willing to provide a Health Home to selected Members with special needs and conditions.

The MCO must require PCPs to coordinate with Members, Caregivers, other Providers, STAR Kids Service Coordinators, and state and non-state entities to assure that the Member's medical and behavioral health needs are met. Other PCP requirements

include screening, identification, and referral to Medically Necessary or Functionally Necessary Covered Services and assessment and coordination of non-clinical services that impact the Member's health. The MCO must ensure that all STAR Kids PCPs provide patient- and family-centered care that serves the goals of improving Member care, outcomes, and satisfaction.

In order to qualify as a PCP for the STAR Kids program, APRNs and PAs must practice under the supervision of a Network physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP under this contract.

Texas Government Code Section 533.005(a)(13) require the MCO to use APRNs and PAs practicing under the supervision of a Network physician. 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. 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,
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 patient population within the specified age range, and
3. The Provider has admitting privileges to a local Hospital that includes admissions to pediatric units.

The PCP 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 such PCP duties must be within the scope of the specialist's license. The Member or the Member's LAR may initiate the request through the MCO for a specialist to serve as a PCP for the Member. The MCO must process such requests in accordance with 28 Tex. Admin. Code § 11.900. Specialists may limit the number of Members for whom they will serve as a PCP.

STAR Kids PCPs must either have admitting privileges at a Medicaid Hospital or make referral arrangements with a Provider who has admitting privileges to a Medicaid Hospital with a Pediatric Unit.

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 include in its Network 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, which meets language requirements of the Major Population Groups and which 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 patient 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 practitioner, 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 patients to leave a message;
3. The office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; and
4. Returning after-hours calls outside of 30 minutes.

The MCO 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 adult members over the age of 18 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: Provider education, Provider profiling, monitoring, and feedback activities.

The MCO must require PCPs, through Network Provider contract provisions or the Provider Manual, 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 these referrals. Best efforts must include, but not be limited to: Provider education activities and review of Provider referral patterns.

This section does not apply to Dual Eligible Members.

8.1.4.10.2 Health Home

The MCO must provide access to a Health Home to any Member the MCO determines would most benefit from a Health Home or for any Member who requests a Health Home. A Health Home must provide an array of services and supports, outlined below, that extend beyond what is required of a PCP. STAR Kids Health Homes must operate through either a primary care practice or, if appropriate, a specialty care practice and must provide a team-based approach to care that is designed to enhance ease of access, coordination between Providers, and quality of care.

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. Patient self-management education;
2. Provider education;
3. Patient-centered and family-centered care;
4. Evidence-based models and minimum standards of care; and
5. Patient and family support (including authorized representatives).

Health Home Services may also include:

1. A mechanism to incentivize providers for provision of timely and quality care;
2. Implementation of interventions that address the continuum of care;
3. Mechanisms to modify or change interventions that are not proven effective;
4. Mechanisms to monitor the impact of the Health Home Services over time, including both the clinical and the financial impact;
5. Comprehensive care coordination and health promotion;
6. Palliative care options in the event of a life-limiting diagnosis;
7. Comprehensive traditional care, including appropriate follow-up, from inpatient to other settings;
8. Data management focused on improving outcome-based quality of care and improved patient and provider satisfaction;
9. Referral to community and social support services, if relevant; and
10. Use of health information technology to link services, as feasible and appropriate.

8.1.4.10.3 Health Home Services and Participating Providers

The MCO must provide information and other resources to PCPs and other Health Home Providers regarding federal incentive programs and nationally recognized accreditation, recognition, and certification programs addressing medical and Health Home models. At a minimum, the MCO must consider offering financial incentives to Health Homes that achieve nationally recognized levels of accreditation, recognition, and certification for the development of a medical or Health Home model.

The MCO must develop provider incentive programs for designated Providers who meet the requirements for patient-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.

8.1.4.11 PCP Notification

The MCO must furnish each PCP with a current list of enrolled Members 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 the enrollment information in alternative formats, such as through access to a secure Internet site, when that format is acceptable to the PCP.

8.1.5 Member Services

The MCO must maintain a Member Services Department to assist Members in obtaining Covered Services. Each Member Services Department or another appropriate department must include Transition Specialists who are dedicated to assisting Members and Service Coordinators with transition planning for adulthood as described in **Section 8.1.38.8**. The MCO must maintain employment standards and requirements for Member Services Department staff and provide a sufficient number of staff for the Member Services Department to meet the requirements of this Section, including Member Hotline response times, and Linguistic Access capabilities, see **Section 8.1.5.6** "Nurse and Member Hotline Requirements." All Member Services Department staff must be provided with training that includes the following topics:

1. Eligibility policy;
2. Covered Services;
3. The STAR Kids Screening and Assessment Instrument and coordinating additional assessments and evaluations;
4. STAR Kids Program requirements;
5. Cultural Competency;
6. Trauma-informed care;
7. Positive Behavior Supports;
8. Community inclusion;
9. Person-centered practices;
10. Member assessments and special evaluations;
11. Communication strategies for Members with limited English proficiency;
12. The purpose and information included in an Individual Service Plan (ISP); and
13. Non-capitated Services.

8.1.5.1 Member Materials

The MCO must design, print, and distribute Member identification (ID) cards and a Member Handbook to Members. Within 5 business days following the receipt of an Enrollment File from the HHSC Administrative Services Contractor, the MCO must mail a Member ID card and Member Handbook to the Case Head or Account Name for each new Member. When the Case Head or Account Name is associated with two or more new Members, the MCO is only required to send one Member Handbook. The MCO is responsible for mailing materials only to those Members for whom valid address data are contained in the Enrollment File.

All 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 making up 10 percent or more of the managed care eligible population in the MCO's Service Area, as specified by HHSC. HHSC will provide the MCO with reasonable notice when the population reaches the 10 percent threshold 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. Member Materials must comply with the requirements set forth in the **UMCM**, including required critical elements and marketing policies and procedures.

The MCO must submit Member Materials to HHSC for approval prior to publication or distribution, including revisions to previously approved Member Materials. If HHSC has not responded to the MCO's request for review within 15 Business Days, the MCO may use the submitted materials provided the MCO first notifies HHSC of its intended use. HHSC reserves the right to require discontinuation, revision, or correction of any Member Materials, including those previously approved by HHSC, that violate the terms of this Contract, including the Marketing Policies and Procedures as described in the **UMCM** Chapter 4.3, "Uniform Managed Care Marketing Policies and Procedures."

If the MCO distributes HHSC-approved Member Materials to groups of Members or all Members (i.e., "mass communications,") it also must post a copy of the materials on its website.

The MCO's Member Materials and other communications cannot contain discretionary clauses, as described in Texas Insurance Code Section 1271.057(b).

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 number;
3. The effective date of the PCP assignment;

4. The PCP's name (not required for Dual Eligible STAR Kids Members), address (optional for all products), and telephone number (not required for Dual Eligible STAR Kids Members);
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 the **UMCM** Chapter 3, "Critical Elements."

The MCO must reissue the Member ID card if a Member reports a lost card, there is a Member 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**, 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 must, at a minimum, meet the Member Materials requirements specified by **Section 8.1.5.1** above and must include critical elements in the **UMCM** Chapter 3, "Critical Elements."

The MCO must produce and distribute 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 the change in Covered Services. In addition to modifying the Member Materials for new Members, the MCO must notify all existing Members of the Covered Services change during the timeframe specified in this subsection.

8.1.5.4 Provider Directory

The Provider Directory and any substantive revisions must be approved by HHSC prior to publication and distribution. The MCO must submit draft Provider directory updates for HHSC's prior review and approval if changes other than PCP information or clerical corrections are incorporated into the Provider Directory.

As described in **Section 7**, during the Readiness Review, the MCO must develop and submit the draft Provider Directory template for HHSC's approval and must submit a final Provider Directory incorporating changes required by HHSC prior to the Operational Start Date. The MCO must submit draft and final Provider to the deadlines established in **Section 7**.

The Provider Directory must, at a minimum, meet the Member Materials requirements specified by **Section 8.1.5.1** above and must include critical elements in the **UMCM**

Chapter 3. The Provider Directory must include only Network Providers credentialed by the MCO in accordance with **Section 8.1.4.2**. 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.

The MCO must update the Provider Directory on a quarterly basis. The MCO must make the updates available to existing Members upon request, and must provide the updates to the HHSC Administrative Services Contractor in hard copy and via File Transfer Protocol (FTP) at the beginning of each state fiscal quarter. HHSC will consult with the MCOs and the HHSC Administrative Services Contractors to discuss methods for reducing the MCO's administrative costs for producing new Provider Directories, including considering submission of new Provider Directories on a semi-annual rather than a quarterly basis if an MCO has not made major changes in its Provider Network, as determined by HHSC. Weight limits for the Provider Directories are included in **UMCM** Chapter 3.1, "MMC Provider Directory." Weight limits may vary by Service Area. HHSC will require MCOs that exceed the weight limits to compensate HHSC for postage fees in excess of the weight limits.

The MCO must send the most recent Provider Directory, including any updates, to Members upon request. The MCO must, at least annually, include written and verbal offers of the Provider Directory in its Member outreach and education materials.

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, its Provider Network, 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's website must comply with HHSC's marketing policies and procedures, as set forth in the **UMCM** Chapter 4.3, "Uniform Managed Care Marketing Policies and Procedures."

To minimize download and "wait times," the website must not use tools or techniques that require significant memory, disk resources, or special intervention on the customer side to install plug-ins or additional software. The MCO may not use proprietary items that would require a specific browser. HHSC strongly encourages the use of tools that take advantage of efficient data access methods, reduce server load, and consume less bandwidth.

The MCO must develop and make available a Member website to provide STAR Kids specific information to Members. The MCO must also optimize this website for mobile device use. The website's STAR Kids content must be:

1. Written in English, Spanish, and the languages of any other Major Population Groups (i.e., groups making up 10 percent or more of the managed care eligible population in the MCO's Service Area. HHSC will provide the MCO with reasonable notice when the population reaches the 10 percent threshold);
2. Culturally appropriate;
3. Person-centered
4. Written for understanding at the 6th grade reading level; and
5. Be geared to the needs of the enrolled population.

At a minimum, the MCO's Member website must include:

1. A Provider Directory or Network Provider search functionality;
2. MCO contact information, including physical and mailing addresses and phone and fax numbers of MCO headquarters and any regional offices;
3. Information about Service Coordination and how to obtain Service Coordination, including contact information;
4. Information about Member Advocates, including contact information;
5. Information about the Complaints and Appeals process, including contact information;
6. A list of Covered Services;
7. Information on outages and downtime for Member-facing systems; and
8. An electronic version of the Member handbook.

The MCO's internet website must contain the requirements of UMCM **Chapter 3.32**, "MMC/CHIP Website Critical Elements."

The MCO's pharmacy website must contain the requirements of UMCM **Chapter 3.29**, "MMC/CHIP Pharmacy Website Required Critical Elements."

The online Provider Directory or online Provider search functionality must also identify Providers that provide MDCP STAR Kids services. All MCOs must list home health and Ancillary Providers on their websites. The search functionality must, at a minimum, allow a user to search or sort by: geographic location (i.e., distance in miles from a starting address); Provider name; practice name; Provider specialty and sub-specialty; open or closed panel; hours of operations and after hour availability; and languages in which the Provider is fluent. Home and Community-based LTSS Providers must be listed by subcategory.

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

The website's content for Providers must provide:

1. Training program schedules and topics and directions for Provider enrollment in training, including continuing education credits for training on issues related to the STAR Kids Population.
2. Information on how to apply to become a Network Provider.
3. Information on cultural competency and how to provide culturally sensitive care.
4. Information on the 24-hour Nurse Hotline and how to seek specialty consultations and referrals.
5. Information regarding outages and downtime for Provider-facing systems.

8.1.5.6 Nurse and Member Hotline Requirements

The MCO must operate a toll-free Nurse Hotline and a toll-free Member Hotline. Nurse Hotline and Member Hotline services must meet Cultural Competency requirements and must appropriately handle calls from non-English speaking callers, as well as calls from individuals who are deaf or hard-of-hearing. The MCO must employ bilingual Spanish-speaking and other multi-lingual Member Services representatives, as appropriate, and must secure the services of other contractors as necessary to meet these requirements. The MCO must provide these oral interpretation services to all Hotline callers free of charge.

For the Member and Nurse Hotlines, the MCO must process all incoming 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 Providers and Members. The MCO must ensure that both toll-free Hotlines meet the following minimum performance requirements:

1. At least 99 percent of calls are answered by the fourth ring or an automated call pick-up system.
2. No more than 1 percent of incoming calls receive a busy signal.
3. 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.
4. The call abandonment rate is seven percent or less.
5. The average hold time is two minutes or less.

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

Members may access the Nurse Hotline and the Member Hotline through the same toll-free number, but must be given the option to direct their calls based on whether they are related to a clinical or non-clinical issue, an emergent issue, or a routine issue. However, the MCO must report hotline call statistics separately for both the Member Hotline and the Nurse Hotline. The Member Hotline must be dedicated to serving STAR Kids Members. The Nurse Hotline may also serve members of other programs operated through the MCO. Staff trained to manage general calls may provide back-up to dedicated Hotline staff during peak periods or in cases of emergency, in order to

maintain Hotline performance standards and respond to urgent Member calls, but at least 95 percent of calls must be answered by dedicated Hotline staff.

The MCO must monitor its performance regarding the Nurse and Member Hotline standards and submit performance reports summarizing call center performance for the Nurse and Member Hotlines as indicated in **Section 8.1.22.2** and the **UMCM** Chapter 5.4.3.

If HHSC determines that it is necessary to conduct onsite monitoring of the MCO's Nurse Hotline or Member Hotline functions, the MCO is responsible for all reasonable travel costs incurred by HHSC or its authorized agent(s) relating to such monitoring. For purposes of this section, "reasonable travel costs" 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.

8.1.5.6.1 Nurse Hotline

The MCO must operate a toll-free Nurse Hotline that Providers and Members can call 24 hours a day, 7 days a week. The Nurse Hotline must be staffed with nurses who are knowledgeable about the STAR Kids Program, Covered Services, the STAR Kids Population, and Provider resources. Nurses must be available 24 hours per day and able to respond to calls from Providers and Members seeking clinical information, guidance on specialty referrals or requests for specialty Provider consultations. Nurses must have access to an on-call licensed Behavioral Health clinician 24 hours per day to assist with crisis calls. Only those persons who can identify themselves through the caller verification process approved by HHSC may obtain personal health information through the Nurse hotline.

At a minimum, the MCO's Nurse Hotline representatives must be:

1. Knowledgeable about Covered Services, including Behavioral Health Services, Texas Health Steps, the Medical Transportation Program, pharmacy and vision.
2. Knowledgeable about the Medical Home Services Model, Health Homes, and Integrated Primary Care.
3. Able to answer questions pertaining to the role of the PCP and the Health Home.
4. Able to answer clinical and non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services.
5. Knowledgeable and trained in issues related to child abuse and how to assist Members seeking care and services.
6. Knowledgeable of crisis services and supports.
7. Able to give information about Providers in a particular geographical area.
8. Trained regarding Cultural Competency.
9. Trained to handle and properly refer behavioral health crises.

10. Able to answer clinical and non-clinical questions pertaining to accessing services that the MCO does not provide or arrange for (such as Non-capitated Services; community and social service resources; and community-based case management services for which the STAR Kids population may be eligible).
11. Able to respond to Provider questions regarding specialty referrals and to arrange for consultations with MCO clinical staff, Service Coordinators or other Providers. For example, a PCP with a Member in their office may call with a need for an immediate consult with MCO clinical staff or a behavioral health Provider.
12. Able to respond to questions regarding the Disease Management programs included in the Model.
13. Trained regarding: a) emergency prescription process and what steps to take to immediately address Members' problems when pharmacies do not provide a 72-hour supply of emergency medicines. 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 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 and DME processes; 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.

8.1.5.6.2 Member Hotline

In addition, the MCO must operate a toll-free Member Hotline that Members can call 24 hours a day, 7 days a week. The Member Hotline must be staffed between the hours of 8:00 a.m. to 5:00 p.m. local time for all areas of the state, Monday through Friday, excluding state-approved holidays. Member Service representatives must be knowledgeable about the STAR Kids Program, Covered Services, Non-capitated Services, and the STAR Kids Population. The MCO must develop a process to authenticate callers as the Member or the Member's LAR through the Member Hotline. Before the MCO implements the caller authentication process, HHSC must approve the process in writing. Only those persons who can identify themselves through the caller authentication process as the Member or the Member's LAR may obtain the Member's personal health information through the Member Hotline.

The MCO must ensure, at a minimum, that after business hours and on weekends and holidays, the Member Services Hotline is answered by an automated system with the capability to provide callers with operating hours, instructions regarding how to access the Nurse Hotline, and instructions on what to do in cases of emergency. All recordings must be in English and in Spanish, and the languages of any Major Population Group. A voice mailbox must be available after-hours for callers to leave messages. The MCO's Member Services representatives must return Member calls received by the automated system 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. In order to ensure service standards are achieved, the MCO must implement a call and customer service monitoring plan. At a minimum, the MCO's Member Service representatives must be:

1. Knowledgeable about Covered Services, including Behavioral Health, Texas Health Steps, MDCP STAR Kids, HCBS Waiver programs, the Medical Transportation Program, pharmacy, dental and vision.
2. 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.
3. Able to answer non-technical questions pertaining to the role of the PCP and about the Health Home and Integrated Primary Care.
4. Trained regarding the Service Coordination process and how to transfer Members to Service Coordinators.
5. Able to answer non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services.
6. Knowledgeable and trained in issues related to child abuse and how to assist Members seeking care and services.
7. Able to give information about Providers in a particular geographical area.
8. 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 in the Program.
9. Trained regarding Cultural Competency.
10. Trained to triage calls to the appropriate MCO staff person.
11. Able to answer non-clinical questions pertaining to accessing services that the MCO does not provide or arrange for (such as Non-capitated Services) and community and social service resources for which the STAR Kids population may be eligible).
12. Trained to help Members obtain Covered Services and Non-capitated Services, as appropriate.
13. Able to provide information on how to file Member Appeals and Complaints.
14. 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 Kids program.

8.1.5.7 Member Education

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

1. How the MCO system operates, including the role of the PCP; Health Home; Individual Service Plan (ISP); prior authorization process; and what may be provided through Service Coordination;
2. How to obtain Covered Services and non-covered services after hours and on weekends;
3. The Member Complaint, Appeals and Fair Hearings process;
4. Covered Services, and limitations and any Value-added Services offered by the MCO;
5. The value of screening and preventive care, and
6. How to obtain Covered Services and non-covered services, including:
 - a. Emergency Services;
 - b. Specialty care;
 - c. HCBS Waiver services;
 - d. Behavioral Health Services;
 - e. Private Duty Nursing;
 - f. Personal Care Services;
 - g. Disease Management services;
 - h. Service Coordination;
 - i. Durable Medical Equipment and Supplies;
 - j. Early Childhood Intervention (ECI) Services;
 - k. Screening and preventive services, including well-child care (Texas Health Steps medical checkups);
 - l. Consumer-Directed Services;
 - m. Member copayment responsibilities (if HHSC implements Medicaid cost sharing after the Effective Date of the Contract);
 - n. suicide prevention;
 - o. Head Start;
 - p. identification and health education related to Obesity;
 - q. Obtaining 72-hour supplies of emergency prescriptions from pharmacies enrolled with HHSC as Medicaid Providers;
 - r. Cognitive Rehab Therapy
 - s. Community First Choice (CFC) services;
 - t. Case Management for Children and Pregnant Women; and
 - u. The Medical Transportation Program.

The MCO must provide health promotion and wellness information tailored to the needs of individual Members. The MCO must propose, implement, and assess innovative Member education strategies for wellness and immunizations, as well as general health promotion and prevention. The MCO must conduct wellness promotion programs to improve the health status of its Members, including information on its Service Coordination (**Section 8.1.38**) and Disease Management (**Section 8.1.14**) programs.

The MCO must work with its Providers to integrate health education, wellness, and prevention training into the care of each Member.

The MCO also must provide condition and disease-specific information and educational materials to Members. Condition- and disease-specific information must be oriented to various groups within the STAR Kids eligible population.

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

8.1.5.7.1 Member Education on Abuse, Neglect, or Exploitation

At the time a STAR Kids 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 must be provided.

8.1.5.8 Cultural Competency Plan

The MCO must have a comprehensive written Cultural Competency Plan describing how the MCO will ensure culturally competent services, and provide Linguistic Access and Disability-related Access. 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 36.303, 42 C.F.R. § 438.10(f)(6)(i), and 1 Tex. Admin. § 353.411.

The Cultural Competency Plan must describe how the individuals and systems within the MCO will effectively provide services to people of all cultures, education levels, family composition, races, ethnic backgrounds, 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. Modifications and amendments to the plan must be submitted to HHSC no later than 30 days prior to implementation. The Plan must also be made available to the MCO's Provider Network. HHSC may require the MCO to update the plan to incorporate new or amended requirements based on HHSC guidance. In that event, the MCO has 60 days to submit the updated plan to HHSC.

As required by 1 Tex. Admin. Code § 353.411, the MCO must arrange and pay for Competent Interpreter services 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 can access Competent Interpreter services (including when the Member is in a Provider's office or accessing emergency services).

8.1.5.9 Member Complaint and Appeal Process

The MCO must develop, implement and maintain a transparent system for tracking, resolving, and reporting Member Complaints regarding its Member assessments, services, processes, procedures, and staff. In this case transparency involves adoption and use of tracking methodologies that are streamlined, document, easily understood and frequently updated. The MCO must ensure that Member Complaints are resolved within 30 calendar days after receipt. 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. The state will refer Member Complaints that it receives regarding the MCO to the MCO for resolution. Please see the **Attachment A**, "STAR Kids Contract Terms," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix."

The MCO must develop, implement, and maintain a transparent system for tracking, resolving, and reporting Member Appeals regarding the denial or limited authorization of a requested service. The system must include information on 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 the Service Coordinator for all Level 1 and Level 2 Members is informed about the status of the Appeal. For all Members the MCO must establish a mechanism that allows Member Service representatives to view and report to the Member or Member's LAR on the status of a Complaint or Appeal.

The MCO must ensure that Member Appeals are resolved within 30 calendar days of receipt, 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 if at least 98 percent of Member Appeals are not resolved within 30 days of receipt of the Appeal by the MCO. Please see **Attachment A**, "STAR Kids Contract Terms," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix."

The MCO must use providers with appropriate experience to review Complaints and Appeals. Appeals submitted on behalf of STAR Kids Members must be reviewed by clinicians with pediatric experience or appropriate specialists before issuing a final decision.

The MCO must follow the Member Complaint and Appeal System described in **Section 8.1.29**.

8.1.5.10 Member Advisory Groups

The MCO must establish and conduct quarterly meetings with Members in each Service Area in which it operates a STAR Kids program. The meetings may only address STAR Kids program and the needs and goals of STAR Kids Members. The MCO must publicize quarterly meetings so that Members, Member families and consumer

advocates are made aware of the meeting time and location at least three weeks in advance of each meeting. Membership in the Member Advisory Group(s) must include, at least three Members or Member's LARs attending each meeting and allow for member advocates to participate. The MCO must maintain a record of Member Advisory Group meetings, including agendas and minutes, for at least three years. The MCO must submit to HHSC a quarterly summary of major items discussed and concerns or feedback received at the Member Advisory Group meetings.

8.1.5.11 Member Eligibility

The MCO is encouraged to provide eligibility renewal assistance for Members whose eligibility is about to expire or have been identified by the MCO as being at risk for losing eligibility.

8.1.6 Marketing and Prohibited Practices

The MCO and its Subcontractors must adhere to the Marketing Policies and Procedures as set forth by HHSC in the STAR Kids Contract, and the **UMCM** Chapter 4.3, "**Uniform Managed Care Marketing Policies and Procedures.**"

8.1.7 Quality Assessment and Performance Improvement (QAPI)

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 QAPI 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(b)(5) and 11.1902. The MCO must also meet the requirements of 42 C.F.R. § 438.240.

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 a requirement securing cooperation with the QAPI in its Network Provider agreements.

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 on-going 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 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 the 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 a file of the Subcontractors. 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 on-going process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members. 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. The MCO must also collect data and monitor and evaluate prevention of inpatient psychiatric utilization resulting from the administration of adequate outpatient Behavioral Health Services.

8.1.7.6 Clinical Practice Guidelines

The MCO must adopt not less than two evidence-based clinical practice guidelines. These practice guidelines must be based on valid and reliable clinical evidence, consider the needs of the MCO's Members, be adopted in consultation with contracting health care professionals, 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 STAR Kids MCOs so that Service Area Providers do not receive 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 90 percent 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 Clinical and Administrative Advisory Committee

The MCO will establish Clinical and Administrative Advisory Committees in each Service Area in which it operates a STAR Kids program. The Clinical and Administrative Advisory Committees will perform the following functions:

1. Assist the MCO in developing, reviewing, and revising clinical practice guidelines, based on clinical best practices and community standards.
2. Assist the MCO in reviewing general clinical practice patterns and assessing Provider compliance with clinical guidelines.

3. Assist the MCO, HHSC, and the state's External Quality Review Organization (EQRO) in developing Quality Improvement strategies and studies.
4. Assist in developing improved administrative procedures.
5. Provide the MCO with recommendations on how to improve care based on Member feedback.
6. Connect network Providers and MCO clinical experts for purposes of peer support and best practice information sharing.

Each Clinical and Administrative Advisory Committee must meet at least once per quarter. The Clinical and Administrative Advisory Committee must be comprised of community Providers and other physical health and Behavioral Health experts that serve STAR Kids Members. The STAR Kids MCO must publicize the meetings to Network Providers and chair the meetings. Membership in the Clinical and Administrative Advisory Committee must include, at a minimum, a PCP, Specialty Care Provider, Behavioral Health Provider, Home and Community Support Services Agency representative, a therapy Provider, a medical equipment and supplies Provider, and a Pharmacy Provider in order to enable it to provide specialized review, expertise and consultation on a variety of health issues. The MCO may establish specialized workgroups that report findings to the Clinical and Administrative Advisory Committee. The MCO must maintain a record of Clinical and Administrative Advisory Committee meetings, including agendas and minutes, for at least three years.

8.1.7.8 Provider Credentialing and Profiling

In accordance with Section 8.1.4.2, 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 5.7.1.

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 the Providers.

Provider profiling activities must include:

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. At least one of the indicators must measure the number of Texas Health Steps checkups completed by the Member's PCP.
2. Including the Medical Advisory Committees Clinical Advisory Committees in reviewing general Provider practice patterns and preparing recommendations for categories of Providers who are not in compliance with clinical practice guidelines.

3. Establishing PCP, Provider, group, Service Area or regional Benchmarks for areas profiled, where applicable; and
4. Providing feedback to individual PCPs and Providers regarding the results of their performance and the overall performance of the Provider Network.

8.1.7.9 Network Management

The MCO must:

Use the results of its Provider profiling activities to identify areas of improvement for PCPs and Providers;

Establish Provider-specific quality improvement goals for priority areas in which a Provider or Providers do not meet established MCO standards or improvement goals;

Develop and implement incentives, which may include financial and non-financial incentives, to motivate Providers to improve performance on profiled measures; and

At least annually, measure and report to HHSC on the Provider Network and individual Providers' progress, or lack of progress, towards the improvement goals.

8.1.7.9.1 Physician Incentive Plans

If the MCO implements a physician incentive plan under 42 C.F.R. §438.6(h), 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 5 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 patients are pooled, the method used (HHSC approval is required for the method used); and

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.

8.1.7.9.2 MCO Value-Based Contracting

The MCO must develop and submit to HHSC a written plan for expansion of value-based contracting with its physician and non-physician Providers that encourages innovation and collaboration, and increases quality and efficiency. Contracting and payment structures should be focused on incentivizing quality outcomes, shared savings, or both resulting from the reduction of inappropriate utilization of services, including inappropriate admissions and readmissions rather than be based on volume. The plan will include mechanisms by which the MCO will provide incentive payments to hospitals, physicians and other health care providers for quality care resulting in reductions of inappropriate services. The plan will include quality metrics required for incentives, recruitment strategies of providers, and a proposed structure for incentive payments, shared savings, or both. Beginning with SFY15, the MCO must submit its state fiscal year plan to HHSC no later than November 1 of each year using UMCM Chapter 8.4, “Plan for Value-Based Contracting.” HHSC will evaluate the plan and provide feedback to the MCO. Upon HHSC’s approval of the plan, HHSC will retrospectively evaluate the MCO on its execution of the written plan. Modifications can be made to the plan after submission but are subject to HHSC review and approval. Plan approval is based on the following criteria: the number of providers, diversity of selected providers, geographic representation, and the methodology of the shared savings, data sharing strategy with providers, and other factors. Each year, the annual plan must show a measurable increase in the percent of business (providers, dollars, or other) being incentivized from the previous year.

HHSC’s retrospective review of the execution of the plan may include a review of encounter data, MCO financial statistical reports, and surveys or interviews with MCO representatives or providers. The MCO must submit additional information upon HHSC's request. HHSC may delay or reduce payments to the MCO if it does not submit a plan that meets the HHSC requirements by the required deadline or if it does not effectively execute a plan that has been approved by HHSC.

8.1.7.10 This Section Intentionally Left Blank

8.1.7.11 Pay-for-Quality Program

To comply with legislative direction, HHSC implemented the Pay-for-Quality (P4Q) Program. The MCO must participate in this program. P4Q uses an incremental improvement approach that provides financial incentives and disincentives to MCOs based on their year-to-year progress toward pre-specified quality goals. The quality of care measures used in this initiative are a combination of process and outcome measures that include select potentially preventable events as well as other measures specific to the STAR Kids population. The specification for the measures, including attainment goals, will be included in the **UMCM**.

The P4Q Program includes an at-risk pool that is currently based on the MCO capitation rate. In the Pay-for-Quality Program, points are assigned to each MCO based on its incremental performance on each quality measure, with positive points assigned for year-to-year improvements over the minimum baseline and negative points assigned for most year-to-year declines. The P4Q Program model sets minimum baseline performance levels for the measures so that low-performing MCOs would not be rewarded for substandard performance. Rewards and penalties are based on rates of improvement or decline over the baseline. All funds recouped from MCOs through the assignment of negative points are redistributed to MCOs through the rewarding of positive points. Each MCO pays in proportion to its total negative points and receives funds in proportion to its total positive points. No funds are returned to the State.

HHSC will use each STAR Kids MCO's performance relative to specified measures during the first year to create the baselines against which each MCO's year two and subsequent years' performances will be measured.

Under the P4Q program, HHSC will place each MCO at risk for 4% of the Capitation Payment. HHSC retains the right to reduce the percentage of the Capitation Payment placed at risk in a given FSR Reporting Period.

HHSC will pay the MCO the full monthly Capitation Payments as described in **Section 6.2**. Then, at the end of the P4Q data collection period HHSC will evaluate the MCO's performance and assign points and dollar amounts using the methodology set out in **UMCM**, Chapter 6.2.12, "Texas Medicaid and CHIP Pay for Quality (P4Q) Technical Specifications." HHSC's objective is that all MCOs achieve performance levels that enable them to retain the full at-risk amount.

Specific contractual requirements, including performance measures, and program details are set forth in **UMCM**, Chapters 6.2.11, "Performance Measures for Pay for Quality," and 6.2.12, "Medicaid/CHIP Pay for Quality (P4Q) Technical Specifications."

Failure to timely provide HHSC with necessary data related to the calculation of the P4Q performance indicators will result in HHSC's assignment of a zero percent (0%) performance rate for each related performance indicator.

MCOs will report actual Capitation Payments received on the Financial Statistical Report (FSR) during the FSR Reporting Period that is at risk (i.e., the MCO will not report Revenues at a level equivalent to 96% of the payments received, leaving four percent (4%) as contingent). Any subsequent loss of the at-risk amount that may be realized will be reported below the income line, as an informational item, and not as an offset to Revenues or as an Allowable Cost (as described in the **UMCM**, Chapter 5.3.1, “Financial Statistical Report and Instructions”).

HHSC will evaluate the P4Q program methodology annually in consultation with MCOs. HHSC may then modify the methodology as it deems necessary and appropriate, in order to motivate, recognize, and reward MCOs for superior performance.

8.1.7.12 Collaboration with the External Quality Review Organization (EQRO)

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 selected HEDIS measures that require chart reviews. During the first year of operations, HHSC anticipates that the selected measures will include, at a minimum, well-child visits and immunizations, appropriate use of asthma medications, measures related to Members with diabetes, and control of high blood pressure.

8.1.7.12.1 Survey Reports

The EQRO conducts Member surveys using validated and nationally accepted instruments, including Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, Experience of Care & Health Outcomes (ECHO) surveys, and the RAND Health surveys. This process helps to ensure that Members’ perspectives about their experiences with care are captured and communicated to stakeholders and the MCOs.

8.1.8 Other Quality Initiatives

MCOs must participate in all quality initiatives developed by HHSC and must provide HHSC, the EQRO, or the Quality Vendor with all information requested for quality purposes. This includes participating in all surveys conducted by HHSC, the EQRO, or the Quality Vendor. MCOs must also collaborate with the EQRO or the Quality Vendor to ensure medical records are available for focused clinical reviews.

8.1.9 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, 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.

The MCO must issue coverage determinations, including adverse determinations, according to the following timelines:

1. Within three Business Days after receipt of the request for authorization of services;
2. Within one Business Day for concurrent hospitalization decisions; and
3. Within 1 hour 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.

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. The prior authorization process does not result in undue delays in services;
4. 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;"
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 after normal business hours. The MCO must respond to calls within one business day;
6. Confidentiality of clinical information; and
7. Compensation to individuals or entities conducting Utilization Review activities is not 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),

and quality is not adversely impacted by financial and reimbursement-related processes and decisions.

For an MCO 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 that the MCO is using the same UM guidelines as those prescribed for use by Local Mental Health Authorities by MHMR which are published at: <http://www.dshs.state.tx.us/mhprograms/RDMUMProcess.shtm>; and
9. Refer suspected cases of Provider or Member Fraud, Abuse, or Waste to the Office of Inspector General (OIG) as required by **Section 8.1.21**.

8.1.9.1 Compliance with State and Federal Prior Authorization Requirements

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 1369.256, 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, once adopted.

8.1.9.2 Toll-free Fax Line for Service Authorizations

The MCO must provide access to a toll-free fax line where Providers may send requests for authorization of services and any supplemental information related to service authorization.

8.1.10 Early Childhood Intervention (ECI)

8.1.10.1 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 otherwise meeting eligibility criteria for ECI services in accordance with 40 Tex. Admin. Code Chapter 108 within seven calendar 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, 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 the Department of Assistive and Rehabilitative Services—Division for Early Childhood Intervention Services 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.

8.1.10.2 Eligibility

The local ECI program will determine eligibility for ECI services using the criteria contained in 40 Tex. Admin. Code Chapter 108.

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.

8.1.10.3 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).

8.1.10.4 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 in amount, duration, scope, and service setting 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.

8.1.10.5 Covered Services and Reimbursement

The interdisciplinary team, including a licensed professional of the healing arts (as defined in 40 Tex. Admin. Code § 108.103) practicing within the scope of their license, determines Medical Necessity for ECI Covered Services established by the 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 Early Childhood Intervention Specialized Skills Training are Non-capitated Services, as described in Section 8.1.24.8. See Section 8.1.16, regarding NorthSTAR coverage for Behavioral Health Services for STAR Kids Members in the Dallas Service Area.

Members in ECI will be classified as Members with Special Healthcare Needs (MSHCN) as described in 8.1.13. MCOs must offer Service Management 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.

8.1.11 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 potentially eligible for WIC. The MCO may use the nutrition education provided by WIC to satisfy certain health education requirements of the Contract.

8.1.12 This Section Intentionally Left Blank

8.1.13 Services for Members with Special Health Care Needs

All STAR Kids Members are considered to be Members with Special Health Care Needs (MSHCN). Due to tremendous variation in the service needs of MSHCN, STAR Kids MCOs must determine service and support needs on an individual basis.

8.1.13.1 Identification

The MCO must use the STAR Kids Screening and Assessment Process described in **Section 8.1.39**, as well as other methods determined appropriate by the MCO, to identify Members who require special services described in this section and ongoing special conditions requiring a course of treatment or regular monitoring. The MCOs assessment methods must use appropriate health care professionals.

The MCO must develop and maintain a system and procedures for identifying:

1. Members who are medically complex;
2. Children with Severe Emotional Disturbance (SED);
3. Members with disabilities or chronic or complex physical, behavioral health, and chemical dependency conditions, including high-cost catastrophic cases;
4. Members with high-risk pregnancies; and
5. Members with significant challenges in their natural support systems.

The MCO will determine whether the Member requires additional Service Coordination and special services. The MCO must provide information to the HHSC Administrative Services Contractor that identifies all Members with Complex Conditions. The information must be provided to HHSC as specified in the Joint Interface Plan found in the **UMCM**, and updated with newly identified Members with Complex Conditions by the 10th day of each month.

In order to prevent duplication of activities if a Member changes MCOs, the former MCO must provide the receiving MCO with information concerning the results of the MCO's identification and assessment of that Member's needs, including results from the STAR Kids Screening and Assessment Instrument (SAI) and the Member's Individual Service Plan (ISP). To ensure Continuity of Care, if a Member is transitioning from another MCO, the MCO must contact the Member's prior MCO and request information regarding the

Member's needs, current Medical Necessity determinations, authorized care, and treatment plans. The receiving MCO must ensure that the Member's new Service Coordinator, once assigned, contacts the Member's former Service Coordinator at the former MCO to ensure a seamless transition of service coordination. The MCO must continue to provide services included in the prior treatment plan until the authorized treatment plan is completed, or until the MCO is able to complete their own STAR Kids Screening and Assessment Process and issue a new treatment plan. The MCO must allow the Member to continue to receive services with his or her existing provider and allow an Out-of-Network authorization to ensure the Member's condition remains stable and services are consistent to meet the Member's needs. The Out-of-Network authorization will continue until the authorized treatment plan is completed or the MCO can provide comparable services to transition the Member to a Provider who will be able to meet the Member's complex needs.

8.1.13.2 Access to Care for MSHCN

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.

8.1.14 Disease Management (DM)

The MCO must provide, or arrange to have provided to Members, comprehensive disease management services consistent with state statutes and regulations. DM services must be part of a person-based approach to DM and holistically address the needs of persons with multiple chronic conditions. The MCO must have a DM Program that addresses asthma and diabetes and must develop and implement DM services that relate to chronic conditions that are prevalent among Members. HHSC will not identify individual Members with chronic conditions. The MCO must implement policies and procedures to ensure that Members that require DM services are identified and enrolled in a program that provides DM services.

The MCO must develop and maintain screening and evaluation procedures for the early detection, prevention, treatment, or referral of participants at risk for or diagnosed with asthma, diabetes, and other chronic conditions identified by the MCO. The MCO must ensure that all Members identified for DM are enrolled into a DM Program with the opportunity to opt out of these services within 30 days while still maintaining access to all other Covered Services.

For all new Members not previously enrolled in the MCO and who require DM services, the MCO must evaluate and ensure continuity of care with any previous DM services in accordance with the requirements in the **UMCM**.

The MCO's DM Program must include:

1. Patient Self-management Education;
2. Provider/Practice Delivery System Design;
3. Provider education;
4. Evidence-based models and minimum standards of care;
5. Standardized protocols and participation criteria;
6. Physician-directed or physician-supervised care;
7. Implementation of interventions that address the continuum of care;
8. Mechanisms to modify or change interventions that are not proven effective; and
9. Mechanisms to monitor the impact of the DM Program over time, including both the clinical and the financial impact; and
10. Technological support

The MCO must maintain a system to track and monitor all DM participants for clinical, utilization, and cost measures.

HHSC encourages MCOs to develop provider incentive programs for Designated Providers who meet the requirements for patient-centered medical homes found in Texas Government Code § 533.0029.

The MCO must provide designated staff to implement and maintain the DM Program and to assist participating Members in accessing DM services. The MCO must educate Members and Providers about the MCO's DM Program and activities. Additional requirements related to the MCO's Disease Management Program and activities are found in the **HHSC UMCM**.

8.1.14.1 Special Populations

The MCO must 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 sub-contracted 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.

The MCO must provide HHSC with its plan for management of super-utilizers including the criteria listed above using UCM Chapter 9.4, "Plan for Special Populations Program." 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 year to year as long as submission reflects the current state of their special population program and is updated as necessary on evaluation methodologies and key findings. HHSC may request updates to the plan during the state fiscal year as part of ongoing quality improvement efforts. .

8.1.14.2 DM Services 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 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 their PCP.

HHSC encourages MCOs to develop provider incentive programs for Designated Providers who meet the requirements for patient-centered medical homes found in Texas Government Code § 533.0029.

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 **Section 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 STAR Kids Program and identified Providers. Based on HHSC's retrospective evaluation, the MCO 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 Comprehensive Care Program Community-Based Services

The MCO must provide all benefits and services authorized through the Comprehensive Care Program (CCP), including Personal Care Services (PCS) and Private Duty Nursing (PDN). PCS must be made available to Members who require assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), or health maintenance activities (HMAs) because of a physical, cognitive, or behavioral limitation that is related to the Member's disability or chronic health condition. PCS must be authorized if determined appropriate through the STAR Kids Screening and Assessment Instrument and upon receipt of a Practitioner Statement of Need (PSON).

PDN services include nursing and caregiver training and education. PDN must be available to all Members determined eligible through the STAR Kids Screening and Assessment Instrument and who obtain the documentation required as described in 1 Tex. Admin. Code § 363.307.

The MCO must ensure STAR Kids Members who receive PCS, PDN, or both, have access to appropriate Providers. For example, if the Member is receiving PCS for Behavioral Health reasons, the PCS Provider should have the experience with or training on working with children and youth with Behavioral Health challenges.

8.1.16 Behavioral Health (BH) Services and Network

Appropriate access to Behavioral Health Services is a critical component of effective healthcare for STAR Kids Members. The MCO must contract with Behavioral Health Providers specializing in treatment of issues that are common to children and young adults in the STAR Kids population. These special populations include children and adolescents with dual or multiple diagnoses, persons with physical disabilities and IDD, and cultural or linguistic minorities. The MCO must identify and attempt to improve inpatient and outpatient treatment options for Members with both IDD and Behavioral Health concerns. Behavioral Health service Providers with experience serving these Members must be trained and willing to provide Behavioral and Mental Health Services that go beyond behavior management in order to identify, address and treat underlying mental health illnesses including depression, bi-polar disorder and post-traumatic stress disorder. All Behavioral Health services must be provided to promote the Recovery of Members experiencing mental illness and enhance the development of resiliency for Members impacted by mental illness, substance abuse issues, or substance abuse issues.

The MCO must include Significant Traditional Providers (STPs) of these benefits in its Network. The MCO must enter into Network Provider agreements with any willing STP of these benefits that meets the Medicaid enrollment requirements and MCO credentialing requirements, and agrees to the MCO's contract terms and rates.

The MCO must maintain a provider education process to inform Behavioral Health Providers in the MCO's Network about how to refer Members for treatment.

Provider Network capacity and distribution must permit Members to have ready access to services as specified in **Section 8.1.3.2**.

The Network must include psychiatrists and child and adolescent psychiatrists; Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient Hospital departments; licensed social workers (LCSWs); licensed marriage and family therapists (LMFTs); licensed professional counselors; Board Certified Behavior Analysts; peer support specialists; Qualified Mental Health Professionals (QMHPs) working under the authority of a Local Mental Health Authority and as defined in 25 Tex. Admin. Code Chapter 412; licensed adolescent chemical dependency treatment facilities; and licensed chemical dependency counselors (LCDCs) with experience treating adults and adolescents. The Network must include Providers who are trained in and knowledgeable about:

1. Screening and treating co-occurring mental health and substance abuse disorders;
2. The diagnosis and treatment of IDD;
3. Treating young children;
4. Treating children dually diagnosed with IDD and mental health issues;
5. Treating children with autism;
6. Treating Members with a disability caused by an accident or illness;
7. Treating Members with traumatic brain injuries;
8. Medication training and support;
9. Working with the LAR and families of children and young adults with behavioral health conditions;
10. Treating children and young adults with life threatening illnesses; and
11. Screening and treating children with fetal alcohol syndrome or related disorders.

The MCO must use available televideo technology, i.e., Telemedicine, to increase access to specialty Behavioral Health assessment and treatment Providers.

To best address the special needs of the STAR Kids population and provide effective treatment, Network Providers must be culturally competent and sensitive to Member issues. The MCO must ensure equal access to services by all racial and ethnic populations, and improve service delivery to underserved populations. The Network must also include clinicians and early intervention specialists who use evidence-based treatments for disorders common to the STAR Kids population.

For MCOs providing Behavioral Health Services in the Dallas Service Area, any Members using NorthSTAR before the Operational Start Date may elect to receive Behavioral Health Services either through NorthSTAR or through STAR Kids. Members in the Dallas Service Area who are new to STAR Kids after the Operational Start Date will use the MCO's Behavioral Health Services. If a STAR Kids Member transitions from NorthSTAR to STAR Kids for Behavioral Health Services, the Member cannot return to NorthSTAR and must receive Behavioral Health Services through the STAR Kids MCO.

8.1.16.1 Member Education and Self-referral for Behavioral Health Services

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

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

The MCO must permit Members to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and must provide the Member with information on accessible Network Providers with relevant experience.

8.1.16.2 Behavioral Health Services Hotline

This Section includes Hotline functions pertaining to Members. Requirements for Provider Hotlines are found in **Section 8.1.5.6**. 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 5.4.3, "Hotline Reports." 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 or Service Areas if the Hotline staff is knowledgeable about all of the MCO Programs or 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 all Service Areas:

1. 99 percent of calls are answered by the fourth ring or an automated call pick-up system;
2. No incoming calls receive a busy signal;

3. 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;
4. The call abandonment rate is 7 percent or less; and
5. The average hold time is 2 minutes or less.

The MCO must conduct on-going 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 8.1.22.2** and the **UMCM**.

If HHSC determines that it is necessary to conduct onsite monitoring of the MCO's Behavioral Health Services Hotline functions, the MCO is responsible for all reasonable costs incurred by HHSC or its authorized agent(s) relating to monitoring. For purposes of this section, "reasonable travel costs" 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.

8.1.16.3 Coordination between the BH Provider and the PCP

The MCO must ensure that the behavioral and physical health information is shared efficiently and effectively between the PCP and Behavioral Health Service Providers. If the MCO uses a Behavioral Health Organization (BHO) as a Material Subcontractor, the MCO must ensure that MCO and BHO have shared, integrated data systems to facilitate Service Coordination and the timely sharing of Member information with PCPs and behavioral health specialists.

The MCO must require, through Provider contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or appropriate referral for, any known or suspected behavioral health problems and disorders. 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 and the sharing of Member information between Behavioral Health Service Providers and PCPs, as clinically indicated. 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. The MCO must require that PCPs and Behavioral Health Service Providers engage in an appropriate level of communication and consultation necessary to properly assess, evaluate, refer, or treat a Member with both a physical health and behavioral health condition. The MCO must develop a simple communication format for sharing information between Behavioral Health Service Providers and PCPs and other subspecialty Providers. The MCO must

consult with PCPs, child psychiatrists, and other relevant Behavioral Health Service Providers when developing the communication format, then require the PCP team to use the format when sharing information among team members. The MCO must educate all Members of the PCP Team members on the role of the Service Coordinator in the coordination and sharing of health information and status. Behavioral Health Service Providers may only provide physical Healthcare Services if they are licensed in Texas to do so.

The MCO must require that Behavioral Health Service Providers and PCPs send each other initial and updated summary reports of a Members' physical and behavioral health status, as agreed to by the PCP Team members.

PCPs must screen Members for any behavioral health condition, and may treat Members within the appropriate scope of their practice and refer Members for treatment through the Provider Network.

The MCO must use evidence-based integrated health care practices. These practices include, for example, the use of an appropriate outcome measurement instrument to monitor effectiveness of medication and psychotherapy, and access to psychiatric consultation for the PCP and Service Manager. The MCO must contractually require all Providers to comply with the *Psychotropic Medication Utilization Parameters for Foster Children* found at http://www.dfps.state.tx.us/documents/Child_Protection/pdf/TxFosterCareParameters-September2013.pdf.

The MCO must seek to recruit PCPs and Behavioral Health Service Providers who are located in the same office or clinic to facilitate access to treatment and services. The MCO will include in its trainings, provider materials and handbooks guidelines, policies and procedures related to physical and behavioral health coordination of treatment and services. The MCO must seek to recruit providers who practice using the Medical Home Model and Integrated Primary Care. The MCO must actively promote these models, provide training in these models, and may differentially reimburse for these models as they have been shown to be more fiscally efficient and clinically effective in the early identification and treatment of behavioral health problems.

MCO training for PCPs must include the use of valid screening and assessment instruments and the use of the Texas Health Steps Forms. The MCO must train Network PCPs on identifying and referring all Members suspected of having a developmental delay or developmental disability, SED, mental illness, or chemical dependency. The MCO must ensure that PCPs have valid screening and assessment instruments to identify and refer children to Providers specializing in evaluations to determine whether a child or young adult has a developmental disability, or is at risk for or has a serious emotional disturbance or mental illness. The MCO must require qualified Providers to conduct appropriate evaluations and psychometric testing for Members who may need access to IDD services and supports and HCBS Waiver services.

The MCO will provide information on evidence-based interventions for behavioral health problems commonly seen in primary care (e.g., depression and anxiety disorders). The MCO will encourage PCPs to contact MCO Service Coordinators to discuss the Member's needs, referral and treatment options, and request names of specialty Behavioral Health Care Providers to address the Member's special needs. For rural areas, the MCO must assist PCPs and other Providers with access by facilitating specialty consults through the use of telemedicine technology. Provider training must include information on how to access televideo resources.

The MCO must require behavioral health providers to refer Members with known or suspected and untreated physical health problems or disorders to their PCP.

8.1.16.4 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 or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Also, prior to discharge the MCO must review the Member's case history and Individual Service Plan (ISP) and attempt to communicate with the Member or Member's LAR and key Providers to determine if additional Community-Based Services and other supports might reduce subsequent need for re-admission. If additional service and support needs are identified through this process, the MCO must work with the Member and the Member's LAR to establish the services.

The MCO must ensure that Behavioral Health Service Providers contact Members who have missed appointments within 24 hours to reschedule appointments. The MCO must adopt additional policies to work with the Member and the Member's LAR following an inpatient BH admission for the purpose of preventing re-admission.

8.1.16.5 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 conform to the standards set forth in 28 Tex. Admin. Code Chapter 3, Subchapter HH.

8.1.16.6 Court-Ordered Services

The MCO must provide inpatient or outpatient psychiatric services to Members under the age of 21 who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Texas Health and Safety Code Chapters 573 and 574, relating to Court-Ordered Commitments to inpatient mental health facilities. The MCO is not obligated to cover placements as a condition of probation, authorized by the Texas Family Code. These placements are Non-capitated Services.

The MCO cannot deny, reduce or controvert the Medical Necessity of inpatient mental health services provided pursuant to a Court-ordered Commitment for Members under

the age of 21. 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 under Texas Health and Safety Code Chapter 573 or 574 can only Appeal the commitment through the court system.

8.1.16.7 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.

The MCO is required to comply with additional Behavioral Health Services requirements relating to coordination with the LMHA and care for special populations. These requirements are described in **Section 8.1.30**.

8.1.16.8 Behavioral Health Emergencies

Through the STAR Kids Screening and Assessment Process, ISP, and Service Coordination, the MCO must identify Members at the highest risk for Behavioral Health Emergencies. The MCO must identify a Behavioral Health Crisis Prevention and Crisis Intervention Plan for those identified at the highest risk. The MCO must seek participation from the Member; the Member's LAR; appropriate Behavioral Health Providers; and identified community groups when developing the Behavioral Health Crisis Prevention Plan.

The MCO must also develop a strategy for effectively responding to Behavioral Health Emergencies and preventing them from reoccurring. Member Services and Service Coordination staff must be informed of the strategy and trained if appropriate.

8.1.16.9 Data Sharing with NorthSTAR

The MCO must provide NorthSTAR with pharmacy and service data, and must accept data from NorthSTAR related to STAR Kids Members with behavioral health issues that may affect physical health issues and treatment compliance.

8.1.16.10 Mental Health Parity

The MCO must comply with all applicable provisions of the Mental Health Parity and Addiction Equity Act of 2008.

8.1.17 Pharmacy Services

The MCO must provide pharmacy-dispensed prescriptions as a Covered Service.

The MCO must submit pharmacy clinical guidelines and prior authorization policies and procedures 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 and must encourage Network pharmacies to also become Medicaid-enrolled durable medical equipment (DME) providers.

The MCO is responsible for negotiating reasonable pharmacy provider reimbursement rates, including individual MCO maximum allowable cost (MAC) rates as described in **Section 8.1.17.11**, "Maximum Allowable Cost Requirements." The MCO must ensure that, as an aggregate, rates comply with 42 C.F.R. Part 50, Subpart E, regarding upper payment limits.

8.1.17.1 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 the Medicaid formulary and 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 PA process.

The MCO must educate Network Providers about how to access HHSC's formularies and the Medicaid PDL on HHSC's website. In addition, the MCO must allow Network Providers access to the Medicaid formulary and PDL through a free, point-of-care web-based application accessible on smart phones, tablets, or similar technology. The application must also identify preferred/non-preferred drugs, Clinical Edits, and any preferred drugs that can be substituted for non-preferred drugs. The MCO must update this information at least weekly. If the MCO has clinical edits that are identical to HHSC VDP's clinical edits or less stringent than VDP's clinical edits, then the MCO can reference VDP's Texas Medicaid formulary on Epocrates.

8.1.17.2 Prior Authorization for Prescription Drugs and 72-Hour Emergency Supplies

The MCO must adopt PA policies and procedures that are consistent with **Section 8.1.9.1** "Compliance with State and Federal Prior Authorization Requirements."

The MCO must adhere to HHSC's PDL for Medicaid. Preferred drugs must adjudicate as payable without PA, unless they are subject to Clinical Edits. HHSC will identify Clinical Edits that the MCO must implement on the Vendor Drug Program website. The MCO may choose to implement additional Clinical Edits once these edits are approved by the Drug Utilization Review (DUR) Board, or alternatively by HHSC when appropriate, and posted on the Vendor Drug Program website. If the MCO has clinical edits that are

identical to HHSC VDP's clinical edits or less stringent than VDP's clinical edits, then the MCO can reference VDP's Texas Medicaid formulary on Epocrates.

The MCO must submit new Clinical Edit proposals to HHSC for DUR Board review and approval. The MCO may also submit any proposed revisions to existing Clinical Edits to HHSC for DUR Board review and approval. The MCO must submit all clinical edit proposals in compliance with the required information outlined in UMCM Chapter 3.29. HHSC will conduct preliminary review of these edit proposals and respond to the MCO before the next DUR Board meeting.

If a requested drug is subject to more than one edit (e.g., the drug is both non-preferred and subject to one or more Clinical Edits), the MCO must process all edits concurrently and independently so that each clinical edit is checked for approval.

HHSC's Medicaid PA, PDL, Clinical Edit, and other policies for the fee-for-service Vendor Drug Program are available on HHSC's Vendor Drug Program website at <http://www.txvendordrug.com/index.shtml>. 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 PA. If HHSC modifies the policies described above on the Vendor Drug Program website, HHSC will notify MCOs.

The MCO 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 a prescription cannot be filled when presented to the pharmacist due to a PA requirement and the prescriber's office cannot be reached, then the MCO must instruct the pharmacy to dispense a 72-hour emergency supply of the prescription when requested by the Member or pharmacy. The pharmacy is not required to dispense a 72-hour supply if the dispensing pharmacist determines that taking the prescribed medication would jeopardize the Member's health or safety, and he or she has made good faith efforts to contact the prescriber. The pharmacy may fill consecutive 72-hour supplies if the prescriber's office remains unavailable. The MCO must reimburse the pharmacy for dispensing the temporary supply of medication.

For second generation antiviral drugs used to treat Hepatitis C, a 72-hour emergency rule should not be utilized. These medications require strict prior authorization procedure, however, the immediate dispensing is not required prior to confirming with the prescriber that the specific clinical criteria is met.

The MCO must provide access to a toll-free call center for prescribers to call to request a PA for non-preferred drugs or drug that are subject to Clinical Edits. 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. If the MCO cannot make a timely PA determination, the MCO must allow the Member to receive a sufficient supply (e.g., a 72-hour supply) of the medication pending resolution of the PA request.

The MCOs must have an automated process that may be used to assess a Medicaid recipient's medical and drug claim history to determine whether the recipient'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 Edits. (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 8.1.4.5**, "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 only impose Clinical Edit PA requirements. 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 8.1.29**.

If a Member changes Medicaid or CHIP MCOs, the previous MCO must provide the new MCO with 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.

8.1.17.3 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 CMS webpage under "Contact Information" (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Rebate-Program.html>).

8.1.17.4 This Section Intentionally Left Blank

8.1.17.5 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 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 physician-administered drugs.

The MCO must implement a process to timely support HHSC's Medicaid rebate dispute resolution processes.

- a. 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.
- b. 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.

8.1.17.6 Drug Utilization Review Program

The MCO must have a process in place to conduct prospective and retrospective utilization review of prescriptions that is consistent with Medicare Part D drug utilization review standards (see 42 C.F.R. § 423.153). Prospective review must take place at the dispensing pharmacy's point-of-sale (POS). The prospective review at the POS must compare the prescribed medication against previous drug history for drug-to-drug interactions, ingredient duplication, therapeutic duplication, age or gender contraindications, drug-allergy contraindications, overutilization or underutilization, incorrect dosage, and high dose situations. 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 must specifically assess prescribing patterns for psychotropic medications as defined by Texas Family Code § 266.001(7). 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 peer-to-peer discussion on the appropriateness of the drug regimen with the prescriber. For children, the MCO must model its parameters on DFPS's "Psychotropic Medication Utilization Parameters for Foster Children." (See DFPS's website for more information: http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp). For adults, the MCO must base its parameters for psychotropic medications on peer-reviewed, industry standard such as the DSHS Psychotropic Drug Formulary at <http://www.dshs.state.tx.us/mhprograms/Formulary.shtm>. The DSHS Psychotropic Drug Formulary provides tables summarizing the recommended dosage ranges for psychotropic drugs for children, adolescents, and adults. These dosage ranges are guidelines, and are not intended to replace other references or the clinician's clinical judgment.

8.1.17.7 Pharmacy Benefit Manager (PBM)

The MCO must use a 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 3, "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.

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 6.1, "Cost Principles for Expenses."

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.

8.1.17.8 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, pharmacy network fees, data sales fees, and any other fees. **Attachment A**, "STAR Kids Contract Terms," **Article 9**, provides HHSC with the right to audit this information 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.

8.1.17.9 Limitations Regarding Registered Sex Offenders

HHSC's Medicaid formulary does not include sexual performance enhancing medications. If these medications are added to the Medicaid formulary after the Effective Date of this Contract, 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 Texas Code of Criminal Procedure Chapter 62.

8.1.17.10 Specialty Drugs

The MCO must develop policies and procedures for reclassifying prescription drugs from retail to specialty drugs for purposes of entering into selective contracting arrangements for specialty drugs. 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.

8.1.17.11 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:

1. 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
2. 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.

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 have a process for allowing Network pharmacies to challenge a MAC price, 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 to a challenge by the 15th day after it is made. If the challenge is successful, the MCO must adjust the drug price, 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 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.

8.1.17.12 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. MCOs and their PBMs cannot reject claims for any drugs in a retail pharmacy for the purpose of (1) redirecting prescriptions

to a plan's a mail order pharmacy or selectively contracted specialty pharmacy, and (2) informing a member about receiving a drug filled by a mail order pharmacy or the plan's selectively contracted specialty 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.

8.1.17.13 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 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 2.2, "Pharmacy Claims Manual." In addition, the MCO cannot impose PA requirements based on non-preferred status ("PDL PAs") for these drugs and products.

8.1.17.14 Pharmacy Claims and File Processing

The MCO must process claims in accordance with **UMCM** Chapter 2.2, "Pharmacy Claims Manual," 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 8.1.23** 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 within two business days of the files becoming available through HHSC's file transfer process, unless clarification is needed or data/ file exceptions are identified. If clarification is needed, the MCO must notify HHSC within the same two business days. 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 calendar days of receipt.

8.1.17.15 Pharmacy Audits

The MCO must comply with the requirements of Texas Insurance Code § 843.3401, regarding audits of pharmacists and pharmacies, including the prohibition on the use of extrapolation.

8.1.17.16 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.

8.1.17.17 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 Network Provider Agreement 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 Network Provider Agreement 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 Texas Administrative Code § 291.34. The Member or Member’s LAR must have the option to withdraw from an automated refill delivery program at any time.

8.1.17.18 Second Generation Direct Acting Antivirals for Hepatitis C

The MCO will provide second generation direct acting antivirals (DAAs) for the treatment of hepatitis C to Members under a non-risk, cost settlement basis, as described in Attachment A, Section 10.18, “Non-risk Payments for Second Generation Direct Acting Antivirals for Hepatitis C.” The MCO must follow HHSC’s clinical review criteria located at www.txvendordrug.com to approve the provision of these drugs. Reimbursement by HHSC may be up to the Medicaid fee-for-service rate that HHSC would have paid for the drug on the date of service for a valid claim. The non-risk payments will cover only the cost of the drugs. Reasonable administrative costs associated with coverage of these drugs as well as adjunctive therapies associated with the DAA treatment for hepatitis C

will be part of the existing Capitation Rate. The MCO may not include the cost of the drugs in the FSR.

8.1.18 Financial Requirements for Covered Services

The MCO must pay for or reimburse Providers for all Medically Necessary Covered Services provided to all Members. The MCO is not liable for costs incurred in connection with health care rendered prior to the date of the Member's Effective Date of Coverage in that MCO. A Member may receive collateral health benefits under a different type of insurance, such as workers compensation or personal injury protection under an automobile policy. If a Member is entitled to coverage for specific services payable under another insurance plan and the MCO paid for these Covered Services, the MCO may obtain reimbursement from the responsible insurance entity not to exceed 100 percent of the value of Covered Services paid.

8.1.19 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), and the cost principles contained in the Cost Principles Document in the **UMCM**. The state 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 STAR Kids 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; and
3. 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.

The MCO agrees to pay for all reasonable costs incurred by HHSC or its designee to perform an examination, review, or audit of the MCO's books pertaining to the Contract.

8.1.19.1 General Access to Accounting Records

The MCO must provide authorized representatives of the Texas and federal governments full access to all financial and accounting records related to the performance of the Contract.

The MCO must:

1. Cooperate with the state and federal governments in their evaluation, inspection, audit, or review of accounting records and any necessary supporting information;
2. Permit authorized representatives of the state and federal government full access, during normal business hours, to the accounting records that the state and the federal governments determine are relevant to the Contract. Access is guaranteed at all times during the performance and retention period of the Contract, and will include both announced and unannounced inspections, on-site audits, and the review, analysis, and reproduction of reports produced by the MCO;
3. Make copies of any accounting records or supporting documentation relevant to the Contract, including Network Provider agreements, available to HHSC or its agents within seven Business Days, or as otherwise specified by HHSC, of receiving a written request from HHSC for specified records or information. If the documentation is not made available as requested, the MCO agrees to reimburse HHSC for all costs, including, but not limited to: transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, and reproduction functions at the location(s) of the accounting records; and
4. Pay any and all additional costs incurred by the state and federal governments that are the result of the MCO's failure to provide the requested accounting records or financial information within 10 business days of receiving a written request from the state or federal government.

8.1.19.2 Financial Reporting Requirements

HHSC will require the MCO to provide financial reports by Service Area to support Contract monitoring as well as state and federal reporting requirements. HHSC will consult with MCOs regarding the format and frequency of the reporting. All financial information and reports are the property of HHSC and will be public record, with the exception of any protected Member information contained within the documents. Any deliverable or report in this section without a specified due date is due quarterly on the last day of the month. 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.

HHSC's **UMCM** will govern the timing, format and content for the following reports.

- (a) **Audited Financial Statement** –The MCO must provide the annual audited financial statement, for each year covered under the Contract, no later than June 30. The MCO must provide the most recent annual financial statements, as required by the Texas Department of Insurance (TDI) for each year covered under the Contract, no later than March 1.
- (b) **Affiliate Report** – The MCO must submit an Affiliate Report to HHSC if this information has changed since the last report submission. The report must contain the following:

1. A list of all Affiliates, and
 2. For HHSC's prior review and approval, a schedule of all transactions with Affiliates that, under the provisions of the Contract, will be allowable as expenses in the FSR Report for services provided to the MCO by the Affiliate. Those must include financial terms, a detailed description of the services to be provided, and an estimated amount that will be incurred by the MCO for the services during the Contract Period.
- (c) **Employee Bonus or Incentive Payment Plan** – If an MCO intends to include Employee Bonus or Incentive Payments as allowable administrative expenses, the MCO must furnish a written Employee Bonus or Incentive Payments Plan to HHSC so it may determine whether the payments are allowable administrative expenses in accordance with the Cost Principles Document in the **UMCM**. 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, and the timing of bonus or incentive payments. The Bonus or Incentive Payment Plan and description must be submitted to HHSC for approval no later than 30 days after the Effective Date of the Contract and any Contract renewal. If the MCO substantively revises the Employee Bonus or Incentive Payment Plan, the MCO must submit the revised plan to HHSC for prior review and approval.
- (d) **Claims Lag Report** - The MCO must submit a Claims Lag Report as a Contract year-to-date report. The report must be submitted quarterly by the last day of the month following the reporting period. The report must be submitted to HHSC in a format specified by HHSC. The report format is contained in the **UMCM** Chapter 5, Section 5.6.2. The report must disclose the amount of incurred claims each month and the amount paid each month.
- (e) **DSP Report** - The MCO must submit a monthly Delivery Supplemental Payment (DSP) Report that includes the data elements specified by HHSC in the format specified by HHSC in the **UMCM**. The DSP Report must include only unduplicated deliveries and only deliveries for which the MCO has made a payment, to either a Hospital or other Provider.
- (f) **MCO Disclosure Statement** - The MCO must file:
1. an updated MCO Disclosure Statement by September 1 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. a change in control, ownership, or affiliations; or,
 - c. a 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 and 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**.

- (g) **FSR Reports** – The MCO must file quarterly and annual Financial-Statistical Reports (FSR) in the format and timeframe specified by HHSC. HHSC will include the FSR format and directions in the **UMCM**. The MCO must incorporate financial and statistical data of delegated networks (e.g., IPAs, ANHCs, Limited Provider Networks), if any, in its FSR Reports. Administrative expenses reported in the FSRs must be reported in accordance with the Cost Principles Document in the **UMCM**. Quarterly FSR reports are due no later than 30 days after the end of the quarter and must provide information for the current quarter and year-to-date information through the current quarter. The first annual FSR report must reflect expenses incurred through the 90th day after the end of the fiscal year. The first annual report must be filed on or before the 120th day after the end of each fiscal year. Subsequent annual reports must reflect data completed through the 334th day after the end of each fiscal year and must be filed on or before the 365th day following the end of each fiscal year.

HHSC will post all FSRs on the HHSC website.

- (h) **HUB Reports** – Upon contract award, the MCO must attend a post-award meeting in Austin, Texas, at a time specified by HHSC, to discuss the development and submission of a Client Services Historically Underutilized Business (HUB) Subcontracting Plan for inclusion, and the MCO's good faith efforts to notify HUBs of subcontracting opportunities. The MCO must maintain its HUB Subcontracting Plan and submit monthly reports documenting the MCO's HUB program efforts and accomplishments to the HHSC HUB Office. The report must include a narrative description of the MCO's HUB program efforts and a financial report reflecting payments made to HUBs. MCOs must use the formats included in HHSC's **UMCM** for the HUB monthly reports. The MCO must comply with HHSC's standard Client Services HUB Subcontracting Plan requirements for all Subcontractors.
- (i) **Out-of-Network Utilization Reports** – The MCO must file quarterly Out-of-Network Utilization Reports in the format and timeframe specified by HHSC. HHSC will include the report format and directions in the **UMCM**. Quarterly reports are due 30 days after the end of each quarter.
- (j) **TDI Examination Report** - The MCO must furnish HHSC with a copy of any TDI Examination Report, including the financial, market conduct, target exam, quality of care components, and corrective action plans and responses, no later than 10 days after receipt of the final report from TDI.

- (k) **TDI Filings** – The MCO must submit annual figures to HHSC for controlled risk-based capital, as well as quarterly financial statements, both as required by TDI.
- (l) **Registration Statement (also known as the “Form B”)** - If the MCO is a part of an insurance holding company system, the MCO must submit to HHSC a complete registration statement, also known as Form B, and all amendments to this form, and any other information filed by the insurer with the insurance regulatory authority of its domiciliary jurisdiction.
- (m) **Third Party Recovery (TPR) Reports** - The MCO must file TPR Reports in accordance with the format developed by HHSC in the **UMCM**. HHSC will require the MCO to submit TPR reports quarterly. TPR reports must include total dollars recovered from third party payors for services to the MCO’s Members, and the total dollars recovered through coordination of benefits, subrogation, and worker’s compensation.
- (n) **Report of Legal and Other Proceedings and Related Events** - The MCO must comply with the **UMCM** Chapter 5.8, regarding the disclosure of certain matters involving the MCO, its Affiliates, or its Material Subcontractors. Reports are due both on an as-occurs basis and annually each August 31st. The as-occurs report is due no later than 30 days after the event that triggered the notification requirement.

8.1.20 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. TPR Subsystem.

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.

HHSC will provide the MCO with a one-time historical pharmacy data file on the MCO's Members through the HHSC Vendor Drug Program. HHSC will provide a sample format of pharmacy data to contract awardees.

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 the systems modifications over the life of the Contract.

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

The MCO must provide HHSC prior 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 the **STAR Kids Contract Terms**. HHSC reserves the right to require a desk or on-site readiness review of the changes.

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 on-going basis.

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

- A new MCO is brought into the STAR Kids Program;
- An existing MCO begins business in a new Service Area;
- An existing MCO changes location;

- An existing MCO changes its processing system, including changes in Material Subcontractors performing MIS or claims processing functions; and
- An existing MCO in one or two HHSC MCO Programs is initiating a Contract to participate in any additional MCO Programs.

If HHSC determines that it is necessary to conduct an onsite review, the MCO is responsible for all reasonable travel costs associated with onsite reviews. For purposes of this section, “reasonable travel costs” 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. 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, the MCO must, upon request by HHSC, either correct the deficiency or submit to HHSC a Corrective Action Plan and Risk Mitigation Plan to address the deficiency as requested by HHSC. Immediately upon identifying a deficiency, HHSC may impose contractual remedies according to the severity of the deficiency. HHSC may also freeze enrollment into the MCO’s plan for any of its MCO Programs until the deficiency is corrected. Refer to **Attachment A, Article 12** and **Attachment B-3** for additional information regarding remedies and damages. Refer to **Section 7** and **Section 8.1.4.1** for additional information regarding MCO Readiness Reviews. Refer to **Attachment A, Section 4.08(c)** for information regarding Readiness Reviews of the MCO’s Material Subcontractors.

8.1.20.1 Encounter Data

The MCO must provide complete and accurate Encounter Data for all Covered Services, including MDCP STAR Kids Covered Services and Value-added Services. 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), and Encounters Submission Guidelines. HHSC will specify the method of transmission, the submission schedule, and any other requirements in the **UMCM**. The MCO must submit Encounter Data transmissions 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 calendar 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 calendar 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 do not meet quality standards must be corrected and returned within a time period specified by HHSC.

In addition to providing Encounter Data in the 837 format described above, HHSC may request that the MCO submit an Encounter Data file to HHSC's EQRO, in the format

provided in the **UMCM**. This additional submission requirement is time-limited and may not be required for the entire term of the Contract.

For reporting Encounters and fee-for-service claims to HHSC, the MCO must use the procedure codes, diagnosis codes, 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. The MCO must also use the Provider numbers as directed by HHSC for both Encounter and fee-for-service claims submissions, as applicable.

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 calendar days after the last day of the quarter. The MCO may be subject to liquidated damages as specified in Attachment B-3 if the report shows variance between the information reported in the FSR and the data warehouse.

The MCO's Provider Agreements 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.

8.1.20.2 MCO Deliverables Related to MIS Requirements

At the beginning of each State Fiscal Year (SFY), 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 Business Continuity Plan and the Disaster Recovery Plan may be combined into one document.

Additionally, at the beginning of each SFY, 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 to HHSC according to the format and schedule identified in the HHSC **UMCM**. Additionally, if a Systems Readiness Review is triggered by one of the events described in **Section 8.1.20**, the MCO must submit all of

the plans identified in this **Section 8.1.20.2** 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 the **UMCM**.

8.1.20.3 System-wide Functions

The MCO's MIS system must include key business processing functions and 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) to describe services delivered and Encounter transactions produced;
7. Accommodate the coordination of benefits;
8. Produce standard Explanation of Benefits (EOBs);
9. Pay financial transactions to Providers in compliance with federal and state laws, rules and regulations;
10. Ensure that all financial transactions are auditable according to GAAP guidelines.
11. Relate and extract data elements to produce report formats (provided within the **UMCM**) or otherwise required by HHSC;
12. Ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS;
13. Maintain and cross-reference all Member-related information with the most current Medicaid Provider number; and
14. Ensure that the MIS is able to integrate pharmacy data from HHSC's Vendor Drug Program file (available through the Virtual Private Network (VPN)) into the MCO's Member data.

8.1.20.4 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) and the Health Information Technology for Economic and Clinical Health Act (HITECH), P.L. 111-5 (February 17, 2009), and as amended or modified. The MCO must comply with HIPAA EDI requirements. The MCO's enrollment files must be in the 834 HIPAA-compliant format. Eligibility inquiries must be in the 270/271 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.

The following website includes the final rules for 5010 Compliancy and ICD-10 Compliancy:

www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp.

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.

8.1.20.5 Claims Processing Requirements

The MCO must process and adjudicate all Provider claims for Medically Necessary health care Covered Services that are filed within the time frames specified in the **UMCM** Chapter 2.0, "Claims Manual," and pharmacy claims in that are filed in accordance with the timeframes specified in **UMCM** Chapter 2.2, "Pharmacy Claims Manual." The MCO is subject to 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 the **UMCM**.

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 the **UMCM**. In addition, the 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, Network Provider, or Out-of-Network 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. The MCO must retain other financial information and records, including all original claims forms, for the time period established in **Attachment A, Section 9.01**. 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.

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 must 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. A Provider Portal brings information together from diverse sources in a uniform way. The Provider Portal functionality must include the following.

1. Client eligibility verification
2. Submission of electronic claims
3. Prior Authorization requests
4. Claims appeals and reconsiderations
5. Exchange of clinical data and other documentation necessary for prior authorization and claim processing

To the extent possible, the Provider Portal must support both online and batch processing as applicable to the information being exchanged. Batch Processing is a billing technique that uses a single program loading to process many individual jobs, tasks, or requests for service. Specifically in managed care, batch billing is a technique that allows Providers to send billing information all at once in a "batch" rather than in separate individual transactions. 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 when processing claims for Medically Necessary Covered Services.

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

1. excluded or suspended from the Medicare, Medicaid, CHIP, or CHIP Perinatal programs for Fraud, Abuse, or Waste;
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; or
5. for maternal services provided on or after September 1, 2019, if submitted by a Hospital that does not have a maternal level of care designation from HHSC;

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.

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 appeals rights. 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.

The MCO is subject to the requirements related to coordination of benefits for secondary payors in the Texas Insurance Code § 843.349(e) and (f).

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 on-site readiness review of the changes.

The MCO must inform all Network Providers about the information required to submit a claim at least 30 days prior to the Operational Start Date and as a provision within the MCO/Provider contract. 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.

The MCO's provider agreement 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 (OIG) as specified in 1 Tex. Admin. Code Chapter 371, Subchapter G.

8.1.20.6 National Correct Coding Initiative

Effective for claims filed on or after October 1, 2010, the MCO must comply with the requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010 (P.L. 11-148), regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

8.1.21 Fraud, Waste, and Abuse

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

- The MCO is subject to and must meet all requirements in [Texas Government Code § 531.113](#), [Texas Government Code § 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.
- 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.
- The MCO must perform pre-payment review for identified providers as directed by OIG.
- 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.

8.1.21.1 Special Investigative Units

In order to facilitate cooperation with 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.

- 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](#).
- The MCO must submit a written Fraud and Abuse compliance plan to OIG for approval each year. 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.) If an MCO has not made any changes to its plan from the previous year, it may notify OIG that: (1) no changes have been made to the previously-approved plan and (2) the plan will remain in place for the upcoming State Fiscal Year. The notification must be signed and certified by an officer or director of the MCO that is responsible for carrying out the Fraud and Abuse compliance plan. Upon receipt of a written request from OIG, the MCO must submit the complete Fraud and Abuse compliance plan.

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

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

- Each MCO must designate one primary and one secondary contact person for all HHSC OIG records requests. HHSC OIG records requests will 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).
- 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 OIG requestor no less than two Business Days prior to the due date.
- The MCO'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 MCO must not include 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.

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

- 1099 data and other financial information – 3 Business Days.
- Claims data for sampling and recipient investigations – 5 Business Days.
- Urgent claims data requests – 3 Business Days (with OIG manager's approval).
- Provider education information – 10 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 OIG.
- Other time-sensitive requests – as needed.

8.1.21.3 Monthly Claims Data Submission Requirements

1. The MCO and its subcontractors shall submit processed claims data on a monthly basis that meets established OIG data quality standards and requirements. These standards are defined by OIG to ensure receipt of complete and accurate data for investigative purposes. OIG will revise and amend these standards and requirements as necessary to ensure continuous quality improvement. The MCO and its subcontractors shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with 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 OIG, including submission of complete 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 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 OIG, in order to support comprehensive financial reporting, utilization analysis and investigative efforts.
4. The MCO and its subcontractors shall submit processed claims data according to standards and formats as defined by 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 OIG.

6. The MCO and its subcontractors shall supply Electronic Funds Transfer (EFT) account numbers on a monthly basis in a format defined by 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 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.

8.1.21.4 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. In Texas, HHSC OIG is responsible for evaluating allegations of fraud and imposing payment suspensions when appropriate. 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 1 business day. When notice of a payment hold or a payment hold lift is received, the MCO must respond to the notice within 3 business days and inform HHSC OIG 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 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 5.5 and provide this information to 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: Sanctions Division, 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 8.1.21** 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.

8.1.21.5 Additional Requirements for STAR Kids MCOs:

In accordance with the Social Security Act § 1902(a)(68), 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, which provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims, and whistleblower protections under those laws, as described in Section 1902(a)(68)(A).
2. Include as part of those written policies, detailed provisions regarding the MCO's or Subcontractor's policies and procedures for detecting and preventing Fraud, Abuse, and Waste.
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, Abuse, and Waste.

8.1.21.6 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, and provide to OIG upon request, 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” about overutilization of prescription medications.

8.1.22 Reporting Requirements

The MCO must provide and must require its Subcontractors to provide at no cost to 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; and
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 time frames and formats reasonably acceptable to both parties.

Any deliverable or report in this section 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.

The MCO’s Chief Executive and Chief Financial Officers, or persons in equivalent positions, must certify that financial data, Encounter Data, and other measurement data has been reviewed by the MCO and is true and accurate to the best of their knowledge after reasonable inquiry.

8.1.22.1 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.

8.1.22.2 Reports

The MCO must provide the following reports, in addition to the Financial Reports described in **Section 8.1.20.2** and those reporting requirements listed elsewhere in the Contract. The **UMCM** will include a list of all required reports and a description of the format, content, file layout, and submission deadlines for each report.

- (a) **Claims Summary Report** - The MCO must submit quarterly Claims Summary Reports to HHSC by MCO Program, Service Area and claim type by the 30th day following the end of the reporting period unless otherwise specified. Claim Types include facility and professional services for Acute Care, Behavioral Health, Vision, Dental, and Community-based LTSS. Within each claim type, claims data must be reported separately on the UB and CMS 1500 claim forms. The format for the Claims Summary Report is contained in the **UMCM** Chapter 5.6.1.
- (b) **QAPI Program Annual Summary Report** - The MCO must submit a QAPI Program Annual Summary in a format and timeframe as specified in the **UMCM**.
- (c) **Fraudulent Practices Report** - Utilizing the HHSC Office of Inspector General (OIG) fraud referral form, the MCO's assigned officer or director must report and refer all possible acts of Fraud, Abuse, and Waste to the HHSC OIG within 30 business days of receiving the reports of possible acts of Fraud, Abuse, and Waste from the MCO's Special Investigative Unit (SIU). The report and referral must include:
1. An investigative report identifying the allegation, statutes/regulations violated or considered, and the results of the investigation;
 2. Copies of program rules and regulations violated for the time period in question;
 3. Copies of any MCO contractual provisions, policies, published MCO program bulletins, policy notification letters, or provider policy or procedure manuals that apply to the alleged conduct for the time period in question;
 4. The estimated overpayment identified;
 5. A summary of the interviews conducted;
 6. The Encounter Data submitted by the Provider for the time period in question; and
 7. All supporting documentation obtained as the result of the investigation.

This requirement applies to all reports of possible acts of Fraud, Abuse, and Waste.

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

- (d) **Provider Termination Report:** - The MCO must submit a quarterly report that identifies any Providers who cease to participate in MCO's Provider Network, either voluntarily or involuntarily. The report must be submitted to HHSC in the format specified by HHSC, no later than 30 days after the end of the reporting period.
- (e) **Summary Report of Member Complaints and Appeals** - The MCO must submit quarterly Member Complaints and Appeals reports. The MCO must include in its reports Complaints and Appeals submitted to its subcontracted risk groups (e.g., IPAs) and any other Subcontractor that provides Member services. The MCO must submit the Complaint and Appeals reports electronically on or before 45 days following the end of the state fiscal quarter, using the format specified by HHSC in the **UMCM** Chapter 5.4.2.
- (f) **Summary Report of Provider Complaints** - The MCO must submit Provider complaint reports on a quarterly basis. The MCO must include in its reports

complaints submitted by Providers to its subcontracted risk groups (e.g., IPAs) and any other Subcontractor that provides Provider services. The complaint reports must be submitted electronically on or before 45 days following the end of the state fiscal quarter, using the format specified by HHSC in the **UMCM** Chapter 5.4.2.

- (g) **Hotline Reports** - The MCO must submit, on a quarterly basis, a status report for the Member Hotline, the Behavioral Health Services Hotline, and the Provider Hotline in comparison with the performance standards set out in **Sections 8.1.5.6.2, 8.1.4.5, and 8.1.16.2**. The MCO must submit the reports using a format to be prescribed by HHSC in consultation with the MCOs.

If the MCO is not meeting a hotline performance standard, HHSC may require the MCO to submit monthly hotline performance reports and implement corrective actions until the hotline performance standards are met. If an MCO has a single hotline serving multiple Service Areas, multiple MCO Programs, or multiple hotline functions, (i.e. Member, Provider, Behavioral Health Services hotlines), HHSC may request on an annual basis that the MCO submit certain hotline response information by MCO Program, by Service Area, and by hotline function, as applicable to the MCO. HHSC may also request this type of hotline information if an MCO is not meeting a hotline performance standard.

- (h) **Audit Reports** – The MCO must comply with the **UMCM** requirements regarding notification and submission of audit reports.
- (i) **Medicaid Managed Care Texas Health Steps Medical Checkups Reports** – The MCO 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. The MCO 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 the **UMCM** Chapter 12.

- (j) **Children of Migrant Farmworkers Annual Report (FWC Annual Report)** - The MCO must submit an annual report, in the timeframe and format described in the **UMCM** Chapter 12 about the identification of and delivery of services to Children of Migrant Farmworkers (FWC).
- (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. Traylor* 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 the **UMCM**, Chapter 12.

- (l) **Frew Annual Provider Training Report** - Per the *Frew v. Traylor* “Corrective Action Order: Health Care Provider Training,” HHSC must compile a summary of the training health care and pharmacy providers receive throughout the year for the October Quarterly Monitoring Report for the court. Medicaid MCOs must report to HHSC health care and pharmacy provider training conducted throughout the year to be included in this report. The training report must include, at a minimum, the number of Medicaid-enrolled healthcare and pharmacy providers that received the training and a description of provider feedback received on the subject matter and methodology of the training.

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

- (m) **Frew Provider Recognition Report** - Per the *Frew v. Traylor* “Corrective Action Order: Health Care Provider Training,” HHSC must recognize Medicaid enrolled healthcare and pharmacy providers who complete Frew, Texas Health Steps (THSteps), or pharmacy benefit education training. Medicaid MCOs must collect and track provider training recognition information for all Frew, Texas Health Steps (THSteps), or pharmacy benefit education trainings conducted and report the names of those Medicaid enrolled health care and pharmacy providers who consent to being recognized to HHSC quarterly.

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

- (n) **Drug Utilization Review (DUR) Reports** – MCOs must submit the DUR reports in accordance with the requirements of **HHSC UMCM**.
- (o) **Children of Migrant Farmworkers Annual Plan** – MCOs must submit an annual plan in the timeframe and format described in the **UMCM** Chapters 12.1 and 12.2 that describes how the MCO will identify and provide accelerated services to Children of Migrant Farmworkers (FWC).
- (p) **Medicaid Managed Care Texas Health Steps Medical Checkups Quarterly Utilization Reports** – For each state fiscal year quarter, MCOs must submit a report of the number and percent of class members receiving at least one THSteps medical checkup in total and broken down by various age groups. The timeframe, format, and details of the report are contained and described in **UMCM** Chapter 12.
- (q) **STAR Kids LTSS Utilization Quarterly Reports** – The MCO must file quarterly LTSS Utilization Reports in accordance with the appropriate chapter in the **UMCM**. Quarterly reports are due 30 days after the end of each quarter.
- (r) **Service Coordination Report** – MCOs must submit data annually on meeting their requirements for Service Coordination (number and types of visits broken out by assigned Service Level).

- (s) **STAR Kids Screening and Assessment Report** - MCOs must submit data annually on the average timeframe between when they receive a new Member and when evaluation using the STAR Kids SAI first occurs.
- (t) **Provider Referral Report**—MCOs must submit reports containing the information required in Texas Government Code § 533.005(a)(20)(B) in accordance with **UMCM** Chapter 5.
- (u) **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.
- (v) **Enrollment/Credentialing Denial Report**: The MCO must submit a quarterly report in accordance with the UMCM Chapter 5.4.1.9 identifying Providers who were denied enrollment in the MCO's network. The report must be submitted in the format specified by HHSC in the UMCM, no later than 30 days after the end of the reporting period.
- (w) **Long-Term Services and Supports Report** – Beginning in CY 2015, the MCO must file quarterly Long-Term Services and Supports Reports including the data specified in the UMCM Chapter 10.1.7, “Performance Indicator Dashboard for Quality Measures.” Quarterly reports are due 30 days after the end of each quarter.
- (x) **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 5.13.4. Reports must be submitted for each MCO and cannot be grouped by the Pharmacy Benefit Manager (PBM).

8.1.23 Continuity of Care and Out-of-Network Providers

The MCO must ensure that the healthcare of newly enrolled Members is not disrupted, compromised, or interrupted. The MCO must take special care to provide continuity in the care of enrolled Members who are Medically Fragile and those whose physical or behavioral health could be placed in jeopardy if Medically Necessary Covered Services are disrupted, compromised, 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 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 calendar days after the transition to a new MCO, (2) until the end of the current authorization period, or (3) until the MCO has appropriately evaluated and administered the STAR Kids Screening and Assessment Process and issued or denied a new authorization. See **Section 8.1.14**, Disease Management, for specific requirements for New Members transferring to the MCO's DM Program.

The MCO is required to ensure that clients receiving Community-Based Services prior to the Operational Start Date continue to receive those services for up to six months after the Operational Start Date, unless the MCO has completed the STAR Kids Screening and Assessment Process and issued new authorizations as described in **Section 8.1.39**. During the Transition Phase an HHS Agency will provide a file identifying these clients to the MCO for this purpose. The MCO must work with HHSC and DADS to ensure that all necessary authorizations are in place within the MCO's system(s) for the continuation of Community-Based Services. The MCO must describe the process it will use to ensure continuation of current Community-Based Services in its Transition/Implementation Plan as noted in **Section 7.3.1**. The MCO must ensure that Community-Based Service Providers are informed and trained on this process prior to the Operational Start Date.

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 and Functionally Necessary Covered Services and equipment and supplies until the Member's records, clinical information, and care can be transferred to a Network Provider, or until the Member is no longer enrolled in that MCO, whichever is shorter. If, at the time of enrollment, the Member has an existing scheduled appointment with an Out-of-Network specialist physician and the MCO does not arrange for an earlier alternative appointment with a Network Provider with a comparable certification, specialty, and expertise, the MCO must authorize and pay the Out-of-Network specialist physician for any Covered Service provided to the Member during that Member's scheduled appointment with the Out-of-Network specialist physician. If the Member requires follow-up care, the MCO may transfer the Member's care to a Network Provider with a comparable certification, specialty, and expertise, in coordination with the Out-of-Network specialist physician and the Member or the Member's LAR. 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 requirement does not extend the obligation of the MCO to reimburse the Member's existing Out-of-Network Providers for on-going care for:

1. More than 90 days after a Member enrolls in the MCO, or
2. For more than 12 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 6 weeks of delivery.

The MCO must provide or pay Out-of-Network Providers who provide Medically Necessary Covered Services to Members who move out of the Service Area through the end of the period for which capitation has been paid for the Member.

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 within 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 the services become available from a Network Provider. If a Member's PCP or other Provider determines that disrupting a Member's existing relationship with an Out-of-Network Provider would subject the Member to unnecessary psychological or medical risk, the MCO must provide the Member access to those Out-of-Network services through an appropriate agreement with the Out-of-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 or does not have the clinical experience in a condition or treatment, at no cost to the Member, in accordance with 42 C.F.R. § 438.206(b)(3). The requirements in this **Section 8.1.23** regarding access to and payment of Out-of-Network providers apply only to Out-of-Network providers who are enrolled Texas Medicaid providers.

8.1.24 Provisions Related to Covered Services for Members

8.1.24.1 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 in the MCO's 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 the professional, facility, and ancillary services 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 to the Hospital emergency department, 24 hours a day, 7 days a week, rendered by either the MCO's Network 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, 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 10 calendar 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 patient. 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)(iii). 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 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 patient until a 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.

The requirements in this section regarding access to and payment of Out-of-Network Providers apply only to Out-of-Network providers who are enrolled Texas Medicaid Providers.

8.1.24.2 Family Planning - Specific Requirements

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 participating 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 family planning Provider. The MCO must provide access to confidential family planning services.

The MCO must provide, at minimum, the full scope of services available under the Texas Medicaid program for family planning services. The MCO will reimburse family planning agencies the Medicaid fee-for-service amounts for family planning services, including Medically Necessary medications, contraceptives, and supplies not covered by the Vendor Drug Program 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. As described in **Section 8.1.33**, the MCO must also have procedures in place to educate the following Members about family planning programs, including the Texas Women's Health Program and DSHS Family Planning, Primary Health Care, and Expanded Primary Health Care programs:

- Pregnant Women in Medicaid who will lose eligibility after delivery
- Young pregnant adults in Children's Medicaid who will have aged out of Children's Medicaid by the time of delivery

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 confidentiality for family planning services.

8.1.24.3 Texas Health Steps (EPSDT)

8.1.24.3.1 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 calendar days after the child's birthday. For New Members birth through age 20, overdue or upcoming Texas Health Steps medical checkups must 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 **UMCM** Chapter 12.4.

8.1.24.3.2 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 check-up. The Provider education must include information about how to assist a Member with referral to a dentist to establish a dental home.

8.1.24.3.3 Lab

The MCO must require Providers to send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section or 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 the **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 Health and Safety Code § 33.016 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.

8.1.24.3.4 Education/Outreach

The MCO must ensure that Members are provided information and educational materials about the following Covered Services and how they may be obtained:

1. Texas Health Steps
2. Personal Care Services
3. Private Duty Nursing
4. Behavioral Health Services
5. Durable Medical Equipment (DME) and supplies

The information must tell the Member how they can obtain dental benefits, services through the Medical Transportation Program, and advocacy assistance from the MCO. Standard language describing Texas Health Steps services, including medical, dental, and case management services is provided in the **UMCM**. The MCO must use this language 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 will encourage Network pharmacies to also become Medicaid-enrolled DME Providers.

The MCO must provide outreach to Members to ensure they receive prompt services and are effectively informed about available Texas Health Steps 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 the Members to schedule the service as soon as possible. MCO staff must coordinate with the Texas Health Steps outreach unit to ensure that Members have access to the Medical Transportation Program, and that any coordination with other agencies is maintained.

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 Children of Migrant Farmworkers and other migrant populations who may transition into and out of the MCO more rapidly 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 make a good faith effort to comply with Head Start's requirement that Members participating in

Head Start receive their Texas Health Steps checkup no later than 45 days after enrolling into either program.

8.1.24.3.5 Training

The MCO must provide appropriate training to all Network Providers and Provider staff in the Providers' area of practice regarding the scope of benefits available and the Texas Health Steps Program. Training must include:

1. Texas Health Steps benefits,
2. The periodicity schedule for Texas Health Steps medical checkups and immunizations,
3. The required elements of Texas Health Steps medical checkups,
4. providing or arranging for all required lab screening tests (including lead screening), and Comprehensive Care Program (CCP) services available under The Texas Health Steps program to Members birth through age 20;
5. Medical Transportation services available to Members such as rides to healthcare service by bus, taxi, van, airfare, gas money, mileage reimbursement, meals and lodging when away from home;
6. Importance of updating contact information to ensure accurate Provider Directories and the Medicaid Online Provider Lookup;
7. Information about MCO's process for acceleration of Texas Health Steps services for Children of Migrant Farmworkers;
8. Missed appointment referrals and assistance provided by the Texas Health Steps Outreach and Informing Unit;
9. Administrative issues such as claims filing and services available to Members;
10. 72-hour emergency supply prescription policy and procedures;
11. Outpatient prescription drug prior authorization process;
12. How to access the Medicaid formulary and preferred drug list (PDL) on HHSC's website;
13. The MCO prior authorization process;
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), in addition to medical supplies and other items commonly found in a pharmacy that are available for class members.

The MCO must also educate and train Providers regarding the requirements imposed on HHSC and contracting MCOs under the Consent Decree and Corrective Action Orders entered in *Frew v. Traylor, et. al.* Providers must 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 Texas 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 at

http://www.dshs.state.tx.us/lead/pdf_files/pb_109_physician_reference.pdf. 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.

8.1.24.3.6 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 Network Providers being investigated for potential Fraud, Abuse, or Waste without notice to the MCO or the Provider.

8.1.24.4 Perinatal Services

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 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; and
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 must 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 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 in **Section 8.1.22.2**, “Reports” and in the **UMCM** Chapter 5.

The MCO must have procedures in place to contact and assist a pregnant/delivering Member about selecting a PCP for her baby either before the birth or as soon as the baby is born.

The MCO must provide Medically Necessary Covered Services relating to the labor and delivery for its pregnant/delivering Members, including inpatient care and professional services for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated Caesarian delivery. The MCO must provide all Medically Necessary neonatal care to the Newborn Member, and may not place limits on the duration of the care.

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.

8.1.24.5 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 a child's consent to treatment. 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.

8.1.24.6 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 8.1.24.8** as Medicaid 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 working day of identification, using the most recent DSHS forms and procedures for reporting TB. Upon request, the MCO must provide access to Member medical records to DSHS and the local TB control program for all confirmed and suspected TB cases.

The MCO must coordinate with the local TB control program to ensure that all Members with suspected or confirmed 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 Chapter 81 of the Texas Health and Safety Code.

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.

8.1.24.7 Objection to Provide Certain Services

In accordance with 42 C.F.R. § 438.102, the MCO may file an objection to providing, reimbursing for, or providing coverage of, a counseling or referral service for a Covered Service based on moral or religious grounds. 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, 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, no less than 120 days prior to the proposed effective date of the policy change.

8.1.24.8 Medicaid Non-capitated Services

The following Texas programs, services, or benefits have been excluded from MCO Covered Services. Members may be 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 must refer to relevant chapters in the **Texas Medicaid Provider Procedures Manual** for more information.

1. Texas Health Steps dental (including orthodontia);
2. Texas Health Steps environmental lead investigation (ELI)

3. Early Childhood Intervention (ECI) case management/service coordination;
4. Early Childhood Intervention Specialized Skills Training;
5. Case Management for Children and Pregnant Women;
6. Texas School Health and Related Services (SHARS);
7. Department of Assistive and Rehabilitative Services Blind Children's Vocational Discovery and Development Program;
8. Tuberculosis services provided by DSHS-approved Providers (directly observed therapy and contact investigation);
9. Health and Human Services Commission's Medical Transportation Program;
10. DADS hospice services;
11. DADS or DSHS HCBS Waiver programs, authorized under Social Security Act § 1915(c), including Youth Empowerment Services (YES), Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Texas Home Living (TxHmL), and Home and Community-based Services (HCS);
12. Court-Ordered Commitments to inpatient mental health facilities as a condition of probation;
13. Nursing facility services and intermediate care facility (ICF) services; and
14. *Behavioral Health (BH) Services in the Dallas Service Area (NorthSTAR).

*See **Section 8.1.16** for exceptions to non-capitated BH Services.

8.1.24.9 Referrals for Non-capitated Services

Although the MCO is not responsible for paying or reimbursing for Non-capitated Services, the MCO is 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.

8.1.24.10 Cooperation with Immunization Registry

The MCO must work with HHSC and health care Providers to improve the immunization rate of STAR Kids clients and the reporting of immunization information for inclusion in the Texas Immunization Registry, called "ImmTrac."

8.1.24.11 Case Management for Children and Pregnant Women Services

The MCO must coordinate services with Case Management for Children and Pregnant Women services. This coordination includes, but is not limited to, client education, outreach, case collaboration and referrals to Case Management for Children and Pregnant Women services. The MCO is required to follow referral procedures as outlined by the State. Referrals to Case Management for Children and Pregnant Women services are to be based upon guidelines provided by the State, assessment, plan of care, change in client's physical, mental or psychosocial condition or at client's request.

Annually, all MCO Service Coordination and Case Management Staff must complete the Texas Health Steps Online module titled: Case Management Services in Texas and maintain proof of completion.

8.1.24.12 Children of Migrant Farmworkers (FWC)

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, in accordance with the Contract's timeframes, to FWC Members and other migrant populations who may transition into and out of the MCO more rapidly or unpredictably than the general population.

The MCO must provide accelerated services to FWC Members. For purposes of this section, "accelerated services" are services that are provided to FWC Members prior to their leaving Texas for work in other states. Accelerated services include the provision of preventive Health Care Services that will be due during the time the FWC Member is out of Texas. The need for accelerated services must be determined on a case-by-case basis according to the FWC Member's age, periodicity schedule, and healthcare needs.

The MCO must develop an annual plan identifying the process and methods it will use to identify/validate FWC and provide accelerated services to FWC Members in accordance with **UMCM** Chapter 12.

8.1.24.13 Immunizations

The MCO must educate Providers on the Immunization Standard Requirements set forth in Chapter 161, Health and Safety Code; 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 is responsible for administration of the immunization and must not refer children to Local Health Departments to receive immunizations.

The MCO must educate Providers about, and require Providers to comply with the requirements of Texas Health and Safety Code, Chapter 161, relating to the Texas Immunization Registry (ImmTrac), to include parental consent on the Vaccine Information Statement.

The MCO must notify 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 ImmTrac Registry.

8.1.24.14 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 40 Tex. Admin. Code §§ 17.101, 17.102(25), and 17.301.

8.1.25 Medicaid Significant Traditional Providers

Medicaid STPs are defined as PCPs and Community-Based Service providers that, when listed by provider type and county in descending order by unduplicated number of clients, served the top 80 percent of unduplicated clients. Hospitals receiving Disproportionate Share Hospital (DSH) funds are also considered STPs in the Service Area in which they are located. The HHSC website includes a list of Medicaid STPs by Service Area.

In the first three operational years of a Medicaid MCO Program, the MCO is required to offer Network Provider agreements to all Medicaid Significant Traditional Providers (STPs) identified by HHSC. The RFP documents included a list of Medicaid STPs by Service Area. 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 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 contracted with DADS 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 apply in the following manner.

Provider Type	STAR Kids Program Service Area	Expiration Date
Substance use disorders (SUD) providers	statewide	See 8.1.41.2 Providers
Nursing Facilities	statewide	August 31, 2019
LMHAs	statewide	August 31, 2019
CFC Providers	statewide	August 31, 2019
Pharmacy providers	statewide	August 31, 2019
All other provider types	statewide	August 31, 2019

For three years following the Operational Start Date, Network Providers and non-network providers who believe they meet the STP requirements may contact HHSC and request HHSC's consideration for STP status.

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 Provider 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 (TJC) is not the sole grounds for exclusion from the Provider Network.

The MCO may terminate a Network Provider agreement 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.

8.1.26 Payments to 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 reimburse FQHCs, RHCs, and Municipal Health Department public clinics for Health Care Services provided outside of regular business hours, as defined by HHSC in rules, including weekend days or holidays, at a rate that is equal to the allowable rate for those services as determined under Texas Human Resources Code § 32.028, if the Member does not have a referral from their PCP.

The MCO must pay full encounter rates to FQHCs and RHCs for Medically Necessary Covered Services provided to STAR Kids Members 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, HHSC cost settlements (or "wrap payments") do not apply.

8.1.27 Provider Complaints and Appeals

8.1.27.1 Provider Complaints

The MCO must develop, implement, and maintain a system for tracking and resolving all 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 resolve Provider Complaints within 30 days from the date the Complaint is received by the MCO. The MCO 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 MCO. Please see the **Attachment A**, "STAR Kids Contract Terms," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix."

MCOs must also resolve Provider Complaints received by HHSC no later than the due date indicated on HHSC's notification form. HHSC will generally provide MCOs 10 Business Days to resolve 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 remedies, including liquidated damages if Provider Complaints are not resolved by the timeframes indicated in this section.

The MCO must use appropriately trained pediatric providers for the purposes of reviewing all medically-based Provider Complaints, such as Provider Complaints about the quality of care or services, utilization review or management, or claims processing.

8.1.27.2 Appeal of Provider Claims

The MCO must develop, implement, and maintain a system for tracking and resolving all 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 Provider's claims payment appeal and establish a tracking mechanism to document the status and final disposition of each Provider's claims payment appeal. The MCO's process must comply with the requirements of Texas Government Code § 533.005(a)(19). The MCO must allow Community-Based LTSS Providers to appeal claims that the MCO has not paid or denied by the 31st day following receipt.

The MCO is subject to liquidated damages if at least 98 percent of Provider Appeals are not resolved within 30 calendar days of the MCO's receipt.

In addition, the MCO must contract with physicians who are not Network Providers 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 the 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.

8.1.28 Member Rights and Responsibilities

In accordance with 42 C.F.R. § 438.100, all Medicaid MCOs must maintain written policies and procedures for informing Members of their rights and responsibilities, and must notify their Members of their right to request a copy of these rights and

responsibilities. The Member Handbook must include notification of Member rights and responsibilities, as set forth in the **UMCM**.

8.1.29 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 MCOs.

MCOs also must resolve Member Complaints referred by HHSC no later than the due date indicated on HHSC’s notification form. HHSC will provide MCOs up to 10 Business Days to resolve Complaints, depending on the severity 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 remedies, including liquidated damages if Member Complaints are not resolved by the timeframes indicated herein.

The Complaint and Appeal system must include a Complaint process, an Appeal process, and access to HHSC’s 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 their implementation.

The MCO must use appropriately trained pediatric providers for the purposes of reviewing all medically-based Member Complaints and Appeals, such as Member Appeals regarding a benefit denial or limitation and Member Complaints about the quality of care or services, the accessibility or availability of services, or claims processing.

8.1.29.1 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. For purposes of this **Section 8.1.29**, an “authorized representative” is any person or entity acting on behalf of the Member and with the Member’s written consent. A Provider may be an authorized representative.

The MCO must accept a Complaint that is submitted orally or in writing. A Complaint submitted by a Member, a Member’s LAR, or a Member’s Service Provider must be accepted by the MCO. The MCO must resolve Complaints within 30 days from the date the Complaint is received by the MCO and notify the Member or Member’s LAR in writing to acknowledge the Complaint and following resolution. The resolution letter must

summarize the Complaint, information considered in investigating the Complaint, and final conclusions and actions. 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 **S Attachment A**, "STAR Kids Contract Terms," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix." The Complaint procedure must be the same for all Members under the Contract. 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 8.1.29.2**, 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 non-English 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 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 publish this number in the Member Handbook. The MCO must provide this 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. Date;
2. Identification of the individual filing the Complaint;
3. Identification of the individual recording the Complaint, including professional credentials;
4. Nature of the Complaint;
5. Disposition of the Complaint (i.e., how the MCO resolved the Complaint);
6. Corrective action required; and
7. Date resolved.

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.

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. Cooperation may include providing information or assistance to HHSC Complaint team members.

The MCO must provide designated STAR Kids Member Advocates to assist Members in understanding and using the MCO's Complaint system as described in **Section 8.1.29 and 8.1.29.1**. Members must be able to simply access a Member Advocate through the Member Hotline. The availability of Member Advocates must also be noted in the STAR Kids Member Handbook. Member Advocates must assist Members and Members' LARs with how to write a written Complaint and are responsible for monitoring Complaints they become aware of through the MCO's Complaint process.

8.1.29.2 Standard Member 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 Action as defined in **Attachment A**, "STAR Kids Contract Terms." The Appeal procedure must be the same for all Members. When a Member or a Member's LAR expresses orally or in writing any dissatisfaction or disagreement with an Action, the MCO must treat the expression of dissatisfaction as a request to Appeal an Action.

A Member or Member's LAR must file a request for an Appeal with the MCO within 30 days from receipt of the notice of the Action. The MCO is subject to remedies, including liquidated damages, if at least 98 percent of Member Appeals are not resolved within 30 days of receipt of the Appeal by the MCO. Please see the **Attachment A**, "STAR Kids Contract Terms," and **Attachment B-3**, "Deliverables/Liquidated Damages Matrix." To ensure continuation of currently authorized services, however, the Member must file the Appeal on or before the later of 10 days following the MCO's mailing of the notice of the Action, or the intended effective date of the proposed Action. The MCO must designate

an officer who has primary responsibility for ensuring that Appeals are resolved in compliance with written policy and within the 30-day time limit.

The provisions of Texas Insurance Code, Chapter 4201, relating to a Member's right to Appeal an Adverse Determination made by the MCO or a utilization review agent to an independent review organization, do not apply to a Medicaid recipient. Texas Insurance Code, Chapter 4201 is preempted by federal Fair Hearings requirements.

The MCO must have policies and procedures in place outlining the Medical Director's role in an Appeal of an Action. 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 8.1.29.9**, 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 non-English 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 Action. The MCO must provide oral interpretive service to callers free of charge.

The MCO's process must require that every oral Appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless the Member or his or her representative requests an expedited resolution. All Appeals must be recorded in a written record and logged with the following details:

1. Date notice is sent;
2. Effective date of the Action;
3. Date the Member or his or her representative requested the Appeal;
4. Date the Appeal was followed up in writing;
5. Identification of the individual filing;
6. Nature of the Appeal; and
7. Disposition of the Appeal, and notice of disposition to Member.

The MCO must send a letter to the Member within 5 business days acknowledging receipt of the Appeal request. Except for the resolution of an Expedited Appeal as provided in **Section 8.1.29.3**, the MCO must complete the entire standard Appeal process within 30 calendar days after receipt of the initial written or oral request for Appeal. The timeframe for a standard Appeal may be extended up to 14 calendar 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 or the legal representative of a deceased Member's estate.

In accordance with 42 C.F.R. § 438.420, the MCO must continue the 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 course of treatment;
3. The services were ordered by an authorized Provider;
4. The original period covered by the original authorization has not expired; and
5. The Member requests an extension of the benefits.

If, at the Member's request, the 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;
2. Ten days pass after the MCO mails the notice resolving the Appeal against the Member, unless the Member, within the 10-day timeframe, has requested a Fair Hearing with continuation of benefits until a Fair Hearing decision can be reached; or
3. A state Fair Hearing officer issues a hearing decision adverse to the Member or the time period or service limits of a previously authorized service have been met.

In accordance with 42 C.F.R. § 438.420(d), if the final resolution of the Appeal is adverse to the Member and upholds the MCO's Action, then, to the extent that the services were furnished to comply with the Contract, the MCO may recover those costs from the Member.

If the MCO or state Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires.

If the MCO 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 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.

8.1.29.3 Expedited Appeals

In accordance with 42 C.F.R. § 438.410, the MCO must establish and maintain an expedited review process for Appeals, 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 or health. The MCO must follow all Appeal requirements for standard Member Appeals as set forth in **Section 8.1.29.2**), except where differences are specifically noted. The MCO must accept oral or written requests for Expedited Appeals.

Members must exhaust the MCO's Expedited Appeal process before making a request for an Expedited Fair Hearing. After the MCO receives the request for an Expedited Appeal, it must hear an approved request for a Member to have an Expedited Appeal and notify the Member of the outcome of the Expedited Appeal within 3 business days, 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 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 Appeal may be extended up to 14 calendar 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 8.1.29.5**. The MCO is responsible for notifying the Member of his or her right to access an expedited Fair Hearing from HHSC. The MCO will be responsible for providing documentation to the state and the Member, indicating how the decision was made, prior to HHSC's expedited Fair Hearing.

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for requesting an Expedited Appeal. The MCO must ensure that punitive action is not taken against a Provider who requests an Expedited Appeal 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 calendar days with a written notice.

8.1.29.4 Access to Fair Hearing for Medicaid Members

The MCO must inform Members that they have the right to access the Fair Hearing process at any time during the Appeal system provided by the MCO. In the case of an expedited Fair Hearing process, the MCO must inform the Member that he or she must first exhaust the MCO's internal Expedited Appeal process prior to filing an Expedited Fair Hearing. The MCO must notify Members that they may be represented by an authorized representative in the Fair Hearing process.

If a Member requests a Fair Hearing, the MCO will complete the request for Fair Hearing, and submit the form via facsimile to the appropriate Fair Hearings office, within five calendar days of the Member's request for a Fair Hearing.

Within five calendar days of notification that the Fair Hearing is set, the MCO will prepare an evidence packet for submission to the HHSC Fair Hearings staff and send a copy of the packet to the Member. The evidence packet must comply with HHSC's Fair Hearings requirements.

8.1.29.5 Notices of Action 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 Action. The notice must, at a minimum, include any information required by 1 Tex. Admin. Code Chapter 357 that relates to a MCO's notice

of Action and any information required by 42 C.F.R. § 438.404 as directed by HHSC, including but not limited to:

1. The dates, types, and amount of service requested;
2. The Action the MCO has taken or intends to take;
3. The reasons for the Action (If the Action taken is based upon a determination that the requested service is not Medically Necessary, the MCO must provide an explanation of the medical basis for the decision, application of policy or accepted standards of medical practice to the individuals medical circumstances, in its notice to the Member.);
4. The Member's right to access the MCO's Appeal process.
5. The procedures by which the Member may Appeal the MCO's Action;
6. The circumstances under which expedited resolution is available and how to request it;
7. The circumstances under which a Member may continue to receive benefits pending resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services;
8. The date the Action will be taken;
9. A reference to the MCO policies and procedures supporting the MCO's Action;
10. An address where written requests may be sent and a toll-free number that the Member can call to request the assistance of a Member representative, file an Appeal, or request a Fair Hearing;
11. An explanation that Members may represent themselves, or be represented by a Provider, a friend, a relative, legal counsel, or another spokesperson;
12. A statement that if the Member wants a Fair Hearing on the Action, the Member must make the request for a Fair Hearing within 90 days of the date on the notice or the right to request a hearing is waived;
13. A statement explaining that the MCO must make its decision within 30 days from the date the Appeal is received by the MCO, or three business days in the case of an Expedited Appeal; and
14. A statement explaining that the hearing officer must make a final decision within 90 days from the date a Fair Hearing is requested.

8.1.29.6 Timeframe for Notice of Action

In accordance with 42 C.F.R. § 438.404(c), the MCO must mail a notice of Action within the following timeframes:

1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 C.F.R. §§ 431.211, 431.213, and 431.214;
2. For denial of payment, at the time of any Action 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 an Appeal 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; and
6. For expedited service authorization decisions, within the timeframes specified in 42 C.F.R. § 438.210(d).

8.1.29.7 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 Appeals. The written resolution notice must include the results and date of the Appeal resolution. For decisions not wholly in the Member's favor, the notice must contain:

- The right to request a Fair Hearing;
- How to request a Fair Hearing;
- The circumstances under which the Member may continue to receive benefits pending a Fair Hearing;
- How to request the continuation of benefits;
- If the MCO's Action is upheld in a Fair Hearing, the Member may be liable for the cost of any services furnished to the Member while the Appeal is pending; and
- Any other information required by 1 Tex. Admin. Code Chapter 357 that relates to a MCO's notice of disposition of an Appeal.

8.1.29.8 Timeframe for Notice of Resolution of Appeals

In accordance with 42 C.F.R. § 438.408, the MCO must provide written notice of the resolution of Appeals, including Expedited Appeals, as expeditiously as the Member's health condition requires, but the notice must not exceed the timelines as provided in this Section for Standard or Expedited Appeals. For expedited resolution of Appeals, the MCO must make reasonable efforts to give the Member prompt oral notice of the resolution of the Appeal, and follow up with a written notice within the timeframes set forth in this Section for Expedited Appeals. If the MCO denies a request for expedited resolution of an Appeal, the MCO must transfer the Appeal to the timeframe for standard resolution as provided in this Section, and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two calendar days with a written notice.

8.1.29.9 Member Advocates

The MCO must provide Member Advocates to assist Members. Member Advocates must be physically located within each MCO Service Area where the MCO operates a STAR

Kids program, unless an exception is approved by HHSC. Member Advocates must be trained and knowledgeable about the MCO complaints and conflict resolution process. Member Advocates must inform Members of the following:

1. Their rights and responsibilities,
2. The functions and contact information for the HHSC Office of the Ombudsman,
3. The Complaint process,
4. The Appeal process,
5. Covered Services available to them, including preventive services, and
6. 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 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 available to meet Member needs that are not available from the MCO as Covered Services. Member Advocates must be trained to handle complaints regarding Service Coordination. Member Advocates must work with appropriate MCO personnel to address complaints about Service Coordinators, either by requesting reassignment or by working with the Member, the Service Coordinator, and other appropriate MCO staff to facilitate resolution.

The MCO must ensure access to Spanish-speaking Member Advocates or Member Advocates who speak languages of other Major Population Groups, if requested.

8.1.29.10 Member Pre-Appeal Process

The MCO must develop, implement, and maintain a Pre-Appeals process for Members for tracking, resolving, and reporting disputes regarding the potential 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. The purpose of this process is to facilitate and expedite the resolution of disputes that may escalate and delay or impair the Member's receipt of services. The MCO must make consistent good-faith efforts to reach compromise and resolution, with the goal of resolving the majority of disagreements regarding potential denials or limited authorization of services before they become formal Member Appeals. All STAR Kids MCOs must submit a proposed process for Pre-Appeals during the Readiness Review period. HHSC will review proposals and provide formal approval of Pre-Appeal plans.

8.1.30 Additional Medicaid Behavioral Health Provisions

8.1.30.1 Mental Health Rehabilitative Services and Mental Health Targeted Case Management Services

Mental Health Rehabilitative Services, and Mental Health Targeted Case Management Services must be available to eligible STAR Kids Members who require these services based on the appropriate standardized assessment (the Child and Adolescent Needs and Strengths (CANS) through a qualified Network of entities. Qualified entities can include both Local Mental Health Authorities (LMHAs) and other entities, such as multi-specialty groups 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 to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms of 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), and must ensure that it coordinates with providers of Mental Health Targeted Case Management to ensure integration of behavioral and physical health needs of Members.

Additionally, the MCO must ensure the following:

1. Providers of Mental Health Rehabilitative Services and Mental Health Targeted Case Management use, and are trained and certified to use, HHSC approved assessment tools for assessing Member's needs.

2. STAR Kids Service Coordinators coordinate with providers of Mental Health Targeted Case Management and Mental Health Rehabilitative Services to ensure the integration of behavioral and physical health needs of Members.
3. STAR Kids Service Coordinators refer Members that lose Medicaid eligibility to the Local Mental Health Authorities for indigent mental health services.

8.1.31 Third Party Liability and Recovery

Medicaid coverage is secondary 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 HHSC's administrative rules regarding Out-of-Network payment (1 Tex. Admin. Code § 353.4).

The MCO is responsible for establishing a plan and process for avoiding and recovering costs for services that must have been paid through a third party in accordance with state and federal law and regulations, including the Social Security Act, Sections 1902(a)(25)(E) and (F), which require MCOs to pay and later seek recovery from liable third parties: (1) for prenatal and preventive pediatric care, and (2) in the context of a state child support enforcement action. To recognize this requirement, capitation payments to the MCO are reduced by the projected amount of TPR that the MCO is expected to recover.

The MCO must provide required reports as stated in **Section 8.1.19.2**, Financial Reporting Requirements.

Beginning 120 days after the date of adjudication on any claim, Encounter, or other Medicaid-related payment by the MCO subject to Third Party Recovery, HHSC may attempt recovery independent of any MCO action. HHSC will retain, in full, all funds received as a result of the state-initiated recovery or subrogation action.

The MCO must provide a Member quarterly file that contains the following information, if available to the MCO: the Member name, address, claim submission address, group number, employer's mailing address, social security number, and date of birth for each subscriber or policyholder and each dependent of the subscriber or policyholder covered by the insurer. The file must be used for the purpose of matching the Texas Medicaid eligibility file against the MCO Member file to identify clients enrolled in the MCO.

8.1.32 Coordination with Public Health Entities

8.1.32.1 Reimbursed Arrangements with Public Health Entities

The MCO must make a good faith effort to enter into Network Provider agreements for Covered Services with Public Health Entities. Possible Covered Services that could be provided by Public Health Entities include, but are not limited to, the following services:

1. Sexually Transmitted Disease (STD) services;
2. Confidential HIV testing;
3. Immunizations;
4. Tuberculosis (TB) care;
5. Family planning services;
6. Texas Health Steps medical checkups, and
7. Prenatal services.

These subcontracts must be available for review by HHSC or its designated agent(s) on the same basis as all other subcontracts. If the MCO is unable to enter into a contract with Public Health Entities, the MCO must document efforts to contract with Public Health Entities, and make that documentation available to HHSC upon request.

MCO 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.

The MCO must:

1. Identify care managers who will be available to assist public health Providers and PCPs in efficiently referring Members to the public health Providers, specialists, and health-related service Providers, either within or outside the MCO's Network; and
2. Inform Members that confidential healthcare information will be provided to the PCP, and educate Members on how to better utilize their PCPs, public health Providers, emergency departments, specialists, and health-related service Providers.

8.1.32.2 Non-Reimbursed Arrangements with Local Public Health Entities

The MCO must coordinate with Public Health Entities in each Service Area 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, as defined by state law, of communicable disease outbreaks involving Members;

3. Educate Members and Providers regarding WIC services available to Members; and
4. Require Providers to coordinate with local Public Health Entities that have a child lead program, or with DSHS Texas Childhood Lead Poisoning Prevention Program when the local Public Health Entity does not have a child lead program, for follow-up of suspected or confirmed cases of childhood lead exposure.

8.1.33 Coordination with Other State Health and Human Services Programs

The MCO must coordinate with other state Health and Human Services (HHS) Programs in each Service Area, or each Texas Health and Human Service Region, regarding the provision of essential public healthcare services. The MCO must meet the following requirements:

1. Coordinate with the Department of Aging and Disability Services and providers of Long-Term Services and Supports for Members who receive Long-Term Services and Supports outside of the MCO.
2. 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 8.1.24.3.3** under Laboratory Services;
3. Notify Providers of the availability of vaccines through the Texas Vaccines for Children Program;
4. Work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac Registry;
5. Educate Providers and Members about the Department of State Health Services (DSHS) Case Management for Children and Pregnant Women services available;
6. Coordinate services with Case Management for Children and Pregnant Women specifically in regard to an MCO Member's health care needs that are identified by Case Management for Children and Pregnant Women and referred to the MCO;
7. 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;
8. Cooperate with activities required of state and local public health authorities necessary to conduct the annual population and community-based needs assessment;
9. 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 of 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 at http://www.dshs.state.tx.us/lead/pdf_files/pb_109_physician_reference.pdf;

10. Coordinate with Texas Health Steps Outreach Unit;
11. Coordinate Covered Services and hospice services for terminally ill Members with a life expectancy of six months or less who are receiving hospice services through DADS; and
12. Educate Providers and Members about primary and family planning services available through the Texas Women's Health Program and DSHS Family Planning, Primary Health Care, and Expanded Primary Health Care programs.

8.1.34 Minimum Wage Requirements for STAR Kids Attendants in Community Settings

The MCO must ensure that facilities and agencies that provide Personal Care Services (PCS) Personal Care Services – CFC, Acquisition, maintenance and enhancement of skills in CFC, and MDCP STAR Kids attendant services pay attendants at or above \$8.00 per hour.

8.1.35 Advance Directives

Federal and state law 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. Part 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, as well as the following state laws and rules:

1. A Member's right to self-determination in making health care decisions;
2. The Advance Directives Act, Texas Health and Safety Code, Chapter 166, 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. The Declaration for Mental Health Treatment, Texas Civil Practice and Remedies Code, Chapter 137, 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 the MCO or 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 its 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 7th – 8th 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 7th – 8th 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.

8.1.36 Covered Community-Based Services

The MCO must ensure that Members needing Community-Based Services are identified and that services are referred and authorized in a timely manner. Community-Based Services include Home and Community-Based LTSS for MDCP STAR Kids Members and home health Covered Services for all Members. The MCO must ensure that Providers of Community-based Services are appropriately licensed to deliver the service they provide.

Community-Based Services may be necessary for preventative reasons to avoid more expensive hospitalizations, emergency room visits, or institutionalization. Community-Based Services must also be made available to Members to assure maintenance of the highest level of functioning possible in the least restrictive setting. MCOs must provide all necessary Covered Services to Members. A Member's need for Community-based Services to assist with activities of daily living and instrumental activities of daily living must be considered as important as needs related to a medical condition.

8.1.36.1 Electronic Visit Verification

HHSC requires STAR Kids MCOs to contract with EVV Vendors who use a system to verify attendant care services, private duty nursing, and other services identified by UMCM Chapter 8.7.

MCOs must contract with EVV Vendors for the provision of EVV services in a manner consistent with the **UMCM** Chapter 8.6.

The MCO may not pass EVV transaction costs to providers.

8.1.36.2 Community First Choice Services Available to Qualified Members

Community First Choice provides Community-Based Services to eligible Members with physical or cognitive disabilities as an alternative to living in an institution. To be eligible for Community First Choice 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 medical necessity/level of care requirements for Nursing Facility care, an Intermediate Care Facility, or an Institution for Mental Diseases. The MCO must make available to Members who meet these eligibility requirements the array of services allowable under Community First Choice (see **Attachment B-2**, “Covered Services”).

The MCO must contract with Providers of CFC services to ensure access to these services for all qualified STAR Kids 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**, “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.
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.

8.1.37 STAR Kids Service Delivery Options

There are three options available to Members desiring to self-direct the delivery of Personal Care Services (PCS), Personal Care Services or acquisition, maintenance and enhancement of skills in CFC, and, for the MDCP STAR Kids in-home or out-of-home respite, Supported Employment, and Employment Assistance. The three options are:

1. Consumer—Directed Services Option;
2. Service-Related Option; and
3. Agency Option

The MCO must provide information, including the risks and benefits about the three options to all eligible Members.

In addition to providing information concerning the three options, the MCO must provide Member orientation in the option selected by the Member. The MCO must provide information regarding all available options:

1. At initial assessment;
2. At annual reassessment or annual contact with the Member;
3. At any time when a Member requests the information; and
4. In the Member Handbook.

The MCO must contract with Providers who are able to offer PCS, in-home or out-of-home respite, Community First Choice services, Supported Employment, and Employment Assistance and must also educate/train the MCO Network Providers regarding the three options. Network Providers must meet licensure/certification requirements as indicated in **Section 8.3.2**.

8.1.37.1 Consumer Directed Services Model

Consumer Directed Services (CDS) is a service delivery option in which a Member or Member's LAR employs and retains service providers and directs the delivery of PCS and respite services. In the CDS Model the Member or the Member's LAR is the employer of record and retains control over the hiring, management, and termination of an individual providing PCS or in-home or out-of-home respite. The Member or Member's LAR is responsible for assuring that the employee meets the qualifications and requirements for PCS or in-home or out-of-home respite. The Member is required to select a Financial Management Services Agency (FMSA) to handle functions such as processing payroll, withholding taxes, and filing tax-related reports to the Internal Revenue Service and the Texas Workforce Commission for these services. The FMSA is also responsible for providing training on being an employer, verifying provider qualifications (including criminal history and registry checks), and approving the budget. The FMSA must be qualified to perform these services, by having completed the mandatory FMSA enrollment training, holding a DADS FMSA contract, or becoming part of an existing MCO's network.

8.1.37.2 Service Related Option Model

In the Service Related Option (SRO) Model, the Member or the Member's LAR is actively involved in choosing his/her personal attendant or respite provider but is not the employer of record. The Home and Community Support Services Agency (HCSSA) in the MCO's Provider Network is the employer of record for the personal attendant employee and respite provider. In this model, the Member selects the personal attendant or respite provider from the HCSSA's personal assistance employees. The personal attendant's/respite provider's schedule is set up based on the Member input, and the Member manages the PCS or in-home or out-of-home respite. The Member retains the right to supervise and train the personal attendant. The Member may request a different personal attendant, and the HCSSA would be expected to honor the request as long as the new attendant is a Network Provider. The HCSSA establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of PCS or in-home or out-of-home respite. The MCO contracts with HCSSAs that are the employer or contractor of record for the attendant or nurse. In this model, the Member selects the attendant or nurse from the MCO's Provider Network. The attendant or nurse schedule is set up based on the Member's input, and the Member manages the attendant services or Nursing Services. The Member retains the right to supervise and train the attendant or nurse. The Member may request a different attendant or nurse, and the MCO must honor the request as long as the attendant or nurse is a Network Provider. The HCSSA establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of attendant services or Nursing Services.

8.1.37.3 Agency Model

In the Agency Model, the MCO contracts with a HCSSA or a certified Home and Community-based Services or Texas Home Living Agency for the delivery of services. The HCSSA is the employer of record for the personal attendant, respite provider, or nurse. The HCSSA establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports for the service provider.

8.1.38 Service Coordination

8.1.38.1 Service Coordination Description

Service Coordination provides the Member with initial and ongoing assistance identifying, selecting, obtaining, coordinating, and using Covered Services and other supports to enhance the Member's well-being, independence, integration in the community, and potential for productivity. Service coordination must be used to:

1. Provide a holistic evaluation of the Member's individual dynamics, needs and preferences.
2. Educate and help provide health-related information to the Member, the Member's LAR, and others in the Member's Support Network;

3. Help identify the Member's physical, behavioral, functional, and psychosocial needs;
4. Engage the Member and the Member's LAR and other caretakers in the design of the Member's Individual Service Plan (ISP);
5. Connect the Member to Covered and non-covered services necessary to meet the Member's identified needs;
6. Monitor to ensure the Member's access to covered services is timely and appropriate;
7. Coordinate Covered and non-Covered Services; and
8. Intervene on behalf of the Member if approved by the Member.

8.1.38.2 Individual Service Plan (ISP) Description

Each STAR Kids MCO must create and regularly update a comprehensive Person-centered ISP for each STAR Kids Member. The purpose of the ISP is to articulate assessment findings, short and long-term goals, service needs, and Member preferences. The ISP must be used to communicate and help align expectations between the Member, their LAR, the MCO and key service providers. The ISP may also be used by the MCO and HHSC to measure Member outcomes over time. All ISPs must account for the following information:

1. A summary document describing the recommended service needs identified through the STAR Kids Screening and Assessment Process;
2. Covered Services currently received;
3. Covered Services not currently received, but that the Member might benefit from;
4. A description of non-covered services that could benefit the Member;
5. Member and family goals and service preferences;
6. Natural strengths and supports of the Member including helpful family members, community supports, or special capabilities of the Member;
7. With respect to maintaining and maximizing the health and well-being of the Member, a description of roles and responsibilities for the Member, their LAR, others in the Member's Support Network, key service providers, the Member's Health Home, the MCO, and the Member's school (if applicable);
8. A plan for coordinating and integrating care between Providers and Covered and Non-Covered Services;
9. Short and long-term goals for the Member's health and well-being;
10. If applicable, services provided to the Member through YES, TxHmL, DBMD, HCS, CLASS, or third-party resources, and the sources or providers of those services;
11. Plans specifically related to transitioning to adulthood for Members age 15 and older; and
12. Any additional information to describe strategies to meet service objectives and Member goals.

The ISP must be informed by findings from the STAR Kids Screening and Assessment Process, in addition to input from the Member; their family and caretakers; Providers; and any other individual with knowledge and understanding of the Member's strengths and service needs who is identified by the Member, the Member's LAR, or the MCO. To

the extent possible and applicable, the ISP must also account for school-based service plans and service plans provided outside of the MCO. The MCO is encouraged to request, but may not require the Member to provide a copy of the Member's Individualized Education Plan (IEP).

8.1.38.3 ISP Requirements

Each Member's ISP must be updated:

1. at least annually;
2. following a significant change in health condition that impacts service needs;
3. upon request from the Member or the Member's LAR;
4. at the recommendation of the Member's PCP;
5. following a change in life circumstance; and
6. following the STAR Kids Screening and Assessment Process or re-assessment process.

The MCO must provide a printed or electronic copy of the ISP to each Member or the Member's LAR following any significant update and no less than annually. The MCO must provide a copy of the ISP to the Member's providers and other individuals specified by the Member or Member's LAR. The MCO must give the completed ISP in the format that the Member or Member's LAR requests. The MCO must write the ISP in plain language that is clear to the Member or the Member's LAR and must be furnished in Spanish or languages of other Major Population Groups if requested. The named Service Coordinator is responsible for examining the ISP for all Level 1 and 2 Members prior to a face-to-face visit and for ensuring the document is up-to-date and adequately reflects the Member's status, goals, preferences and needs. The MCO is responsible for developing a strategy to ensure the ISP is closely reviewed and monitored on a regular basis for all Level 3 Members. The named Service Coordinator or a representative of the MCO must review and update each Member's ISP with the Member and their LAR no less than annually during a face-to-face visit.

The MCO must complete the ISP in an electronic format compatible with HHSC requirements. The MCO must provide HHSC with information from the ISP upon request, in the format prescribed by HHSC. The MCO must retain all previous versions of the ISP in the Member's file for a period of no less than 5 years. HHSC reserves the right to use information collected in the ISP to measure the quality of Service Coordination and overall care.

8.1.38.4 Service Coordination Structure

Through Service Coordination and other methods determined appropriate by the MCO, the MCO must implement a systematic process to coordinate Non-capitated Services and, if determined advantageous to the Member, enlist the involvement of community organizations providing non-covered services that are important to the health and well-being of Members. The MCO also must also seek to establish relationships with state

and local programs and community organizations, such as the following, to make referrals for Members who need community services.

1. Peer supports and Family Partners for Behavioral Health conditions;
2. Community Resource Coordination Groups (CRCGs);
3. Early Childhood Intervention (ECI) Program;
4. Local school districts (Special Education);
5. Health and Human Services Commission (HHSC) Medical Transportation Program (MTP);
6. Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program;
7. Department of State Health (DSHS) services, including community mental health programs, the Title V Maternal and Child Health, Case Management for Children and Pregnant Women, Children with Special Health Care Needs (CSHCN) Programs, and Youth Empowerment Services (YES) HCBS Waiver;
8. Supplemental Nutrition Assistance Program (SNAP), the Women, Infants, and Children's (WIC) Program, and Head Start;
9. Department of Aging and Disability Services (DADS) HCBS Waivers, including Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Texas Home Living (TxHmL), and Home and Community-based Services (HCS); and
10. Civic and religious organizations and consumer and advocacy groups, such as Easter Seals and the Arc, that also work on behalf of specific Member populations.

To assure coordination between programs for all STAR Kids Members who are enrolled in DADS or DSHS HCBS Waivers, the named STAR Kids Service Coordinator must communicate regularly with the DADS or DSHS staff members or contractors responsible for overseeing the Member's HCBS Waiver services.

8.1.38.5 Service Coordination Teams

Service Coordination Teams are Member-centered support networks designed to enhance services provided by the Service Coordinator. Service Coordination Team members must be individually selected based on the needs and preferences of the Member. The MCO will provide a Service Coordination Team when the MCO or a Provider determines the Member could benefit from a multidisciplinary approach to Service Coordination or determines specific expertise is necessary to address needs identified in the Member's Individual Service Plan (ISP). Service Coordination Teams must be led by at least one Service Coordinator employed by the MCO, or appropriate Health Home employee if the Member receives Service Coordination through their Health Home. If a Member has a named Service Coordinator, the named Service Coordinator must lead the Service Coordination Team. Service Coordination Teams must have access to individuals with expertise or access to identified subject matter experts in the following areas:

1. Behavioral health
2. Co-occurring behavioral health conditions and IDD

3. Medically complex conditions
4. Substance abuse
5. Local resources (e.g., basic needs like housing, food, utility assistance)—MCOs are encouraged to use certified Community Health Workers to support individuals in local areas
6. Pediatrics
7. Long Term Services and Supports (LTSS), including HCBS Waiver programs
8. Durable Medical Equipment (DME)
9. End of life/advanced illness
10. Curative treatment or palliative care
11. Acute care
12. Preventive care
13. Cultural competency based on National Standards for Culturally and Linguistically Appropriate Services (CLAS)
14. Pharmacology
15. Nutrition
16. Consumer Directed Services
17. Texas Promoting Independence strategies such as diversion and relocation
18. Person-Centered Planning
19. Family Partners
20. Peer Supports
21. Positive behavior support
22. Assistive Technology including augmentative communication and seating and positioning
23. Supported employment
24. Permanency planning
25. School transition

A Member's interaction with a Service Coordination Team must be tied to the level and frequency of coordination desired by the Member and the Member's LAR and appropriate to the Member's needs. The named Service Coordinator responsible for leading the Service Coordination Team must work with the team to ensure the team addresses objectives identified in the Member's ISP.

All Members who receive LTSS through a Nursing Facility, the ICF/IID program, or through Non-capitated HCBS Waiver programs must be offered access to a Service Coordination Team that includes representatives from the Member's STAR Kids MCO, and at least one coordinator representing the individual's non-capitated LTSS. All STAR Kids MCO representatives on a Service Coordination team must work in collaboration with other members of the Service Coordination Team to ensure the individual receives adequate and appropriate Covered and non-covered services.

8.1.38.6 Service Coordination Levels

The MCO must furnish a named Service Coordinator to all Members who request one. The MCO must also furnish a named Service Coordinator to a Member when the MCO

determines one is required through an assessment of the Member's health and support needs. The MCO will have three tiers of Service Coordination and assign Members to the appropriate tier based on their level of need. The MCO may use a Health Home employee as the named Service Coordinator.

Each MCO must develop and submit a Service Coordination Plan to HHSC during Readiness Review. The Service Coordination Plan must address service planning for Members from all Service Coordination Levels. 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 the following for all STAR Kids Members.

1. A description of Service Coordination;
2. A phone number to contact if the Member needs Service Coordination or is experiencing problems with Service Coordination;
3. The name of their Service Coordinator, if applicable;
4. The phone number and e-mail address of their named Service Coordinator or information on how to reach a Service Coordinator if the Member does not have a named Service Coordinator;
5. The minimum number of contacts the Member will receive every year; and
6. The types of contacts the Member will receive and instructions on how to request additional Service Coordination assistance at any time
7. How to access a Member Advocate if the Member has complaints about a Service Coordinator.

If the named Service Coordinator changes, the MCO must notify Members within 5 Business Days of the name and phone number of their new Service Coordinator. Within the same time period, the MCO must also post the new Service Coordinator's information on the portal or website Members use to obtain plan information.

Based on findings from talking with the Member, the Member's LAR, and relevant service Providers, and based on the guidelines below, the MCO must structure Service Coordination Levels as follows.

8.1.38.6.1 Level 1 Members

Level 1 Members include the following Member types:

- MDCP STAR Kids Members
- Members with Complex Needs or a history of developmental or behavioral health issues (multiple outpatient visits, hospitalization, or institutionalization within the past year)
- Members with SPMI.
- Members at risk for institutionalization.
- Members with psychosocial needs that present significant challenges to the Member's health and wellbeing.

All Level 1 Members must receive a minimum of four face-to-face Service Coordination contacts annually, in addition to monthly phone calls, unless otherwise requested by the Member or Member's LAR.

MCOs must provide a Level 1 Member with a named Service Coordinator.

8.1.38.6.2 Level 2 Members

Level 2 Members include the following Member types:

- Members who do not meet the requirements for Level 1 classification but receive Personal Care Services (PCS), Community First Choice (CFC), or Nursing Services.
- Members the MCO believes would benefit from a higher level of service coordination based on results from the STAR Kids SAI and additional MCO findings.
- Members with a history of substance abuse (multiple outpatient visits, hospitalization, or institutionalization within the past year).
- Members with non-SPMI behavioral health issues.

All Level 2 Members must receive a minimum of two face-to-face and six telephonic Service Coordination contacts annually unless otherwise requested by the Member or Member's LAR.

MCOs must provide a Level 2 Member with a named Service Coordinator.

8.1.38.6.3 Level 3 Members

Level 3 Members include those who do not qualify as Level 1 or Level 2. The MCO must provide access to service coordination services to all Level 3 Members.

All Level 3 Members must receive a minimum of one face-to-face visit annually and make at least three telephonic service coordination outreach contacts yearly.

At the Member's request, the MCO must provide Level 3 Members with a named Service Coordinator.

8.1.38.7 Service Coordinator Roles and Responsibilities

The purpose of a Service Coordinator is to maximize a Member's health, wellbeing, and independence. Service Coordination should consider and address the Member's situation as a whole, including his or her medical, behavioral, social, and educational needs. The Service Coordinator must work with the Member's PCP to coordinate all Covered Services, Non-capitated Services, and non-covered services available through other sources. This requirement applies regardless of whether the PCP is in the MCO's

Network. 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, and Providers of Non-capitated Services and non-covered services. When families request information regarding a referral to a Nursing Facility or other long-term care facility, the MCO must inform the Member and family about options available through home and community-based service programs, in addition to facility-based options.

The MCO may allow a Member to receive Service Coordination through an integrated Health Home if the individual providing Service Coordination and the Service Coordination structure meet STAR Kids program requirements. The MCO must reimburse a Health Home that provides Service Coordination to its Members through an enhanced rate structure, a per-member-per-month fee, or other reasonable methodology agreed to between the MCO and Health Home. The MCO must employ Service Coordinators who are experienced in meeting the needs of vulnerable populations who have Chronic or Complex Conditions. Service Coordination personnel and management must have expertise in pediatric care and, in addition to physical and behavioral health challenges. Service Coordinators that serve STAR Kids Members must be solely dedicated to serving STAR Kids Members. The MCO must pair a Member with a Service Coordinator who has appropriate experience relating to the individual Member's needs. Service Coordinator managers are Key MCO Personnel as described in **Attachment A**.

The MCO must maintain a sufficient number of Service Coordination personnel and management to ensure the timely completion of assessments and Individualized Service Plans and the successful coordination of services as required by **Sections 8.1.38.1** and **8.1.38.2**. The MCO must ensure that Service Coordinator-to-Member ratios are clinically appropriate and evidence-informed. A named Service Coordinator must attend at least 75 percent of face-to-face meetings between the MCO and the Member. For each Member to whom the Service Coordinator is assigned and no less than twice per year, the named Service Coordinator must review the Member's ISP to determine if updates are required. A named Service Coordinator must return Member phone calls and e-mails within two business days. If a named Service Coordinator is unavailable due to illness or personal leave, the MCO must ensure Members who attempt to contact the named Service Coordinator are provided with the name and contact information of an alternate Service Coordinator.

If a STAR Kids Member does not have a named Service Coordinator, the MCO must ensure a Service Coordinator reviews the Member's ISP no less than twice per year in order to determine if updates are appropriate. The MCO must ensure a Service Coordinator returns a phone call received on behalf of a Member seeking service coordination within two business days.

The MCO must continuously monitor the staff's ability to complete these functions in a timely and thorough nature and will take corrective action as necessary. Member and Provider feedback must also be measured by the MCO in reviewing Service Coordination outcomes.

The MCO must maintain a sufficient number of regional offices in which Service Coordinators will be housed. Regional offices will be located in areas throughout the state that are determined by agreement between the MCO and HHSC to have the greatest Member density. All STAR Kids MCOs must provide dedicated toll-free Service Coordination phone numbers or include a Service Coordination option through their Member Services phone number. If the caller requests to speak to a named Service Coordinator, these numbers, if not regional, must warm transfer callers to the named Service Coordinator.

The MCO must provide access to ongoing training and continuing education for Service Coordinators. Service Coordinator training should include focus on evidence-based best practices in case management for children and young adults with disabilities; Person-Centered Planning; and Cultural Competency.

As described in Sections 8.1.38.6.1, 8.1.38.6.2, and 8.1.38.6.3, all STAR Kids Members must receive a minimum of one face-to-face annual visit. A face-to-face visit may be coordinated to coincide with the annual STAR Kids Reassessment, as described in Section 8.1.39.1. For Level 1 and Level 2 Members, the MCO must ensure that the named Service Coordinator attends the annual STAR Kids Reassessment.

During the face-to-face visit, the Service Coordinator must:

- Review the Member's current short-term and long-term goals and objectives, as documented in the ISP;
- Acknowledge and document goals and objectives that the Member has achieved or with which the Member has made progress;
- Acknowledge and document goals and objectives that may need to be adjusted;
- Develop new goals and objectives with input from the Member, Member's family, and Member's providers;
- Update the Member's ISP;
- Educate the Member and Member's LAR about their rights regarding acts that constitute Abuse or Neglect (CPS) and Abuse, Neglect, or Exploitation (APS); and
- Review Member rights and MCO processes for service authorization, appeals, and complaints.

Service Coordinators must meet the following requirements:

1. A Service Coordinator for a **Level 1** Member must be a registered nurse (RN), nurse practitioner (NP), a physician's assistant (PA), a licensed social worker, or Licensed Professional Counselor if the Member's service needs are primarily behavioral.
2. A Service Coordinator for a **Level 2** Member must be a registered nurse (RN), nurse practitioner (NP), physician's assistant (PA), have an undergraduate or graduate degree in social work or a related field, or be a licensed vocational nurse (LVN) with previous service coordination or case management experience.

3. A Service Coordinator for a **Level 3** Member must have a minimum of a high school diploma or GED and direct experience working with children and young adults with similar conditions or behaviors in three of the last five years.
4. Service Coordinators must possess knowledge of the principles of most integrated settings, including federal and state requirements.
5. Service Coordinators must complete 16 hours of service coordination training every two years. MCOs must administer the training, which must include:
 - a. Information related to the population served;
 - b. How to assess Member's medical, behavioral health, and social needs and concerns;
 - c. How to assess and provide information to Members related to Employment Assistance and Supported Employment;
 - d. How to provide Targeted Case Management for Members receiving Mental Health Rehabilitative Services;
 - e. Consumer Directed Services;
 - f. Person-Centered Planning;
 - g. Trauma-informed care;
 - h. Permanency planning;
 - i. Behavioral supports;
 - j. Identifying and reporting Critical Events or Incidents such as Abuse, Neglect, or Exploitation and educating Members regarding protections;
 - k. Cultural competency based on National Standards for Culturally and Linguistically Appropriate Services (CLAS); and
 - l. Refresher of available local and statewide resources.
6. Service Coordinators working with Members receiving Community-Based Services, including CFC and STAR Kids MDCP 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. As part of continuing education, Service Coordinators must also complete by March 1, 2017, (or within two years of hire date for Service Coordinators hired after March 1, 2015) a comprehensive training on Person-Centered Practices and Person-Centered Plan Facilitation using a certified trainer or an HHSC-approved curriculum. This training is in addition to current Service Coordinator training requirements.

Service Coordinators are responsible for helping to connect the Member to an extended service network to meet their needs, which may include:

1. Mental health services;
2. Natural support networks;
3. Advocacy groups;
4. Support groups;
5. Recreational services;
6. Substance abuse services;
7. Health services;

8. Educational services;
9. Social services;
10. Long-Term Services and Supports;
11. Support services for families;
12. Transition planning for aging out of STAR Kids;
13. Home modification and housing resources;
14. Transportation programs;
15. Vocational services; and
16. Juvenile justice system.

Members who receive LTSS through a Nursing Facility, the ICF/IID program, or Non-capitated HCBS Waiver programs administered through DADS or DSHS must be provided with access to Service Coordinators that are trained in effectively working with individuals with intellectual or developmental disabilities. For the purposes of coordinating with waiver service providers, members enrolled in DADS waiver programs must be provided with a named Service Coordinator. STAR Kids Members who receive services through the YES Waiver must be assigned a named Service Coordinator, as described in **Section 8.1.38.6**, with training and experience in serving children and young adults with SED. For all Members also enrolled in a HCBS Waiver program, except MDCP STAR Kids Members, the MCO must provide all Medicaid Covered Services not otherwise approved through an HCBS program. The STAR Kids Service Coordinator must engage with other entities and individuals involved with a Member's HCBS Waiver program. As part of this process, the STAR Kids Service Coordinator must facilitate an ongoing exchange of information with individuals or entities responsible for coordinating, implementing, and monitoring HCBS Waiver services. To help facilitate this process HHSC will furnish MCOs with initial service plan information for members who receive HCBS Waiver services within 90 days of the STAR Kids Operational Start Date. Additional information on individuals and entities involved with each HCBS waiver program is available in the Procurement Library.

8.1.38.7.1 CDS Information Sharing

The Service Coordinator is responsible for annually providing any Member who receives PCS, respite services, or Supported Employment or Employment Assistance with information regarding the Consumer Directed Services (CDS) model including the option to choose between the CDS, SRO, and Agency option. The Service Coordinator must inform the Member or the Member's LAR about the responsibilities of the employer and FMSA under the CDS model. The Service Coordinator must present the Member or the Member's LAR with a list of contracted FMSA providers. The Service Coordinator must document the Member or Member's LAR's decision on whether to use the CDS option in the ISP and, if elected, provide required materials to the selected FMSA. The Service Coordinator must also provide the FMSA with the authorized schedule of applicable services.

8.1.38.8 Adult Transition Planning

The MCO must help to assure that teens and young adult Members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their 21st birthday. Each MCO is responsible for conducting ongoing transition planning starting when the Member turns 15 years old. The MCO must provide transition planning services as a team approach through the named Service Coordinator if applicable and with a Transition Specialist within the Member Services Division. Transition Specialists must be an employee of the MCO and wholly dedicated to counseling and educating Members and others in their support network about considerations and resources for transitioning out of STAR Kids. Transition Specialists must be trained on the STAR+PLUS system and maintain current information on local and state resources to assist the Member in the transition process. Transition planning must include the following activities:

1. Development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model without a break in service.
2. Prior to the age of 10, the MCO must inform the Member and the Member's LAR regarding LTSS programs offered through the Department of Aging and Disability Services (DADS) and, if applicable, provide assistance in completing the information needed to apply. DADS LTSS programs include CLASS, DBMD, TxHmL, and HCS.
3. Beginning at age 15, the MCO must regularly update the ISP with transition goals.
4. Coordination with DARS to help identify future employment and employment training opportunities.
5. If desired by the Member or the Member's LAR, coordination with the Member's school and Individual Education Plan (IEP) to ensure consistency of goals.
6. Health and wellness education to assist the Member with Self-Management.
7. Identification of other resources to assist the Member, the Member's LAR, and others in the Member's support system to anticipate barriers and opportunities that will impact the Member's transition to adulthood.
8. Assistance applying for community services and other supports under the STAR+PLUS program after the Member's 21st birthday.
9. Assistance identifying adult healthcare providers.

8.1.38.9 Referral to Community Organizations

The MCO must provide information about, and refer the Member to, community organizations that may not be providing Covered Services, but are otherwise important to the health and well-being of Members. These organizations include the following:

1. State/federal agencies (e.g., those agencies with jurisdiction over aging, public health, substance abuse, mental health/intellectual or developmental disabilities, rehabilitation, income support, nutritional assistance, family support);

2. Social service agencies (e.g., residential support agencies, disability groups, centers for independent living, supported employment agencies, Aging and Disability Resource Centers, local intellectual disability authorities);
3. City and county agencies (e.g., welfare departments, housing programs);
4. Civic and religious organizations;
5. Family support agencies; and
6. Consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning).

8.1.38.10 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 or other care or treatment facility, including inpatient psychiatric facilities. On behalf of STAR Kids Members who are hospitalized, the MCO's Service Coordinator must work with the Member's PCP, the Hospital or inpatient psychiatric 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 an inpatient psychiatric facility, Service Coordinators must contact the Member within 1 Business Day. To the extent feasible, the MCO must ensure discharge planning begins before the Member's discharge. Discharge planning must include establishing appropriate service authorizations. When long-term care is needed, the MCO must ensure that the Member's discharge plan includes arrangements for receiving Community-Based Services as appropriate. The MCO must ensure that the Member, the Member's family, and the Member's PCP are well informed of all service options available to meet the Member's needs in the community.

The MCO must also have a protocol for quickly assessing the needs of Members who have or will soon be discharged from a Nursing Facility or ICF-IID. The MCO must assure timely access to Service Coordination and arrange for Medically Necessary or Functionally Necessary PCS or Nursing Services immediately upon the Member's transition from a Nursing Facility or ICF/IID to the community.

8.1.38.11 Conversion Plan for New STAR Kids Members

The MCO must establish a Conversion Plan for newly enrolled Members. The Conversion Plan must include:

1. The Member's history;
2. A summary of current medical, Behavioral Health, and social needs and concerns;
3. Immediate and short-term needs;
4. A list of services required, their frequency; and
5. A description of who will provide these services.

The Conversion Plan may include information for services outside the scope of Covered Services, such as how to access affordable, integrated housing.

The Conversion Planning process must include the following:

1. Review of existing care plans, ISPs, and covered services received, in addition to the Individual Plan of Care for Members enrolled in MDCP;
2. Preparation of a Conversion Plan that ensures continuous care under the Member's existing treatment plan while the STAR Kids MCO conducts appropriate assessments and completes a new or updated ISP;
3. If durable medical equipment or supplies were 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;
4. Payment to the existing provider(s) of service under any existing authorization, care plan, or service plan for up to 6 months, until the MCO has completed the STAR Kids Screening and Assessment Process and issued a new authorization and ISP; and
5. For Members new to the Medicaid program, an initial telephonic communication to the Member completed within five business of enrollment.

For those already enrolled in the Medicaid program, HHSC or the Member's previous Medicaid MCO contractor will provide, upon enrollment in STAR Kids, the Member's STAR Kids MCO with information on existing care plans and names of current Providers. HHSC 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.

Except as provided below, the MCO must review any existing care plan or ISP and begin to develop a Conversion Plan within 10 business days of receiving the Member's enrollment or receipt of the plan of care if not received at the time of enrollment. For existing care plans and for ISPs received prior to the Operational Start Date, the MCO will have additional time to complete this process, not-to-exceed 30 calendar days after the Member's enrollment or receipt of the plan of care if not received at the time of enrollment. The Conversion Plan will remain in place until the MCO develops a new or updated ISP with input from the Member and, if applicable, the Member's LAR.

Once the Member is enrolled and until a Conversion Plan is complete, the STAR Kids MCO must ensure that current Providers are paid for Medically Necessary Covered Services that are delivered in accordance with the Member's existing care plan.

Prior to the Operational Start Date, MCOs must develop a plan that identifies how the MCO will identify and reach out to Members with the most immediate service needs. The plan must outline procedures the MCO will follow to ensure timely assessments for potential enrollees and incoming Members and to provide continuity of care for incoming

Members. HHSC will also provide the MCO with information concerning Members who will be enrolled through manual processes and will need expedited access to services.

8.1.38.12 Centralized Medical Record and Confidentiality

The Service Coordinator is responsible for maintaining a centralized record related to Member contacts, assessments, and service authorizations. The MCO must ensure that the centralized Member record meets all applicable professional standards ensuring confidentiality of Member records, referrals, organization, and documentation of information.

The MCO must have a systematic process for generating and receiving referrals and sharing confidential medical, treatment, and planning information across Providers.

8.1.38.13 Participation in Texas Promoting Independence Initiative

The MCO must participate in the Texas Promoting Independence Initiative. The goal of the Promoting Independence (PI) Initiative is to help aged and disabled individuals live in the most integrated setting possible. PI is Texas' response to the U.S. Supreme Court ruling in *Olmstead v. L.C.* that requires states to provide Community-Based Services for persons with disabilities who would otherwise be entitled to institutional services, when:

1. The state's treatment professionals determine that the placement is appropriate;
2. The affected persons do not oppose the treatment; and
3. The placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state supported disability services.

In accordance with legislative direction, the MCO must designate a point of contact to receive referrals for Nursing Facility residents who may be able to return to the community through the use of MDCP or another HCBS Waiver program. To be eligible for this option, an individual must reside in a Nursing Facility until the individual meets the eligibility criteria for entry into MDCP STAR Kids. This will include the development and approval of a written plan of care for safely moving back into a community setting. If a Member chooses to remain in the Nursing Facility and meets Nursing Facility level of care as identified in the Minimum Data Set, the MCO must honor this choice.

A STAR Kids Member who enters a Nursing Facility or an ICF/IID will remain enrolled in their STAR Kids MCO for the provision of any Covered Services, including those provided through the Comprehensive Care Program, not provided through the facility as part of the daily rate. See **Section 8.1.15** for further information.

When a STAR Kids Member enters a Nursing Facility or an ICF/IID the MCO must:

1. Determine the Member's assigned permanency planner;

2. Contact the Member's assigned permanency planner within 7 calendar days of the Member's facility admission;
3. Collaborate with the Member, the Member's LAR, and the assigned permanency planner to develop a plan of care to transition the Member back to the community;
4. Contact and assess the Member no less than every 90 days while the Member remains in the facility. As part of the quarterly assessment process the MCO must collaborate with HHSC or an HHSC contracted family-based alternatives provider to work with the Member and the Member's family to review community-based options;
5. Work with the Member, the Member's LAR, and the assigned permanency planner in the development of a transition plan when a Member is discharged from the facility.

The MCO will provide these services as part of the Texas Promoting Independence Initiative. The MCO must maintain documentation of the assessments completed as part of this initiative and make them available for state review at any time.

8.1.38.14 STAR Kids Coordination of Services for Dual Eligibles

The STAR Kids program is intended to coordinate program services for Dual Eligible recipients. To facilitate coordination, HHSC encourages the MCO to contract with CMS and operate as a MA Dual SNP in the most populous counties in the Service Area(s) or as a Dual Eligible Medicare-Medicaid Plan (MMP) in the designated demonstration counties. STAR Kids MCOs that are not MA Dual SNPs or an MMP must coordinate care for Dual Eligibles to the fullest extent possible. Additional requirements regarding certain categories of Dual Eligibles are described in **Section 8.2**.

8.1.38.15 Section 811 Project Rental Assistance

The MCO Service Coordinator must coordinate with the DADS Section 811 Project Rental Assistance (PRA) Program point of contact on an ongoing basis for Members with disabilities exiting a Nursing Facility and receiving services from the Section 811 PRA program.

8.1.38.16 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 Kids Community Long-term Services and Supports.

8.1.38.16.1 For Members have Physical Disabilities

To be eligible for the Community First Choice services, the Member must be eligible for Medicaid and meet Medical Necessity/Level of Care criteria.

The MCO must complete the STAR Kids Screening and Assessment Instrument, including the MDCP module, 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 STAR Kids MDCP waiver. The MCO must complete these activities within the timeframe specified by HHSC at a later date.

8.1.38.16.2 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 level of care assessment Local IDD Authority when determining eligibility. The MCO is also responsible for completing the assessment documentation, and preparing a service plan identifying the needed Community First Choice services. The MCO must complete these activities within the timeframe specified by HHSC.

8.1.38.16.3 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, ANSA LOC 4, or membership in the Youth Empowerment Services (YES) waiver.

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 MDCP waiver. The MCO must complete these activities within the timeframe specified by HHSC.

8.1.38.16.4 Eligibility

The MCO will notify the Member of the eligibility determination, which will be based on results of the assessments. If the STAR Kids 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 Fair Hearing process. The MCO is responsible for preparing any requested documentation regarding its assessments and service plans and attending the Fair Hearing.

8.1.38.16.5 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 STAR Kids Screening and Assessment Instrument, including the MDCP module; 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.

8.1.39 STAR Kids Screening and Assessment Process

The MCO must conduct an initial telephonic Member screening for all new Members. The telephonic screening must be used to help the MCO prioritize which Members require the most immediate attention. The MCO must also review claims data to prioritize Members who may need the most immediate assistance. For all Members who are new to the STAR Kids MCO on the Operational Start Date of the STAR Kids program, the STAR Kids MCO may take up to 15 Business Days for the initial telephonic Member screening unless notified by the Member, LAR, or Member's PCP by phone or in writing of a more urgent need. Members who enroll in STAR Kids six months after the Operational Start Date or later must receive the initial telephonic Member screening within five business days from the day the Member is enrolled with the MCO.

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

As a part of the telephonic communication with the Member or Member's LAR, or through written materials provided by the MCO to the Member, the MCO must inform the Member about the STAR Kids Screening and Assessment Process and include the following details:

1. Information on the purpose and goals of the STAR Kids Screening and Assessment Process;
2. The estimated timeframe it will take to complete the STAR Kids Screening and Assessment Instrument (SAI);
3. Information the family should be prepared to discuss as a part of STAR Kids Screening and Assessment Process including medication information, diagnoses, current services, and general questions and concerns.

In addition to the initial telephonic Member screening, all STAR Kids MCOs are responsible for conducting a comprehensive, holistic, and evidence-based service needs assessments for all Members. This process will be known as the “STAR Kids Screening and Assessment Process” and must help to inform or identify:

1. Service Coordination Level;
2. Service preferences and goals for the Member and the Member's LAR;
3. Natural strengths and supports such as Member abilities or helpful family members;
4. Non-capitated services and community supports that the Member already receives or that would be beneficial to the Member;
5. Members requiring immediate attention;
6. Members who need LTSS;
7. Members with behavioral health needs;
8. Members who need physical, occupational, speech, or other specialized therapy services;
9. Members who require Durable Medical Equipment and medical supplies;
10. Members who currently receive and those who meet functional criteria to receive MDCP STAR Kids or HCBS Waiver services;
11. Members who need Personal Care Services (PCS);
12. Members who need Nursing Services, including Home Health Skilled Nursing, Private Duty Nursing, and Nursing Services offered through a Prescribed Pediatric Extended Care Center;

The MCO must prioritize how quickly individual Members receive the STAR Kids SAI based on urgency identified through the initial telephonic screening and claims data. Immediately following the STAR Kids Operational Start Date, Members must receive the face-to-face STAR Kids SAI within the following timelines:

1. Priority 1 (those who become STAR Kids Members after the Operational Start Date and request immediate services); within seven Business Days of requesting services.
2. Priority 2 (those with the most complex medical or behavioral health needs or with an urgent need for services or service coordination): within 30 Business Days of enrollment.
3. Priority 3 (those with needs that are less variable and who are currently receiving the services they require to remain stable): within six months of enrollment.

Six months after the Operational Start Date, the MCO must attempt to schedule the STAR Kids SAI within 15 Business Days of a new Member's enrollment.

The MCO must ensure:

1. the Member and the Member's LAR are involved in the STAR Kids Screening and Assessment Process and are fully informed about the Conversion Planning process;

2. the Member and the Member's LAR are included in the development of the ISP;
3. the Member and the Member's LAR understand and, to the greatest extent possible, are in agreement with the completed ISP; and
4. the Member and the Member's LAR receives a completed copy of the STAR Kids SAI.

As a critical component of the STAR Kids Screening and Assessment Process, the MCO or the MCO's Subcontractor must administer the HHSC designated STAR Kids SAI in an electronic format that will be determined by HHSC. The STAR Kids SAI includes four modules:

1. The Core Module
2. The Personal Care Assessment Module (PCAM)
3. The Nursing Care Assessment Module (NCAM)
4. The MDCP Module

The MCO must provide the Core Module to all STAR Kids Members. The Core Module will be used to:

1. determine Member preferences;
2. trigger for the PCAM, NCAM, or both;
3. identify follow-up assessment needs;
4. help determine Service Coordination Level; and
5. inform the development of the Member's ISP.

The STAR Kids SAI must be provided in the Member's place of residence, unless otherwise requested by the Member or the Member's LAR. The Member and Member's LAR must be present when the STAR Kids SAI is administered. The STAR Kids SAI will include certain information that must be relayed to the Member and Member's LAR. This information will include information concerning Member rights and responsibilities and Covered Services. More information about the SAI Modules is included in the **Procurement Library**.

Needs identified through the STAR Kids SAI must inform the types of follow-up assessments that must be administered. If determined through the STAR Kids Core Module that PCS or Nursing Services may be appropriate, the MCO must administer the STAR Kids SAI's PCAM module, NCAM module or both the PCAM and the NCAM module.

A registered nurse must administer the STAR Kids SAI, and it may not be provided by any contracted entity that is or will be providing direct services to the Member. The MCO must train all individuals that will administer the STAR Kids SAI using a training module required by HHSC before the individuals administer the SAI. For quality monitoring purposes, HHSC or its Administrative Services Subcontractor may request specific data obtained through the STAR Kids SAI. The MCO must provide any requested data to

HHSC or its Administrative Services Subcontractor in accordance with the terms of this Contract.

The Personal Care Assessment Module (PCAM) must be used to assess Member's need for Functionally Necessary Personal Care Services. MCOs may adapt the PCAM to reflect the MCO's name or distribution instructions, but all other elements must be the same. Instructions for completion must be followed exactly as stated.

The Nursing Care Assessment Module (NCAM) is a module included in the STAR Kids SAI that captures information on diagnosis and physical condition in order to determine Nursing Service needs. The MCO must use the NCAM to establish the need for Nursing Services and to help determine the number of PDN hours needed. MCOs may adapt the NCAM to reflect the MCO's name or distribution instructions, but all other elements must be the same. Instructions for completion must be followed exactly as stated.

The PCAM and NCAM confirm if a Member meets Functional or Medical Necessity criteria for PCS or Nursing Services, and if so, provide an appropriate range of service hours. The MCO must provide a summary document on significant findings from the STAR Kids SAI and STAR Kids Screening and Assessment Process to the Member's PCP. The summary document must follow HHSC's required format as posted in the UMCM. The MCO must consider information from the Member's utilization history, PCP and Member or Member's LAR to determine the exact number of PCS, Nursing Services, or both. The number of PCS or Nursing Service hours must fall within the range identified through the PCAM, NCAM, or both. If the PCP of a STAR Kids Member submits an order for services to the STAR Kids MCO before the Member has been assessed in-person by the MCO, the MCO must initiate a short-term plan of care for services until the STAR Kids Screening and Assessment Process is complete.

If a current STAR Kids Member is considered by HHSC for entry into the MDCP STAR Kids program, the MCO must use the STAR Kids SAI, including the MDCP Module, for the purposes of gathering and submitting medical information to HHSC or its designee for Medical Necessity determinations.

The STAR Kids SAI will indicate if further screening or evaluation is needed for behavioral health services, physical therapy, occupational therapy, and speech therapy. The MCO may use additional evidence-based assessments or promising practices to further inform these specific behavioral health and therapy services, as well as DME, medical supplies, or any other need identified during the STAR Kids Screening and Assessment Process. The MCO, a Subcontractor, a Local IDD Authority, or a Provider may complete additional assessment instruments, but the MCO remains responsible for the data recorded. To the extent appropriate, MCOs must ensure additional assessment tools administered are either evidence or research-based.

For Members with a physical disability seeking or needing Community First Choice services, the MCO must use the STAR Kids Screening and Assessment Instrument, including the MDCP module, and supply current medical information for Medical Necessity determinations. After the initial service plan is established, it must be

completed on an annual basis. The STAR Kids Screening and Assessment Instrument, including the MDCP module, 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 STAR Kids Screening and Assessment Instrument for Members who are physically disabled. An Initial Medical Necessity Level of Care determination will expire 120 days after it is approved by the HHSC Administrative Services Contractor if CFC services have not begun. The MCO cannot submit a renewal of the STAR Kids Screening and Assessment Instrument, including the MDCP module, earlier than 90 days prior to the expiration date of the ISP. The renewal will expire 90 days after it is approved by the HHSC Administrative Services Contractor.

For all Members who receive Behavioral Health services, the MCO must encourage participation of both the Member's PCP and Behavioral Health Providers in the assessment and treatment planning process.

If the Member or the Member's LAR indicates an immediate need for Covered Services the MCO must provide appropriate authorizations prior to administering the face-to-face STAR Kids Screening and Assessment Instrument. If at any time prior to conducting the STAR Kids SAI the MCO is notified or becomes aware of an increase in the Member's needs, the MCO must initiate the change based on the urgency of the Member's condition, but no longer than ten calendar days of becoming aware of the increase in the Member's needs.

8.1.39.1 STAR Kids Reassessment

No less than once per calendar year, the MCO must re-administer the STAR Kids SAI and make necessary adjustments to the Member's ISP. If the MCO determines the Member's health and support needs have not changed significantly within a calendar year of completing the STAR Kids SAI based on utilization records, Member reports, and Provider input, the MCO may administer an abbreviated version of the STAR Kids SAI approved by HHSC. The MCO may not administer the abbreviated STAR Kids SAI more than once every other calendar year and may not administer the abbreviated SAI without previously completing the full STAR Kids SAI. For Members who receive PCS, the MCO must complete reassessments using the PCAM every twelve months and as requested by the Member or the Member's LAR. The PCAM must also be completed at any time the MCO determines the Member may require a change in the number of authorized Personal Care Service hours. The MCO must complete Reassessments using the NCAM every twelve months and as requested by the Member or the Member's LAR. The MCO must also complete the NCAM at any time it determines the Member may require a change in the number of authorized hours or Nursing Services.

To ensure continuity of care, the MCO must ensure that the Member is reassessed using the STAR Kids SAI prior to the expiration date of the Member's ISP. The MCO must ensure that the reassessment is timed to prevent any lapse in service authorization or program eligibility.

For Members receiving services through the MDCP STAR Kids, the MCO must reassess eligibility annually as described in **Section 8.3.1**.

The MCO must also review and update a Member's ISP under the following circumstances:

1. Upon discharge from an inpatient stay;
2. Upon discharge from a long-term care facility;
3. Upon a significant change in the Member's condition that results in a need for additional or reduced services;
4. Upon notification of a significant change in life circumstance (change in family structure, a physical move or death in the family); and
5. Within seven calendar days of the Member's request.

8.1.39.2 STAR Kids Screening and Assessment Instrument Electronic Application

The MCO must develop and deploy an electronic application to facilitate administration of the STAR Kids Screening and Assessment Instrument (SAI). The application must be optimized for use on a mobile device such a smart phone or tablet. The MCO must design and implement its electronic SAI application in accordance with technical specifications as defined by HHSC. In implementing the electronic application, the MCO must not alter the content of the SAI, including specific wording, item order, algorithms, and question logic.

8.1.40 Community-Based Service Providers

8.1.40.1 Training

The MCO must comply with **Section 8.1.4.4** regarding Provider Manual and Provider Training specific to the STAR Kids Program. The MCO must train all Community-Based Service Providers regarding the requirements of the Contract and needs of STAR Kids 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 those services. The MCO must place special emphasis on Community-based LTSS and STAR Kids requirements, policies, and procedures that vary from Medicaid Fee-for-Service and commercial coverage rules, including payment policies and procedures.
2. The transition process of up to 6 months for the continuation of Community-based LTSS for Members receiving those services at the time of program implementation, including provider billing practices for these services and who to contact at the MCO for assistance with this process.
3. Inpatient Stay Hospital services and the authorization and billing of those services for STAR Kids Members.
4. Relevant requirements of the STAR Kids Contract, including the role of the Service Coordinator;

5. Processes for making referrals and coordinating Non-capitated Services;
6. The MCO's quality assurance and performance improvement program and the Provider's role in the programs; and
7. The MCO's STAR Kids policies and procedures, including those relating to Network and Out-of-Network referrals.

8.1.40.2 Long-Term Care (LTC) Provider Billing

LTC Providers are not 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 these Providers to allow for a smooth transition from traditional Fee-for-Service Medicaid to Managed Care Medicaid. HHSC also encourages MCOs to provide a no-cost alternative for providers to allow billing without the use of a clearinghouse and to include attendant care payments as part of the regular claims payment process.

All STAR Kids MCOs are required to utilize the standardized method of long-term care billing described in **HHSC UMCM** Chapter 2.1.1 and the STAR+PLUS Handbook.

8.1.40.3 Rate Enhancement Payments for Agencies Providing Attendant Care

All MCOs participating in the STAR Kids program must allow their LTC Providers to participate in the STAR Kids Attendant Care Enhancement Program.

The **UMCM** will explain the methodology that the MCO will use to implement and pay the enhanced payments, including a description of the timing of the payments, in accordance with the intent of the 2000-01 General Appropriations Act (Rider 27, House Bill 1, 76th Legislature, Regular Session, 1999) and 1 Tex. Admin. Code Chapter 355. In addition to the requirements in UMCM Chapter 2.1.3, the MCO must apply vendor holds to participating Providers in accordance with 1 Tex. Admin. Code § 355.101 (as effective 9/1/14) and recoup enhancement payments made to Providers at HHSC's direction. Additionally, upon HHSC's request, the MCO must provide HHSC with 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), Texas Health Steps Personal Care Services (PCS), and Personal Care Services and acquisition, maintenance, and enhancement of skills in CFC.

8.1.40.4 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.

8.1.41 Substance Abuse Benefit

8.1.41.1 Substance Abuse and Dependency Treatment Services

Substance use disorder includes substance abuse and dependence as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

8.1.41.2 Providers

Providers for the substance abuse and dependency treatment benefit include: hospitals, chemical dependency treatment facilities licensed by the Department of State Health Services, and licensed practitioners of the healing arts.

MCOs must include Significant Traditional Providers (STPs) of these benefits in its Network, and provide STPs with expedited credentialing. MCOs must enter into provider agreements with any willing Significant Traditional Provider (STP) of these benefits that meets the Medicaid enrollment requirements and 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 the Department of State Health Services (DSHS) to receive funding for treatment under the Federal Substance Abuse Prevention and Treatment block grant.

MCOs must maintain a provider education process to inform substance abuse treatment Providers in the MCO's Network on how to refer Members for treatment.

8.1.41.3 Substance Abuse Service Coordination

MCOs must provide specialized Service Coordination 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 DSHS, DFPS, and their designees for Members requiring Non-Capitated Services. Non-Capitated Services include, without limitation, services that are not available for coverage under this Contract, State Plan, or Waiver that are available under the Federal Substance Abuse and Prevention and Treatment block grant when provided by a DSHS-funded provider or covered by the DFPS under direct contract with a treatment provider. MCOs must work with DSHS, 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.

8.1.41.4 Member Education and Self-Referral for Substance Abuse 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 abuse treatment services, including information on self-referral.

8.1.42 STAR Kids Handbook

The STAR Kids Handbook contains HHSC-approved policies and procedures related to the STAR Kids Program, including policies and procedures relating to the Texas Healthcare Transformation and Quality Improvement Program 1115 waiver. The STAR Kids Handbook includes additional requirements regarding the STAR Kids Program and guidance for the MCOs, the STAR Kids Support Units at DADS, and HHSC staff for administrating and managing STAR Kids Program operations. The STAR Kids Handbook is incorporated by reference into this Contract.

8.1.43 Required Contact with STAR Kids Members

The MCO is required to contact each STAR Kids Member a minimum of four times per calendar year unless the Member or Member's LAR requests less frequent contact and the MCO documents that request. This contact can be done telephonically or in-person depending upon the Member's level of need and preferences. The MCO must document the mechanisms, number and method of contacts, and outcomes within the MCO's Service Coordination system. During at least one of the annual contacts the MCO must remind the Member or the Member's LAR about timeframes and deadlines applicable to filing complaints and appeals.

No later than 1 month following completion of the ISP, the Service Coordinator must follow up with the Member or Member's LAR, either face-to-face or telephonically, to ensure that necessary services are in place. The MCO must document the visit. This contact is in addition to required Service Coordination contacts as described in **Section 8.1.38.6**.

8.1.44 Medical Transportation

HHSC reserves the right to amend the scope of the Contract to include medical transportation services (MTP) for Medicaid Members. For additional information regarding the MTP Program, the MCO must refer to the Nonemergency Medical Transportation (NEMT) Full Risk Broker Services RFP. MCOs must note that the MTP Program includes numerous *Frew v. Traylor* requirements, including enhanced call center performance standards. If MTP services are added to the scope of the Contract, HHSC will provide advance written notice and conduct appropriate Readiness Review.

8.1.45 Facility-Based Care

A STAR Kids Member who enters a Nursing Facility or ICF/IID will remain a STAR Kids Member.

The MCO will not be responsible for the cost of care provided in a Nursing Facility or ICF/IID. The MCO will not maintain Nursing Facilities and ICFs/IID in its Provider Network and will not reimburse the Nursing Facilities and ICFs/IID for Covered Services.

The MCO must provide Service Coordination and any Covered Services that occur outside of the Nursing Facility or ICF/IID when a STAR Kids Member is in a Nursing Facility or ICF/IID. Throughout the duration of the Nursing Facility or ICF/IID stay, the STAR Kids MCO must work with the Member and the Member's LAR to identify Community-Based Services and LTSS programs to help the Member return to the community.

HHSC reserves the right to amend the scope of the Contract to include Nursing Facility and Intermediate Care Facility services for STAR Kids Members. If these services are added to the scope of the Contract, HHSC will provide advance written notice and conduct appropriate Readiness Review.

8.1.46 Telemedicine, Telehealth, and Telemonitoring Access

Telemedicine, telehealth, and telemonitoring are Covered Services and are benefits of Texas Medicaid as provided in the Texas Medicaid Provider Procedures Manual. MCOs are encouraged to contract with Providers offering these services to provide better access to healthcare for its Members. In addition, a Medicaid MCO must be able to accept and process Provider claims for these services in conformity with the Texas Medicaid benefit.

8.1.47 Reporting Abuse, Neglect, or Exploitation

The MCO, its subcontractors, and Providers must report any suspicion or allegation of Abuse, Neglect, or Exploitation in accordance with Texas Human Resources Code § 48.051; Texas Health and Safety Code § 260A.002; and Texas Family Code § 261.101.

8.2 Integrated Healthcare Services for Dual-Eligible Members

One of HHSC's goals for this Contract is to provide integrated healthcare services to Dual Eligible Members enrolled in STAR Kids. The STAR Kids MCO must provide all medically necessary Covered Services that are not covered by Medicare to Dual Eligible Members. MCOs must also reimburse Medicare providers for the Medicare cost-sharing obligations that HHSC would otherwise be required to pay on behalf of qualified STAR

Kids Dual Eligible Members. Under the Agreement, the MCO will be required to provide all enrolled STAR Kids Dual Eligible Members with the coordinated care and other services.

8.2.1 Medicaid Wrap-Around Services

The STAR Kids MCO will supplement Medicare coverage for STAR Kids Members by providing services, supplies, and outpatient drugs and biologicals that are available under the Texas Medicaid program. There are three categories of Medicaid wrap-around services:

1. Medicaid Only Services (i.e., services that do not have a corresponding Medicare service);
2. Medicare Services that become a Medicaid expense due to a Medicare benefit limitation; and
3. Medicare Services that become a Medicaid expense due to coinsurance (True Cross-over Claims).

Section 8.2.1.1 includes requirements for Medicaid wrap-around services for outpatient drugs and biological products. HHSC will provide advance written notice to the MCOs identifying other types of Medicaid wrap-around services that will become Covered Services, and the effective date of coverage.

8.2.1.1 Medicaid Wrap-Around Services for Outpatient Drugs and Biological Products

STAR Kids MCOs will 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 Kids Members under a non-risk, cost settlement basis, as described in **Attachment A, Section 10.15**, “Supplemental Payments for Medicaid wrap-around Services for Outpatient Drugs and Biological Products.” Refer to HHSC’s **UMCM Chapter 2.2**, “Pharmacy Claims Manual,” for additional information regarding the claims processing requirements for these Medicaid wrap-around services.

8.3 Additional Requirements Regarding the Medically Dependent Children Program (MDCP) STAR Kids

The purpose of MDCP STAR Kids is to prevent unnecessary placement of an individual in a long-term care facility and to support de-institutionalization of individuals who reside in nursing facilities by providing them with support services in the community. The programmatic goals for MDCP STAR Kids are to:

1. enable children and young adults who are medically dependent to remain safely in their homes;
2. offer cost-effective alternatives to placement in nursing facilities and hospitals; and
3. support families in their role as the primary caregiver for their children and young adults who are medically dependent.

8.3.1 Program Eligibility

MDCP STAR Kids provides Community-based LTSS for individuals under the age of 21 with complex medical needs as a cost-effective alternative to living in a Nursing Facility. Total enrollment in MDCP is limited to the number of individuals and the amount of state funding approved by the Texas Legislature except as otherwise provided in 40 Tex. Admin. Code § 51.211(b)–(c). Individuals will be considered for program entry through an interest list process or following an institutional stay. If an individual being considered by HHSC for MDCP entry is not already a STAR Kids Member, HHSC will provide the individual and the individual's LAR with a list of STAR Kids MCOs in the individual's Service Area. Individuals identified by HHSC will select a MCO. HHSC will provide the selected MCO an authorization form to perform the STAR Kids SAI, including the MDCP Module. MCOs must schedule and complete the STAR Kids SAI, including the MDCP Module, within 14 calendar days of notice from HHSC. Once the STAR Kids SAI and MDCP module are complete, the MCO must submit results from the SAI to the HHSC Administrative Services Contractor (ASC) within 72 hours.

If a current STAR Kids Member is considered by HHSC for MDCP entry, the MCO must schedule and complete the STAR Kids SAI, including the MDCP module, within 14 days of notice from HHSC. Once the STAR Kids SAI and MDCP Module are complete, the MCO must submit the results from the SAI to the HHSC Administrative Services Contractor (ASC) within 72 hours.

To be eligible for MDCP STAR Kids services, an individual must meet disability and medical necessity criteria and other program requirements determined by HHSC or its designee. A determination of medical necessity must be based on information collected as part of the STAR Kids SAI and MDCP Module. A medical necessity determination must be authorized through HHSC or its designee.

Once enrolled in MDCP STAR Kids, the MCO must ensure medical necessity is reviewed for each Member on an annual basis. Annual assessments for MDCP eligibility must occur at the same time as annual reassessment with the STAR Kids SAI. The MCO must work to prevent a lapse in MDCP eligibility by performing the Member's annual reassessment for MDCP eligibility and submitting the medical necessity determination to HHSC in time to prevent coverage gaps. The MCO must reassess the Member using the STAR Kids SAI and MDCP module prior to the expiration of the Member's medical necessity determination. The reassessment must be timed to ensure that the HHSC ASC has sufficient time to process the Member's medical necessity determination so that the Member does not experience a lapse in STAR Kids MDCP program eligibility.

8.3.2 MDCP STAR Kids Covered Services

The MCO must provide MDCP STAR Kids Covered Services (see **Attachment B-2**, “Covered Services”) to eligible Members. The MCO must contract with Providers with the following qualifications, consistent with any effective MDCP HCBS Waiver. A list of current MDCP Providers is also included in the **Procurement Library**. HHSC may also require the MCO to enroll certain MDCP Providers who agree to the MCO’s terms and conditions and are identified by HHSC in its Provider Network, such as Camps for Respite Care. For additional information, see 40 Tex. Admin. Code Chapter 51.

Community-based Long-Term Services Available and Supports under MDCP STAR Kids	
Service	Licensure and Certification Requirements
Respite Care	<p>Attendants providing respite care must be at least 18 years of age. The attendant must have a high school diploma or certificate of high school equivalency (GED credentials) and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the required services as needed by the individual.</p> <p>Registered nurses and licensed vocational nurses must have current licenses under Texas Occupations Code Chapter 301.</p> <p>Child Day Care Facilities must be licensed under 40 Tex. Admin. Code Chapter 745. Children with special healthcare needs must receive the care recommended by a healthcare professional or qualified professional affiliated with the local school district or early childhood intervention program.</p> <p>Specific licensure requirements apply based on the place of service for respite care. These requirements are as follows.</p> <p>In-home Respite</p> <p><u>HCSSA—licensed by DADS under 40 Tex. Admin. Code Chapter 97</u></p> <p>Nurse: Skilled care must be performed by a registered nurse or licensed vocational nurse or delegated by a registered nurse. Non-licensed individuals providing delegated skilled tasks must be supervised by a registered nurse. Any delegated skilled care must meet the requirements of the Texas Nursing Practice Act</p> <p>Attendant: The home and community support services agency must employ a respite attendant who must meet the following requirements:</p> <ul style="list-style-type: none"> • Be at least 18 years of age; • Have a high school diploma, certificate of high school equivalency (General Educational Development credentials), or documentation of a proficiency evaluation of experience and competence to perform job tasks;

Community-based Long-Term Services Available and Supports under MDCP STAR Kids	
Service	Licensure and Certification Requirements
	<ul style="list-style-type: none"> • Be trained in CPR and first-aid; • Pass criminal history checks; • Not be on the Employee Misconduct Registry or Nurse Aide Registry; • Not be on the state and federal lists of excluded persons and entities; • Be familiar with individual's specific tasks; • Not be the individual's spouse; and • Must not be the caregiver whether or not the provider is related to the individual. <p>Out-of-home Respite</p> <p><u>Host Family—licensed as a foster home by DFPS or verified as a foster home by a child-placing agency that is licensed by DFPS (40 Tex. Admin. Code Chapters 745, 749, 750)</u></p> <p>The provider of the respite service component must be at least 18 years of age and have a high school diploma or certificate of high school equivalency (GED credentials). The host family must not provide services in its residence to more than four persons unrelated to the individual at one time.</p> <p>The host family must ensure that the individual participates in age-appropriate community activities; and the host family home environment is healthy and safe for the individual.</p> <p>The host family must provide services in a residence that the host family owns or leases. The residence must be a typical residence in the neighborhood and must meet the needs of the individual.</p> <p><u>Child Day Care Facilities—licensed by DFPS under 40 Tex. Admin. Code Chapter 745</u></p> <p>The provider of the respite service component must be at least 18 years of age. The provider must have a high school diploma or certificate of high school equivalency (GED credentials) and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the required services as needed by the individual.</p> <p>Registered nurses and licensed vocational nurses must have current licenses under Texas Occupations Code Chapter 301.</p> <p>Child Day Care Facilities must be licensed under 40 Tex. Admin. Code Chapter 745. Children with special healthcare needs must receive the care recommended by a healthcare professional or qualified professional affiliated with the local school district or early childhood intervention program.</p> <p><u>Special Care Facilities—licensed by DSHS under 25 Tex. Admin. Code Chapter 125</u></p> <p>The provider of the respite service component must be at least 18 years of age. The provider must have a high school diploma</p>

Community-based Long-Term Services Available and Supports under MDCP STAR Kids	
Service	Licensure and Certification Requirements
	<p>or certificate of high school equivalency (GED credentials) and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the required services as needed by the individual.</p> <p>Registered nurses and licensed vocational nurses must have current licenses under Occupations Code, Chapter 301.</p> <p><u>Hospital—licensed by DSHS under 25 Tex. Admin. Code Chapter 133 and participating in Medicare under 42 C.F.R. Part 482</u></p> <p>The provider of the respite service component must be at least 18 years of age. The provider must have a high school diploma or certificate of high school equivalency (GED credentials) and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the required services as needed by the individual.</p> <p>Registered nurses and licensed vocational nurses must have current licenses under Texas Occupations Code Chapter 301.</p> <p><u>Nursing Facility—licensed by DADS under 40 Tex. Admin. Code Chapter 19</u></p> <p>The nursing facility respite provider must employ staff who must:</p> <ul style="list-style-type: none"> • Be at least 18 years of age; • Have a high school diploma or certificate of high school equivalency (General Educational Development credentials) and documentation of a proficiency evaluation of experience and competence to perform job tasks; • Be trained in CPR and first-aid; • Pass criminal history checks; • Not be on the Employee Misconduct Registry or Nurse Aide Registry list; • Be familiar with the individual's tasks; • Not be on the state and federal lists of excluded individuals and entities; <p><u>Camp—licensed by DSHS under 25 Tex. Admin. Code Chapter 265, Subchapter B</u></p> <p>The provider of the respite service component must be at least 18 years of age. The provider must have a high school diploma or certificate of high school equivalency (GED credentials) and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the required services as needed by the individual.</p> <p>Registered nurses and licensed vocational nurses must have current licenses under Texas Occupations Code Chapter 301.</p> <p>These camps must be accredited by the American Camping Association.</p>

Community-based Long-Term Services Available and Supports under MDCP STAR Kids	
Service	Licensure and Certification Requirements
Supported Employment	<p>HCSSA—licensed by DADS under 40 Tex. Admin. Code Chapter 97</p> <p>The Provider of supported employment services must meet all of the criteria in one of these three options.</p> <p>Option 1:</p> <ul style="list-style-type: none"> • 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. <p>Option 2:</p> <ul style="list-style-type: none"> • 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. <p>Option 3:</p> <ul style="list-style-type: none"> • a high school diploma or GED; and • two years of documented experience providing services to people with disabilities in a professional or personal setting.
Financial Management Services	<p>Private entities furnish financial management services. These entities, called financial management services agencies, are procured through an open enrollment process and are required to hold a Medicaid provider agreement with the State. Through a delegation arrangement, DADS executes a contract with the required elements of Medicaid provider agreement on behalf of HHSC.</p> <p>A financial management service agency must comply with the requirements for delivery of financial management services, including attending a DADS mandatory 3-day training session. Topics covered in the training session include: contracting requirements and procedures; financial management service agency responsibilities; consumer/employer responsibilities; DADS case manager/service coordinators responsibilities; enrollment, transfer, suspension and termination of the consumer directed services option; employer budgets; reporting abuse, neglect and exploitation allegations; oversight of consumer directed services; contract compliance and financial monitoring. The required training materials include the definition and responsibilities of a vendor fiscal/employer agent in accordance with IRS Revenue Procedure 70-6, 1970-1 C.B. 420 and an explanation of fiscal employer agent based on Section 3504 of the IRS code and state tax (unemployment) requirements as a Vendor Fiscal/Employer Agent. The training also covers IRS</p>

Community-based Long-Term Services Available and Supports under MDCP STAR Kids	
Service	Licensure and Certification Requirements
	<p>Forms SS-4 and 2678. The rules for the consumer directed services option, located at 40 Tex. Admin. Code Chapter 41, require financial management services agencies to act as vendor fiscal/employer agents along with describing responsibilities such as the revocation of IRS Form 2678 if the individual terminates the consumer directed services option or transfers to another financial management service agency.</p> <p>The financial management services agency must not be the individual's legal guardian; the spouse of the individual's legal guardian; the individual's designated representative; or the spouse of the individual's designated representative.</p>
Adaptive Aids	Be a durable medical equipment supplier or be a manufacturer of items not supplied through durable medical equipment suppliers.
Employment Assistance	<p><u>HCSSA—licensed by DADS under 40 Tex. Admin. Code Chapter 97</u></p> <p>The Provider must meet all of the criteria in one of these three options.</p> <p>Option 1:</p> <ul style="list-style-type: none"> • 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. <p>Option 2:</p> <ul style="list-style-type: none"> • 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. <p>Option 3:</p> <ul style="list-style-type: none"> • a high school diploma or GED; and • two years of documented experience providing services to people with disabilities in a professional or personal setting.
Flexible Family Support Services	<p><u>HCSSA—licensed by DADS under 40 Tex. Admin. Code Chapter 97</u></p> <p>Nurse: Skilled care must be performed by a registered nurse or licensed vocational nurse or delegated by a registered nurse. Non-licensed individuals providing delegated skilled tasks must be supervised by a registered nurse. Any delegated skilled care must meet the requirements of the Texas Nursing Practice Act</p> <p>Attendant: The HCSSA must employ a respite attendant who must meet the following requirements:</p>

Community-based Long-Term Services Available and Supports under MDCP STAR Kids	
Service	Licensure and Certification Requirements
	<ul style="list-style-type: none"> • Be at least 18 years of age; • Have a high school diploma, certificate of high school equivalency (General Educational Development credentials), or documentation of a proficiency evaluation of experience and competence to perform job tasks; • Be trained in CPR and first-aid; • Pass criminal history checks; • Not be on the Employee Misconduct Registry or Nurse Aide Registry; • Not be on the state and federal lists of excluded persons and entities; • Be familiar with individual's specific tasks; • Not be the individual's spouse; and • Must not be the caregiver whether or not the provider is related to the individual.
Minor Home Modifications	<p>A minor home modification program provider must comply with city building codes and American with Disabilities Act standards.</p> <p>A minor home modification program provider must have:</p> <ol style="list-style-type: none"> (1) Five years of experience as a building contractor; (2) Three references from previous contractor clients; and (3) Current General Comprehensive Liability coverage for Errors & Omissions.
Transition Assistance Services (TAS)	<p>The Transition Assistance Services provider must comply with the requirements for delivery of Transition Assistance Services, which include requirements regarding allowable purchases, costs limits, and time frames for delivery. Transition Assistance Services providers must demonstrate knowledge of, and history in, successfully serving individuals who require home and community- based services.</p>

The MCO must offer and make available the Consumer Directed Services (CDS) option for Respite, Flexible Family Supports services, Supported Employment, and Employment Assistance.

8.3.3 Additional Service Coordination Requirements for MDCP STAR Kids Members

The MDCP Module of the STAR Kids SAI will establish an annual cost limit for each Member receiving MDCP services, which will be based on the anticipated cost if the Member received services in a Nursing Facility. As a part of the ISP planning process, the MCO must establish an MDCP plan of care as a part of the STAR Kids ISP that does not exceed the Member's cost limit. If the MCO does not properly establish this plan of

care and the Member's cost exceeds the individual limit, the MCO must continue to provide MDCP services to the Member at the MCO's expense. The MCO may not terminate MDCP enrollment if a Member exceeds his or her cost limit. The MCO must also adopt a methodology to track each Member's MDCP-related expenditures on a monthly basis and provide an update on the progress to the Member and the Member's LAR no less than once per month. The MCO must provide information about each MDCP Member's individual budget to HHSC in a prescribed format and on an annual basis.

Service authorizations for MDCP must include the amount, frequency, and duration of each service to be provided, and the schedule for when services will be rendered. The MCO must ensure the MDCP Member does not experience gaps in authorizations and that authorizations are consistent with information in the Member's ISP.

Prior to the Operational Start Date of STAR Kids, HHSC will provide each MCO with a file on each MDCP STAR Kids Member, including when each Member is due for their next annual reassessment. The MCO must prioritize MDCP reassessments to ensure they occur on schedule. The MCO must continue to follow the Member's existing MDCP Individual Plan of Care (IPC) or ISP and may not reduce or replace services until the Member has been screened and assessed through the STAR Kids SAI and the Member's initial STAR Kids ISP is complete. If a STAR Kids MDCP Member changes MCOs prior to annual reassessment, the previous MCO must supply the new MCO with the results from the previous MDCP Module, and the new MCO must honor the previous assessment findings until the MDCP Module is provided again upon annual review.

If a Member or a Member's LAR notifies the MCO that the Member has experienced a significant change in condition that may warrant an adjustment to their cost limit, the MCO must use an HHSC-approved assessment to confirm if an adjustment is needed. If the assessment validates a change in cost limit, the MCO must work with the Member and the Member's LAR to update the Member's ISP accordingly.

For all MDCP STAR Kids Members, the MCO must consult with the Member and the Member's LAR to determine if the Member needs Minor Home Modifications and Adaptive Aids as part of the annual STAR Kid Screening and Assessment Process or if the Member experiences a change in condition or requests assistance. The MCO must obtain vendors to provide Minor Home Modifications or Adaptive Aids for MDCP STAR Kids Members with a need.

As referenced in **Section 8.1.38.6**, any Member who receives services through MDCP STAR Kids must receive Level 1 Service Coordination. Additionally, named Service Coordinators who provide services to Members enrolled in MDCP STAR Kids must be trained and proficient in the following:

1. The full STAR Kids and MDCP service array;
2. Provider requirements for each service;
3. The CDS option;
4. Eligibility and assessment requirements; and

5. Monitoring and reporting requirements.

8.3.4 Additional ISP Requirements for MDCP STAR Kids Members

In addition to the requirements in **Section 8.1.38.3**, the MCO must use the Person-Centered Planning process described in 42 C.F.R. § 441.301(c)(1) to develop an ISP for an MDCP STAR Kids Member. The MDCP STAR Kids Member's ISP must include the components of a person-centered service plan described in 42 C.F.R. § 441.301(c)(2).

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: Attachment B-1 – HHSC STAR Kids MCO RFP, Section 9

Version 1.0

DOCUMENT HISTORY LOG

STATUS¹	DOCUMENT REVISION²	EFFECTIVE DATE	DESCRIPTION³
Baseline	n/a	October 1, 2015	Initial version of Attachment B-1, RFP Section 9, "Turnover Requirements" that includes all modifications negotiated by the Parties.

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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9 Turnover Requirements

9.1 Introduction

Turnover is defined as the activities that the MCO is required to perform prior to or upon termination of the Contract, in situations where the MCO will transition data and documentation to HHSC or a subsequent contractor.

9.2 Turnover Plan

Twelve months after the start of the Contract, the MCO must provide a Turnover Plan covering the turnover of the records and information maintained to either HHSC or a subsequent contractor. The Turnover Plan will be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan should also include information about third-party software used by the MCO in the performance of duties under the contract, including the manner in which the software is used and terms of the software license agreement, so that HHSC can determine if this software is needed to transition operations under Section 9.2 of the Contract. HHSC must approve the Turnover Plan.

9.3 Transfer of Data and Information

The MCO must transfer to HHSC or a subsequent contractor all data and information necessary to transition operations, including: data and reference tables; data entry software; license agreements for third-party software and modifications if required by HHSC; documentation relating to software and interfaces; functional business process flows; and operational information, including correspondence, documentation of ongoing or outstanding issues, operations support documentation, and operational information regarding Subcontractors. For purposes of this provision, "documentation" means all operations, technical, and user manuals used in conjunction with the software, Services, and Deliverables, in whole or in part, that HHSC determines are necessary to view and extract application data in a proper format. The MCO must provide the documentation in the formats in which the documentation exists at the expiration or termination of the Contract.

In addition, the MCO must provide the following to HHSC.

1. The MCO must provide data, information, and services necessary and sufficient to enable HHSC to map all MCO Program data from the MCO's system(s) to the replacement system(s) of HHSC or a successor contractor, including a comprehensive data dictionary as defined by HHSC.
2. The MCO must provide all necessary data, information, and services will be provided in the format defined by HHSC, and must be HIPAA compliant.

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: Attachment B-1 – HHSC STAR Kids MCO RFP, Section 9

Version 1.0

3. The MCO must provide all of the data, information, and services mentioned in this section using its best efforts to ensure the efficient administration of the contract. The data and information must be supplied in media and format specified by HHSC and according to the schedule approved by HHSC in the Turnover Plan. The data, information, and services provided as detailed in this section must be provided at no additional cost to HHSC.

HHSC or the subsequent contractor must receive and verify all relevant data and information. If HHSC determines that data or information are not accurate, complete, or HIPAA-compliant, HHSC reserves the right to hire an independent contractor to assist HHSC in obtaining and transferring all the required data and information and to ensure that all the data are HIPAA-compliant. The MCO is responsible for the reasonable cost of providing these services.

9.4 Turnover Services

Six months prior to the end of the Initial Contract Period, the MCO must propose a Turnover Plan. Twelve months prior to the end of any extension in the Contract Period, the MCO must update its Turnover Plan and submit it to HHSC. If HHSC terminates the Contract prior to the expiration of the Initial Contract Period or Contract Period, then HHSC may require the MCO to propose or update the Turnover Plan sooner than twelve months prior to the termination date. In these cases, HHSC's notice of termination will include the date the Turnover Plan is due.

The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the Turnover tasks. The Turnover Plan must describe the MCO's policies and procedures that guarantee the following.

1. The least disruption in the delivery of Healthcare Services to Members who are enrolled with the MCO during the transition to a subsequent contractor or provider.
2. Cooperation with HHSC and the subsequent contractor or provider in notifying Members of the transition, as requested and in the form required or approved by HHSC.
3. Cooperation with HHSC and the subsequent contractor or provider in transferring information to the subsequent contractor or provider, as requested and in the form required or approved by HHSC.

HHSC must approve the Turnover Plan, which must include the following at a minimum.

1. The MCO's approach and schedule for the transfer of data, information, and services as described in this Section.
2. The quality assurance process that the MCO will use to monitor Turnover activities.
3. The MCO's approach to training HHSC or a subsequent contractor's staff in the operation of its business processes.

HHSC is not limited or restricted in the ability to require additional information from the MCO or modify the Turnover Plan as necessary.

9.5 Post-Turnover Services

Thirty days following Turnover of operations, the MCO must provide HHSC with a Turnover Results Report documenting the completion and results of each step of the Turnover Plan. HHSC will not consider Turnover completed until HHSC approves the Turnover Plan.

If the MCO does not provide the required data, information, or services necessary for HHSC or the subsequent contractor to assume the operational activities successfully, the MCO agrees to reimburse HHSC for all reasonable costs and expenses, including: transportation, lodging, and subsistence to carry out inspection, audit, review, analysis, reproduction, and transfer functions at the location(s) of any necessary records; and attorneys' fees and costs. This section does not limit HHSC's ability to impose remedies or damages as set forth in the Contract.

DOCUMENT HISTORY LOG

STATUS¹	DOCUMENT REVISION²	EFFECTIVE DATE	DESCRIPTION³
Baseline	n/a	October 1, 2015	Initial version of Attachment B-2, "STAR Kids Covered Services" that includes all modifications negotiated by the Parties.

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.

STAR Kids Covered Services

The following is a non-exhaustive, high-level listing of Covered Services included under the STAR Kids Medicaid managed care program.

Medicaid MCOs are responsible for providing a benefit package to STAR Kids Members that includes all Medically Necessary services covered under the traditional, fee-for-service Medicaid programs, except for Non-capitated Services provided to Medicaid Members outside of the MCO capitation and listed in **Section 8.1.24.8**. In accordance with **Section 8.1.24.8**, Nursing Facility Services are examples of services that are excluded from the capitation payment to STAR Kids MCOs and are paid through HHSC's Administrative Contractor responsible for payment of Traditional Medicaid fee-for-service claims. The MCO must coordinate care for STAR Kids Members for these Non-capitated Services so that STAR Kids Members have access to a full range of medically necessary Medicaid services, both capitated and non-capitated. The MCO may elect to offer additional Value-added Services.

The MCO should refer to the current **Texas Medicaid Provider Procedures Manual** for a more inclusive list of limitations and exclusions that apply to each Medicaid benefit category. This document can be accessed online at: <http://www.tmhp.com>.

The services listed in this Attachment are subject to modification based on federal and state laws and regulations and HHSC policy updates.

Services included under the MCO capitation payment

- Emergency and non-emergency ambulance services
- Audiology services, including hearing aids
- Behavioral Health Services (Exception: BH services for STAR Kids Members in the Dallas Service Area choosing NorthSTAR to provide BH services, per Section 8.1.24.8), including
 - Inpatient mental health services. The MCO may provide these services in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting.
 - Outpatient mental health services
 - Psychiatry services
 - Substance use disorder treatment services, including
 - Outpatient services, such as:
 - Assessment
 - Detoxification services
 - Counseling treatment
 - Medication assisted therapy
 - Residential services, which may be provided in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting, including

- Detoxification services
 - Substance use disorder treatment (including room and board)
- Prenatal care provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center
- Birthing services provided by a physician and CNM in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic, and treatment service
- Chiropractic services
- Dialysis
- Drugs and biologicals provided in an inpatient setting
- Durable medical equipment and supplies
- Early Childhood Intervention (ECI) services
- Emergency Services
- Family planning services
- Home health care services
- Hospital services, inpatient and outpatient
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
 - inpatient services; outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
 - all stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
 - surgery and reconstruction on the other breast to produce symmetrical appearance;
 - treatment of physical complications from the mastectomy and treatment of lymphedemas; and
 - prophylactic mastectomy to prevent the development of breast cancer.
 - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
- Medical checkups and Comprehensive Care Program (CCP) Services through the Texas Health Steps Program (EPSDT)
- Mental health rehabilitation services
- Mental health targeted case management
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age;
- Optometry, glasses, and contact lenses, if medically necessary
- Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals
- Personal Care Services (PCS)
- Podiatry
- Prescribed pediatric extended care center (PPECC) services
- Primary care services
- Private Duty Nursing (PDN) services
- Radiology, imaging, and X-rays
- Specialty physician services

- Telemonitoring
- Telehealth
- Therapies – physical, occupational, and speech
- Transplantation of organs and tissues
- Vision services

Community First Choice services for those Members who qualify for these services

The state provides an enriched array of services to Members who would otherwise qualify for care in a Nursing Facility, an ICF/IDD, or an Institution for Mental Diseases (IMD).

- Personal Care Services - CFC - All qualified Members may receive medically and functionally necessary Personal Assistance Services under CFC.
- Acquisition, maintenance and enhancement of skills - All qualified Members may receive this service to enable the Member to accomplish ADLs, IADLs and health-related tasks.
- Emergency Response Services - CFC - (Emergency call button) - All qualified Members may receive necessary Emergency Response Services under CFC.
- Support Management - All qualified Members may receive voluntary training on how to select, manage and dismiss attendants.

Services included under the MCO capitation payment for MDCP STAR Kids

The following is a list of Covered Services for Members who qualify for MDCP STAR Kids services. The MCO must provide Medically and Functionally Necessary services to Members who meet the functional and financial eligibility for MDCP STAR Kids.

1. Respite Care;
2. Supported Employment;
3. Financial Management Services;
4. Adaptive Aids;
5. Employment Assistance;
6. Flexible Family Support Services;
7. Minor home modifications; and
8. Transition Assistance Services.

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: Attachment B-3 – HHSC STAR Kids MCO RFP, Deliverables/Liquidated Damages Matrix

Version 1.0

DOCUMENT HISTORY LOG

STATUS¹	DOCUMENT REVISION²	EFFECTIVE DATE	DESCRIPTION³
Baseline	n/a	October 1, 2015	Initial version of Attachment B-3, "Deliverables/Liquidated Damages Matrix" that includes all modifications negotiated by the Parties.

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.

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: Attachment B-3 – HHSC STAR Kids MCO RFP, Deliverables/Liquidated Damages Matrix

Version 1.0

#	Service/ Component ¹	Performance Standard ²	Measurement Period ³	Measurement Assessment ⁴	Liquidated Damages
1.	General Requirement: Failure to Perform an Administrative Service STAR Kids Contract Terms RFP §§ 6, 7, 8 and 9	The MCO fails to timely perform an MCO Administrative Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, the failure either: (1) results in actual harm to a Member or places a Member at risk of imminent harm; or (2) materially affects HHSC's ability to administer the Program.	Ongoing	Each incident of non-compliance per Service Area (SA)	HHSC may assess up to \$5,000 per calendar day for each incident of non-compliance per SA.
2.	General Requirement: Failure to Provide a Covered Service STAR Kids Contract Terms, RFP §§ 6, 7, 8 and 9	The MCO fails to timely provide a Covered Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, this failure results in actual harm to a Member or places a Member at risk of imminent harm.	Ongoing	Each calendar day of non-compliance	HHSC may assess up to \$7,500 per calendar day for each incident of non-compliance.

¹ Derived from the RFP, Contract, or HHSC's UCMC.

² Standard specified in the RFP or Contract. Where the due date states 30 days, the MCO must 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 must provide the deliverable by the 15th day of the second month following the end of the reporting period.

³ Period during which HHSC will evaluate service for purposes of tailored remedies.

⁴ Measure against which HHSC will apply remedies.

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: Attachment B-3 – HHSC STAR Kids MCO RFP, Deliverables/Liquidated Damages Matrix

Version 1.0

#	Service/ Component ¹	Performance Standard ²	Measurement Period ³	Measurement Assessment ⁴	Liquidated Damages
3.	STAR Kids Contract Terms , Section 4.08 Subcontractors	<p>The MCO must notify HHSC in writing:</p> <ul style="list-style-type: none"> (i) three Business Days after receiving notice from a Material Subcontractor of its intent to terminate a Subcontract; (ii) 180 calendar days prior to the termination date of a Material Subcontract for MIS systems operation or reporting; (iii) 90 calendar days prior to the termination date of a Material Subcontract for non-MIS MCO Administrative Services; and (iv) 30 calendar days prior to the termination date of any other Material Subcontract. 	Transition Period; Quarterly during the Operations Period	Each calendar day of non-compliance, per SA	HHSC may assess up to \$5,000 per calendar day of non-compliance.
4.	RFP §§ 6, 7, 8 and 9 Uniform Managed Care Manual (UMCM)	All reports and deliverables as specified in RFP Sections 6, 7, 8, and 9 must be submitted according to the timeframes and requirements stated in the Contract (including all attachments) and HHSC's UMCM. (Specific Reports or deliverables listed separately in this matrix are subject to the specified liquidated damages.)	Transition Period; Quarterly during Operations Period	Each calendar day of non-compliance, per SA	HHSC may assess up to \$250 per calendar day if the report/deliverable is not submitted, is late, inaccurate, or incomplete.
4.1	Contract	All reports as specified in Sections	Transition Period,	Per incident of	HHSC may assess up to \$2000 if the

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: Attachment B-3 – HHSC STAR Kids MCO RFP, Deliverables/Liquidated Damages Matrix

Version 1.0

#	Service/Component ¹	Performance Standard ²	Measurement Period ³	Measurement Assessment ⁴	Liquidated Damages
	Attachment B-1, RFP §§ 6, 7, 8 and 9 UMCM	6, 7, 8 and 9 of Attachment B-1 must be submitted according to the requirements stated in the Contract (including all attachments) and the UMCM.	Quarterly during Operations Period	noncompliance, per Medicaid MCO, per Service Area.	report is not submitted in the format/template required by HHSC.
5.	RFP §7.3 – Transition Phase Schedule and Tasks RFP §8.1– General Scope of Work	The MCO must be operational no later than the agreed upon Operational Start Date. HHSC, or its agent, will determine when the MCO is considered operational based on the requirements in RFP Sections 7 and 8.	Operational Start Date	Each calendar day of non-compliance, per SA	HHSC may assess up to \$10,000 per calendar day for each day beyond the Operational Start Date that the MCO is not operational until the day that the MCO is operational, including all systems.
6.	RFP §7.3.5 – System Readiness Review	The MCO must submit to HHSC or to the designated Readiness Review Contractor the following plans for review, no later than 120 days prior to Operational Start Date: <ol style="list-style-type: none"> 1. Disaster Recovery Plan; 2. Business Continuity Plan; 3. Security Plan; 4. Joint Interface Plan; 5. Risk Management Plan; 6. Systems Quality Assurance Plan 	Transition Period	Each calendar day of non-compliance, per report, per SA	HHSC may assess up to \$1,000 per calendar day for each day a deliverable is not submitted, is late, inaccurate, or incomplete.
7.	RFP §7.3.7 – Operations Readiness	Final versions of the Provider Directory must be submitted to the Administrative Services Contractor no later than 95 days prior to the Operational Start Date.	Transition Period	Each calendar day of non-compliance, per directory, per SA	HHSC may assess up to \$1,000 per calendar day for each day the directory is not submitted, is late, inaccurate, or incomplete.

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: Attachment B-3 – HHSC STAR Kids MCO RFP, Deliverables/Liquidated Damages Matrix

Version 1.0

#	Service/ Component ¹	Performance Standard ²	Measurement Period ³	Measurement Assessment ⁴	Liquidated Damages
8.	RFP §§ 7.3.7 and 8.1.21	The MCO must submit or comply with the requirements of the HHSC-approved Fraud, Waste, and Abuse Compliance Plan.	Transition Period, Operations Period, and Turnover Period	Each incident of noncompliance	HHSC may assess up to \$1,000 per calendar day for each incident of noncompliance.
9.	RFP § 8.1.3 Access to Care UMCM Chapter 5.14 Geo- Mapping	The MCO must comply with the contract's mileage standards and benchmarks for member access.	Quarterly	Per incident of noncompliance, Service Area, and Provider type	HHSC may assess up to \$1,000 per quarter, per Service Area, and per Provider type.
10.	RFP §8.1.4 Provider Network UMCM Chapter 5.3.8 Out-of- Network Utilization Report	(1) No more than 15 percent of an MCO's total hospital admissions, by service delivery area, may occur in out-of-network facilities. (2) No more than 20 percent of an MCO's total emergency room visits, by service delivery area, may occur in out-of-network facilities. (3) No more than 20 percent of total dollars billed to an MCO for "other outpatient services" may be billed by out-of-network providers.	Quarterly	Per incident of non- compliance, per Service Area	HHSC may assess up to \$25,000 per quarter, per standard, per Service Area.
11.	RFP §8.1.4.5 – Provider Hotline	A. The MCO must operate a toll-free Provider telephone hotline for Provider inquiries from 8 AM – 5 PM, local time for the SA, Monday through Friday, excluding State-approved holidays.	Operations and Turnover	A. Each incident of non-compliance per SA B. Each percentage point below the standard for 1 and each percentage	HHSC may assess: A. Per SA, up to \$100 for each hour or portion of the hour that appropriately staffed toll-free lines are not operational. If the MCO's failure to meet the performance standard is caused

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: Attachment B-3 – HHSC STAR Kids MCO RFP, Deliverables/Liquidated Damages Matrix

Version 1.0

#	Service/Component ¹	Performance Standard ²	Measurement Period ³	Measurement Assessment ⁴	Liquidated Damages
		<p>B. Performance Standards:</p> <ol style="list-style-type: none"> 1. Call pick-up rate – At least 99 percent of calls are answered on or before the fourth ring, or an automated call pick-up system is used; 2. No more than 1% of incoming calls receive a busy signal. 3. Call abandonment rate— Call abandonment rate is 7 percent or less. <p>C. Average hold time is 2 minutes or less.</p>		<p>point above the standard for 2 and 3 per SA</p> <p>C. Per month, for each 30-second time increment, or portion of it, by which the average hold time exceeds the maximum acceptable hold time</p>	<p>by a Force Majeure Event, HHSC will not assess liquidated damages unless the MCO fails to implement its Disaster Recovery Plan.</p> <p>B. Up to \$100 per SA for each percentage point for each standard that the MCO fails to meet the requirements for a monthly reporting period for any MCO operated toll-free lines.</p> <p>C. Up to \$100 may be assessed for each 30-second time increment, or portion of the time increment, by which the MCO's average hold time exceeds the maximum acceptable hold time.</p>
12.	RFP §8.1.5.1 Member Materials	No later than the 5th Business Day following the receipt of the enrollment file from the Administrative Services Contractor, the MCO must mail a Member's ID card and Member Handbook to the Account Name or Case Head for each new Member	Transition, Operations, Turnover	Each incident of noncompliance	HHSC may assess up to \$500 per incident of the MCO's failure to mail Member Materials.
13.	RFP §8.1.5.6.2 –Member Hotline Requirements	A. The MCO must operate a toll-free hotline that Members can call 24 hours a day, 7 days a week.	Ongoing during Operations and Turnover	<p>A. Each incident of non-compliance per SA</p> <p>B. Each percentage</p>	<p>HHSC may assess:</p> <p>A. Per SA, up to \$100 for each hour or portion of the hour that toll-free lines are not operational. If</p>

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: Attachment B-3 – HHSC STAR Kids MCO RFP, Deliverables/Liquidated Damages Matrix

Version 1.0

#	Service/Component ¹	Performance Standard ²	Measurement Period ³	Measurement Assessment ⁴	Liquidated Damages
		<p>B. Performance Standards.</p> <ol style="list-style-type: none"> 1. Call pick-up rate—At least 99 percent of calls are answered on or before the fourth ring, or an automated call pick-up system is used; 2. No more than 1%of incoming calls receive a busy signal; 3. Call hold rate—At least 80 percent of calls must be answered by toll-free line staff within 30 seconds; 4. Call abandonment rate— Call abandonment rate is 7 percent or less. <p>C. Average hold time is 2 minutes or less.</p>		<p>point below the standard for 1 and 3 and each percentage point above the standard for 2 and 4 per SA</p> <p>C. Per month, for each 30-second time increment, or portion of the increment, by which the average hold time exceeds the maximum acceptable hold time</p>	<p>the MCO’s failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the MCO fails to implement its Disaster Recovery Plan.</p> <p>B. Per SA, up to \$100 for each percentage point for each standard that the MCO fails to meet the requirements for a monthly reporting period for any MCO operated toll-free lines.</p> <p>C. Up to \$100 may be assessed for each 30-second time increment, or portion of the increment, by which the MCO’s average hold time exceeds the maximum acceptable hold time.</p>
14.	RFP §8.1.5.9– Member Complaint and Appeal Process RFP §8.1.27.1 Provider Complaints	The MCO must resolve at least 98 percent of Member and Provider Complaints within 30 calendar days from the date the Complaint is received by the MCO.	Quarterly during the Operations Period	Per reporting period, per SA	HHSC may assess up to \$250 per reporting period if the MCO fails to meet the performance standard.
15.	RFP §8.1.5.9– Member	The MCO must resolve at least 98% of Member Appeals within 30	Quarterly during the Operations	Per reporting period, per SA	HHSC may assess up to \$500 per reporting period if the MCO fails to

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Subject: Attachment B-3 – HHSC STAR Kids MCO RFP, Deliverables/Liquidated Damages Matrix

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#	Service/Component ¹	Performance Standard ²	Measurement Period ³	Measurement Assessment ⁴	Liquidated Damages
	Complaint and Appeal Process	calendar days of the MCO's receipt.	Period		meet the performance standard.
16.	RFP §8.1.6 – Marketing and Prohibited Practices UMCM 4.3	The MCO may not engage in prohibited marketing practices.	Transition, Quarterly during the Operations Period	Per incident of non-compliance	HHSC may assess up to \$1,000 per incident of non-compliance.
17.	RFP §8.1.16.2 – Behavioral Health Services Hotline	<p>A. The MCO must have an emergency and crisis Behavioral Health services Hotline available 24 hours a day, 7 days a week, toll-free throughout the SA(s).</p> <p>B. Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess behavioral health emergencies.</p> <p>C. The MCO must ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for the STAR+PLUS Program:</p> <ol style="list-style-type: none"> 1. Call pick-up rate: 99 percent of calls are answered by the fourth ring, or by an automated call pick-up system; 	Operations and Turnover	<p>A. Each incident of non-compliance per SA</p> <p>B. Each incident of non-compliance per SA</p> <p>C. Per SA, per month, each percentage point below the standard for 1 and 3 and each percentage point above the standard for 2 and 4</p> <p>D. Per month, for each 30-second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold</p>	<p>HHSC may assess:</p> <p>A. Up to \$100 for each hour or portion of the hour that appropriately staffed toll-free lines are not operational. If the MCO's failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the MCO fails to implement its Disaster Recovery Plan.</p> <p>B. Up to \$100 per incident for each occurrence that HHSC identifies through its recurring monitoring processes that toll-free line staff were not qualified or did not have access to qualified professionals to assess behavioral health emergencies.</p> <p>C. Up to \$100 for each percentage point for each standard that the</p>

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#	Service/Component ¹	Performance Standard ²	Measurement Period ³	Measurement Assessment ⁴	Liquidated Damages
		<p>2. No more than 1% of incoming calls receive a busy signal;</p> <p>3. Call hold rate: At least 80 percent of calls must be answered by toll-free line staff within 30 seconds;</p> <p>4. Call abandonment rate: The call abandonment rate is 7 percent or less.</p> <p>D. Average hold time is 2 minutes or less.</p>		time	<p>MCO fails to meet the requirements for a monthly reporting period for any MCO-operated toll-free lines.</p> <p>D. Up to \$100 may be assessed for each 30-second time increment, or portion of the increment, during which the MCO's average hold time exceeds the maximum acceptable hold time.</p>
18.	RFP §8.1.19.2 – Financial Reporting Requirements UMCM – Chapter 5	<p>Financial Statistical Reports (FSR): For each SA, the MCO must file quarterly and annual FSRs. Quarterly reports are due no later than 30 days after the conclusion of each State Fiscal Quarter (SFQ). The first annual report is due no later than 120 days after the end of each Contract Year and the second annual report is due no later than 365 days after the end of each Contract Year.</p>	Quarterly during the Operations Period	Per calendar day of non-compliance, per SA	HHSC may assess up to \$1,000 per calendar day a quarterly or annual report is not submitted, is late, inaccurate, or incomplete.
19.	RFP §8.1.19.2 – Financial Reporting Requirements	<p>Medicaid Disproportionate Share Hospital (DSH) Reports: The MCO must submit, on an annual basis, preliminary and final DSH Reports.</p>	4th Quarter of the Operations Period (6/1–8/31)	Per calendar day of non-compliance, per SA	HHSC may assess up to \$1,000 per calendar day, per SA, for each day the report is not submitted, is late, inaccurate, or incomplete.

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	UMCM – Chapter 5	The Preliminary report is due no later than June 1 after each reporting year, and the final report is due no later than July 1 after each reporting year. Any claims added after July 1 must include supporting claim documentation for HHSC validation.			
20.	RFP §8.1.19.2 Financial Reporting Requirements UMCM Chapters 5.6.2 and 5.6.1	Claims Lag Report must be submitted by the last day of the month following the reporting period.	Operations, Turnover	Per calendar day of non-compliance.	HHSC may assess up to \$1,000 per calendar day/per Program the report is not submitted, late, inaccurate, or incomplete.
21.	RFP §8.1.19.2, Financial Reporting Requirements	Financial Disclosure Report: an annual submission no later than 30 days after the end of each calendar year and update after any change, no later than 30 days after the change.	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$1,000 per calendar day the report is not submitted, late, inaccurate, or incomplete.
22.	RFP §8.1.19.2, Financial Reporting Requirements	Affiliate Report: on an as-occurs basis and annually by August 31 of each year in accordance with the UMCM. The “as-occurs” update is due within 30 days of the event triggering the change.	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$1,000 per calendar day the report is not submitted, late, inaccurate, or incomplete.
23.	RFP §8.1.19.2, Financial Reporting	TDI Examination Report: furnish HHSC with a full and complete copy of any TDI Examination Report	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$1,000 per calendar day the report is not submitted, late, inaccurate, or

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#	Service/ Component ¹	Performance Standard ²	Measurement Period ³	Measurement Assessment ⁴	Liquidated Damages
	Requirements	issued by TDI no later than 10 calendar days after receipt of the final version from TDI.			incomplete.
24.	RFP §8.1.19.2, Financial Reporting Requirements	TDI Financial Filings: Submit copies to HHSC of reports submitted to TDI.	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$500 per calendar day the report is not submitted, late, inaccurate, or incomplete.
25.	RFP §8.1.19.2, Financial Reporting Requirements	Filings with Other Entities, and Other Annual Financial Reports: submit an electronic copy of the reports or filings pertaining to the MCO, or its parent, or its parent's parent.	Operations, Turnover	Per calendar day of non-compliance	HHSC may assess up to \$500 per calendar day the report is not submitted, late, inaccurate, or incomplete.
26.	RFP §8.1.19.2, Financial Reporting Requirements UMCM Chapter 5.3.11	Audit Reports—comply with UMCM requirements regarding notification or submission of audit reports.	Operations,	Per calendar day of non-compliance	HHSC may assess up to \$500 per calendar day the report is not submitted, late, inaccurate, or incomplete.
27.	RFP §8.1.19.2, Financial Reporting Requirements UMCM Chapter 5.8	Report of Legal and Other Proceedings and Related Events — comply with UMCM requirements regarding the disclosure of certain matters involving the MCO, its Affiliates, or its Material Subcontractors, as specified. This requirement is both on an as-occurs basis and an annual report due annually on August 31.	Transition, Operations,	Per calendar day of non-compliance	HHSC may assess up to \$1,000 per calendar day the report is not submitted, late, inaccurate, or incomplete.

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#	Service/Component ¹	Performance Standard ²	Measurement Period ³	Measurement Assessment ⁴	Liquidated Damages
28.	RFP §8.1.19.2, Financial Reporting Requirements	Employee Bonus and/or Incentive Payment Plan, Registration Statement (aka "Form B"), and Third Party Recovery (TPR) Reports.	Operations	Per calendar day of non-compliance	HHSC may assess up to \$500 per calendar day the report is not submitted, late, inaccurate, or incomplete.
29.	RFP §8.1.20 – Management Information System Requirements	The MCO's MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan.	Quarterly during the Operations Period	Per calendar day of non-compliance, per SA	HHSC may assess up to \$5,000 per calendar day of non-compliance.
30.	RFP §8.1.20.1 – Encounter Data	<p>The MCO must submit Encounter Data transmissions and include all Encounter Data and Encounter Data adjustments processed by the MCO on a monthly basis, not later than the 30th calendar day after the last day of the month in which the claims are adjudicated. Pharmacy Encounter Data must be submitted no later than 25 calendar days after the date of adjudication and include all Encounter Data and Encounter Data Adjustments.</p> <p>Additionally, the MCO will be subject to liquidated damages if 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</p>	Quarterly during Operations Period.	Per incidence of non-compliance, per Service Area	<p>Liquidated Damages:</p> <p>a) Failure to submit Encounter Data (non-pharmacy):</p> <ol style="list-style-type: none"> For the initial quarter: HHSC may assess up to \$2,500 per month, per SA if the MCO fails to submit monthly encounter data in a quarter. For each subsequent quarter: HHSC may assess up to \$5,000 per month, per SA for each month in any subsequent quarter that the MCO fails to submit monthly Encounter Data. <p>b) Encounter Data Reconciliation (non-pharmacy): Additionally, HHSC may assess up to \$2,500</p>

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#	Service/ Component ¹	Performance Standard ²	Measurement Period ³	Measurement Assessment ⁴	Liquidated Damages
		reported in the Vision 21 Data Warehouse) includes more than a 2-percent variance.			<p>per Quarter, per SA if the MCO is not within the 2% variance. HHSC may assess up to \$5,000 per Quarter, per SA for each additional Quarter that the MCO is not within the 2% variance.</p> <p>c) Pharmacy Encounter Data:</p> <ol style="list-style-type: none"> 1. HHSC may assess up to \$10,000 per program, per quarter, that the MCO fails to submit pharmacy Encounter Data in a timely manner for the initial quarter. 2. For each subsequent quarter: HHSC may assess up to \$15,000 per program if the MCO fails to submit Pharmacy Encounter Data in a timely manner. <p>d) Pharmacy Encounter Data Reconciliation: Additionally, HHSC may assess up to \$2,500 per Quarter, per Program if the MCO is not within the 2% variance. HHSC may assess up to \$5,000 per Quarter, per Program, for each additional Quarter that the MCO is not within the 2% variance.</p>
31.	RFP §8.1.20.3 –	The MCO's MIS system must meet	Quarterly during	Per calendar day of	HHSC may assess up to \$5,000 per

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#	Service/Component ¹	Performance Standard ²	Measurement Period ³	Measurement Assessment ⁴	Liquidated Damages
	System-Wide Functions	all requirements in RFP Section 8.1.20.3.	the Operations Period	non-compliance, per SA	calendar day of non-compliance.
32.	RFP §8.1.20.5 -- Claims Processing Requirements UMCM Chapter 2	<p>For a Clean Claim not adjudicated within 30 days of receipt by the MCO, the MCO must pay the provider interest at 18 percent per annum, calculated daily for the full period in which the Clean Claim remains adjudicated beyond the 30-day claims processing deadline. Interest owed to the provider must be paid on the same date as the claim.</p> <p>For a Clean Claim for outpatient pharmacy benefits not adjudicated within (1) 18 days after receipt by the MCO if submitted electronically, or (2) 21 days after receipt by the MCO if submitted non-electronically, the MCO must pay the provider interest at 18% per annum, calculated daily for the full period in which the Clean Claim remains adjudicated beyond the 18-day or 21-day claims-processing deadline. Interest owed to the provider must be paid on the same date as the claim.</p>	Quarterly during the Operations Period	Per incident of non-compliance	HHSC may assess up to \$1,000 per claim if the MCO fails to pay interest timely.
33.	RFP §8.1.20.5 – Claims	The MCO must comply with the claims processing requirements and	Quarterly during the Operations	Except for pharmacy claims, per quarterly	Except for pharmacy claims, HHSC may assess liquidated damages of up

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#	Service/ Component ¹	Performance Standard ²	Measurement Period ³	Measurement Assessment ⁴	Liquidated Damages
	Processing Requirements UMCM – Chapters 2.0 and 2.2	standards.	Period	reporting period, per Service Area, per claim type. For pharmacy claims: Per quarterly reporting period, per MCO Program.	to \$5,000 for the first quarter that an MCO's Claims Performance percentages by claim type, and by service area, fall below the performance standards. HHSC may assess up to \$25,000 per quarter for each additional quarter that the Claims Performance percentages by claim type, and by service area, fall below the performance standards. HHSC may assess liquidated damages of up to \$5,000 for the first quarter that an MCO's pharmacy Claims Performance percentages by Program, fall below the performance standards. HHSC may assess up to \$25,000 per quarter for each additional quarter that the Claims Performance percentages by Program, fall below the performance standards.
34.	RFP §8.1.21 Fraud, Waste, and Abuse	The MCO must respond to Office of Inspector General request for information in the manner and format requested.	Transition, Operations, and Turnover	Each calendar day of noncompliance	HHSC may assess up to \$1,000 per calendar day that the report is not submitted, is late, inaccurate, or incomplete. This amount will increase to \$5,000 per day per MCO program for the fourth and each subsequent occurrence within a 12-month period.
34.1	Attachment B-1, RFP Section	The MCO must respond to Office of Inspector General request for	Transition, Operations, and	Per instance of noncompliance, per	HHSC may assess up to the difference between the amount

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	8.1.21	payment hold amounts accurately and in the manner and format requested.	Turnover	MCO Program.	reported and the amount received by HHSC OIG.
34.2	Attachment B-1, RFP Section 8.1.21	The MCO fails to hold or improperly releases funds subject to a payment hold	Transition, Operations, and Turnover	Per instance of noncompliance, per MCO	HHSC may assess up to the amount not held or released
34.3	Attachment B-1, RFP Section 8.1.21	The MCO fails to submit claims data as prescribed by OIG.	Transition, Operations, and Turnover	Each instance of noncompliance, per MCO	HHSC may assess up to \$1,000 per calendar day, per MCO Program, that the report is not submitted, late, inaccurate, or incomplete. This amount will increase to \$5,000 per day per MCO program for the fourth and each subsequent occurrence within a 12-month period.
35.	RFP §8.1.22 Reporting Requirements RFP §8.1.27.1 Provider Complaints RFP §8.1.29 Member Complaint and Appeal System	The MCO fails to submit a timely response to an HHSC Member or Provider Complaint received by HHSC and referred to the MCO by the specified due date. The MCO response must be submitted according to the timeframes and requirements stated within the MCO Notification Correspondence (letter, e-mail, etc.).	Quarterly during the Operations Period	Each incident of non-compliance per SA	HHSC may assess up to \$250 per calendar day for each day beyond the due date specified within the MCO Notification Correspondence.
36.	RFP §8.1.22.2– Reports UMCM Chapters 2 and 5	Claims Summary Report: The MCO must submit quarterly Claims Summary Reports to HHSC by SA, and by claim type, by the	Quarterly during the Operations Period	Per calendar day of non-compliance, per SA, per claim type	HHSC may assess up to \$1,000 per calendar day the report is not submitted, is late, inaccurate, or incomplete.

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		30th day following the reporting period unless otherwise specified.			
37.	RFP §8.1.22.2 UMCM Chapter 5.5	The MCO must submit a Fraudulent Practices Report to the HHSC-OIG within 30 Business Days of receiving a report of possible Fraud, Waste, or Abuse from the MCO's Special Investigative Unit (SIU). The MCO must submit quarterly MCO Open Case List Reports.	Transition, Operations, and Turnover	Each calendar day of noncompliance	HHSC may assess up to \$1,000 per calendar day that the report is not submitted, late, inaccurate, or incomplete. This amount will increase to \$5,000 per day per MCO program for the fourth and each subsequent occurrence within a 12-month period.
38.	RFP §8.1.22.2 Reports; UMCM Chapter 12	(a) Medicaid Managed Care Texas Health Steps Medical Checkups Reports – The MCO must submit an annual report of the number of New Members and Existing Members that receive timely Texas Health Steps (THSteps) medical checkups or refuse to obtain medical checkups. (b) Children of Migrant Farmworkers Annual Plan and Children of Migrant Farmworkers Annual Report – The MCO must submit an annual plan that describes how the MCO will identify and provide accelerated services to Children of Migrant Farmworkers and an annual report that	(a) Annually (b) Annually (c) Quarterly (d) Annually (e) Quarterly (f) Quarterly	(a) Per calendar day of non-compliance (b) Plan: Per calendar day of non-compliance Report: Per calendar day of non-compliance per Service Area (c) Per calendar day of non-compliance per MCO (d) Per calendar day of non-compliance per MCO (e) Per calendar day of non-compliance per MCO	HHSC may assess up to \$1,000 per calendar day the reports are not submitted, are late, inaccurate, or incomplete.

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#	Service/ Component ¹	Performance Standard ²	Measurement Period ³	Measurement Assessment ⁴	Liquidated Damages
		<p>summarizes the MCO's migrant efforts as stated in its annual plan.</p> <p>(c) Frew Quarterly Monitoring Report – The MCO must submit each quarter responses to questions on this report's template addressing the status of Frew Consent Decree paragraphs.</p> <p>(d) Frew Annual Provider Training Report – The MCO must submit an annual report of health care and pharmacy provider training conducted throughout the year on Texas Health Steps, Frew, or pharmacy benefit education topics that includes the number of Medicaid providers that received training and feedback received on the subject matter and methodology of the training.</p> <p>(e) Frew Provider Recognition Report – The MCO must submit a quarterly report of Medicaid enrolled healthcare and pharmacy providers who attended the MCO's training on Frew, Texas Health Steps, or pharmacy benefit education topics and consented to being recognized as having attended training on the HHSC website.</p>		<p>(f) Per calendar day of non-compliance</p>	

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		(f) Medicaid Managed Care Texas Health Steps Medical Checkups Quarterly Utilization Reports – For each state fiscal year quarter, the MCO must submit a report of the number and percent of members birth through age 20 receiving at least one Texas Health Steps medical checkup in total and broken down by various age groups.			
39.	Contract Attachment B-1, §8.1.17.1 Formulary and Preferred Drug List	The MCO must allow Network Providers free access to a point-of-care web-based application accessible to smart phones, tablets, or similar technology. The application must also identify preferred/non-preferred drugs; Clinical Edits, and any preferred drugs that can be substituted for non-preferred drugs. The MCO must update this information at least weekly. If the MCO has clinical edits that are identical to HHSC VDP's clinical edits or less stringent than VDP's clinical edits, then the MCO can reference VDP's Texas Medicaid formulary on Epocrates.	Ongoing	Each calendar day of noncompliance	HHSC may assess up to \$10,000 per calendar day for each incident of noncompliance per MCO Program.
39.1	Contract Attachment B-1, 8.1.17.1 Formulary and	MCO fails to adhere to HHSC's formularies and the Medicaid PDL.	Ongoing	Per incident of noncompliance	HHSC may assess up to \$500 for each incident per Member and per drug of non-compliance per MCO Program, not to exceed \$10,000 per

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	PDL				calendar day.
40.	Contract Attachment B-1, §8.1.17.2 Prior Authorization (PA) for Prescription Drugs and 72-Hour Emergency Supplies	The MCO must reimburse a pharmacy for providing a 72-hour emergency supply as outlined in this section or fails to make a prior authorization determination within 24 hours of the request. The MCO must instruct a pharmacy to dispense a 72-hour emergency supply of the prescription as outlined in this section or must make a prior authorization determination within 24 hours of the request.	Ongoing	Per incident of noncompliance	HHSC may assess up to \$5,000 per incident of noncompliance per MCO Program.
41.	Contract Attachment B-1, §8.1.17.5 Pharmacy Rebate Program UMCM Chapters 2.0 and 2.2	The MCO fails to include valid national drug codes (NDCs) on encounters for outpatient prescription drugs, including physician-administered drugs.	Ongoing	Each incident of noncompliance	HHSC may assess up to \$500 for each incident of noncompliance per MCO Program.
42.	Contract Attachment B-1, §8.1.17.16 E-Prescribing	The MCO fails to provide timely data updates to the national e-prescribing network	Ongoing	Each calendar day of noncompliance	HHSC may assess up to \$5,000 per calendar day of noncompliance per MCO Program.
43.	RFP §8.1.27.2, Appeal of Provider Claims	The MCO must resolve at least 98% of Provider Appeals within 30 calendar days of the MCO's receipt.	Operations, Turnover	Per reporting period, per MCO Program, per SA.	HHSC may assess up to \$5000 per reporting period if the MCO fails to meet the performance standard.

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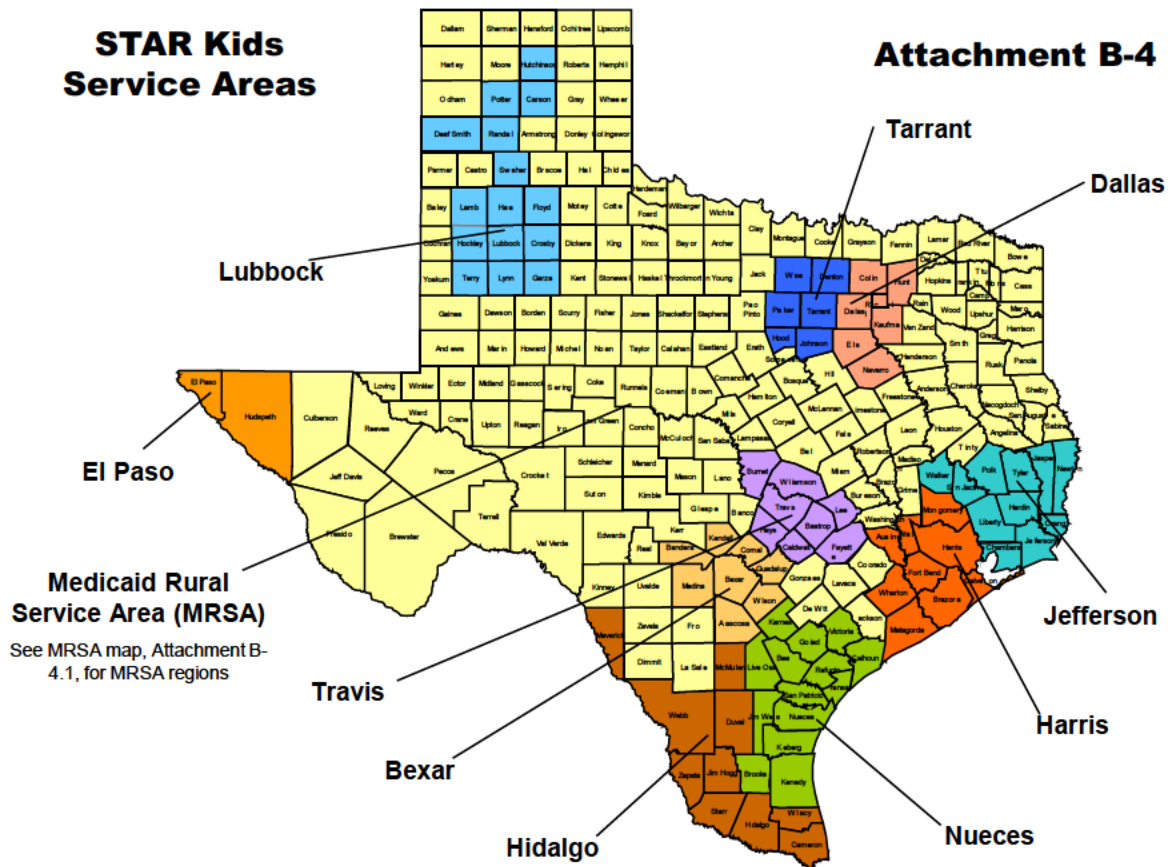
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#	Service/ Component ¹	Performance Standard ²	Measurement Period ³	Measurement Assessment ⁴	Liquidated Damages
44.	RFP §9.3 – Transfer of Data and Information	The MCO must transfer all data regarding the provision of Covered Services to Members to HHSC or a new MCO, at the sole discretion of HHSC and as directed by HHSC. All transferred data must comply with the Contract requirements, including HIPAA.	At Time of Transfer of Data and ongoing after the Transfer of Data until satisfactorily completed	Per incident of non-compliance (failure to provide data or failure to provide data in required format), per SA	HHSC may assess up to \$10,000 per calendar day the data is not submitted, late, inaccurate, or incomplete.
45.	RFP §9.4 – Turnover Services	Twelve months prior to the end of the contract period or any extension thereof, the MCO must propose a Turnover Plan covering the possible turnover of the records and information maintained to either the State (HHSC) or a successor MCO.	Measured at Twelve Months prior to the end of the contract period or any extension thereof and ongoing until satisfactorily completed	Each calendar day of non-compliance, per SA	HHSC may assess up to \$1,000 per calendar day the Plan is not submitted, late, inaccurate, or incomplete.
46.	RFP §9.5 – Post-Turnover Services	The MCO must provide HHSC with a Turnover Results report documenting the completion and results of each step of the Turnover Plan 30 days after the Turnover of Operations.	Turnover Period	Each calendar day of non-compliance, per SA	HHSC may assess up to \$250 per calendar day the report is not submitted, late, inaccurate, or incomplete.

STAR Kids Service Areas

Attachment B-4



HHSC Program Operations
November 2013

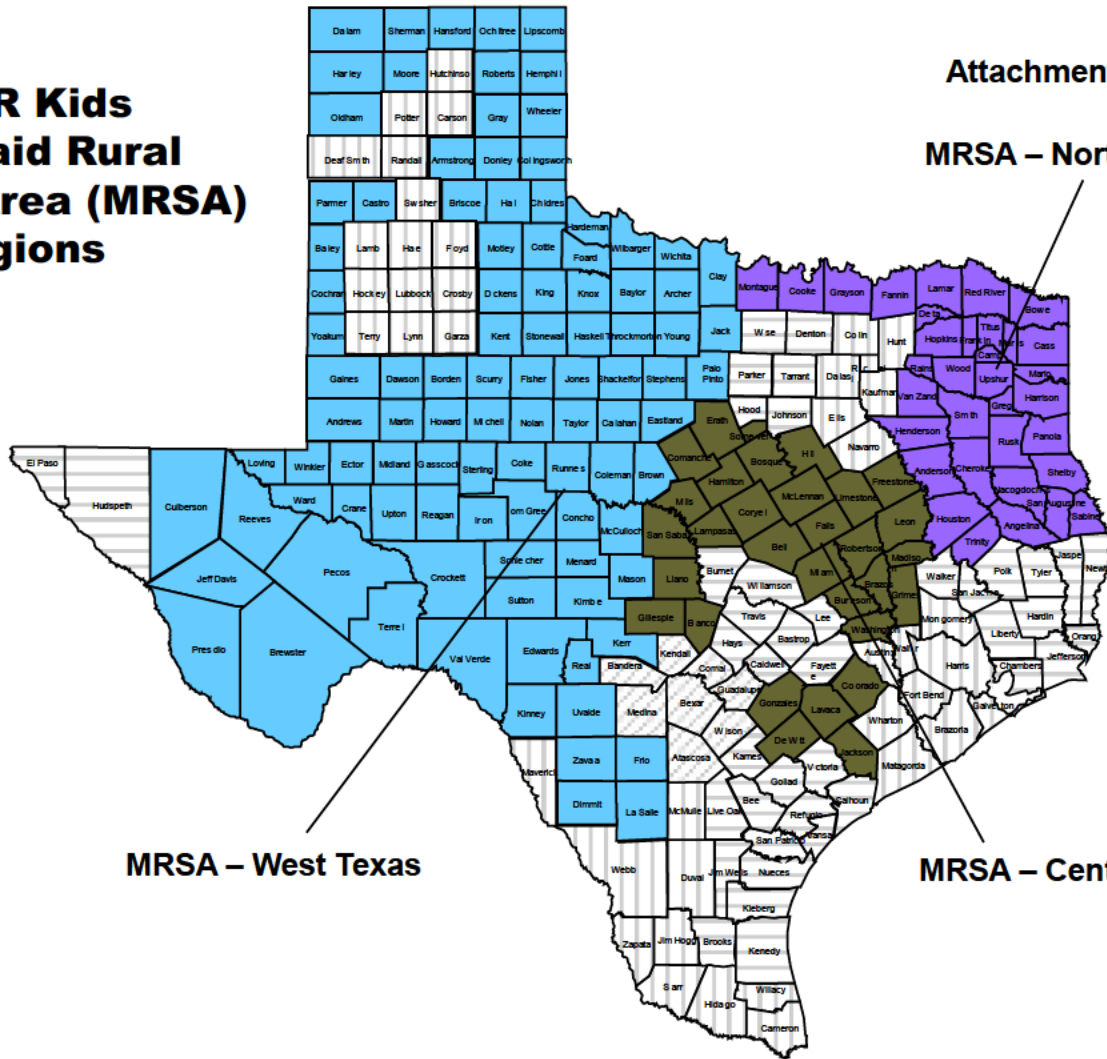
Service Area Counties Served

Bexar	Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson
Dallas	Collin, Dallas, Ellis, Hurt, Kaufman, Navarro, Rockwall
El Paso	El Paso, Hudspeth
Harris	Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton
Hidalgo	Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata
Jefferson	Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker
Lubbock	Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry
Medicaid RSA	Anderson, Andrews, Angelina, Archer, Armstrong, Bailey, Baylor, Bell, Blanco, Borden, Bosque, Bowie, Brazos, Brewster, Briscoe, Brown, Burleson, Callahan, Camp, Cass, Castro, Cherokee, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Colorado, Comanche, Concho, Cooke, Coryell, Cottle, Crane, Crockett, Culberson, Dallam, Dawson, Delta, DeWitt, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Erath, Falls, Fannin, Fisher, Foard, Franklin, Freestone, Frio, Gaines, Gillespie, Glasscock, Gonzales, Gray, Grayson, Gregg, Grimes, Hall, Hamilton, Hansford, Hardeman, Harrison, Hartley, Haskell, Hemphill, Henderson, Hill, Hopkins, Houston, Howard, Irion, Jack, Jackson, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, La Salle, Lamar, Lampasas, Lavaca, Leon, Limestone, Lipscomb, Llano, Loving, Madison, Marion, Martin, Mason, McCulloch, McLennan, Menard, Midland, Milam, Mills, Mitchell, Montague, Moore, Morris, Motley, Nacogdoches, Nolan, Ochiltree, Oldham, Palo Pinto, Panola, Parmer, Pecos, Presidio, Rains, Reagan, Real, Red River, Reeves, Roberts, Robertson, Runnels, Rusk, Sabine, San Augustine, San Saba, Schleicher, Scurry, Shackelford, Shelby, Sherman, Smith, Somervell, Stephens, Sterling, Stonewall, Sutton, Taylor, Terrell, Throckmorton, Titus, Tom Green, Trinity, Upshur, Upton, Uvalde, Val Verde, Van Zandt, Ward, Washington, Wheeler, Wichita, Wilbarger, Winkler, Wood, Yoakum, Young, Zavala
Nueces	Aransas, Bee, Brooks, Calhoun, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria
Tarrant	Denton, Hood, Johnson, Parker, Tarrant, Wise
Travis	Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson

STAR Kids Medicaid Rural Service Area (MRSA) Regions

Attachment B-4.1

MRSA – Northeast Texas



MRSA – West Texas

MRSA – Central Texas

HHSC, Program Operations
November 2013

Service Area Counties Served

Medicaid RSA – Central Texas Bell, Blanco, Bosque, Brazos, Burleson, Colorado, Comanche, Coryell, DeWitt, Erath, Falls, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Jackson, Lampasas, Lavaca, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Washington

Medicaid RSA – Northeast Texas Anderson, Angelina, Bowie, Camp, Cass, Cherokee, Cooke, Delta, Fannin, Franklin, Grayson, Gregg, Harrison, Henderson, Hopkins, Houston, Lamar, Marion, Montague, Morris, Nacogdoches, Panola, Rains, Red River, Rusk, Sabine, San Augustine, Shelby, Smith, Titus, Trinity, Upshur, Van Zandt, Wood

Medicaid RSA – West Texas Andrews, Archer, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Brown, Callahan, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Culberson, Dallam, Dawson, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Fisher, Foard, Frio, Gaines, Glasscock, Gray, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill, Howard, Irion, Jack, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, La Salle, Lipscomb, Loving, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Palo Pinto, Parmer, Pecos, Presidio, Reagan, Real, Reeves, Roberts, Runnels, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Taylor, Terrell, Throckmorton, Tom Green, Upton, Uvalde, Val Verde, Ward, Wheeler, Wichita, Wilbarger, Winkler, Yoakum, Young, Zavala

DOCUMENT HISTORY LOG

STATUS¹	DOCUMENT REVISION²	EFFECTIVE DATE	DESCRIPTION³
Baseline	n/a	October 1, 2015	Initial version of Attachment D, "Corporate Guarantee."

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.

Attachment D

CORPORATE GUARANTEE

In consideration of the execution by the **Texas Health and Human Services Commission** (HHSC) of the STAR Kids Contract (or Contract), effective _____, 2015, with _____ (Subsidiary), _____ (Parent)

unconditionally and irrevocably guarantees to HHSC, on the terms and conditions in this Corporate Guarantee (Guarantee), the full and faithful performance by Subsidiary of all of Subsidiary's obligations in the Contract and any subsequent amendments.

If Subsidiary fails or refuses to complete any of its obligations, Parent will complete, or ensure completion of, any obligation that Subsidiary failed or refused to complete or will be in breach of the Contract to the same extent as Subsidiary and may be subject to damages. The obligations of Parent under this Guarantee (i) are joint and several obligations made for HHSC's benefit and (ii) are direct and unconditional obligations to HHSC, independent of obligations of Subsidiary or any other guarantor. These obligations may be the basis of a separate action by HHSC against any or all guarantors that may be asserted without first bringing an action against Subsidiary.

Parent authorizes HHSC, without notice or demand and without affecting its liability under this Guarantee, from time to time to: (a) waive or delay the exercise of any rights or remedies of HHSC against Subsidiary or any guarantor; (b) release or substitute any guarantor; (c) renew, amend, extend, compromise, or waive any obligation of any guarantor; and (d) renew, compromise, extend, waive, or amend any term of the Contract pursuant to its terms.

Parent agrees that, until its obligations have been performed or paid in full, Parent will not be released by or because of the taking, or failure to take, any action by Subsidiary or HHSC that might in any manner or to any extent vary the risks of Parent under this Guarantee or that, but for this paragraph, might discharge or otherwise reduce, limit, or modify Parent's obligations under this Guarantee. Parent waives and surrenders any defense to any liability under this Guarantee based upon any such action, including any action of HHSC described in the immediately preceding paragraph of this Guarantee, provided, however, Parent does not waive any defenses, remedies, or offsets to which Subsidiary is entitled under or with respect to the Contract. It is the express intent of Parent that Parent's obligations under this Guarantee are absolute, irrevocable, and unconditional guarantees of performance and payment of Subsidiary and are not merely guarantees of collection.

Parent waives:

- (a) the right to require HHSC to proceed against Subsidiary;
- (b) all requirements of presentment, protest, or default and notices of presentment, protest, or default;
- (c) any right to require HHSC to proceed against Subsidiary or to pursue any other remedy in HHSC's power;

- (d) notice of acceptance of this Guarantee;
- (e) notice of any amendments, work authorizations, extensions of time for performance, changes in the work, or other acts by HHSC affecting Subsidiary's rights or obligations under the Contract;
- (f) notice of any breach or claim of breach by Subsidiary, provided HHSC has complied with any required notice provisions to Subsidiary under the Contract;
- (g) any defense arising out of the exercise by HHSC of any right or remedy it may have with respect to the Contract, including the right to amend the Contract and the right to waive or delay the exercise of any rights it may otherwise have against Subsidiary;
- (h) notice of the settlement or compromise of any claim of HHSC against Subsidiary relating to any of Subsidiary's obligations under the Contract; and
- (i) the benefit of suretyship defenses generally.

No provision or waiver in this Guarantee limits the generality of any other waiver contained in this Guarantee.

Parent irrevocably waives all claims it has or may acquire against Subsidiary in respect of Parent's obligations under this Guarantee, including rights of exoneration, reimbursement, and subrogation, but excluding any rights it may have under any surety bonds. Parent agrees to indemnify HHSC, and hold it harmless from and against all loss and expense, including legal fees, suffered or incurred by HHSC as the prevailing party in the enforcement of the Contract or this Guarantee.

Parent warrants that the execution, delivery, and performance of the obligations contained in this Guarantee have been authorized by all appropriate action and will not constitute a breach of or contravene any agreement or instrument to which Parent is a party, and that this Guarantee is a valid and binding obligation of Parent enforceable against Parent in accordance with its terms.

Parent consents to all of the terms and conditions of the Contract and any future amendments agreed to between HHSC and the Subsidiary. All Contract terms and conditions are incorporated by reference into this Guarantee, except that all references to the parties will mean HHSC and Parent, all references to Subsidiary will mean Parent, all references to the Contract will be to this Guarantee, and notices to Parent will be sent to the address in this Guarantee instead of to the address in the Contract.

Parent may not directly or indirectly assign or otherwise transfer (except as a result of a merger or acquisition of or involving Parent) or delegate any rights or obligations in this Guarantee, including any claim arising by subrogation, and any attempt by Parent to assign or delegate any of its rights or obligations in this Guarantee will be void. This Guarantee binds the Parent's successors and assigns and benefits HHSC's successors and assigns.

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: Attachment D – HHSC STAR Kids MCO RFP, STAR Kids Corporate Guarantee

Version 1.0

If any provision of this Guarantee is held invalid, illegal, or unenforceable in any respect in any jurisdiction, then, to the fullest extent permitted by law:

- (a) all other provisions in this Guarantee remain in full force and effect in such jurisdiction and will be liberally construed in favor of HHSC in order to carry out the intentions of the parties to this Guarantee as nearly as possible; and
- (b) any invalidity, illegality, or unenforceability will not affect the validity or enforceability of that provision in any other jurisdiction.

This Guarantee will be governed by and interpreted in accordance with the laws of the State of Texas. Parent irrevocably submits to the jurisdiction of any state district court sitting in Travis County, State of Texas, in any action or proceeding brought to enforce or otherwise arising out of or relating to this Guarantee. Parent irrevocably waives to the fullest extent permitted by law any defense asserting an inconvenient forum in connection with this Guarantee. Service of process by HHSC in connection with such action or proceeding will be binding on Parent if sent to Parent by registered or certified mail at its address specified below. Parent agrees to pay all of HHSC's expenses in connection with the lawful enforcement of this Guarantee, including, without limitation, costs of collection incurred as the prevailing party in any such action.

PARENT

Name of Parent: _____

By: _____

Printed Name: _____

Title: _____

Address: _____

Date: _____