Texas Health & Human Services Commission

General Contract Terms & Conditions

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	June 30, 2010	Initial version of the General Terms & Conditions that includes all modifications negotiated by the Parties.
Revision	1.1	February 1, 2011	Contract amendment did not revise Attachment A General Contract Terms and Conditions
Revision	1.2	March 1, 2011	Definition of “Major Population Group” is modified. The definition of “Medically Necessary” is revised to address the review criteria applicable to children in Medicaid, consistent with 42 USC §1396(r)(5) and Alberto N requirements. The HMOs are already contractually obligated to comply with these requirements, so the change is for clarification only. Definition for “Non-capitated Services” is modified to correct contract reference. Definition of “Outpatient Hospital Services” is modified to remove language that is included in the UMCM. Definition of “Post-stabilization Care Services” is modified. Definition of “Texas Health Network” is deleted. Definition of “Uniform Managed Care Manual” is modified. Section 4.08 is modified to prohibit Medicaid payments to entities located outside the U.S. in conformance with the Affordable Care Act. Section 4.10 is modified to prohibit Medicaid payments to entities located outside the U.S. in conformance with the Affordable Care Act. Section 5.04(a)(3) is modified to correct contract cross-reference. Section 7.02(a) is modified to remove case identification information from the Frew and Alberto N items. Section 9.01 is revised to clarify the requirements for record retention in accordance with Federal requirements. Section 10.08 is modified to let the HMOs consolidate their DFW STAR+PLUS experience with their other STAR+PLUS products. Section 12.15 is added to establish a pre-termination process.

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	1.3	September 1, 2011	Definition for Fair Hearing is modified. Definition of PPACA is added. Definition for Transition Phase is modified. Section 4.08 is modified to add language for the ACA requirement regarding Healthcare Acquired Conditions (HAC). Section 4.10 is modified to add language for the ACA requirement regarding Healthcare Acquired Conditions (HAC). Section 7.08, "Historically Underutilized Business Participation Requirements" is added. Section 9.01 is modified to clarify compliance with 45 CFR 74.53. Section 10.01 is modified to remove pass through funds for high volume providers from the list of Capitation Rate components. Section 10.07(a) is modified to include a new item addressing the State's right to recoup if the CMS has imposed a payment denial as a sanction (42 CFR §438.726(b)), and to modify (a)(1-2). Section 10.17 is modified to remove the Bariatric Supplemental Payment for dates of service on or after September 1, 2011, when all funding will be included in the capitation rates. Section 11.08, "Information Security" is added. Section 12.02(d) is modified to refer to the circumstances prompting temporary management in 42 C.F.R. §438.706.
Revision	1.4	January 1, 2012	Contract amendment did not revise Attachment A "General Contract Terms and Conditions"
Revision	1.5	March 1, 2012	Definition for 1915(c) Nursing Facility Waiver is modified. Definition for Bariatric Supplemental Payment is deleted. Definition for CPW is added. Definition for Medically Necessary is modified for clarification. The State has determined that all acute care behavioral health and non-behavioral health services for Medicaid children fall within the scope of Texas Health Steps. Note that for LTSS, such as PCS (PAS) services for children in STAR+PLUS, the functional necessity

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			standard for LTSS also applies (see Attachment B-1, Section 8.3.3). Section 4.04 is modified to clarify the requirements for Medical Director designees, and to clarify that the provision does not apply to prior authorization determinations made by Texas licensed pharmacists. Section 4.10 is modified to add language required by Gov't Code §533.005(a)(24) (amended by SB 7). New Section 4.11 "Prohibition Against Performance Outside of the United States" added. Section 5.02(b) is modified to clarify that HMOs may not sell or transfer their Member base. Section 5.04(a) is modified to clarify the exceptions to enrollment in an HMO during an Inpatient Stay and the responsibility for payment; and to clarify that Members cannot move from one HMO to another during residential treatment or residential detoxification. References to the PCCM program are removed. Section 7.02 is modified to include additional legal citations and to clarify applicability to pharmacy. Section 7.08(b) is modified to correct cross-reference. Section 9.02 is modified to comply with the requirements of Gov't §533.012 (as amended by SB 7). Section 10.08 is modified to consolidate STAR+PLUS with STAR and CHIP for the Experience Rebate calculation. Section 10.09 is modified to consolidate STAR+PLUS into STAR and CHIP for the Experience Rebate calculation. Section 12.03(b) is modified to add language regarding terminations for criminal convictions.

[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 in accordance 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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Article 1. Introduction

Section 1.01 Purpose.

The purpose of this Contract is to set forth the terms and conditions for the HMO's participation as a managed care organization in the STAR+PLUS Program administered by HHSC. Under the terms of this Contract, HMO will provide comprehensive health care services to qualified Program recipients through a managed care delivery system.

Section 1.02 Risk-based contract.

This is a Risk-based contract.

Section 1.03 Inducements.

In making the award of this Contract, HHSC relied on HMO's assurances of the following:

(1) HMO is an established health maintenance organization or Approved Non-Profit Health Corporation (ANHC) that arranges for the delivery of health care services, is currently licensed as such in the State of Texas and is fully authorized to conduct business in the Service Areas;

(2) HMO and the HMO Administrative Service Subcontractors have the skills, qualifications, expertise, financial resources and experience necessary to provide the Services and Deliverables described in the RFP, HMO's Proposal, and this 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) HMO has thoroughly reviewed, analyzed, and understood the RFP, has timely raised all questions or objections to the 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 the State during the Contract term;

(4) HMO has had the opportunity to review and understand the State's stated objectives in entering into this Contract and, based on such review and understanding, HMO currently has the capability to perform in accordance with the terms and conditions of this Contract;

(5) HMO also has reviewed and understands the risks associated with the STAR+PLUS Program as described in the RFP, including the risk of non-appropriation of funds.

Accordingly, on the basis of the terms and conditions of this Contract, HHSC desires to engage HMO to perform the Services and provide the Deliverables described in this Contract under the terms and conditions set forth in this Contract.

Section 1.04 Construction of the Contract.

(a) Scope of Introductory Article.

The provisions of any introductory article to the Contract are intended to be a general introduction and are not intended to expand the scope of the Parties' obligations under the Contract or to alter the plain meaning of the terms and conditions of the Contract.

(b) References to the "State."

References in the Contract to the "State" shall mean the State of Texas unless otherwise specifically indicated and shall be interpreted, as appropriate, to mean or include HHSC and other agencies of the State of Texas that may participate in the administration of the HMO Programs, provided, however, that no provision will be interpreted to include any entity other than HHSC as the contracting agency.

(c) Severability.

If any provision of this Contract is construed to be illegal or invalid, such interpretation will not affect the legality or validity of any of its other provisions. The illegal or invalid provision will be deemed stricken and deleted to the same extent and effect as if never incorporated in this Contract, but all other provisions will remain in full force and effect.

(d) Survival of terms.

Termination or expiration of this Contract for any reason will not release either Party from any liabilities or obligations set forth in this Contract that:

(1) The Parties have expressly agreed shall survive any such termination or expiration; or

(2) Arose prior to the effective date of termination and remain to be performed or by their nature would be intended to be applicable following any such termination or expiration.

(e) Headings.

The article, section and paragraph headings in this Contract are for reference and convenience only and may not be considered in the interpretation of this Contract.

(f) Global drafting conventions.

(1) The terms "include," "includes," and "including" are terms of inclusion, and where used in this Contract, are deemed to be followed by the words "without limitation."

(2) Any references to "sections," "appendices," "exhibits" or "attachments" are deemed to be references to sections, appendices, exhibits or attachments to this Contract.

(3) Any references to laws, rules, regulations, and manuals in this Contract are deemed references to these documents as amended, modified, or supplemented from time to time during the term of this Contract.

Section 1.05 No implied authority.

The authority delegated to HMO by HHSC is limited to the terms of this Contract. HHSC is the state agency designated by the Texas Legislature to administer the HMO Programs, and no other agency of the State grants HMO any authority related to this program unless directed through HHSC. HMO may not rely upon implied authority, and specifically is not delegated authority under this Contract to:

(1) make public policy;

(2) promulgate, amend or disregard administrative regulations or program policy decisions made by State and federal agencies responsible for administration of HHSC Programs; or

(3) unilaterally communicate or negotiate with any federal or state agency or the Texas Legislature on behalf of HHSC regarding the HHSC Programs.

HMO is required to cooperate to the fullest extent possible to assist HHSC in communications and negotiations with state and federal governments and agencies concerning matters relating to the scope of the Contract and the HMO Program(s), as directed by HHSC.

Section 1.06 Legal Authority.

(a) HHSC is authorized to enter into this Contract under Chapters 531 and 533, Texas Government Code; Section 2155.144, Texas Government Code; and/or Chapter 62, Texas Health & Safety Code. HMO is authorized to enter into this Contract pursuant to the authorization of its governing board or controlling owner or officer.

(b) The person or persons signing and executing this Contract on behalf of the Parties, or representing themselves as signing and executing this Contract on behalf of the Parties, warrant and guarantee that he, she, or they have been duly authorized to execute this Contract and to validly and legally bind the Parties to all of its terms, performances, and provisions.

Article 2. Definitions

As used in this Contract, the following terms and conditions shall have the meanings assigned below:

Definition for 1915(c) Nursing Facility Waiver modified by Version 1.5

1915(c) Nursing Facility Waiver means the HHSC waiver program that provides home and community based services to aged and disabled adults as cost-effective alternatives to institutional care in nursing homes. Should HHSC begin operating this waiver program under a 1115 Waiver structure, then references to the 1915(c) Nursing Facility Waiver or SPW will mean the home and community based services component of the 1115 Waiver for Members who qualify for the additional services described in Attachment B 2, "STAR+PLUS Covered Services," under the heading "1915 (c) Nursing Facility Waiver Services for those Members who qualify for such services."

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid or CHIP Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medicaid or CHIP Program.

Account Name means the name of the individual who lives with the child(ren) and who applies for the Children's Health Insurance Program coverage on behalf of the child(ren).

Action means:

(1) the denial or limited authorization of a requested Medicaid service, including the type or level of service;

(2) the reduction, suspension, or termination of a previously authorized service;

(3) the denial in whole or in part of payment for service;

(4) the failure to provide services in a timely manner;

(5) the failure of an HMO to act within the timeframes set forth in the Contract and 42 C.F.R. §438.408(b); or

(6) for a resident of a rural area with only one HMO, the denial of a Medicaid Members' request to obtain services outside of the Network.

An Adverse Determination is one type of Action.

Acute Care means preventive care, primary care, and other medical care provided under the direction of a physician for a condition having a relatively short duration.

Acute Care Hospital means a hospital that provides acute care services

Adjudicate means to deny or pay a clean claim.

Administrative Services see HMO Administrative Services.

Administrative Services Contractor see HHSC Administrative Services Contractor.

Adverse Determination means a determination by an HMO or Utilization Review agent that the Health Care Services furnished, or proposed to be furnished to a patient, are not Medically Necessary or not appropriate.

Affiliate means any individual or entity that meets *any* of the following criteria: 1) owns or holds more than a five percent (5%) interest in the HMO (either directly, or through one or more intermediaries); 2) in which the HMO owns or holds

more than a five percent (5%) interest (either directly, or through one or more intermediaries); 3) any parent entity or subsidiary entity of the HMO, regardless of the organizational structure of the entity; 4) any entity that has a common parent with the HMO (either directly, or through one or more intermediaries); 5) any entity that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the HMO; or, 6) any entity that would be considered to be an affiliate by any Securities and Exchange Commission (SEC) or Internal Revenue Service (IRS) regulation, Federal Acquisition Regulations (FAR), or by another applicable regulatory body.

Agreement or Contract means this formal, written, and legally enforceable contract and amendments thereto between the Parties.

Allowable Expenses means all expenses related to the Contract between HHSC and the HMO that are incurred during the Contract Period, are not reimbursable or recovered from another source, and that conform with the HHSC Uniform Managed Care Manual's "Cost Principles for Expenses."

AAP means the American Academy of Pediatrics.

Approved Non-Profit Health Corporation (ANHC) means an organization formed in compliance with Chapter 844 of the Texas Insurance Code and licensed by TDI. See also **HMO**.

Appeal means the formal process by which a Member or his or her representative request a review of the HMO's Action, as defined above.

Auxiliary Aids and Services includes:

(1) qualified interpreters or other effective methods of making aurally delivered materials understood by persons with hearing impairments;

(2) taped texts, large print, Braille, or other effective methods to ensure visually delivered materials are available to individuals with visual impairments; and

(3) other effective methods to ensure that materials (delivered both aurally and visually) are available to those with cognitive or other Disabilities affecting communication.

Definition for Bariatric Supplemental Payment deleted by Version 1.5

Behavioral Health Services means Covered Services for the treatment of mental, emotional, or chemical dependency disorders.

Benchmark means a target or standard based on historical data or an objective/goal.

Business Continuity Plan or BCP means a plan that provides for a quick and smooth restoration of MIS operations after a disruptive event. BCP includes business impact analysis, BCP development, testing, awareness, training, and maintenance. This is a day-to-day plan.

Business Day means any day other than a Saturday, Sunday, or a state or federal holiday on which HHSC's offices are closed, unless the context clearly indicates otherwise.

CAHPS means the Consumer Assessment of Health Plans Survey. This survey is conducted annually by the EQRO.

Call Coverage means arrangements made by a facility or an attending physician with an appropriate level of health care provider who agrees to be available on an as-needed basis to provide medically appropriate services for routine, high risk, or Emergency Medical Conditions or Emergency Behavioral Health Conditions that present without being scheduled at the facility or when the attending physician is unavailable.

Capitation Rate means a fixed predetermined fee paid by HHSC to the HMO each month in accordance with the Contract, for each enrolled Member in a defined Rate Cell, in exchange for the HMO arranging for or providing a defined set of Covered Services to such a Member, regardless of the amount of Covered Services used by the enrolled Member.

Capitation Payment means the aggregate amount paid by HHSC to the HMO on a monthly basis for the provision of Covered Services to enrolled Members in accordance with the Capitation Rates in the Contract.

Case Head means the head of the household that is applying for Medicaid.

C.F.R. means the Code of Federal Regulations.

Chemical Dependency Treatment means treatment provided for a chemical dependency condition by a Chemical Dependency Treatment facility, chemical dependency counselor or hospital.

Children's Health Insurance Program or **CHIP** means the health insurance program authorized and funded pursuant to Title XXI, Social Security Act (42 U.S.C. §§ 1397aa-1397jj) and administered by HHSC.

Child (or Children) with Special Health Care Needs (**CSHCN)** means a child (or children) who:

(1) ranges in age from birth up to age nineteen (19) years;

(2) has a serious ongoing illness, a complex chronic condition, or a disability that has lasted or is anticipated to last at least twelve (12) continuous months or more;

(3) has an illness, condition or disability that results (or without treatment would be expected to result) in limitation of function, activities, or social roles in comparison with accepted pediatric age-related milestones in the general areas of physical, cognitive, emotional, and/or social growth and/or development;

(4) requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel; and

(5) has a need for health and/or health-related services at a level significantly above the usual for the child's age.

CHIP HMO Program, or CHIP Program, means the State of Texas program in which HHSC contracts with HMOs to provide, arrange for, and coordinate Covered Services for enrolled CHIP Members.

CHIP HMOs means HMOs participating in the CHIP HMO Program.

CHIP Perinatal HMOs means HMOs participating in the CHIP Perinatal Program.

CHIP Perinatal Program means the State of Texas program in which HHSC contracts with HMOs to provide, arrange for, and coordinate Covered Services for enrolled CHIP Perinate and CHIP Perinate Newborn Members. Although the CHIP Perinatal Program is part of the CHIP Program, for Contract administration purposes it is identified independently in this Contract. An HMO must specifically contract with HHSC as a CHIP Perinatal HMO in order to participate in this part of the CHIP Program.

CHIP Perinate means a CHIP Perinatal Program Member identified prior to birth.

CHIP Perinate Newborn means a CHIP Perinate who has been born alive.

Chronic or Complex Condition means a physical, behavioral, or developmental condition which may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated.

Clean Claim means a claim submitted by a physician or provider for medical care or health care services rendered to a Member, with the data necessary for the MCO or subcontracted claims processor to adjudicate and accurately report the claim. A Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate 837-(claim type) encounter guides as follows:

(1) 837 Professional Combined Implementation Guide

(2) 837 Institutional Combined Implementation Guide

(3) 837 Professional Companion Guide

(4) 837 Institutional Companion Guide

The HMO may not require a physician or provider to submit documentation that conflicts with the requirements of Texas Administrative Code, Title 28, Part 1, Chapter 21, Subchapters C and T.

CMS means the Centers for Medicare and Medicaid Services, formerly known as the Health Care Financing Administration (HCFA), which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid and CHIP.

COLA means the Cost of Living Adjustment.

Community-based Long Term Care Services means services provided to STAR+PLUS Members in their home or other community based settings necessary to provide assistance with activities of daily living to allow the Member to remain in the most integrated setting possible. Community-based Long-term Care includes services available to all STAR+PLUS Members as well as those services available only to STAR+PLUS Members who qualify under the 1915(c) Nursing Facility Waiver services.

Community Resource Coordination Groups (CRCGs) means a statewide system of local interagency groups, including both public and private providers, which coordinate services for "multi-need" children and youth. CRCGs develop individual service plans for children and adolescents whose needs can be met only through interagency cooperation. CRCGs address Complex Needs in a model that promotes local decision-making and ensures that children receive the integrated combination of social, medical and other services needed to address their individual problems.

Complainant means a Member or a treating provider or other individual designated to act on behalf of the Member who filed the Complaint.

Complaint means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the HMO, about any matter related to the HMO other than an Action. As provided by 42 C.F.R. §438.400, possible subjects for Complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights.

Complex Need means a condition or situation resulting in a need for coordination or access to services beyond what a PCP would normally provide, triggering the HMO's determination that Care Coordination is required.

Comprehensive Care Program: See definition for Texas Health Steps.

Confidential Information means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) consisting of:

(1) Confidential Client information, including HIPAA-defined protected health information;

(2) All non-public budget, expense, payment and other financial information;

(3) All Privileged Work Product;

(4) All information designated by HHSC or any other State agency as confidential, and all information designated as confidential under the Texas Public Information Act, Texas Government Code, Chapter 552;

(5) The pricing, payments, and terms and conditions of the Contract, unless disclosed publicly by HHSC or the State; and

(6) Information utilized, developed, received, or maintained by HHSC, the HMO, or participating State agencies for the purpose of fulfilling a duty or obligation under this Contract and that has not been disclosed publicly.

Consumer-Directed Services means the Member or his legal guardian is the employer of and retains control over the hiring, management, and termination of an individual providing personal assistance or respite.

Continuity of Care means care provided to a Member by the same PCP or specialty provider to ensure that the delivery of care to the Member remains stable, and services are consistent and unduplicated.

Contract or **Agreement** means this formal, written, and legally enforceable contract and amendments thereto between the Parties.

Contract Period or **Contract Term** means the Initial Contract Period plus any and all Contract extensions.

Contractor or **HMO** means the HMO that is a party to this Contract and is an insurer licensed by TDI as an HMO or as an ANHC formed in compliance with Chapter 844 of the Texas Insurance Code.

Corrective Action Plan means the detailed written plan that may be required by HHSC to correct or resolve a deficiency or event causing the assessment of a remedy or damage against HMO.

Court-Ordered Commitment means a commitment of a STAR, STAR+PLUS or CHIP Member to a psychiatric facility for treatment ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII Subtitle C.

Covered Services means Health Care Services the HMO must arrange to provide to Members, including all services required by the Contract and state and federal law, and all Value-added Services negotiated by the Parties (see **Attachments B-2, B-2.1, B-2.2 and B-3** of the **HHSC Managed Care Contract** relating to "Covered Services" and "Value-added Services"). Covered Services include Behavioral Health Services.

Definition for CPW added by Version 1.5

CPW means Case Management for Children and Pregnant Women; a Medicaid program for children with a health condition/health risk, birth through 20 years of age and to women with high-risk pregnancies of all ages, in order to help them gain access to medical, social, educational and other health-related services.

Credentialing means the process of collecting, assessing, and validating qualifications and other relevant information pertaining to a health care provider to determine eligibility and to deliver Covered Services.

Cultural Competency means the ability of individuals and systems to provide services effectively to people of various cultures, races, ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves their dignity.

Date of Disenrollment means the last day of the last month for which HMO receives payment for a Member.

Day means a calendar day unless specified otherwise.

Default Enrollment means the process established by HHSC to assign a STAR+PLUS enrollee who has not selected an MCO to an MCO.

Deliverable means a written or recorded work product or data prepared, developed, or procured by HMO as part of the Services under the Contract for the use or benefit of HHSC or the State of Texas.

DADS means the Texas Department of Aging and Disability Services or its successor agency (formerly Department of Human Services).

DSHS means the Texas Department of State Health Services or its successor agency (formerly Texas Department of Health and Texas Department of Mental Health and Mental Retardation).

Discharge means a formal release of a Member from an Inpatient Hospital stay when the need for continued care at an inpatient level has concluded. Movement or Transfer from one Acute Care Hospital or Long Term Care Hospital /facility and readmission to another within 24 hours for continued treatment is not a discharge under this Contract.

Disease Management means a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.

Disproportionate Share Hospital (DSH) means a hospital that serves a higher than average number of Medicaid and other low-income patients and receives additional reimbursement from the State.

Disabled Person or Person with Disability means a person under sixty-five (65) years of age, including a child, who qualifies for Medicaid services because of a disability.

Disability means a physical or mental impairment that substantially limits one or more of an

individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

Disability-related Access means that facilities are readily accessible to and usable by individuals with disabilities, and that auxiliary aids and services are provided to ensure effective communication, in compliance with Title III of the Americans with Disabilities Act.

Disaster Recovery Plan means the document developed by the HMO that outlines details for the restoration of the MIS in the event of an emergency or disaster.

DSM-IV means the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, which is the American Psychiatric Association's official classification of behavioral health disorders.

Dual Eligibles means Medicaid recipients who are also eligible for Medicare.

ECI means Early Childhood Intervention, a federally mandated program for infants and children under the age of three with or at risk for developmental delays and/or disabilities. The federal ECI regulations are found at 34 §C.F.R. 303.1 *et seq*. The State ECI rules are found at 25 TAC §621.21 *et seq*.

EDI means electronic data interchange.

Effective Date means the effective date of this Contract, as specified in the HHSC Managed Care Contract document.

Effective Date of Coverage means the first day of the month for which the HMO has received payment for a Member.

Eligibles means individuals residing in one of the Service Areas and eligible to enroll in a STAR, STAR+PLUS, CHIP, or CHIP Perinatal HMO, as applicable.

Emergency Behavioral Health Condition means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

(1) requires immediate intervention and/or medical attention without which Members would present an immediate danger to themselves or others, or

(2) which renders Members incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Services means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the Contract and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including Post-stabilization Care Services.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

(1) placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions;

(3) serious dysfunction of any bodily organ or part;

(4) serious disfigurement; or

(5) in the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.

Encounter means a Covered Service or group of Covered Services delivered by a Provider to a Member during a visit between the Member and Provider. This also includes Value-added Services.

Encounter Data means data elements from Fee-for-Service claims or capitated services proxy claims that are submitted to HHSC by the HMO in accordance with HHSC's required format for Medicaid and CHIP HMOs.

Enrollment Report/Enrollment File means the daily or monthly list of Eligibles that are enrolled with an HMO as Members on the day or for the month the report is issued.

EPSDT means the federally mandated Early and Periodic Screening, Diagnosis and Treatment program contained at 42 U.S.C. 1396d(r). The name has been changed to Texas Health Steps (THSteps) in the State of Texas.

Exclusive Provider Organization (EPO) means the vendor contracted with HHSC to operate the CHIP EPO in Texas.

Expansion Area means a county or Service Area that has not previously provided healthcare to HHSC's HMO Program Members utilizing a managed care model.

Expansion Children means children who are generally at least one, but under age 6, and live in a family whose income is at or below 133 percent of the federal poverty level (FPL). Children in this coverage group have either elected to bypass TANF or are not eligible for TANF in Texas.

Experience Rebate means the portion of the HMO's net income before taxes that is returned to the State in accordance with Section 10.08 for the STAR+PLUS Program ("Experience Rebate").

Expedited Appeal means an appeal to the HMO in which the decision is required quickly based on the

Member's health status, and the amount of time necessary to participate in a standard appeal could jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

Expiration Date means the expiration date of this Contract, as specified in HHSC's Managed Care Contract document.

External Quality Review Organization (EQRO) means the entity that contracts with HHSC to provide external review of access to and quality of healthcare provided to Members of HHSC's HMO Programs.

Definition for Fair Hearing modified by Version 1.3

Fair Hearing means the process adopted and implemented by HHSC in 1 T.A.C. Chapter 357, in compliance with federal regulations and state rules relating to Medicaid Fair Hearings.

Farmworker Child (FWC) means a child under age 21 of a Migrant Farmworker.

Fee-for-Service means the traditional Medicaid Health Care Services payment system under which providers receive a payment for each unit of service according to rules adopted pursuant to Chapter 32, Texas Human Resources Code.

Force Majeure Event means any failure or delay in performance of a duty by a Party under this Contract that is caused by fire, flood, hurricane, tornadoes, earthquake, an act of God, an act of war, riot, civil disorder, or any similar event beyond the reasonable control of such Party and without the fault or negligence of such Party.

FQHC means a Federally Qualified Health Center, certified by CMS to meet the requirements of §1861(aa)(3) of the Social Security Act as a federally qualified health center, that is enrolled as a provider in the Texas Medicaid program.

FPL means the Federal Poverty Level.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

FSR means Financial Statistical Report.

Functionally Necessary Covered Services means Community-based Long Term Care services provided to assist STAR+PLUS Members with activities of daily living based on a functional assessment of the Member's activities of daily living and a determination of the amount of supplemental supports necessary for the STAR+PLUS Member to remain independent or in the most integrated setting possible.

Habilitative and Rehabilitative Services means Health Care Services described in **Attachment B-2** that may be required by children who fail to reach (habilitative) or have lost (rehabilitative) age appropriate developmental milestones.

Health Care Services means the Acute Care, Behavioral Health Care and health-related services that an enrolled population might reasonably require in order to be maintained in good health.

Health and Human Services Commission or **HHSC** means the administrative agency within the executive department of Texas state government established under Chapter 531, Texas Government Code, or its designee, including, but not limited to, the HHS Agencies.

Health-related Materials are materials developed by the HMO or obtained from a third party relating to the prevention, diagnosis or treatment of a medical condition.

HEDIS, the Health Plan Employer Data and Information Set, is a registered trademark of NCQA. HEDIS is a set of standardized performance measures designed to reliably compare the performance of managed health care plans. HEDIS is sponsored, supported and maintained by NCQA.

HHS Agency means the Texas health and human service agencies subject to HHSC's oversight under Chapter 531, Texas Government Code, and their successor agencies.

HHSC Administrative Services Contractor (ASC) means an entity performing HMO administrative services functions, including member enrollment functions, for STAR, STAR+PLUS, CHIP, or CHIP Perinatal HMO Programs under contract with HHSC.

HHSC HMO Programs or HMO Programs mean the STAR, STAR+PLUS, CHIP, and CHIP Perinatal HMO Programs.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (August 21, 1996), as amended or modified.

HMO or **Contractor** means the HMO that is a party to this Contract, and is either:

(1) an insurer licensed by TDI as a Health Maintenance Organization in accordance with Chapter 843 of the Texas Insurance Code, or

(2) a certified Approved Non-Profit Health Corporation (ANHC) formed in compliance with Chapter 844 of the Texas Insurance Code.

HMO Administrative Services means the performance of services or functions, other than the direct delivery of Covered Services, necessary for the management of the delivery of and payment for Covered Services, including but not limited to Network, utilization, clinical and/or quality management, service authorization, claims processing, management information systems operation and reporting.

Home and Community Support Services Agency or HCSS means an entity licensed to provide home health, hospice, or personal assistance services provided to individuals in their own home or independent living environment as prescribed by a physician or individualized service plan. Each HCSS must provide clients with a plan of care that includes specific services the agency agrees to perform. The agencies are licensed and monitored by DADS or its successor.

Hospital means a licensed public or private institution as defined by Chapter 241, Texas Health and Safety Code, or in Subtitle C, Title 7, Texas Health and Safety Code.

ICF-MR means an intermediate care facility for the mentally retarded.

Individual Family Service Plan (IFSP) means the plan for services required by the Early Childhood Intervention (ECI) Program and developed by an interdisciplinary team.

Initial Contract Period means the Effective Date of the Contract through the subsequent 36 months.

Inpatient Stay means at least a 24-hour stay in a facility licensed to provide hospital care.

JCAHO means Joint Commission on Accreditation of Health Care Organizations.

Joint Interface Plan (JIP) means a document used to communicate basic system interface information. This information includes: file structure, data elements, frequency, media, type of file, receiver and sender of the file, and file I.D. The JIP must include each of the HMO's interfaces required to conduct business under this Contract. The JIP must address the coordination with each of the HMO's interface partners to ensure the development and maintenance of the interface; and the timely transfer of required data elements between contractors and partners.

Key HMO Personnel means the critical management and technical positions identified by the HMO in accordance with **Article 4**.

Linguistic Access means translation and interpreter services, for written and spoken language to ensure effective communication. Linguistic access includes sign language interpretation, and the provision of other auxiliary aids and services to persons with disabilities.

Local Health Department means a local health department established pursuant to Health and Safety Code, Title 2, Local Public Health Reorganization Act §121.031.

Local Mental Health Authority (LMHA) means an entity within a specified region responsible for planning, policy development, coordination, and resource development and allocation and for supervising and ensuring the provision of mental health care services to persons with mental illness in one or more local service areas.

Definition for Major Population Group Modified by Version 1.2

Major Population Group means any population, that represents at least 10% of the STAR+PLUS Program population in the Service Area served by the HMO.

Mandated or Required Services means services that a state is required to offer to categorically needy clients under a state Medicaid plan.

Marketing means any communication from the HMO to a Medicaid or CHIP Eligible who is not enrolled with the HMO that can reasonably be interpreted as intended to influence the Eligible to:

(1) enroll with the HMO; or

(2) not enroll in, or to disenroll from, another MCO.

Marketing Materials means materials that are produced in any medium by or on behalf of the HMO and can reasonably be interpreted as intending to market to potential Members. Health-related Materials are not Marketing Materials.

Material Subcontractor or **Major Subcontractor** means any entity that contracts with the HMO, where the value of the subcontract exceeds $100,000, or is reasonably expected to exceed $100,000, per State Fiscal Year, including any amendments. For purposes of this Agreement, Material Subcontractors do not include Providers in the HMO's Provider Network, and contracts with any non-Affiliates for utilities (e.g., water, electricity, telephone, Internet), mail/shipping, office space, or computer hardware. Material Subcontractors may include, without limitation, Affiliates, subsidiaries, and affiliated and unaffiliated third parties.

MCO means managed care organization.

Medicaid means the medical assistance entitlement program authorized and funded pursuant to Title XIX, Social Security Act (42 U.S.C. §1396 *et seq*.) and administered by HHSC.

Medicaid HMOs means contracted HMOs participating in STAR, STAR+PLUS, and/or STAR Health.

Medical Assistance Only (MAO) means a person that does not receive SSI benefits but qualifies financially and functionally for limited Medicaid assistance.

Medical Home means a PCP or specialty care Provider who has accepted the responsibility for providing accessible, continuous, comprehensive and coordinated care to Members participating in a HHSC HMO Program.

Medically Necessary means:

Definition for Medically Necessary Modified by Versions 1.2 and 1.5

(1) For Medicaid Members birth through age 20, the following Texas Health Steps services:

(a) screening, vision, and hearing services; and

(b) other Health Care Services, including Behavioral Health Services, that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:

(i) must comply with the requirements of the *Alberto N., et al. v. Suehs, et al*. partial settlement agreements; and

(ii) may include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) and (3)(b-g) of this definition.

(2) Non-behavioral health related Health Care Services that are:

(a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life;

(b) provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;

(c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;

(d) consistent with the Member's diagnoses;

(e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;

(f) are not experimental or investigative; and

(g) are not primarily for the convenience of the Member or Provider; and

(3) Behavioral Health Services that are:

(a) are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;

(b) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

(c) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(d) are the most appropriate level or supply of service that can safely be provided;

(e) could not be omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered;

(f) are not experimental or investigative; and

(g) are not primarily for the convenience of the Member or Provider.

Member means a person who:

(1) is entitled to benefits under Title XIX of the Social Security Act and Medicaid, is in a Medicaid eligibility category included in the STAR+PLUS Program, and is enrolled in the HMO;

(2) is entitled to benefits under Title XIX of the Social Security Act and Medicaid, is in a Medicaid eligibility category included as a voluntary participant in the STAR+PLUS Program, and is enrolled in the STAR+PLUS Program and the HMO's STAR+PLUS HMO.

Member Materials means all written materials produced or authorized by the HMO and distributed to Members or potential members containing information concerning the HMO Program(s). Member Materials include, but are not limited to, Member ID cards, Member handbooks, Provider directories, and Marketing Materials.

Member Month means one Member enrolled with the HMO during any given month. The total Member Months for each month of a year comprise the annual Member Months.

Member(s) with Special Health Care Needs (MSHCN) includes a Child or Children with a Special Health Care Need (CSHCN) and any adult Member who:

(1) has a serious ongoing illness, a Chronic or Complex Condition, or a Disability that has lasted or is anticipated to last for a significant period of time, and

(2) requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel.

Migrant Farmworker means a migratory agricultural worker, generally defined as an individual:

(1) whose principal employment is in agriculture on a seasonal basis;

(2) who has been so employed within the last twenty-four months;

(3) who performs any activity directly related to the production or processing of crops, dairy

products, poultry, or livestock for initial commercial sale or as a principal means of personal subsistence; and

(4) who establishes for the purposes of such employment a temporary abode.

Minimum Data Set for Home Care (MDS-HC) means the assessment instrument included in the **Uniform Managed Care Manual** that is used to collect data such as health, social support and service use information on persons receiving long term care services outside of an institutional setting.

MIS means Management Information System.

National Committee for Quality Assurance (NCQA) means the independent organization that accredits HMOs, managed behavioral health organizations, and accredits and certifies disease management programs. HEDIS and the Quality Compass are registered trademarks of NCQA.

Net Income before Taxes means an aggregate excess of Revenues over Allowable Expenses.

Network or Provider Network means all Providers that have a contract with the HMO, or any Subcontractor, for the delivery of Covered Services to the HMO's Members under the Contract.

Network Provider or Provider means an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with the HMO for the delivery of Covered Services to the HMO's Members.

Definition for Non-Capitated Services Modified by Version 1.2

Non-capitated Services means those Medicaid services identified in Attachment B-1, Section 8.1.22.8.

Non-provider Subcontracts means contracts between the HMO and a third party that performs a function, excluding delivery of health care services, that the HMO is required to perform under its Contract with HHSC.

Nursing Facility Cost Ceiling means the annualized cost of serving a client in a nursing facility. A per diem cost is established for each Medicaid nursing facility resident based on the level of care needed. This level of care is referred to as the Texas Index for Level of Effort or the TILE level. The per diem cost is annualized to achieve the nursing facility ceiling.

Nursing Facility Level of Care means the determination that the level of care required to adequately serve a STAR+PLUS Member is at or above the level of care provided by a nursing facility.

OB/GYN means obstetrician-gynecologist.

Open Panel means Providers who are accepting new patients for the HMO Program(s) served.

Operational Start Date means the first day on which an HMO is responsible for providing Covered Services to Members of an HMO Program in a Service Area in exchange for a Capitation Payment under the Contract. The Operational Start Date may vary per HMO Program and Service Area. The Operational Start Date(s) applicable to this Contract are set forth in the **HHSC Managed Care Contract** document.

Operations Phase means the period of time when HMO is responsible for providing the Covered Services and all related Contract functions for a Service Area. The Operations Phase begins on the Operational Start Date, and may vary by HMO Program and Service Area.

Definition for Outpatient Hospital Services Modified by Version 1.2

Outpatient Hospital Services means diagnostic, therapeutic, and rehabilitative services that are provided to Members in an organized medical facility, for less than a 24-hour period, by or under the direction of a physician.-

Out-of-Network (OON) means an appropriately licensed individual, facility, agency, institution, organization or other entity that has not entered into a contract with the HMO for the delivery of Covered Services to the HMO's Members.

Parties means HHSC and HMO, collectively.

Party means either HHSC or HMO, individually.

Pended Claim means a claim for payment, which requires additional information before the claim can be adjudicated as a clean claim.

Population Risk Group means a distinct group of members identified by age, age range, gender, type of program, or eligibility category.

Post-stabilization Care Services means Covered Services, related to an Emergency Medical Condition that are provided after a Medicaid Member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 §§C.F.R. 438.114(b)&(e) and 42 C.F.R. §422.113(c)(iii) to improve or resolve the Medicaid Member's condition.

Definition for PPACA added by Version 1.3

PPACA – means the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA).

Primary Care Physician or Primary Care Provider (PCP) means a physician or provider who has agreed with the HMO to provide a Medical Home to Members and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

Provider types that can be PCPs are from any of the following practice areas: General Practice, Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology (OB/GYN), Advanced Practice Nurses (APNs) and Physician Assistants (when APNs

and PAs are practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP under this contract), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and similar community clinic s; and specialist physicians who are willing to provide a Medical Home to selected Members with special needs and conditions.

Proposal means the proposal submitted by the HMO in response to the RFP.

Provider or Network Provider means an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with the HMO for the delivery of Covered Services to the HMO's Members.

Provider Contract means a contract entered into by a direct provider of health care services and the HMO or an intermediary entity.

Provider Network or Network means all Providers that have contracted with the HMO for the applicable HMO Program.

Proxy Claim Form means a form submitted by Providers to document services delivered to Members under a capitated arrangement. It is not a claim for payment.

Public Health Entity means a HHSC Public Health Region, a Local Health Department, or a hospital district.

Public Information means information that:

(1) Is collected, assembled, or maintained under a law or ordinance or in connection with the transaction of official business by a governmental body or for a governmental body; and

(2) The governmental body owns or has a right of access to.

Quality Improvement means a system to continuously examine, monitor and revise processes and systems that support and improve administrative and clinical functions.

Rate Cell means a Population Risk Group for which a Capitation Rate has been determined.

Rate Period 1 means the period of time beginning on the Operational Start Date and ending August 31, 2012.

Rate Period 2 means the period of time beginning on September 1, 2012 and ending on August 31, 2013.

Real-Time Captioning (also known as CART, Communication Access Real-Time Translation) means a process by which a trained individual uses a shorthand machine, a computer, and real-time translation software to type and simultaneously translate spoken language into text on a computer screen. Real Time Captioning is provided for individuals who are deaf, have hearing impairments, or have unintelligible speech. It is usually used to interpret spoken English into text English but may be used to translate other spoken languages into text.

Readiness Review means the assurances made by a selected HMO and the examination conducted by HHSC, or its agents, of HMO's ability, preparedness, and availability to fulfill its obligations under the Contract.

Request for Proposals or **RFP** means the procurement solicitation instrument issued by HHSC under which this Contract was awarded and all RFP addenda, corrections or modifications, if any.

Revenue means all managed care revenue received by the HMO pursuant to this Contract during the Contract Period, including retroactive adjustments made by HHSC. This would include any funds earned on Medicaid or CHIP managed care funds such as investment income, earned interest, or third party administrator earnings from services to delegated Networks.

Risk means the potential for loss as a result of expenses and costs of the HMO exceeding payments made by HHSC under the Contract.

Routine Care means health care for covered preventive and medically necessary Health Care Services that are non-emergent or non-urgent.

Rural Health Clinic (RHC) means an entity that meets all of the requirements for designation as a rural health clinic under 1861(aa)(1) of the Social Security Act and approved for participation in the Texas Medicaid Program.

Service Coordination means a specialized care management service that is performed by a Service Coordinator and that includes but is not limited to:

(1) identification of needs, including physical health, mental health services and for STAR+PLUS Members, long term support services,

(2) development of a Service Plan to address those identified needs;

(3) assistance to ensure timely and a coordinated access to an array of providers and Covered Services;

(4) attention to addressing unique needs of Members; and

(5) coordination of Plan services with social and other services delivered outside the Plan, as necessary and appropriate.

Service Coordinator means the person with primary responsibility for providing service coordination and care management to STAR+PLUS Members.

Scope of Work means the description of Services and Deliverables specified in this Contract, the RFP, the HMO's Proposal, and any agreed modifications to these documents.

SDX means State Data Exchange.

SED means severe emotional disturbance as determined by a Local Mental Health Authority.

Service Area means the counties included in any HHSC-defined Service Area as applicable to the STAR+PLUS Program.

Service Plan (SP) means an individualized plan developed with and for Members with Special Health Care Needs, including persons with disabilities or chronic or complex conditions. The SP includes, but is not limited to, the following:

(1) the Member's history;

(2) summary of current medical and social needs and concerns;

(3) short and long term needs and goals;

(4) a list of services required, their frequency, and

(5) a description of who will provide such services.

The Service Plan should incorporate as a component of the plan the Individual Family Service Plan (IFSP) for members in the Early Childhood Intervention (ECI) Program

The Service Plan may include information for services outside the scope of covered benefits such as how to access affordable, integrated housing.

Services are the tasks, functions, and responsibilities assigned and delegated to the HMO under this Contract.

Significant Traditional Provider or STP \means primary care providers and long-term care providers, identified by HHSC as having provided a significant level of care to Fee-for-Service clients. Disproportionate Share Hospitals (DSH) are also Medicaid STPs.

Software means all operating system and applications software used by the HMO to provide the Services under this Contract.

SPMI means severe and persistent mental illness as determined by the Local Mental Health Authority.

Specialty Hospital means any inpatient hospital that is not a general Acute Care hospital.

Specialty Therapy means physical therapy, speech therapy or occupational therapy.

SSA means the Social Security Administration.

Stabilize means to provide such medical care as to assure within reasonable medical probability that no deterioration of the condition is likely to result from, or occur from, or occur during discharge, transfer, or admission of the Member.

STAR+PLUS or STAR+PLUS Program means the State of Texas Medicaid managed care program in which HHSC contracts with HMOs to provide, arrange, and coordinate preventive, primary, acute and long term care Covered Services to adult persons with disabilities and elderly persons age 65 and over who qualify for Medicaid through the SSI program and/or the MAO program. Children under age 21, who qualify for Medicaid through the SSI program, may voluntarily participate in the STAR+PLUS program.

STAR+PLUS HMOs means contracted HMOs participating in the STAR+PLUS Program.

State Fiscal Year (SFY) means a 12-month period beginning on September 1 and ending on August 31 the following year.

Subcontract means any agreement between the HMO and other party to fulfill the requirements of the Contract.

Subcontractor means any individual or entity, including an Affiliate, that has entered into a Subcontract with HMO.

Subsidiary means an Affiliate controlled by such person or entity directly or indirectly through one or more intermediaries.

Supplemental Security Income (SSI) means a Federal income supplement program funded by general tax revenues (not Social Security taxes) designed to help aged, blind and disabled people with little or no income by providing cash to meet basic needs for food, clothing and shelter.

T.A.C. means Texas Administrative Code.

TDD means telecommunication device for the deaf. It is interchangeable with the term Teletype machine or TTY.

Definition for Texas Health Network Deleted by Version 1.2

TDI means the Texas Department of Insurance.

Temporary Assistance to Needy Families (TANF) means the federally funded program that provides assistance to single parent families with children who meet the categorical requirements for aid. This program was formerly known as the Aid to Families with Dependent Children (AFDC) program.

Texas Health Steps (THSteps) is the name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. It includes the State's Comprehensive Care Program extension to EPSDT, which adds benefits to the federal EPSDT requirements contained in 42 U.S.C. §1396d(r), and defined and codified at 42 C.F.R. §§440.40 and 441.56-62. HHSC's rules are contained in 25 T.A.C., Chapter 33 (relating to Early and Periodic Screening, Diagnosis and Treatment).

Texas Medicaid Bulletin means the bi-monthly update to the Texas Medicaid Provider Procedures Manual.

Texas Medicaid Provider Procedures Manual means the policy and procedures manual published by or on behalf of HHSC that contains policies and procedures required of all health care providers who participate in the Texas Medicaid program. The manual is published annually and is updated bi-monthly by the Texas Medicaid Bulletin.

Texas Medicaid Service Delivery Guide means an attachment to the Texas Medicaid Provider Procedures Manual.

Third Party Liability (TPL) means the legal responsibility of another individual or entity to pay for all or part of the services provided to Members under the Contract (see 1 TAC §354.2301 *et seq*., relating to Third Party Resources).

Third Party Recovery (TPR) means the recovery of payments on behalf of a Member by HHSC or the HMO from an individual or entity with the legal responsibility to pay for the Covered Services.

TP 13 means Type Program 13, which is a Medicaid program eligibility type assigned to persons determined eligible for federal SSI assistance by the Social Security Administration (SSA). If a subsequent eligibility system uses a different identifier for this eligibility type, references to TP 13 include the subsequent identifier.

TP 40 means Type Program 40, which is a Medicaid program eligibility type assigned to pregnant women under 185% of the federal poverty level (FPL). If a subsequent eligibility system uses a different identifier for this eligibility type, references to TP 40 include the subsequent identifier.

TP 45 means Type Program 45, which is a Medicaid program eligibility code assigned to newborns (under 12 months of age) who are born to mothers who are Medicaid eligible at the time of the child's birth. If a subsequent eligibility system uses a different identifier for this eligibility type, references to TP 40 include the subsequent identifier.

Transfer means the movement of the Member from one Acute Care Hospital or Long Term Care Hospital/facility and readmission to another Acute Care Hospital or Long Term Care Hospital/facility within 24 hours for continued treatment.

Definition for Transition Phase modified by Version 1.3

Transition Phase includes all activities the HMO is required to perform between the Contract Effective Date and the Operational Start Date for all or part of a Service Area.

Turnover Phase includes all activities the HMO is required to perform in order to close out the Contract and/or transition Contract activities and operations for a Service Area to HHSC or a subsequent contractor.

Turnover Plan means the written plan developed by HMO, approved by HHSC, to be employed during the Turnover Phase. The Turnover Plan describes HMO's policies and procedures that will assure:

(1) The least disruption in the delivery of Health Care Services to those Members who are enrolled with the HMO during the transition to a subsequent health plan;

(2) Cooperation with HHSC and the subsequent health plan in notifying Members of the transition and of their option to select a new plan, as requested and in the form required or approved by HHSC; and

(3) Cooperation with HHSC and the subsequent health plan in transferring information to the subsequent health plan, as requested and in the form required or approved by HHSC.

Definition for Uniform Managed Care Manual Modified by Version 1.2

Uniform Managed Care Manual (UMCM) means the manual published by or on behalf of HHSC that contains policies and procedures required of all HMOs participating in the HHSC Programs. The UMCM, as amended or modified, is incorporated by reference into the Contract.

URAC /American Accreditation Health Care Commission means the independent organization that accredits Utilization Review functions and offers a variety of other accreditation and certification programs for health care organizations.

Urgent Behavioral Health Situation means a behavioral health condition that requires attention and assessment within twenty-four (24) hours but which does not place the Member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment.

Urgent Condition means a health condition including an Urgent Behavioral Health Situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within twenty-four (24) hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

Utilization Review or **Utilization Management** means the system for retrospective, concurrent, or prospective review of the medical necessity and appropriateness of Health Care Services provided, being provided, or proposed to be provided to a Member. The term does not include elective requests for clarification of coverage.

Value-added Services means additional services for coverage beyond those specified in **Attachments B-2 and B-8**. Value-added Services may be actual Health Care Services, benefits, or positive incentives that HHSC determines will

promote healthy lifestyles and improve health outcomes among Members. Value-added Services that promote healthy lifestyles should target specific weight loss, smoking cessation, or other programs approved by HHSC. Temporary phones, cell phones, additional transportation benefits, and extra home health services may be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.

Waste means practices that are not cost-efficient.

Article 3. General Terms & Conditions

Section 3.01 Contract elements.

(a) Contract documentation.

The Contract between the Parties will consist of the HHSC Managed Care Contract document and all attachments and amendments.

(b) Order of documents.

In the event of any conflict or contradiction between or among the contract documents, the documents shall control in the following order of precedence:

(1) The final executed **HHSC Managed Care Contract** document, and all amendments thereto;

(2) HHSC Managed Care Contract **Attachment A** – "HHSC's Uniform Managed Care Contract Terms and Conditions," and all amendments thereto;

(3) HHSC Managed Care Contract **Attachment B** – "Scope of Work/Performance Measures," and all attachments and amendments thereto;

(4) The **HHSC Uniform Managed Care Manual**, and all attachments and amendments thereto;

(5) HHSC Managed Care Contract **Attachment C-3** – "Agreed Modifications to HMO's Proposal;"

(6) HHSC Managed Care Contract **Attachment C-2**, "HMO Supplemental Responses," and

(7) HHSC Managed Care Contract **Attachment C-1 –** "HMO's Proposal."

Section 3.02 Term of the Contract.

The term of the Contract will begin on the Effective Date and will conclude on the Expiration Date. The Parties may renew the Contract for an additional period or periods, but the Contract Term may not exceed a total of eight (8) years. All reserved contract extensions beyond the Expiration Date will be subject to good faith negotiations between the Parties and mutual agreement to the extension(s).

Section 3.03 Funding.

This Contract is expressly conditioned on the availability of state and federal appropriated funds. HMO will have no right of action against HHSC in the event that HHSC is unable to perform its obligations under this Contract as a result of the suspension, termination, withdrawal, or failure of funding to HHSC or lack of sufficient funding of HHSC for any activities or functions contained within the scope of this Contract. If funds become unavailable, the provisions of **Article 12** ("Remedies and Disputes") will apply. HHSC will use all reasonable efforts to ensure that such funds are available, and will negotiate in good faith with HMO to resolve any HMO claims for payment that represent accepted Services or Deliverables that are pending at the time funds become unavailable. HHSC shall make best efforts to provide reasonable written advance notice to HMO upon learning that funding for this Contract may be unavailable.

Section 3.04 Delegation of authority.

Whenever, by any provision of this Contract, any right, power, or duty is imposed or conferred on HHSC, the right, power, or duty so imposed or conferred is possessed and exercised by the Commissioner unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of HHSC. The Commissioner will reduce any such delegation of authority to writing and provide a copy to HMO on request.

Section 3.05 No waiver of sovereign immunity.

The Parties expressly agree that no provision of this Contract is in any way intended to constitute a waiver by HHSC or the State of Texas of any immunities from suit or from liability that HHSC or the State of Texas may have by operation of law.

Section 3.06 Force majeure.

Neither Party will be liable for any failure or delay in performing its obligations under the Contract if such failure or delay is due to any cause beyond the reasonable control of such Party, including, but not limited to, unusually severe weather, strikes, natural disasters, fire, civil disturbance, epidemic, war, court order, or acts of God. The existence of such causes of delay or failure will extend the period of performance in the exercise of reasonable diligence until after the causes of delay or failure have been removed. Each Party must inform the other in writing with proof of receipt within five (5) Business Days of the existence of a force majeure event or otherwise waive this right as a defense.

Section 3.07 Publicity.

(a) HMO may use the name of HHSC, the State of Texas, any HHS Agency, and the name of the HHSC HMO Program in any media release, public announcement, or public disclosure relating to the Contract or its subject matter only if, at least seven (7) calendar days prior to distributing the material, the HMO submits the information to HHSC for review and comment. If HHSC has not responded within seven

(7) calendar days, the HMO may use the submitted information. HHSC reserves the right to object to and require changes to the publication if, at HHSC's sole discretion, it determines that the publication does not accurately reflect the terms of the Contract or the HMO's performance under the Contract. .

(b) HMO will provide HHSC with one (1) electronic copy of any information described in Subsection 3.07(a) prior to public release. HMO will provide additional copies, including hard copies, at the request of HHSC.

(c) The requirements of Subsection 3.07(a) do not apply to:

(1) proposals or reports submitted to HHSC, an administrative agency of the State of Texas, or a governmental agency or unit of another state or the federal government;

(2) information concerning the Contract's terms, subject matter, and estimated value:

(i) in any report to a governmental body to which the HMO is required by law to report such information, or

(ii) that the HMO is otherwise required by law to disclose; and

(3) Member Materials (the HMO must comply with **the Uniform Managed Care Manual's** provisions regarding the review and approval of Member Materials).

Section 3.08 Assignment.

(a) Assignment by HMO.

HMO shall not assign all or any portion of its rights under or interests in the Contract or delegate any of its duties without prior written consent of HHSC. Any written request for assignment or delegation must be accompanied by written acceptance of the assignment or delegation by the assignee or delegation by the delegate. Except where otherwise agreed in writing by HHSC, assignment or delegation will not release HMO from its obligations pursuant to the Contract. An HHSC-approved Material Subcontract will not be considered to be an assignment or delegation for purposes of this section.

(b) Assignment by HHSC.

HMO understands and agrees HHSC may in one or more transactions assign, pledge, transfer, or hypothecate the Contract. This assignment will only be made to another State agency or a non-State agency that is contracted to perform agency support.

(c) Assumption.

Each party to whom a transfer is made (an "Assignee") must assume all or any part of HMO'S or HHSC's interests in the Contract, the product, and any documents executed with respect to the Contract, including, without limitation, its obligation for all or any portion of the purchase payments, in whole or in part.

Section 3.09 Cooperation with other vendors and prospective vendors.

HHSC may award supplemental contracts for work related to the Contract, or any portion thereof. HMO will reasonably cooperate with such other vendors, and will not commit or permit any act that may interfere with the performance of work by any other vendor.

Section 3.10 Renegotiation and reprocurement rights.

(a) Renegotiation of Contract terms.

Notwithstanding anything in the Contract to the contrary, HHSC may at any time during the term of the Contract exercise the option to notify HMO that HHSC has elected to renegotiate certain terms of the Contract. Upon HMO's receipt of any notice pursuant to this Section, HMO and HHSC will undertake good faith negotiations of the subject terms of the Contract, and may execute an amendment to the Contract in accordance with **Article 8**.

(b) Reprocurement of the services or procurement of additional services.

Notwithstanding anything in the Contract to the contrary, whether or not HHSC has accepted or rejected HMO's Services and/or Deliverables provided during any period of the Contract, HHSC may at any time issue requests for proposals or offers to other potential contractors for performance of any portion of the Scope of Work covered by the Contract or Scope of Work similar or comparable to the Scope of Work performed by HMO under the Contract.

(c) Termination rights upon reprocurement.

If HHSC elects to procure the Services or Deliverables or any portion of the Services or Deliverables from another vendor in accordance with this Section, HHSC will have the termination rights set forth in **Article 12** ("Remedies and Disputes").

Section 3.11 RFP errors and omissions.

HMO will not take advantage of any errors and/or omissions in the RFP or the resulting Contract. HMO must promptly notify HHSC of any such errors and/or omissions that are discovered.

Section 3.12 Attorneys' fees.

In the event of any litigation, appeal, or other legal action to enforce any provision of the Contract, HMO agrees to pay all reasonable expenses of such action, including attorneys' fees and costs, if HHSC is the prevailing Party.

Section 3.13 Preferences under service contracts.

HMO is required in performing the Contract to purchase products and materials produced in the State of Texas when they are available at a price and

time comparable to products and materials produced outside the State.

Section 3.14 Time of the essence.

In consideration of the need to ensure uninterrupted and continuous HHSC HMO Program performance, time is of the essence in the performance of the Scope of Work under the Contract.

Section 3.15 Notice

(a) Any notice or other legal communication required or permitted to be made or given by either Party pursuant to the Contract will be in writing and in English, and will be deemed to have been given:

(1) Three (3) Business Days after the date of mailing if sent by registered or certified U.S. mail, postage prepaid, with return receipt requested;

(2) When transmitted if sent by facsimile, provided a confirmation of transmission is produced by the sending machine; or

(3) When delivered if delivered personally or sent by express courier service.

(b) The notices described in this Section may not be sent by electronic mail.

(c) All notices must be sent to the Project Manager identified in the **HHSC Managed Care Contract** document. In addition, legal notices must be sent to the Legal Contact identified in the **HHSC Managed Care Contract** document.

(d) Routine communications that are administrative in nature will be provided in a manner agreed to by the Parties.

Article 4. Contract Administration & Management

Section 4.01 Qualifications, retention and replacement of HMO employees.

HMO agrees to maintain the organizational and administrative capacity and capabilities to carry out all duties and responsibilities under this Contract. The personnel HMO assigns to perform the duties and responsibilities under this Contract will be properly trained and qualified for the functions they are to perform. Notwithstanding transfer or turnover of personnel, HMO remains obligated to perform all duties and responsibilities under this Contract without degradation and in accordance with the terms of this Contract.

Section 4.02 HMO's Key Personnel.

(a) Designation of Key Personnel.

HMO must designate key management and technical personnel who will be assigned to the Contract. For the purposes of this requirement, Key Personnel are those with management responsibility or principal technical responsibility for the following functional areas for each HMO Program included within the scope of the Contract:

(1) Member Services;

(2) Management Information Systems;

(3) Claims Processing,

(4) Provider Network Development and Management;

(5) Benefit Administration and Utilization and Care Management;

(6) Quality Improvement;

(7) Behavioral Health Services;

(8) Financial Functions;

(9) Reporting;

(10) STAR+PLUS Executive Director as defined in **Section 4.03** ("Executive Director");

(11) STAR+PLUS Medical Director f as defined in **Section 4.04** ("Medical Director"); and

(12) Management positions for STAR+PLUS Service Coordinators for STAR+PLUS HMOs as defined in **Section 4.04.1** ("STAR+PLUS Service Coordinator.")

(b) Support and Replacement of Key Personnel.

The HMO must maintain, throughout the Contract Term, the ability to supply its Key Personnel with the required resources necessary to meet Contract requirements and comply with applicable law. The HMO must ensure project continuity by timely replacement of Key Personnel, if necessary, with a sufficient number of persons having the requisite skills, experience and other qualifications. Regardless of specific personnel changes, the HMO must maintain the overall level of expertise, experience, and skill reflected in the Key HMO Personnel job descriptions and qualifications included in the HMO's proposal.

(c) Notification of replacement of Key Personnel.

HMO must notify HHSC within fifteen (15) Business Days of any change in Key Personnel. Hiring or replacement of Key Personnel must conform to all Contract requirements. If HHSC determines that a satisfactory working relationship cannot be established between certain Key Personnel and HHSC, it will notify the HMO in writing. Upon receipt of HHSC's notice, HHSC and HMO will attempt to resolve HHSC's concerns on a mutually agreeable basis.

Section 4.03 Executive Director.

(a) The HMO must employ a qualified individual to serve as the Executive Director for its HHSC HMO Program(s). Such Executive Director must be employed full-time by the HMO, be primarily dedicated to HHSC HMO Program(s), and must hold a Senior Executive or Management position in the HMO's organization, except that the HMO may

propose an alternate structure for the Executive Director position, subject to HHSC's prior review and written approval.

(b) The Executive Director must be authorized and empowered to represent the HMO regarding all matters pertaining to the Contract prior to such representation. The Executive Director must act as liaison between the HMO and the HHSC and must have responsibilities that include, but are not limited to, the following:

(1) ensuring the HMO's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

(2) receiving and responding to all inquiries and requests made by HHSC related to the Contract, in the time frames and formats specified by HHSC. Where practicable, HHSC must consult with the HMO to establish time frames and formats reasonably acceptable to the Parties;

(3) attending and participating in regular HHSC HMO Executive Director meetings or conference calls;

(4) attending and participating in regular HHSC Regional Advisory Committees (RACs) for managed care (the Executive Director may designate key personnel to attend a RAC if the Executive Director is unable to attend);

(5) making best efforts to promptly resolve any issues identified either by the HMO or HHSC that may arise and are related to the Contract;

(6) meeting with HHSC representative(s) on a periodic or as needed basis to review the HMO's performance and resolve issues, and

(7) meeting with HHSC at the time and place requested by HHSC, if HHSC determines that the HMO is not in compliance with the requirements of the Contract.

Section 4.04 Medical Director.

Section 4.04 Modified by Version 1.4

(a) The HMO must have a qualified individual to serve as the Medical Director for its HHSC STAR+PLUS Program. The Medical Director must be currently licensed in Texas under the Texas Medical Board as an M.D. or D.O. with no restrictions or other licensure limitations. The Medical Director must comply with the requirements of 28 T.A.C. §11.1606 and all applicable federal and state statutes and regulations.

(b) The Medical Director, or his or her designee, must be available by telephone 24 hours a day, seven days a week, for Utilization Review decisions. The Medical Director, and his/her designee, must either possess expertise with Behavioral Health Services, or ready access to such expertise to ensure timely and appropriate medical decisions for Members, including after regular business hours.

(c) The Medical Director, or his or her designee, must be authorized and empowered to represent the HMO regarding clinical issues, Utilization Review and quality of care inquiries. The Medical Director, or his or her designee, must exercise independent medical judgment in all decisions relating to medical necessity. The HMO must ensure that its decisions relating to medical necessity are not adversely influenced by fiscal management decisions. HHSC may conduct reviews of decisions relating to medical necessity upon reasonable notice.

(d) For purposes of this section, the Medical Director's designee must be:

(1) a physician that meets the qualifications for a Medical Director, as described in subparts (a) through (c), above; or

(2) for prior authorization determinations for outpatient pharmacy benefits, a Texas-licensed pharmacist working under the direction of the Medical Director, provided such delegation is included in the HMO's TDI-approved utilization review plan.

(e) The Medical Director, or his or her physician designee, must make determinations regarding Utilization Review appeals, including appeals of prior authorization denials for outpatient pharmacy benefits.

Section 4.04.1 STAR+PLUS Service Coordinator

(a) STAR+PLUS HMOs must employ as Service Coordinators persons experienced in meeting the needs of people with disabilities, old and young, and vulnerable populations who have Chronic or Complex Conditions. A Service Coordinator must have an undergraduate and/or graduate degree in social work or a related field, or be a Registered Nurse, Licensed Vocational Nurse, Advanced Nurse Practitioner, or a Physician Assistant.

(b) The STAR+PLUS HMO must monitor the Service Coordinator's workload and performance to ensure that he or she is able to perform all necessary Service Coordination functions for the STAR+PLUS Members in a timely manner.

(c) The Service Coordinator must be responsible for working with the Member or his or her representative, the PCP and other Providers to develop a seamless package of care in which primary, Acute Care, and long-term care service needs are met through a single, understandable, rational plan. Each Member's Service Plan must also be well coordinated with the Member's family and community support systems, including Independent Living Centers, Area Agencies on Aging and Mental Retardation Authorities. The Service Plan should be agreed to and signed by the Member or the Member's representative to indicate agreement with the plan. The plan should promote consumer direction and self-determination and may include information for

services outside the scope of Covered Services such as how to access affordable, integrated housing. For dual eligible Members, the STAR+PLUS HMO is responsible for meeting the Member's Community Long- term Care Service needs.

(d) The STAR+PLUS HMO must empower its Service Coordinators to authorize the provision and delivery of Covered Services, including Community Long-term Care Covered Services.

Section 4.05 Responsibility for HMO personnel and Subcontractors.

(a) HMO's employees and Subcontractors will not in any sense be considered employees of HHSC or the State of Texas, but will be considered for all purposes as the HMO's employees or its Subcontractor's employees, as applicable.

(b) Except as expressly provided in this Contract, neither HMO nor any of HMO's employees or Subcontractors may act in any sense as agents or representatives of HHSC or the State of Texas.

(c) HMO agrees that anyone employed by HMO to fulfill the terms of the Contract is an employee of HMO and remains under HMO's sole direction and control. HMO assumes sole and full responsibility for its acts and the acts of its employees and Subcontractors.

(d) HMO agrees that any claim on behalf of any person arising out of employment or alleged employment by the HMO (including, but not limited to, claims of discrimination against HMO, its officers, or its agents) is the sole responsibility of HMO and not the responsibility of HHSC. HMO will indemnify and hold harmless the State from any and all claims asserted against the State arising out of such employment or alleged employment by the HMO. HMO understands that any person who alleges a claim arising out of employment or alleged employment by HMO will not be entitled to any compensation, rights, or benefits from HHSC (including, but not limited to, tenure rights, medical and hospital care, sick and annual/vacation leave, severance pay, or retirement benefits).

(e) HMO agrees to be responsible for the following in respect to its employees:

(1) Damages incurred by HMO's employees within the scope of their duties under the Contract; and

(2) Determination of the hours to be worked and the duties to be performed by HMO's employees.

(f) HMO agrees and will inform its employees and Subcontractor(s) that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to them by HMO pursuant to this Contract or any judgment rendered against the HMO. HHSC's liability to the HMO's employees, agents and Subcontractors, if any, will be governed by the Texas Tort Claims Act, as amended or modified (TEX. CIV. PRACT. & REM. CODE §101.001et seq.).

(g) HMO understands that HHSC does not assume liability for the actions of, or judgments rendered against, the HMO, its employees, agents or Subcontractors. HMO agrees that it has no right to indemnification or contribution from HHSC for any such judgments rendered against HMO or its Subcontractors.

Section 4.06 Cooperation with HHSC and state administrative agencies.

(a) Cooperation with Other MCOs.

HMO agrees to reasonably cooperate with and work with the other MCOs in the HHSC HMO Programs, Subcontractors, and third-party representatives as requested by HHSC. To the extent permitted by HHSC's financial and personnel resources, HHSC agrees to reasonably cooperate with HMO and to use its best efforts to ensure that other HHSC contractors reasonably cooperate with the HMO.

(b) Cooperation with state and federal administrative agencies.

HMO must ensure that HMO personnel will cooperate with HHSC or other state or federal administrative agency personnel at no charge to HHSC for purposes relating to the administration of HHSC programs including, but not limited to the following purposes:

(1) The investigation and prosecution of fraud, abuse, and waste in the HHSC programs;

(2) Audit, inspection, or other investigative purposes; and

(3) Testimony in judicial or quasi-judicial proceedings relating to the Services and/or Deliverables under this Contract or other delivery of information to HHSC or other agencies' investigators or legal staff.

Section 4.07 Conduct of HMO personnel.

(a) While performing the Scope of Work, HMO's personnel and Subcontractors must:

(1) Comply with applicable State rules and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations; and

(2) Otherwise conduct themselves in a businesslike and professional manner.

(b) If HHSC determines in good faith that a particular employee or Subcontractor is not conducting himself or herself in accordance with this Contract, HHSC may provide HMO with notice and documentation concerning such conduct. Upon receipt of such notice, HMO must promptly investigate

the matter and take appropriate action that may include:

(1) Removing the employee from the project;

(2) Providing HHSC with written notice of such removal; and

(3) Replacing the employee with a similarly qualified individual acceptable to HHSC.

(c) Nothing in the Contract will prevent HMO, at the request of HHSC, from replacing any personnel who are not adequately performing their assigned responsibilities or who, in the reasonable opinion of HHSC's Project Manager, after consultation with HMO, are unable to work effectively with the members of the HHSC's staff. In such event, HMO will provide replacement personnel with equal or greater skills and qualifications as soon as reasonably practicable. Replacement of Key Personnel will be subject to HHSC review. The Parties will work together in the event of any such replacement so as not to disrupt the overall project schedule.

(d) HMO agrees that anyone employed by HMO to fulfill the terms of the Contract remains under HMO's sole direction and control.

(e) HMO shall have policies regarding disciplinary action for all employees who have failed to comply with federal and/or state laws and the HMO's standards of conduct, policies and procedures, and Contract requirements. HMO shall have policies regarding disciplinary action for all employees who have engaged in illegal or unethical conduct.

Section 4.08 Subcontractors.

Section 4.08 Modified by Versions 1.2 and 1.3

(a) HMO remains fully responsible for the obligations, services, and functions performed by its Subcontractors to the same extent as if such obligations, services, and functions were performed by HMO's employees, and for purposes of this Contract such work will be deemed work performed by HMO. HHSC reserves the right to require the replacement of any Subcontractor found by HHSC to be unacceptable and unable to meet the requirements of the Contract, and to object to the selection of a Subcontractor.

(b) HMO must:

(1) actively monitor the quality of care and services, as well as the quality of reporting data, provided under a Subcontract;

(2) provide HHSC with a copy of TDI filings of delegation agreements.

(3) unless otherwise provided in this Contract, provide HHSC with written notice no later than:

(i) three (3) Business Days after receiving notice from a Material Subcontractor of its intent to terminate a Subcontract;

(ii) 180 calendar days prior to terminating a Material Subcontract for MIS systems operation or reporting;

(iii) 90 calendar days prior to terminating a Material Subcontract for non-MIS HMO Administrative Services; and

(iv) 30 calendar days prior to terminating any other Material Subcontract.

HHSC may grant a written exception to these notice requirements if, in HHSC's reasonable determination, the HMO has shown good cause for a shorter notice period.

(c) During the Contract Period, Readiness Reviews by HHSC or its designated agent may occur if:

(1) a new Material Subcontractor is employed by HMO;

(2) an existing Material Subcontractor provides services in a new Service Area;

(3) an existing Material Subcontractor provides services for a new HMO Program;

(4) an existing Material Subcontractor changes locations or changes its MIS and or operational functions;

(5) an existing Material Subcontractor changes one or more of its MIS subsystems, claims processing or operational functions; or

(6) a Readiness Review is requested by HHSC.

The HMO must submit information required by HHSC for each proposed Material Subcontractor as indicated in **Attachment B-1, Section 7**. Refer to **Attachment B-1, Sections 8.1.1.2 and 8.1.18** for additional information regarding HMO Readiness Reviews during the Contract Period.

(d) HMO must not disclose Confidential Information of HHSC or the State of Texas to a Subcontractor unless and until such Subcontractor has agreed in writing to protect the confidentiality of such Confidential Information in the manner required of HMO under this Contract.

(e) HMO must identify any Subcontractor that is a subsidiary or entity formed after the Effective Date of the Contract, whether or not an Affiliate of HMO, substantiate the proposed Subcontractor's ability to perform the subcontracted Services, and certify to HHSC that no loss of service will occur as a result of the performance of such Subcontractor. The HMO will assume responsibility for all contractual responsibilities whether or not the HMO performs them. Further, HHSC considers the HMO to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the Contract.

(f) Except as provided herein, all Subcontracts must be in writing and must provide HHSC the right to examine the Subcontract and all Subcontractor records relating to the Contract and the Subcontract. This requirement does not apply to agreements with utility or mail service providers.

(g) A Subcontract whereby HMO receives rebates, recoupments, discounts, payments, or other consideration from a Subcontractor (including without limitation Affiliates) pursuant to or related to the execution of this Contract must be in writing and must provide HHSC the right to examine the Subcontract and all records relating to such consideration.

(h) All Subcontracts described in subsections (f) and (g) must show the dollar amount or the value of any consideration that HMO pays to or receives from the Subcontractor.

(i) HMO must submit a copy of each Material Subcontract executed prior to the Effective Date of the Contract to HHSC no later than thirty (30) days after the Effective Date of the Contract. For Material Subcontracts executed or amended after the Effective Date of the Contract, HMO must submit a copy to HHSC no later than five (5) Business Days after execution or amendment.

(j) Network Provider Contracts must include the mandatory provisions included in the **HHSC Uniform Managed Care Manual**.

(k) HHSC reserves the right to reject any Subcontract or require changes to any provisions that do not comply with the requirements or duties and responsibilities of this Contract or create significant barriers for HHSC in monitoring compliance with this Contract.

(l) HMO must comply with the requirements of Section 6505 of PPACA, entitled "Prohibition on Payments to Institutions or Entities Located Outside of the United States."

(m) Provider payment must comply with the requirements of Section 2702 of PPACA, entitled "Payment Adjustment for Health Acquired Conditions."

Section 4.09 HHSC's ability to contract with Subcontractors.

The HMO may not limit or restrict, through a covenant not to compete, employment contract or other contractual arrangement, HHSC's ability to contract with Subcontractors or former employees of the HMO.

Section 4.10 HMO Agreements with Third Parties.

Section 4.10 Modified by Versions 1.2, 1.3, and 1.5

(a) If the HMO intends to report compensation paid to a third party (including without limitation an Affiliate) as an Allowable Expense under this Contract, and the compensation paid to the third party exceeds $100,000, or is reasonably anticipated to exceed $100,000, in a State Fiscal Year, then the HMO's agreement with the third party must be in writing. The agreement must provide HHSC the right to examine the agreement and all records relating to the agreement.

(b) All agreements whereby HMO or its Subcontractors receives discounts, incentives, rebates, fees, free goods, bundling arrangements, recoupments, retrocession, payments, or other consideration from a third party (including without limitation Affiliates) pursuant to or related to the execution of this Contract, must be in writing and must provide HHSC and the Office of Attorney General the right to examine the agreement and all records relating to such consideration. .

(c) All agreements described in subsections (a) and (b) must show the dollar amount, the percentage of money, or the value of any consideration that HMO pays to or receives from the third party.

(d) HMO must submit a copy of each third party agreement described in subsections (a) and (b) to HHSC. If the third party agreement is entered into prior to the Effective Date of the Contract, HMO must submit a copy no later than thirty (30) days after the Effective Date of the Contract. If the third party agreement is executed after the Effective Date of the Contract, HMO must submit a copy no later than five (5) Business Days after execution.

(e) For third party agreements valued under $100,000 per State Fiscal Year that are reported as Allowable Expenses, the HMO must maintain financial records and data sufficient to verify the accuracy of such expenses in accordance with the requirements of **Article 9**.

(f) HHSC reserves the right to reject any third party agreement or require changes to any provisions that do not comply with the requirements or duties and responsibilities of this Contract or create significant barriers for HHSC in monitoring compliance with this Contract.

(g) Upon request, the HMO and its Subcontractors must provide all information described in Section 4.10 to HHSC and the Office of Attorney General at no cost.

(h) This section shall not apply to Provider Contracts, or agreements with utility or mail service providers.

(i) HMO must comply with the requirements of Section 6505 of PPACA, entitled "Prohibition on Payments to Institutions or Entities Located Outside of the United States."

(j) Provider payment must comply with the requirements of Section 2702 of PPACA, entitled "Payment Adjustment for Health Acquired Conditions."

Section 4.11 Prohibition Against Performance Outside the United States.

Section 4.11 Added by Version 1.5

(a) Findings.

(1) HHSC finds the following:

(i) HHSC is responsible for administering several public programs that require the collection and maintenance of information relating to persons who apply for and receive services from HHSC programs. This information consists of, among other things, personal financial and medical information and information designated "Confidential Information" under state and federal law and this Agreement. Some of this information may, within the limits of the law and this Agreement, be shared from time to time with HMO or a subcontractor for purposes of performing the Services or providing the Deliverables under this Agreement.

(ii) HHSC is legally responsible for maintaining the confidentiality and integrity of information relating to applicants and recipients of HHSC services and ensuring that any person or entity that receives such information—including HMO and any subcontractor—is similarly bound by these obligations.

(iii) HHSC also is responsible for the development and implementation of computer software and hardware to support HHSC programs. These items are paid for, in whole or in part, with state and federal funds. The federal agencies that fund these items maintain a limited interest in the software and hardware so developed or acquired.

(iv) Some of the software used or developed by HHSC may also be subject to statutory restrictions on the export of technology to foreign nations, including but not limited to the Export Administration Regulations, 15 C.F.R. Parts 730-774.

(2) In view of these obligations, and to ensure accountability, integrity, and the security of the information maintained by or for HHSC and the work performed on behalf of HHSC, HHSC DETERMINES that it is necessary and appropriate to require THAT:

(i) All work performed under this Agreement must be performed exclusively within the United States; and

(ii) All information obtained by HMO or a subcontractor under this Agreement must be maintained within the United States.

(3) Further, HHSC finds it necessary and appropriate to forbid the performance of any work or the maintenance of any information relating or obtained pursuant to this Agreement to occur outside of the United States except as specifically authorized or approved by HHSC.

(b) Meaning of "within the United States" and "outside the United States."

(1) As used in this Section 4.11, the term "within the United States" means any location inside the territorial boundaries comprising the republic of the United States of America, including of any of the 48 coterminous states in North America, the states of Alaska and Hawaii, and the District of Columbia.

(2) Conversely, the phrase "outside the United States" means any location that is not within the territorial boundaries comprising the republic of the United States of America, including of any of the 48 coterminous states in North America, the states of Alaska and Hawaii, and the District of Columbia.

(c) Maintenance of Confidential Information.

(1) HMO and all subcontractors, vendors, agents, and service providers of or for HMO must not allow any Confidential Information that HMO receives from or on behalf of HHSC to leave the United States by any means (physical or electronic) at any time, for any period of time, for any reason.

(2) HMO and all subcontractors, vendors, agents, and service providers of or for HMO must not permit any person to have remote access to HHSC information, systems, or Deliverables from a location outside the United States.

(d) Performance of Work under Agreement.

(1) Unless otherwise approved in advance by HHSC in writing, and subject to the exceptions specified in paragraph (d) of this Section 4.11, HMO and all subcontractors, vendors, agents, and service providers of or for HMO must perform all services under the Agreement, including all tasks, functions, and responsibilities assigned and delegated to HMO under this Agreement, within the United States.

(i) This obligation includes, but is not limited to, all Services, including but not limited to information technology services, processing, transmission, storage, archiving, data center services, disaster recovery sites and services, customer support), medical, dental, laboratory and clinical services.

(ii) All custom software prepared for performance of this Agreement, and all modifications of custom, third party, or vendor proprietary software, must be performed within the United States.

(2) Unless otherwise approved in advance by HHSC in writing, and subject to the exceptions specified in paragraph (d) of this Section 4.11, HMO and all subcontractors, vendors, agents, and service providers of or for HMO must not permit any person to perform work under this Agreement from a location outside the United States.

(e) Exceptions.

(1) COTS Software. The foregoing requirements will not preclude the acquisition or use of commercial off-the-shelf software that is developed outside the United States or hardware that is generically configured outside the United States.

(2) Foreign-made Products and Supplies. The foregoing requirements will not preclude HMO from acquiring, using, or reimbursing products or supplies that are manufactured outside the United States, provided such products or supplies are commercially available within the United States for acquisition or reimbursement by HHSC.

(3) HHSC Prior Approval. The foregoing requirements will not preclude HMO from performing work outside the United States that HHSC has approved in writing and that HHSC has confirmed will not involve the sharing of Confidential Information outside the United States.

(f) Disclosure.

HMO must disclose all Services and Deliverables under or related to this Agreement that HMO intends to perform or has performed outside the United States, whether directly or via subcontractors, vendors, agents, or service providers.

(g) Remedy.

(1) HMO's violation of this Section 4.11 will constitute a material breach in accordance with Article 12. HMO will be liable to HHSC for all monetary damages, in the form of actual, consequential, direct, indirect, special and/or liquidated damages in accordance with this Agreement.

(2) HHSC may terminate the Agreement with notice to HMO at least one calendar day before the effective date of such termination.

Article 5. Member Eligibility & Enrollment

Section 5.01 Eligibility Determination

The State or its designee will make eligibility determinations for each of the HHSC HMO Programs.

Section 5.02 Member Enrollment & Disenrollment.

Section 5.02 Modified by Version 1.5

(a) The HHSC Administrative Services Contractor will enroll and disenroll eligible individuals in the STAR+PLUS Program. To enroll in an HMO, the Member's permanent residence must be located within the HMO's Service Area. The HMO is not allowed to induce or accept disenrollment from a Member. The HMO must refer the Member to the HHSC Administrative Services Contractor.

(b) HHSC makes no guarantees or representations to the HMO regarding the number of eligible Members who will ultimately be enrolled into the HMO or the length of time any such enrolling Members remain enrolled with the HMO beyond the minimum mandatory enrollment periods established for each HHSC HMO Program. The HMO has no ownership interest in its Member base, and therefore cannot sell or transfer this base to another entity.

(c) The HHSC Administrative Services Contractor will electronically transmit to the HMO new Member information and change information applicable to active Members.

(d) As described in the following Sections, depending on the HMO Program, special conditions may also apply to enrollment and span of coverage for the HMO.

(e) A Medicaid HMO has a limited right to request a Member be disenrolled from HMO without the Member's consent. HHSC must approve any HMO request for disenrollment of a Member for cause. HHSC may permit disenrollment of a Member under the following circumstances:

(1) Member misuses or loans Member's HMO membership card to another person to obtain services.

(2) Member is disruptive, unruly, threatening or uncooperative to the extent that Member's membership seriously impairs HMO's or Provider's ability to provide services to Member or to obtain new Members, and Member's behavior is not caused by a physical or behavioral health condition.

(3) Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow HMO to treat the underlying medical condition).

(4) HMO must take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include

providing education and counseling regarding the offensive acts or behaviors.

(5) Under limited conditions, the HMO may request disenrollment of Members who are totally dependent on a ventilator or who have been diagnosed with End Stage Renal Disease.

(f) HHSC must notify the Member of HHSC's decision to disenroll the Member if all reasonable measures have failed to remedy the problem.

(g) If the Member disagrees with the decision to disenroll the Member from HMO, HHSC must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's Fair Hearing process.

(h) HMO cannot request a disenrollment based on adverse change in the member's health status or utilization of services that are Medically Necessary for treatment of a member's condition.

Section 5.03 STAR enrollment for pregnant women and infants.

(a) The HHSC Administrative Services Contractor will retroactively enroll some pregnant Members in a Medicaid HMO based on their date of eligibility.

(b) The HHSC Administrative Services Contractor will enroll newborns born to Medicaid eligible mothers who are enrolled in a STAR HMO in the same HMO for at least 90 days following the date of birth, unless the mother requests a plan change as a special exception. The Administrative Service Contractor will consider such requests on a case-by-case basis. The HHSC Administrative Services Contractor will retroactively, to date of birth, enroll newborns in the applicable STAR HMO.

Section 5.03.1 Enrollment for infants born to pregnant women in STAR+PLUS.

If a newborn is born to a Medicaid-eligible mother enrolled in a STAR+PLUS HMO, the HHSC Administrative Service Contractor will enroll the newborn into that HMO's STAR HMO product, if one exists. All rules related to STAR newborn enrollment will apply to the newborn. If the STAR+PLUS HMO does not have a STAR product but the newborn is eligible for STAR, the newborn will be enrolled in traditional Fee-for-Service Medicaid, and given the opportunity to select a STAR HMO.

Section 5.04 Span of Coverage

(a) Medicaid HMOs.

Section 5.04 Modified by Versions 1.2 and 1.5

(1) Open Enrollment.

HHSC will conduct continuous open enrollment for Medicaid Eligibles and the HMO must accept all persons who choose to enroll as Members in the HMO or who are assigned as Members in the HMO by HHSC, without regard to the Member's health status or any other factor.

(2) Enrollment of New Medicaid Eligibles.

Persons who become eligible for Medicaid during an Inpatient Stay in a Hospital will not be enrolled in a Medicaid HMO until discharged from the Hospital, with the following exceptions: (1) Members retroactively enrolled in STAR in accordance with Section 5.03, "STAR Enrollment of Pregnant Women and Infants," (2) all Medicaid-eligible newborns, and (3) Members retroactively enrolled in STAR in accordance with Section 5.03.1, "Enrollment for infants born to pregnant women in STAR+PLUS." If a Member is enrolled in a Medicaid HMO during an Inpatient Stay under either of the above-referenced exceptions, responsibility for the Inpatient Stay services is assigned as follows:

Responsibility for Inpatient Stay Services		
Exception	Hospital Facility Charges	Professional Services Charges
Member Retroactively Enrolled in STAR per §5.03 or in STAR+PLUS per §5.03.1	HMO	HMO
Member ≤ 12 Months of Age Who Is Prospectively Enrolled in STAR or STAR+PLUS	Medicaid FFS	HMO

(3) Movement between STAR or STAR+PLUS HMOs.

Except as provided in Section 5.04(a)(8), a Member cannot change from a STAR or STAR+PLUS HMO to a different STAR or STAR+PLUS HMO during an Inpatient Stay in a Hospital, residential substance use disorder treatment facility, or residential detoxification for substance use disorder treatment facility.

(4) Movement from Medicaid Fee-for-Service to a STAR or STAR+PLUS HMO.

A Medicaid recipient can move from Medicaid Fee-for-Service into a STAR or STAR+PLUS HMO during an Inpatient Stay in a Hospital. Except as provided in subpart (a)(2), responsibility for claims incurred during the Inpatient Stay will be divided as follows: (1) the Medicaid Fee-for-Service program will continue to pay allowable facility charges until the earlier of the date of Discharge or loss of Medicaid eligibility; and (2) beginning on the Effective Date of Coverage, the STAR or STAR+PLUS HMO will pay for all other Covered Services.

(5) Movement from a STAR HMO to the STAR Health MCO.

A Medicaid recipient can move from the STAR Program into the STAR Health Program during an Inpatient Stay. In such cases, responsibility for claims incurred during the Inpatient stay will be divided as follows: (1) the STAR HMO will continue to pay Hospital facility charges for Covered Services until the earlier of the date of Discharge or loss of Medicaid eligibility, and (2) beginning on the Effective Date of Coverage, the STAR Health MCO will pay for all other Covered Services.

(6) Movement from a STAR+PLUS HMO to the STAR Health MCO.

A Medicaid recipient can move from the STAR+PLUS program into the STAR Health Program during an Inpatient Stay. In such cases, responsibility for claims incurred during the Inpatient stay will be divided as follows: (1) the STAR+PLUS HMO will continue to pay Hospital facility charges for Behavioral Health Covered Services until the earlier of the date of Discharge or loss of Medicaid eligibility, (2) and the Medicaid FFS program will continue to pay Hospital facility charges for non-Behavioral Health Covered Services until the earlier of the date of Discharge or loss of Medicaid eligibility, and (3) beginning on the Effective Date of Coverage, the STAR Health MCO will pay for all other Covered Services.

(7) Movement from STAR+PLUS to Medicaid Fee-for-Service.

A Medicaid recipient can move from the STAR+PLUS program to FFS (if a child) during an Inpatient Stay. In such cases, responsibility for claims incurred during the Inpatient Stay will be divided as follows: (1) the STAR+PLUS HMO will continue to pay Hospital facility charges for inpatient mental health Covered Services until the earlier of the date of Discharge or loss of Medicaid eligibility, and (2) beginning on the effective date of FFS coverage, FFS will pay for all other covered services.

(8) Movement from STAR to STAR+PLUS or Medicaid Fee-for-Service due to SSI Status.

When a STAR member becomes qualified for SSI, HHSC will allow the STAR member to move to FFS (if a child) or STAR+PLUS (if a child or adult) as set forth in Section 5.04(c). If a move occurs during an Inpatient Stay in a Hospital, residential substance use disorder treatment facility, or residential detoxification for substance use disorder treatment facility, responsibility for claims incurred during the Inpatient Stay will be divided as follows: (1) the STAR HMO will continue to pay facility charges for Covered Services until the earlier of the date of Discharge or loss of Medicaid eligibility, and (2) beginning on the Effective Date of Coverage for STAR+PLUS or the effective date of FFS coverage, the new entity will pay for all other Covered Services.

(9) Responsibility for Costs Incurred After Loss of Medicaid Eligibility.

Medicaid HMOs are not responsible for services incurred on or after the effective date of loss of Medicaid eligibility.

(10) Reenrollment after Temporary Loss of Medicaid Eligibility.

Members who are disenrolled because they are temporarily ineligible for Medicaid will be automatically re-enrolled into the same health plan, if available. Temporary loss of eligibility is defined as a period of six months or less.

(c) Effective Date of SSI Status.

SSI status is effective on the date the State's eligibility system identifies a STAR, CHIP, or CHIP Perinatal Program Member as Type Program 13 (TP 13). HHSC is responsible for updating the State's eligibility system within 45 days of official notice of the Member's Federal SSI status by the Social Security Administration (SSA). Once HHSC has updated the State's eligibility system to identify the STAR, CHIP, or CHIP Perinatal Program Member as TP13, following standard eligibility cut-off rules, HHSC will allow the Member to:

(1) prospectively move to Medicaid FFS (if the Member is a child in any part of the State, or an adult in a Service Area not covered by STAR+PLUS);

(2) prospectively move to STAR+PLUS (if the Member is a child or adult in a STAR+PLUS Service Area);

(3) remain in STAR (if the Member is a child who is already enrolled in STAR in the El Paso or Lubbock Service Areas); or

HHSC will not retroactively disenroll a Member from the STAR, CHIP, or CHIP Perinatal Programs.

Section 5.05 Verification of Member Eligibility.

HMOs are prohibited from entering into an agreement to share information regarding their Members with an external vendor that provides verification of Medicaid recipients' eligibility to Medicaid providers. All such external vendors must contract with the State and obtain eligibility information from the State.

Section 5.06 Default Methodology for Frew Incentives

As required by the "Frew vs. Hawkins Corrective Action Order: Managed Care," this Contract includes a system of incentives and disincentives associated with the Medicaid Managed Care Texas Health Steps Medical Checkups Reports. The default assignment methodology associated with these reports, and corresponding incentives and disincentives for Medicaid HMOs will be included in the **Uniform Managed Care Manual**.

Article 6. Service Levels & Performance Measurement

Section 6.01 Performance measurement.

Satisfactory performance of this Contract will be measured by:

(a) Adherence to this Contract, including all representations and warranties;

(b) Delivery of the Services and Deliverables described in Attachment B;

(c) Results of audits performed by HHSC or its representatives in accordance with **Article 9** ("Audit and Financial Compliance");

(d) Timeliness, completeness, and accuracy of required reports; and

(e) Achievement of performance measures developed by HMO and HHSC and as modified from time to time by written agreement during the term of this Contract.

Article 7. Governing Law & Regulations

Section 7.01 Governing law and venue.

This Contract is governed by the laws of the State of Texas and interpreted in accordance with Texas law. Provided HMO first complies with the procedures set forth in **Section 12.13** ("Dispute Resolution,") proper venue for claims arising from this Contract will be in the State District Court of Travis County, Texas.

Section 7.02 HMO responsibility for compliance with laws and regulations.

Section 7.02 Modified by Versions 1.2 and 1.5

(a) HMO must comply, to the satisfaction of HHSC, with all provisions set forth in this Contract, all applicable provisions of state and federal laws, rules, regulations, federal waivers, policies and guidelines, and any court-ordered consent decrees, settlement agreements, or other court orders that govern the performance of the Scope of Work including, but not limited to:

(1) Titles XIX and XXI of the Social Security Act;

(2) Chapters 62 and 63, Texas Health and Safety Code;

(3) Chapters 531 and 533, Texas Government Code;

(4) 42 C.F.R. Parts 417, 455, and 457, as applicable;

(5) 45 C.F.R. Parts 74 and 92;

(6) 48 C.F.R. Part 31, or OMB Circular A-122, based on whether the entity is for-profit or nonprofit;

(7) 1 T.A.C. Part 15, Chapters 361, 370, 371, 391, and 392;

(8) Consent Decree and Corrective Action Orders, *Frew et al. v. Suehs, et al.* (Medicaid HMOs only);

(9) partial settlement agreements, *Alberto N., et al. v. Suehs, et al.* (Medicaid HMOs only);

(10) Texas Human Resources Code Chapters 32 and 36;

(11) Texas Penal Code Chapter 35A (Medicaid Fraud);

(12) 1 T.A.C. Chapter 353;

(13) 1 T.A.C. Chapter 354, Subchapters B, J, and F, with the exception of the following provisions in Subchapter F: 1 T.A.C. §354.1865, §354.1867, §354.1873, and Division 6, "Pharmacy Claims; and §354.3047:

(14) 1 T.A.C. Chapter 354, Subchapters I and K, as applicable;

(15) the Patient Protection and Affordable Care Act ("PPACA"; Public Law 111-148);

(16) the Health Care and Education Reconciliation Act of 2010 ("HCERA"; Public Law 111-152) 42 CFR Part 455; and

(17) all State and Federal tax laws, State and Federal employment laws, State and Federal regulatory requirements, and licensing provisions.

(b) The Parties acknowledge that the federal and/or state laws, rules, regulations, policies, or guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that affect the performance of the Scope of Work may change from time to time or be added, judicially interpreted, or amended by competent authority. HMO acknowledges that the HMO Programs will be subject to continuous change during the term of the Contract and, except as provided in Section 8.02, HMO has provided for or will provide for adequate resources, at no additional charge to HHSC, to reasonably accommodate such changes. The Parties further acknowledge that HMO was selected, in part, because of its expertise, experience, and knowledge concerning applicable Federal and/or state laws, regulations, policies, or guidelines that affect the performance of the Scope of Work. In keeping with

HHSC's reliance on this knowledge and expertise, HMO is responsible for identifying the impact of changes in applicable Federal or state legislative enactments and regulations that affect the performance of the Scope of Work or the State's use of the Services and Deliverables. HMO must timely notify HHSC of such changes and must work with HHSC to identify the impact of such changes on how the State uses the Services and Deliverables.

(c) HHSC will notify HMO of any changes in applicable law, regulation, policy, or guidelines that HHSC becomes aware of in the ordinary course of its business.

(d) HMO is responsible for any fines, penalties, or disallowances imposed on the State or HMO arising from any noncompliance with the laws and regulations relating to the delivery of the Services or Deliverables by the HMO, its Subcontractors or agents.

(e) HMO is responsible for ensuring each of its employees, agents or Subcontractors who provide Services under the Contract are properly licensed, certified, and/or have proper permits to perform any activity related to the Services.

(f) HMO warrants that the Services and Deliverables will comply with all applicable Federal, State, and County laws, regulations, codes, ordinances, guidelines, and policies. HMO will indemnify HHSC from and against any losses, liability, claims, damages, penalties, costs, fees, or expenses arising from or in connection with HMO's failure to comply with or violation of any such law, regulation, code, ordinance, or policy.

Section 7.03 TDI licensure/ANHC certification and solvency.

(a) Licensure

HMO must be either licensed by the TDI as an HMO or a certified ANHC in all counties for the Service Areas included within the scope of the Contract.

(b) Solvency

HMO must maintain compliance with the Texas Insurance Code and rules promulgated and administered by the TDI requiring a fiscally sound operation. HMO must have a plan and take appropriate measures to ensure adequate provision against the risk of insolvency as required by TDI. Such provision must be adequate to provide for the following in the event of insolvency:

(1) continuation of benefits, until the time of discharge, to Members who are confined on the date of insolvency in a Hospital or other inpatient facility;

(2) payment to unaffiliated health care providers and affiliated health care providers whose agreements do not contain member "hold harmless" clauses acceptable to TDI, and

(3) continuation of benefits for the duration of the Contract period for which HHSC has paid a Capitation Payment.

Provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI.

Section 7.04 Immigration Reform and Control Act of 1986.

HMO shall comply with the requirements of the Immigration Reform and Control Act of 1986 and the Immigration Act of 1990 (8 U.S.C. §1101, *et seq*.) regarding employment verification and retention of verification forms for any individual(s) hired on or after November 6, 1986, who will perform any labor or services under this Contract.

Section 7.05 Compliance with state and federal anti-discrimination laws.

(a) HMO agrees to comply with state and federal anti-discrimination laws, including without limitation:

(1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*);

(2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);

(3) Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq*.);

(4) Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);

(5) Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);

(6) Food Stamp Act of 1977 (7 U.S.C. §200 *et seq*.); and

(7) The HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

HMO agrees to comply with all amendments to the above-referenced laws, and all requirements imposed by the regulations issued pursuant to these laws. These laws provide in part that no persons in the United States may, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service or other benefits provided by Federal or State funding, or otherwise be subjected to discrimination.

(b) HMO agrees to comply with Title VI of the Civil Rights Act of 1964, and its implementing regulations at 45 C.F.R. Part 80 or 7 C.F.R. Part 15, prohibiting a contractor from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of clients in its programs, benefits, or

activities on the basis of national origin. Applicable state and federal civil rights laws require contractors to provide alternative methods for ensuring access to services for applicants and recipients who cannot express themselves fluently in English. HMO agrees to ensure that its policies do not have the effect of excluding or limiting the participation of persons in its programs, benefits, and activities on the basis of national origin. HMO also agrees to take reasonable steps to provide services and information, both orally and in writing, in appropriate languages other than English, in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities.

(c) HMO agrees to comply with Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16. These provide in part that any organization that participates in programs funded by direct financial assistance from the United States Department of Agriculture or the United States Department of Health and Human Services shall not, in providing services, discriminate against a program beneficiary or prospective program beneficiary on the basis of religion or religious belief.

(d) Upon request, HMO will provide HHSC Civil Rights Office with copies of all of the HMO's civil rights policies and procedures.

(e) HMO must notify HHSC's Civil Rights Office of any civil rights complaints received relating to its performance under this Agreement. This notice must be delivered no more than ten (10) calendar days after receipt of a complaint. Notice provided pursuant to this section must be directed to:

HHSC Civil Rights Office

701 W. 51st Street, Mail Code W206

Austin, Texas 78751

Phone Toll Free: (888) 388-6332

Phone: (512) 438-4313

TTY Toll Free: (877) 432-7232

Fax: (512) 438-5885.

Section 7.06 Environmental protection laws.

HMO shall comply with the applicable provisions of federal environmental protection laws as described in this Section:

(a) Pro-Children Act of 1994.

HMO shall comply with the Pro-Children Act of 1994 (20 U.S.C. §6081 *et seq.*), as applicable, regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products.

(b) National Environmental Policy Act of 1969.

HMO shall comply with any applicable provisions relating to the institution of environmental quality control measures contained in the National Environmental Policy Act of 1969 (42 U.S.C. §4321 *et seq.*) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality").

(c) Clean Air Act and Water Pollution Control Act regulations.

HMO shall comply with any applicable provisions relating to required notification of facilities violating the requirements of Executive Order 11738 ("Providing for Administration of the Clean Air Act and the Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, or Loans").

(d) State Clean Air Implementation Plan.

HMO shall comply with any applicable provisions requiring conformity of federal actions to State (Clean Air) Implementation Plans under §176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §740 *et seq.*).

(e) Safe Drinking Water Act of 1974.

HMO shall comply with applicable provisions relating to the protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (21 U.S.C. § 349; 42 U.S.C. §§ 300f to 300j-9).

Section 7.07 HIPAA.

(a) HMO shall comply with applicable provisions of HIPAA. This includes, but is not limited to, the requirement that the HMO's MIS system comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA. HMO must comply with HIPAA EDI requirements.

(b) Additionally, HMO must comply with HIPAA notification requirements, including those set forth in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 *et.seq*. HMO must notify HHSC of all breaches or potential breaches of unsecured protected health information, as defined by the HITECH Act, without unreasonable delay and in no event later than 60 calendar days after discovery of the breach or potential breach. If, in HHSC's determination, HMO has not provided notice in the manner or format prescribed by the HITECH Act, then HHSC may require the HMO to provide such notice.

Section 7.08 Historically Underutilized Business Participation Requirements

Section 7.08 Added by Version 1.3 and Modified by Version 1.5

(a) Definitions.

For purposes of this Section:

(1) **"Historically Underutilized Business"** or **"HUB"** means a minority or women-owned business as defined by Texas Government Code, Chapter 2161.

(2) **"HSP"** means a HUB Subcontracting Plan.

(b) HUB Requirements.

(1) In accordance with Attachment B-1, Section 8.1.17.2, the HMO must submit an HSP for HHSC's approval during the Transition Phase, and maintain the HSP thereafter.

(2) HMO must report to HHSC's contract manager and HUB Office monthly, in the format required by Chapter 5.4.4.5 of the Uniform Managed Care Manual, its use of HUB subcontractors to fulfill the subcontracting opportunities identified in the HSP.

(3) HMO must obtain prior written approval from the HHSC HUB Office before making any changes to the HSP. The proposed changes must comply with HHSC's good faith effort requirements relating to the development and submission of HSPs.

(i) The HMO must submit a revised HSP to the HHSC HUB Office when it: changes the dollar amount of, terminates, or modifies an existing Subcontract for MCO Administrative Services; or enters into a new Subcontract for MCO Administrative Services. All proposed changes to the HSP must comply with the requirements of this Agreement**.**

(4) HHSC will determine if the value of Subcontracts to HUBs meet or exceed the HUB subcontracting provisions specified in the HMO's HSP. If HHSC determines that the HMO's subcontracting activity does not demonstrate a good faith effort, the HMO may be subject to provisions in the Vendor Performance and Debarment Program (Title 34, Part 1, Chapter 20, Subchapter C, Rule §20.105), and subject to remedies for Breach.

Article 8. Amendments & Modifications

Section 8.01 Mutual agreement.

This Contract may be amended at any time by mutual agreement of the Parties. The amendment must be in writing and signed by individuals with authority to bind the Parties.

Section 8.02 Changes in law or contract.

If Federal or State laws, rules, regulations, policies or guidelines are adopted, promulgated, judicially interpreted or changed, or if contracts are entered or changed, the effect of which is to alter the ability of either Party to fulfill its obligations under this Contract, the Parties will promptly negotiate in good faith appropriate modifications or alterations to the Contract and any schedule(s) or attachment(s) made a part of this Contract. Such modifications or alterations must be in writing and signed by individuals with authority to bind the parties, equitably adjust the terms and conditions of this Contract, and must be limited to those provisions of this Contract affected by the change.

Section 8.03 Modifications as a remedy.

This Contract may be modified under the terms of **Article 12** ("Remedies and Disputes").

Section 8.04 Modifications upon renewal or extension of Contract.

(a) If HHSC seeks modifications to the Contract as a condition of any Contract extension, HHSC's notice to HMO will specify those modifications to the Scope of Work, the Contract pricing terms, or other Contract terms and conditions.

(b) HMO must respond to HHSC's proposed modification within the timeframe specified by HHSC, generally within thirty (30) days of receipt. Upon receipt of HMO's response to the proposed modifications, HHSC may enter into negotiations with HMO to arrive at mutually agreeable Contract amendments. In the event that HHSC determines that the Parties will be unable to reach agreement on mutually satisfactory contract modifications, then HHSC will provide written notice to HMO of its intent not to extend the Contract beyond the Contract Term then in effect.

Section 8.05 Modification of HHSC Uniform Managed Care Manual.

(a) HHSC will provide HMO with at least thirty (30) days advance written notice before implementing a substantive and material change in the HHSC Uniform Managed Care Manual (a change that materially and substantively alters the HMO's ability to fulfill its obligations under the Contract). The Uniform Managed Care Manual, and all modifications thereto made during the Contract Term, are incorporated by reference into this Contract. HHSC will provide HMO with a reasonable amount of time to comment on such changes, generally at least ten (10) Business Days. HHSC is not required to provide advance written notice of changes that are not material and substantive in nature, such as corrections of clerical errors or policy clarifications.

(b) The Parties agree to work in good faith to resolve disagreements concerning material and substantive changes to the HHSC Uniform Managed Care Manual. If the Parties are unable to resolve issues relating to material and substantive changes, then either Party may terminate the agreement in accordance with **Article 12** ("Remedies and Disputes").

(c) Changes will be effective on the date specified in HHSC's written notice, which will not be earlier than the HMO's response deadline, and such changes will be incorporated into the HHSC Uniform Managed Care Manual. If the HMO has raised an objection to a material and substantive change to the

HHSC Uniform Managed Care Manual and submitted a notice of termination in accordance with **Section 12.04(d),** HHSC will not enforce the policy change during the period of time between the receipt of the notice and the date of Contract termination.

Section 8.06 CMS approval of Medicaid amendments

The implementation of amendments, modifications, and changes to STAR+PLUS HMO contracts is subject to the approval of the Centers for Medicare and Medicaid Services ("CMS.")

Section 8.07 Required compliance with amendment and modification procedures.

No different or additional services, work, or products will be authorized or performed except as authorized by this Article. No waiver of any term, covenant, or condition of this Contract will be valid unless executed in compliance with this Article. HMO will not be entitled to payment for any services, work or products that are not authorized by a properly executed Contract amendment or modification.

Article 9. Audit & Financial Compliance

Section 9.01 Financial record retention and audit.

Section 9.01 Modified by Versions 1.2 and 1.3

HMO agrees to maintain, and require its Subcontractors to maintain, records, books, documents, and information (collectively "records") that are adequate to ensure that services are provided and payments are made in accordance with the requirements of this Contract, including applicable Federal and State requirements (e.g., 45 CFR §74.53). Such records must be retained by HMO or its Subcontractors for a period of five (5) years after the Contract Expiration Date or until the resolution of all litigation, claim, financial management review or audit pertaining to this Contract, whichever is longer.

Section 9.02 Access to records, books, and documents.

Section 9.02 Modified by Version 1.5

(a) Upon reasonable notice, HMO must provide, and cause its Subcontractors to provide, the officials and entities identified in this Section with prompt, reasonable, and adequate access to any records, books, documents, and papers that are related to the performance of the Scope of Work.

(b) HMO and its Subcontractors must provide the access described in this Section upon HHSC's request. This request may be for, but is not limited to, the following purposes:

(1) Examination;

(2) Audit;

(3) Investigation;

(4) Contract administration; or

(5) The making of copies, excerpts, or transcripts.

(c) The access required must be provided to the following officials and/or entities:

(1) The United States Department of Health and Human Services or its designee;

(2) The Comptroller General of the United States or its designee;

(3) HMO Program personnel from HHSC or its designee;

(4) The Office of Inspector General;

(5) The Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;

(6) Any independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC;

(7) The Office of the State Auditor of Texas or its designee;

(8) A State or Federal law enforcement agency;

(9) A special or general investigating committee of the Texas Legislature or its designee; and

(10) Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

(d) HMO agrees to provide the access described wherever HMO maintains such books, records, and supporting documentation. HMO further agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described in this Section. HMO will require its Subcontractors to provide comparable access and accommodations.

(e) Upon request, the HMO must provide copies of the information described in this Section free of charge to HHSC and the entities described in subsection (c).

(f) In accordance with Texas Government Code §533.012(e), any information submitted to HHSC or the Texas Attorney General's Office pursuant to Texas Government Code §533.012(a)(1) is confidential and is not subject to disclosure under the Texas Public Information Act.

Section 9.03 Audits of Services, Deliverables and inspections.

(a) Upon reasonable notice from HHSC, HMO will provide, and will cause its Subcontractors to provide, such auditors and inspectors as HHSC may from time to time designate, with access to:

(1) HMO service locations, facilities, or installations; and

(2) HMO Software and Equipment.

(b) The access described in this Section will be for the purpose of examining, auditing, or investigating:

(1) HMO's capacity to bear the risk of potential financial losses;

(2) the Services and Deliverables provided;

(3) a determination of the amounts payable under this Contract;

(4) detection of fraud, waste and/or abuse; or

(5) other purposes HHSC deems necessary to perform its regulatory function and/or enforce the provisions of this Contract.

(c) HMO must provide, as part of the Scope of Work, any assistance that such auditors and inspectors reasonably may require to complete such audits or inspections.

(d) If, as a result of an audit or review of payments made to the HMO, HHSC discovers a payment error or overcharge, HHSC will notify the HMO of such error or overcharge. HHSC will be entitled to recover such funds as an offset to future payments to the HMO, or to collect such funds directly from the HMO. HMO must return funds owed to HHSC within thirty (30) days after receiving notice of the error or overcharge, or interest will accrue on the amount due. HHSC will calculate interest at the Department of Treasury's Median Rate (resulting from the Treasury's auction of 13-week bills) for the week in which liability is assessed. In the event that an audit reveals that errors in reporting by the HMO have resulted in errors in payments to the HMO or errors in the calculation of the Experience Rebate, the HMO will indemnify HHSC for any losses resulting from such errors, including the cost of audit.

Section 9.04 SAO Audit

The HMO understands that acceptance of funds under this Contract acts as acceptance of the authority of the State Auditor's Office ("SAO"), or any successor agency, to conduct an investigation in connection with those funds. The HMO further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested. The HMO will ensure that this clause concerning the authority to audit funds received indirectly by Subcontractors through HMO and the requirement to cooperate is included in any Subcontract it awards, and in any third party agreements described in **Section 4.10 (a-b)**.

Section 9.05 Response/compliance with audit or inspection findings.

(a) HMO must take action to ensure its or a Subcontractor's compliance with or correction of any finding of noncompliance with any law, regulation, audit requirement, or generally accepted accounting principle relating to the Services and Deliverables or any other deficiency contained in any audit, review, or inspection conducted under this Article. This action will include HMO'S delivery to HHSC, for HHSC'S approval, a Corrective Action Plan that addresses deficiencies identified in any audit(s), review(s), or inspection(s) within thirty (30) calendar days of the close of the audit(s), review(s), or inspection(s).

(b) HMO must bear the expense of compliance with any finding of noncompliance under this Section that is:

(1) Required by Texas or Federal law, regulation, rule or other audit requirement relating to HMO's business;

(2) Performed by HMO as part of the Services or Deliverables; or

(3) Necessary due to HMO's noncompliance with any law, regulation, rule or audit requirement imposed on HMO.

(c) As part of the Scope of Work, HMO must provide to HHSC upon request a copy of those portions of HMO's and its Subcontractors' internal audit reports relating to the Services and Deliverables provided to HHSC under the Contract.

Section 9.06 Notification of Legal and Other Proceedings, and Related Events.

The HMO must notify HHSC of all proceedings, actions, and events as specified in the Uniform Managed Care Manual, Chapter 5.8, "Report of Legal and Other Proceedings, and Related Events."

Article 10. Terms & Conditions of Payment

Section 10.01 Calculation of monthly Capitation Payment.

Section 10.01 modified by Version 1.3

(a) This is a Risk-based contract. HHSC will pay the HMO fixed monthly Capitation Payments based on the number of eligible and enrolled Members. HHSC will calculate the monthly Capitation Payments by multiplying the number of Members by each applicable Member Rate Cell. In consideration of the Monthly Capitation Payment(s), the HMO agrees to provide the Services and Deliverables described in this Contract.

(b) HMO will be required to provide timely financial and statistical information necessary in the Capitation Rate determination process. Encounter Data provided by HMO must conform to all HHSC requirements. Encounter Data containing non-compliant information, including, but not limited to, inaccurate client or member identification numbers, inaccurate provider identification numbers, or diagnosis or procedures codes insufficient to adequately describe the diagnosis or medical procedure performed, will not be considered in the HMO's experience for rate-setting purposes.

(c) Information or data, including complete and accurate Encounter Data, as requested by HHSC for rate-setting purposes, must be provided to HHSC: (1) within thirty (30) days of receipt of the letter from

HHSC requesting the information or data; and (2) no later than March 31st of each year.

(d) The fixed monthly Capitation Rate consists of the following components:

(1) an amount for Health Care Services performed during the month;

(2) an amount for administering the program, and

(3) an amount for the HMO's Risk margin.

Capitation Rates may vary by Service Area and HMO. HHSC will employ or retain qualified actuaries to perform data analysis and calculate the STAR+PLUS Capitation Rates for each Rate Period.

(e) HMO understands and expressly assumes the risks associated with the performance of the duties and responsibilities under this Contract, including the failure, termination or suspension of funding to HHSC, delays or denials of required approvals, and cost overruns not reasonably attributable to HHSC.

Section 10.02 Time and Manner of Payment.

(a) During the Contract Term and beginning after the Operational Start Date, HHSC will pay the monthly Capitation Payments by the 10th Business Day of each month.

(b) The HMO must accept Capitation Payments by direct deposit into the HMO's account.

(c) HHSC may adjust the monthly Capitation Payment to the HMO in the case of an overpayment to the HMO, for Experience Rebate amounts due and unpaid, and if money damages are assessed in accordance with **Article 12** ("Remedies and Disputes").

(d) HHSC's payment of monthly Capitation Payments is subject to availability of federal and state appropriations. If appropriations are not available to pay the full monthly Capitation Payment, HHSC may:

(1) equitably adjust Capitation Payments for all participating Contractors, and reduce scope of service requirements as appropriate in accordance with **Article 8**, or

(2) terminate the Contract in accordance with **Article 12** ("Remedies and Disputes").

Section 10.03 Certification of Capitation Rates.

HHSC will employ or retain a qualified actuary to certify the actuarial soundness of the STAR+PLUS Capitation Rates contained in this Contract. HHSC will also employ or retain a qualified actuary to certify all revisions or modifications to the STAR+PLUS Capitation Rates.

Section 10.04 Modification of Capitation Rates.

The Parties expressly understand and agree that the agreed Capitation Rates are subject to modification in accordance with **Article 8** ("Amendments and Modifications,") if changes in state or federal laws, rules, regulations or policies affect the rates or the actuarial soundness of the rates. HHSC will provide the HMO notice of a modification to the Capitation Rates 60 days prior to the effective date of the change, unless HHSC determines that circumstances warrant a shorter notice period. If the HMO does not accept the rate change, either Party may terminate the Contract in accordance with **Article 12** ("Remedies and Disputes").

Section 10.05 STAR+PLUS Capitation Structure

(a) STAR+PLUS Rate Cells.

STAR+PLUS Capitation Rates are defined on a per Member per month basis by Rate Cells. STAR+PLUS Rate Cells are based on client category as follows:

(1) Medicaid Only Standard Rate

(2) Medicaid Only 1915 (c) Nursing Facility Waiver Rate

(3) Dual Eligible Standard Rate

(4) Dual Eligible 1915(c) Nursing Facility Waiver Rate.

These Rate Cells are subject to change after Rate Period 1.

(b) STAR+PLUS Capitation Rates

HHSC will establish the Rate Period 1 Capitation Rates by Service Area based on fee-for-service experience in the counties included in the Service Area. HHSC reserves the right to trend forward these rates for subsequent Rate Periods until sufficient Encounter Data is available to base Capitation Rates on Encounter Data.

(c) Delay in Increased Capitation Level for Certain Members Receiving Waiver Services

Once a current HMO Member has been certified to receive STAR+PLUS Waiver (SPW) services, there is a two-month delay before the HMO will begin receiving the higher capitation payment.

Non-Waiver Members who qualify for STAR+PLUS based on eligibility for SPW services and Waiver recipients who transfer from another region will not be subject to this two-month delay in the increased capitation payment.

All SPW recipients will be registered into Service Authorization System Online (SASO). The Premium Payment System (PPS) will process data from the SASO system in establishing a Member's correct capitation payment.

Section 10.06 HMO Input During Rate Setting Process

(a) HHSC will allow the HMO to review and comment on data used by HHSC to determine base Capitation Rates. This will include Fee-for-Service data for Rate Period 1. HHSC will notify the HMO of deadline for submitting comments, which will include a reasonable amount of time for response. HHSC will not consider comments received after the deadline in its rate analysis.

(b) During the rate setting process, HHSC will conduct at least two (2) meetings with the HMO. HHSC may conduct the meetings in person, via teleconference, or by another method deemed appropriate by HHSC. Prior to the first meeting, HHSC will provide the HMO with proposed Capitation Rates. During the first meeting, HHSC will describe the process used to generate the proposed Capitation Rates, discuss major changes in the rate setting process, and receive input from the HMO. HHSC will notify the HMO of the deadline for submitting comments, which will include a reasonable amount of time to review and comment on the proposed Capitation Rates and rate setting process. After reviewing such comments, HHSC will conduct a second meeting to discuss the final Capitation Rates and changes resulting from HMO comments, if any.

Section 10.07 Adjustments to Capitation Payments.

Section 10.07 Modified by Version 1.3

(a) Recoupment.

HHSC may recoup a payment made to the HMO for a Member if:

(1) the Member is enrolled into the HMO in error;

(2) the Member moves outside the United States;

(3) the Member dies before the first day of the month for which the payment was made;

(4) a Medicaid Member's eligibility status or program type is changed, corrected as a result of error, or is retroactively adjusted; or

(5) payment has been denied by the CMS in accordance with the requirements in 42 C.F.R. §438.730.

(b) Appeal of recoupment.

The HMO may appeal the recoupment or adjustment of capitations in the above circumstances using the HHSC dispute resolution process set forth in **Section 12.13**, ("Dispute Resolution").

Section 10.08 STAR+PLUS Experience Rebate

Section 10.08 Modified by Version 1.2

(a) HMO's duty to pay.

At the end of each Rate Period beginning with Rate Period 1, the HMO must pay an Experience Rebate to HHSC if the HMO's Net Income before Taxes is greater than the percentage set forth below of the total Revenue for the period. With respect to the determination of the Experience Rebate, the Net Income Before Taxes and the Revenues are each on a consolidated basis, across all the HHSC managed care "applicable Programs" in which the HMO participates. Applicable Programs for the Experience Rebate include STAR+PLUS, STAR, and CHIP. The Experience Rebate is calculated in accordance with the tiered rebate method set forth below based on the consolidated Net Income before Taxes for all of the HMO's Service Areas in the State, as measured by the Financial-Statistical Report (FSR) as reviewed and confirmed by HHSC.

(b) Graduated Experience Rebate Sharing Method.

Pre-tax Income as a % of Revenues	HMO Share	HHSC Share
≤ 3%	100%	0%
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	60%	40%
> 7% and ≤ 9%	40%	60%
> 9% and ≤ 12%	20%	80%
> 12%	0%	100%

For Rate Period 1 and thereafter, HHSC and the HMO will share the Net Income before Taxes for the applicable Programs as follows:

(1) The HMO will retain all the Net Income before Taxes that is equal to or less than 3% of the total applicable Program Revenues received by the HMO.

(2) HHSC and the HMO will share that portion of the Net Income before Taxes that is over 3% and less than or equal to 5% of the total applicable Program Revenues received, with 80% to the HMO and 20% to HHSC.

(3) HHSC and the HMO will share applicable Program Revenues received, with 60% to the HMO and 40% to HHSC.

(4) HHSC and the HMO will share that portion of the Net Income before Taxes that is over 7% and less than or equal to 9% of the total applicable Program Revenues received, with 40% to the HMO and 60% to HHSC.

(5) HHSC and the HMO will share that portion of the Net Income before Taxes that is over 9% and less than or equal to 12% of the total applicable Program Revenues received, with 20% to the HMO and 80% to HHSC.

(6) HHSC will be paid the entire portion of the Net Income before Taxes that exceeds 12% of the total applicable Program Revenues.

(c) Net income before taxes.

(1) The HMO must compute the Net Income before Taxes in accordance with the **HHSC Uniform Managed Care Manual's "Cost Principles for Expenses"** and **"FSR Instructions for Completion"** and applicable federal regulations. The Net Income before Taxes will be confirmed by HHSC or its agent for the Rate Year relating to all revenues and expenses incurred pursuant to the Contract. HHSC reserves the right to modify the **"Cost Principles for Expenses"** and **"FSR Instructions for Completion"** found in **HHSC's Uniform Managed Care Manual** in accordance with Section 8.05.

(2) For purposes of calculating Net Income before Taxes, the following items are not Allowable Expenses:

(i) the payment of an Experience Rebate;

(ii) any interest expense associated with late or underpayment of the Experience Rebate;

(iii) financial incentives, including without limitation the Quality Challenge Award described in Attachment B-1, Section 6.3.2.3, and the STAR+PLUS Hospital Inpatient Incentive Shared Savings Award described in Attachment B-1, Section 6.3.2.5.2; and

(iv) financial disincentives, including without limitation: the Performance-based Capitation Rate described in Attachment B-1, Section 6.3.2.2; the STAR+PLUS Hospital Inpatient Disincentive Administrative Fee at Risk described in Attachment B-1, Section 6.3.2.5.1; and the liquidated damages described in Attachment B-5.

(3) Financial incentives are true net bonuses and shall not be reduced by the potential increased Experience Rebate payments. Financial disincentives are true net disincentives, and shall not be offset in whole or part by potential decreases in Experience Rebate payments.

(4) For FSR reporting purposes, financial incentives incurred shall not be reported as an increase in Revenues or as an offset to costs, and any award of such will not increase reported income. Financial disincentives incurred shall not be included as reported expenses, and shall not reduce reported income. The reporting or recording of any of these incurred items will be done on a memo basis, which is below the income line, and will be listed as separate items.

(d) Carry forward of prior Rate Year losses.

Losses incurred on a consolidated basis for the applicable Programs by the HMO for one Rate Period may be carried forward to the next Rate Period, and applied as an offset against applicable Program pre-tax net income. Prior losses may be carried forward for two contiguous Rate Periods for this purpose. If the HMO offsets a loss against another applicable Program and/or Service Area, only that portion of the loss that was not used as an offset may be carried forward to the next Rate Period.

In the case of a loss in a given Rate Period being carried forward and applied against profits in *both* of the next two Rate Periods, the loss must first be applied against the first subsequent Rate Period such that the profit in the first subsequent Rate Period is reduced to a zero pre-tax income; any additional loss then remaining unapplied may be carried forward to any profit in the next subsequent Rate Period. In such case, the revised income in the third Rate Period would be equal to the cumulative income of the three contiguous periods.

(e) Settlements for payment; interest.

(1) There may be one or more HMO payment(s) of the State share of the Experience Rebate on income generated for a given State Fiscal Year under the applicable Programs. The first scheduled payment (the "Primary Settlement") will equal 100% of the State share of the Experience Rebate as derived from the FSR, and will be paid on the same day the 90-day FSR Report is submitted to HHSC.

The "Primary Settlement," as utilized herein, refers strictly to what should be paid with the 90-day FSR, and does not refer to the first instance in which an HMO may tender a payment. For example, an HMO may submit a 90-day FSR indicating no Experience Rebate is due, but then submit a 334-day FSR with a higher income and a corresponding Experience Rebate payment. In such case, this initial payment would be subsequent to the Primary Settlement.

(2) The next scheduled payment will be an adjustment to the Primary Settlement, if required, and will be paid on the same day that the 334-day FSR Report is submitted to HHSC if the adjustment is a payment from the HMO to HHSC. Section 10.08(f) describes the interest expenses associated with any payment after the Primary Settlement.

An HMO may make non-scheduled payments at any time to reduce the accumulation of interest under Section 10.08(f). HHSC may require an adjusted FSR and/or Experience Rebate calculation form in connection with any such non-scheduled payment.

(3) HHSC or its agent may audit or review the FSRs. If HHSC determines that corrections to the FSRs are required, based on an HHSC audit/review or other documentation acceptable to HHSC, then HHSC will make final adjustments. Any payment resulting from an audit or final adjustment will be due from the HMO within 30 days of the earlier of:

(i) the date of the management representation letter resulting from the audit; or

(ii) the date of any invoice issued by HHSC.

Payment within this 30-day timeframe will not relieve the HMO of any interest payment obligation that may exist under Section 10.08(f).

(4) In the event that any Experience Rebates and/or corresponding interest payments owed to the State are not paid by the required due dates, then HHSC may offset such amounts from any future Capitation Payments, or collect such sums directly from the HMO. HHSC may adjust the Experience Rebate if HHSC determines the HMO has paid amounts for goods or services that are not reasonable, necessary, and allowable in accordance with the **HHSC Uniform Managed Care Manual's "Cost Principles for Expenses,"** the HHSC **"FSR Instructions for Completion,"** the Federal Acquisition Regulations (FAR), or other applicable federal or state regulations. HHSC has final authority in auditing and determining the amount of the Experience Rebate.

(f) Interest on Experience Rebate.

(1) Interest on *any* Experience Rebate owed to HHSC will be charged beginning 35 days after the due date of the Primary Settlement, as described in this section. Thus, any Experience Rebate due or paid on or after the Primary Settlement will accrue interest starting at 35 days after the due date for the 90-day FSR Report. For example, any Experience Rebate payment (s) made in conjunction with the 334-day FSR, or as a result of audit findings, will accrue interest back to 35 days after the due-date for submission of the 90-day FSR.

The HMO has the option of preparing an additional FSR based on 120 days of claims run-out (a "120- day FSR"). If a 120-day FSR, and an Experience Rebate payment based on it, are received by HHSC before the interest commencement date above, then such a payment would be counted as part of the Primary Settlement.

(2) If an audit or adjustment determines a downward revision of income after an interest payment has previously been required for the same State Fiscal Year, then HHSC will recalculate the interest and, if necessary, issue a full or partial refund or credit to the HMO.

(3) Any interest obligations that are incurred pursuant to Section 10.08 that are not timely paid will be subject to accumulation of interest as well, at the same rate as applicable to the underlying Experience Rebate.

(4) All interest assessed pursuant to Section 10.08 will continue to accrue until such point as a payment is received by HHSC, at which point interest on the amount received will stop accruing. If a balance remains at that point that is subject to interest, then the balance will continue to accrue interest. If interim payments are made, then any interest that may be due will only be charged on amounts for the time period during which they remained unpaid. By way of example only, if $100,000 is subject to interest commencing on a given day, and a payment is received for $75,000 45 days after the start of interest, then the $75,000 will be subject to 45 days of interest, and the $25,000 balance will continue to accrue interest until paid. The accrual of interest as defined under Section 10.08(f) will not stop during any period of dispute. If a dispute is resolved in the HMO's favor, then interest will only be assessed on the revised unpaid amount.

(5) If the HMO incurs an interest obligation pursuant to Section 10.08 for an Experience Rebate payment due, HHSC will assess such interest at 12% per annum, compounded daily. If any interest rate stipulated hereunder is found by a court of competent jurisdiction to be outside the range deemed legal and enforceable, then in such specific case the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

(6) Any such interest expense incurred pursuant to Section 10.08 is not an Allowable Expense for reporting purposes on the FSR.

Section 10.09 Administrative Expense Cap

(a) General requirement.

Section 10.09 Modified by Version 1.5

Beginning with Rate Period 2, the calculation methodology of Experience Rebates described in Section 10.08 will be adjusted by an Administrative Expense Cap ("Admin Cap.") The Admin Cap is a calculated maximum amount of administrative expense dollars (corresponding to a given FSR) that can be deducted from Revenues for purposes of determining income subject to the Experience Rebate. While Administrative Expenses may be limited by the Admin Cap to determine Experience Rebates, all valid Allowable Expenses will continue to be reported on the Financial Statistical Reports (FSRs). Thus, the Admin Cap does not impact FSR

reporting, but may impact any associated Experience Rebate calculation.

The calculation of any Experience Rebate due will be subject to limitations on total deductible administrative expenses.

Such limitations will be calculated as follows:-

(b) Calculation methodology.

HHSC will determine the administrative expense component of the applicable Capitation Rate structure for each Service Area prior to each applicable Rate Period. At the conclusion of a Rate Period, HHSC will apply that predetermined administrative expense component against the HMO's actually incurred number of Member Months and aggregate premiums received (monthly Capitation Payments plus Bariatric Supplemental Payments), to determine the specific Admin Cap, in aggregate dollars, for a given HMO, Service Area, and Program.

(c) Data sources.

In determining the amount of Experience Rebate payment to include in the Primary Settlement (or in conjunction with any subsequent payment or settlement), the HMO will need to make the appropriate calculation, in order to assess the impact, if any, of the Admin Cap.

(1) The total premiums paid by HHSC (earned by the HMO), and corresponding Member Months, will be taken from the relevant FSR (or audit report) for the Rate Period.

(2) There are two components of the administrative expense portion of the Capitation Rate structure: the percentage rate to apply against the total premiums paid (the "percentage of premium" within the administrative expenses), and, the dollar rate per Member Month (the "fixed amount" within the administrative expenses). These will be taken from the supporting details associated with the official notification of final Capitation Rates, as supplied by HHSC. This notification is sent to the HMOs during the annual rate setting process via email, labeled as "the final rate exhibits for your health plan." The email has one or more spreadsheet files attached, which are particular to the given HMO. The spreadsheet(s) show the fixed amount and percentage of premium components for the administrative component of the Capitation Rate.

The components of the administrative expense portion of the Capitation Rate can also be found on HHSC's Medicaid website, under "Rate Analysis for Managed Care Services." Under each Program, there is a separate Rate Setting document for each Rate Period that describes the development of the Capitation Rates. Within each such document, there is a section entitled "Administrative Fees," where it refers to "the amount allocated for administrative expenses."

In cases where the administrative expense portion of the Capitation Rate refers to "the greater of (a) [one set of factors], and (b) [another set of factors]," then the Admin Cap will be calculated each way, and the larger of the two results will be the Admin Cap utilized for the determination of any Experience Rebates due.

(d) Separate calculations, by FSR.

Each HMO will have a separate Admin Cap for each Program and Service Area in which it participates. This will require calculating a separate Admin Cap corresponding to each FSR (for annual, or complete period, versions of FSR only). All administrative expenses reported on an FSR in excess of the calculated corresponding Admin Cap will be subtracted from the total Allowable Expense in the Experience Rebate calculation of income for that Service Area, subject to any consolidation or offset that may apply, as described in Section 10.09(e).

By way of example only, HHSC will calculate the Admin Cap for a Rate Period as follows:

(1) Multiply the predetermined administrative expense rate structure "fixed amount," or dollar rate per Member Month (for example, $11.00), by the actual number of Member Months for the Service Area during the Rate Period (for example, 70,000):

- $11.00 x 70,000 = $770,000.

(2) Multiply the predetermined percent of premiums in the administrative expense rate structure (for example, 5.75%), by the actual aggregate premiums earned for the Service Area during the Rate Period (for example, $6,000,000).

- 5.75% x $6,000,000 = $345,000.

(3) Add the totals of items 1-2, plus applicable premium taxes and maintenance taxes (for example, $112,000), to determine the Admin Cap for the Service Area:

- $770,000 + $345,000 + $112,000 = $1,227,000.

In this example, $1,227,000 would be the Admin Cap for a single Service Area for an HMO in a particular Rate Period.

(e) Consolidation and offsets.

HMOs operating in multiple Service Areas and/or applicable Programs will consolidate applicable FSR administrative expense results, and compare that to consolidated Admin Caps. Thus, an HMO that exceeds its Admin Cap limit in one or more Service Areas or Programs, but does not exceed the Admin Cap in another Service Area or Program, may have an offset. The net impact of the Admin Cap across

relevant FSRs will be applied to the Experience Rebate calculation.

(f) Impact on Loss carry-forward.

For Experience Rebate calculation purposes, the calculation of any loss carry-forward, as described in Sections 10.08(d), will be based on the allowable pre-tax loss as determined under the Admin Cap.

(g) HMOs entering a Service Delivery Area.

If an HMO enters a new Service Area, it may be exempt from the Admin Cap for that Service Area for a period of time to be determined by HHSC.

(h) Service Delivery Areas with only one HMO in a Program.

In Service Areas operating with only one HMO for a Program, HHSC may, at its sole discretion, revise the Admin Cap if its application would create an undue hardship on the HMO.

(i) Unforeseen events.

If, in HHSC's sole discretion, it determines that unforeseen events have created significant hardships for one or more HMOs, HHSC may revise or temporarily suspend the Admin Cap as it deems necessary.

Section 10.10 Payment by Members.

Medicaid HMOs and their Network Providers are prohibited from billing or collecting any amount from a Member for Health Care Services covered by this Contract. HMO must inform Members of costs for non-covered services, and must require its Network Providers to:

(1) inform Members of costs for non-covered services prior to rendering such services; and

(2) obtain a signed Private Pay form from such Members.

Section 10.11 Restriction on assignment of fees.

During the term of the Contract, HMO may not, directly or indirectly, assign to any third party any beneficial or legal interest of the HMO in or to any payments to be made by HHSC pursuant to this Contract. This restriction does not apply to fees paid to Subcontractors.

Section 10.12 Liability for taxes.

HHSC is not responsible in any way for the payment of any Federal, state or local taxes related to or incurred in connection with the HMO's performance of this Contract. HMO must pay and discharge any and all such taxes, including any penalties and interest. In addition, HHSC is exempt from Federal excise taxes, and will not pay any personal property taxes or income taxes levied on HMO or any taxes levied on employee wages.

Section 10.13 Liability for employment-related charges and benefits.

HMO will perform work under this Contract as an independent contractor and not as agent or representative of HHSC. HMO is solely and exclusively liable for payment of all employment-related charges incurred in connection with the performance of this Contract, including but not limited to salaries, benefits, employment taxes, workers compensation benefits, unemployment insurance and benefits, and other insurance or fringe benefits for Staff.

Section 10.14 No additional consideration.

(a) HMO will not be entitled to nor receive from HHSC any additional consideration, compensation, salary, wages, charges, fees, costs, or any other type of remuneration for Services and Deliverables provided under the Contract, except by properly authorized and executed Contract amendments.

(b) No other charges for tasks, functions, or activities that are incidental or ancillary to the delivery of the Services and Deliverables will be sought from HHSC or any other state agency, nor will the failure of HHSC or any other party to pay for such incidental or ancillary services entitle the HMO to withhold Services and Deliverables due under the Agreement.

(c) HMO will not be entitled by virtue of the Contract to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays, or other paid leaves of absence of any type or kind whatsoever.

Section 10.15 Federal Disallowance

If the federal government recoups money from the state for expenses and/or costs that are deemed unallowable by the federal government, the state has the right to, in turn, recoup payments made to the HMOs for these same expenses and/or costs, even if they had not been previously disallowed by the state and were incurred by the HMO, and any such expenses and/or costs would then be deemed unallowable by the state. If the state retroactively recoups money from the HMOs due to a federal disallowance, the state will recoup the entire amount paid to the HMO for the federally disallowed expenses and/or costs, not just the federal portion.

Section 10.16 Required Pass Through of Physician Rate Increases

(a) All HMOs participating in the STAR+PLUS Program are required to adjust their physician fee schedules to reflect the physician rate increases funded through Legislative Appropriations during the 80th Regular Legislative Session. The HMOs are required to pass on all appropriated targeted physician rate increases to physicians serving their Members.

(b) The Medicaid Fee Schedule includes the legislatively-mandated physician rate increases based on the age of the Member, under 21 and over 21. The HMO must pay the appropriate rate for the age of the Member on the date of service.

Section 10.17 Bariatric Supplemental Payment.

Section 10.17 Modified by Version 1.3

(a) For dates of service on or after the Operational Start Date to August 31, 2011, STAR+PLUS HMOs will receive a Bariatric Supplemental Payment (BSP) from HHSC for each properly reported and documented bariatric surgery recorded under the group of procedure codes defined as allowable for bariatric reimbursement, as designated in the Texas Medicaid Providers Procedures Manual, including Texas Medicaid Bulletins. The amount of the one-time per surgery BSP payment is identified in the **HHSC Managed Care Contract**.

(1) HMO must submit a monthly BSP Report as described in **Attachment B-1, Section 8** to the **HHSC Managed Care Contract**, in the format and timeframe prescribed in **HHSC's Uniform Managed Care Manual**.

(2) HHSC will pay the Bariatric Supplemental Payment within twenty (20) Business Days after receipt of a complete and accurate report from the HMO.

(3) The HMO will not be entitled to Bariatric Supplemental Payments for surgeries that are not reported to HHSC within 210 days after the date of bariatric surgery, or within thirty (30) days from the date of discharge from the hospital for the stay related to the bariatric surgery, whichever is later. HHSC may grant an exception to this requirement, at its discretion, if the HMO is able to able to demonstrate that the medical service provider did not file a claim for payment to the HMO within the deadline described herein.

(4) HMO must maintain complete claims and adjudication disposition documentation, including paid and denied amounts for each bariatric surgery. The HMO must submit such documentation to HHSC within five (5) Business Days after receiving a written request from HHSC.

(b) For dates of service on or after September 1, 2011, STAR+PLUS HMOs will not receive BSPs for bariatric surgeries. Instead, effective September 1, 2011, all funding for bariatric surgeries will be included in the STAR+PLUS capitation rates.

Article 11. Disclosure & Confidentiality of Information

Section 11.01 Confidentiality.

(a) HMO and all Subcontractors, consultants, or agents under the Contract must treat all information that is obtained through performance of the Services under the Contract, including, but not limited to, information relating to applicants or recipients of HHSC Programs as Confidential Information to the extent that confidential treatment is provided under law and regulations.

(b) HMO is responsible for understanding the degree to which information obtained through performance of this Contract is confidential under State and Federal law, regulations, or administrative rules.

(c) HMO and all Subcontractors, consultants, or agents under the Contract may not use any information obtained through performance of this Contract in any manner except as is necessary for the proper discharge of obligations and securing of rights under the Contract.

(d) HMO must have a system in effect to protect all records and all other documents deemed confidential under this Contract maintained in connection with the activities funded under the Contract. Any disclosure or transfer of Confidential Information by HMO, including information required by HHSC, will be in accordance with applicable law. If the HMO receives a request for information deemed confidential under this Contract, the HMO will immediately notify HHSC of such request, and will make reasonable efforts to protect the information from public disclosure.

(e) In addition to the requirements expressly stated in this Section, HMO must comply with any policy, rule, or reasonable requirement of HHSC that relates to the safeguarding or disclosure of information relating to Members, HMO'S operations, or HMO's performance of the Contract.

(f) In the event of the expiration of the Contract or termination of the Contract for any reason, all Confidential Information disclosed to and all copies thereof made by the HMOI shall be returned to HHSC or, at HHSC's option, erased or destroyed. HMO shall provide HHSC certificates evidencing such destruction.

(g) The obligations in this Section shall not restrict any disclosure by the HMO pursuant to any applicable law, or by order of any court or government agency, provided that the HMO shall give prompt notice to HHSC of such order.

(h) With the exception of confidential Member information, Confidential Information shall not be afforded the protection of the Contract if such data was:

(1) Already known to the receiving Party without restrictions at the time of its disclosure by the furnishing Party;

(2) Independently developed by the receiving Party without reference to the furnishing Party's Confidential Information;

(3) Rightfully obtained by the other Party without restriction from a third party after its disclosure by the furnishing Party;

(4) Publicly available other than through the fault or negligence of the other Party; or

(5) Lawfully released without restriction to anyone.

Section 11.02 Disclosure of HHSC's Confidential Information.

(a) HMO will immediately report to HHSC any and all unauthorized disclosures or uses of HHSC's Confidential Information of which it or its Subcontractor(s), consultant(s), or agent(s) is aware or has knowledge. HMO acknowledges that any publication or disclosure of HHSC's Confidential Information to others may cause immediate and irreparable harm to HHSC and may constitute a violation of State or federal laws. If HMO, its Subcontractor(s), consultant(s), or agent(s) should publish or disclose such Confidential Information to others without authorization, HHSC will immediately be entitled to injunctive relief or any other remedies to which it is entitled under law or equity. HHSC will have the right to recover from HMO all damages and liabilities caused by or arising from HMO's, its Subcontractors', consultants', or agents' failure to protect HHSC's Confidential Information. HMO will defend with counsel approved by HHSC, indemnify and hold harmless HHSC from all damages, costs, liabilities, and expenses (including without limitation reasonable attorneys' fees and costs) caused by or arising from HMO's or its Subcontractors', consultants' or agents' failure to protect HHSC's Confidential Information. HHSC will not unreasonably withhold approval of counsel selected by the HMO.

(b) HMO will require its Subcontractor(s), consultant(s), and agent(s) to comply with the terms of this provision.

Section 11.03 Member Records

(a) HMO must comply with the requirements of state and federal laws, including the HIPAA requirements set forth in **Section 7.07**, regarding the transfer of Member Records.

(b) If at any time during the Contract Term this Contract is terminated, HHSC may require the transfer of Member Records, upon written notice to HMO, to another entity, as consistent with federal and state laws and applicable releases.

(c) The term "Member Record" for this Section means only those administrative, enrollment, case management and other such records maintained by HMO and is not intended to include patient records maintained by participating Network Providers.

Section 11.04 Requests for public information.

(a) HHSC agrees that it will promptly notify HMO of a request for disclosure of information filed in accordance with the Texas Public Information Act, Chapter 552 of the Texas Government Code, that consists of the HMO'S confidential information, including without limitation, information or data to which HMO has a proprietary or commercial interest. HHSC will deliver a copy of the request for public information to HMO.

(b) With respect to any information that is the subject of a request for disclosure, HMO is required to demonstrate to the Texas Office of Attorney General the specific reasons why the requested information is confidential or otherwise excepted from required public disclosure under law. HMO will provide HHSC with copies of all such communications.

(c) To the extent authorized under the Texas Public Information Act, HHSC agrees to safeguard from disclosure information received from HMO that the HMO believes to be confidential information. HMO must clearly mark such information as confidential information or provide written notice to HHSC that it considers the information confidential.

Section 11.05 Privileged Work Product.

(a) HMO acknowledges that HHSC asserts that privileged work product may be prepared in anticipation of litigation and that HMO is performing the Services with respect to privileged work product as an agent of HHSC, and that all matters related thereto are protected from disclosure by the Texas Rules of Civil Procedure, Texas Rules of Evidence, Federal Rules of Civil Procedure, or Federal Rules of Evidence.

(b) HHSC will notify HMO of any privileged work product to which HMO has or may have access. After the HMO is notified or otherwise becomes aware that such documents, data, database, or communications are privileged work product, only HMO personnel, for whom such access is necessary for the purposes of providing the Services, may have access to privileged work product.

(c) If HMO receives notice of any judicial or other proceeding seeking to obtain access to HHSC's privileged work product, HMO will:

(1) Immediately notify HHSC; and

(2) Use all reasonable efforts to resist providing such access.

(d) If HMO resists disclosure of HHSC's privileged work product in accordance with this Section, HHSC will, to the extent authorized under Civil Practices and Remedies Code or other applicable State law, have the right and duty to:

(1) represent HMO in such resistance;

(2) to retain counsel to represent HMO; or

(3) to reimburse HMO for reasonable attorneys' fees and expenses incurred in resisting such access.

(e) If a court of competent jurisdiction orders HMO to produce documents, disclose data, or otherwise breach the confidentiality obligations imposed in the Contract, or otherwise with respect to maintaining the confidentiality, proprietary nature, and secrecy of privileged work product, HMO will not be liable for breach of such obligation.

Section 11.06 Unauthorized acts.

Each Party agrees to:

(1) Notify the other Party promptly of any unauthorized possession, use, or knowledge, or attempt thereof, by any person or entity that may become known to it, of any HHSC Confidential Information or any information identified by the HMO as confidential or proprietary;

(2) Promptly furnish to the other Party full details of the unauthorized possession, use, or knowledge, or attempt thereof, and use reasonable efforts to assist the other Party in investigating or preventing the reoccurrence of any unauthorized possession, use, or knowledge, or attempt thereof, of Confidential Information;

(3) Cooperate with the other Party in any litigation and investigation against third Parties deemed necessary by such Party to protect its proprietary rights; and

(4) Promptly prevent a reoccurrence of any such unauthorized possession, use, or knowledge such information.

Section 11.07 Legal action.

Neither party may commence any legal action or proceeding in respect to any unauthorized possession, use, or knowledge, or attempt thereof by any person or entity of HHSC's Confidential Information or information identified by the HMO as confidential or proprietary, which action or proceeding identifies the other Party information without such Party's consent.

Section 11.08 Information Security

Section 11.08 added by Version 1.3

The HMO and all Subcontractors, consultants, or agents–must comply with all applicable laws, rules, and regulations regarding information security, including without limitation the following:

(1) Health and Human Services Enterprise Information Security Standards and Guidelines;-

(2) Title 1, Sections 202.1 and 202.3 through 202.28, Texas Administrative Code;

(3) The Health Insurance Portability and Accountability Act of 1996 (HIPAA); and

(4) The Health Information Technology for Economic and Clinical Health Act (HITECH Act).

Article 12. Remedies & Disputes

Section 12.01 Understanding and expectations.

The remedies described in this Section are directed to HMO's timely and responsive performance of the Services and production of Deliverables, and the creation of a flexible and responsive relationship between the Parties. The HMO is expected to meet or exceed all HHSC objectives and standards, as set forth in the Contract. All areas of responsibility and all Contract requirements will be subject to performance evaluation by HHSC. Performance reviews may be conducted at the discretion of HHSC at any time and may relate to any responsibility and/or requirement. Any and all responsibilities and/or requirements not fulfilled may be subject to remedies set forth in the Contract.

Section 12.02 Tailored remedies.

Section 12.02 modified by Version 1.3

(a) Understanding of the Parties.

HMO agrees and understands that HHSC may pursue tailored contractual remedies for noncompliance with the Contract. At any time and at its discretion, HHSC may impose or pursue one or more remedies for each item of noncompliance and will determine remedies on a case-by-case basis. HHSC's pursuit or non-pursuit of a tailored remedy does not constitute a waiver of any other remedy that HHSC may have at law or equity.

(b) Notice and opportunity to cure for non-material breach.

(1) HHSC will notify HMO in writing of specific areas of HMO performance that fail to meet performance expectations, standards, or schedules set forth in the Contract, but that, in the determination of HHSC, do not result in a material deficiency or delay in the implementation or operation of the Services.

(2) HMO will, within five (5) Business Days (or another date approved by HHSC) of receipt of written notice of a non-material deficiency, provide the HHSC Project Manager a written response that:

(i) Explains the reasons for the deficiency, HMO's plan to address or cure the deficiency, and the date and time by which the deficiency will be cured; or

(ii) If HMO disagrees with HHSC's findings, its reasons for disagreeing with HHSC's findings.

(3) HMO's proposed cure of a non-material deficiency is subject to the approval of HHSC. HMO's repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by HHSC as a material deficiency and entitle HHSC to pursue any other remedy provided in the Contract or any

other appropriate remedy HHSC may have at law or equity.

(c) Corrective action plan.

(1) At its option, HHSC may require HMO to submit to HHSC a written plan (the "Corrective Action Plan") to correct or resolve a material breach of this Contract, as determined by HHSC.

(2) The Corrective Action Plan must provide:

(i) A detailed explanation of the reasons for the cited deficiency;

(ii) HMO's assessment or diagnosis of the cause; and

(iii) A specific proposal to cure or resolve the deficiency.

(3) The Corrective Action Plan must be submitted by the deadline set forth in HHSC's request for a Corrective Action Plan. The Corrective Action Plan is subject to approval by HHSC, which will not unreasonably be withheld.

(4) HHSC will notify HMO in writing of HHSC's final disposition of HHSC's concerns. If HHSC accepts HMO's proposed Corrective Action Plan, HHSC may:

(i) Condition such approval on completion of tasks in the order or priority that HHSC may reasonably prescribe;

(ii) Disapprove portions of HMO's proposed Corrective Action Plan; or

(iii) Require additional or different corrective action(s).

Notwithstanding the submission and acceptance of a Corrective Action Plan, HMO remains responsible for achieving all written performance criteria.

(5) HHSC's acceptance of a Corrective Action Plan under this Section will not:

(i) Excuse HMO's prior substandard performance;

(ii) Relieve HMO of its duty to comply with performance standards; or

(iii) Prohibit HHSC from assessing additional tailored remedies or pursuing other appropriate remedies for continued substandard performance.

(d) Administrative remedies.

(1) At its discretion, HHSC may impose one or more of the following remedies for each item of material noncompliance and will determine the scope and severity of the remedy on a case-by-case basis:

(i) Assess liquidated damages in accordance with **Attachment B-5** to the **HHSC Managed Care Contract**, "Liquidated Damages Matrix;"

(ii) Conduct accelerated monitoring of the HMO. Accelerated monitoring includes more frequent or more extensive monitoring by HHSC or its agent;

(iii) Require additional, more detailed, financial and/or programmatic reports to be submitted by HMO;

(iv) Decline to renew or extend the Contract;

(v) Appoint temporary management under the circumstances described in 42 C.F.R. §438.706;

(vi) Initiate disenrollment of a Member or Members;

(vii) Suspend enrollment of Members;

(viii) Withhold or recoup payment to HMO;

(ix) Require forfeiture of all or part of the HMO's bond; or

(x) Terminate the Contract in accordance with **Section 12.03**, ("Termination by HHSC").

(2) For purposes of the Contract, an item of material noncompliance means a specific action of HMO that:

(i) Violates a material provision of the Contract;

(ii) Fails to meet an agreed measure of performance; or

(iii) Represents a failure of HMO to be reasonably responsive to a reasonable request of HHSC relating to the Services for information, assistance, or support within the timeframe specified by HHSC.

(3) HHSC will provide notice to HMO of the imposition of an administrative remedy in accordance with this Section, with the exception of accelerated monitoring, which may be unannounced. HHSC may require HMO to file a written response in accordance with this Section.

(4) The Parties agree that a State or Federal statute, rule, regulation, or Federal guideline will prevail over the provisions of this Section unless the statute, rule, regulation, or guidelines can be read together with this Section to give effect to both.

(e) Damages.

(1) HHSC will be entitled to actual and consequential damages resulting from the HMO'S failure to comply with any of the terms of the Contract. In some cases, the actual damage to HHSC or State of Texas as a result of HMO'S failure to meet any aspect of the responsibilities of the Contract and/or to meet specific performance

standards set forth in the Contract are difficult or impossible to determine with precise accuracy. Therefore, liquidated damages will be assessed in writing against and paid by the HMO in accordance with and for failure to meet any aspect of the responsibilities of the Contract and/or to meet the specific performance standards identified by the HHSC in **Attachment B-5 to the HHSC Managed Care Contract, "**Deliverables/Liquidated Damages Matrix." Liquidated damages will be assessed if HHSC determines such failure is the fault of the HMO (including the HMO'S Subcontractors and/or consultants) and is not materially caused or contributed to by HHSC or its agents. If at any time, HHSC determines the HMO has not met any aspect of the responsibilities of the Contract and/or the specific performance standards due to mitigating circumstances, HHSC reserves the right to waive all or part of the liquidated damages. All such waivers must be in writing, contain the reasons for the waiver, and be signed by the appropriate executive of HHSC.

(2) The liquidated damages prescribed in this Section are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of HHSC's projected financial loss and damage resulting from the HMO's nonperformance, including financial loss as a result of project delays. Accordingly, in the event HMO fails to perform in accordance with the Contract, HHSC may assess liquidated damages as provided in this Section.

(3) If HMO fails to perform any of the Services described in the Contract, HHSC may assess liquidated damages for each occurrence of a liquidated damages event, to the extent consistent with HHSC's tailored approach to remedies and Texas law.

(4) HHSC may elect to collect liquidated damages:

(i) Through direct assessment and demand for payment delivered to HMO; or

(ii) By deduction of amounts assessed as liquidated damages as set-off against payments then due to HMO or that become due at any time after assessment of the liquidated damages. HHSC will make deductions until the full amount payable by the HMO is received by HHSC.

(f) Equitable Remedies

(1) HMO acknowledges that, if HMO breaches (or attempts or threatens to breach) its material obligation under this Contract, HHSC may be irreparably harmed. In such a circumstance, HHSC may proceed directly to court to pursue equitable remedies.

(2) If a court of competent jurisdiction finds that HMO breached (or attempted or threatened to breach) any such obligations, HMO agrees that without any additional findings of irreparable injury or other conditions to injunctive relief, it will not oppose the entry of an appropriate order compelling performance by HMO and restraining it from any further breaches (or attempted or threatened breaches).

(g) Suspension of Contract

(1) HHSC may suspend performance of all or any part of the Contract if:

(i) HHSC determines that HMO has committed a material breach of the Contract;

(ii) HHSC has reason to believe that HMO has committed, assisted in the commission of Fraud, Abuse, Waste, malfeasance, misfeasance, or nonfeasance by any party concerning the Contract;

(iii) HHSC determines that the HMO knew, or should have known of, Fraud, Abuse, Waste, malfeasance, or nonfeasance by any party concerning the Contract, and the HMO failed to take appropriate action; or

(iv) HHSC determines that suspension of the Contract in whole or in part is in the best interests of the State of Texas or the HHSC Programs.

(2) HHSC will notify HMO in writing of its intention to suspend the Contract in whole or in part. Such notice will:

(i) Be delivered in writing to HMO;

(ii) Include a concise description of the facts or matter leading to HHSC's decision; and

(iii) Unless HHSC is suspending the contract for convenience, request a Corrective Action Plan from HMO or describe actions that HMO may take to avoid the contemplated suspension of the Contract.

Section 12.03 Termination by HHSC.

Section 12.03 Modified by Version 1.5

This Contract will terminate upon the Expiration Date. In addition, prior to completion of the Contract Term, all or a part of this Contract may be terminated for any of the following reasons:

(a) Termination in the best interest of HHSC.

HHSC may terminate the Contract without cause at any time when, in its sole discretion, HHSC determines that termination is in the best interests of the State of Texas. HHSC will provide reasonable advance written notice of the termination, as it deems appropriate under the circumstances. The termination will be effective on the date specified in HHSC's notice of termination.

(b) Termination for cause.

HHSC reserves the right to terminate this Contract, in whole or in part, upon the following conditions:

(1) *Assignment for the benefit of creditors, appointment of receiver, or inability to pay debts*.

HHSC may terminate this Contract at any time if HMO:

(i) Makes an assignment for the benefit of its creditors;

(ii) Admits in writing its inability to pay its debts generally as they become due; or

(iii) Consents to the appointment of a receiver, trustee, or liquidator of HMO or of all or any part of its property.

(2) *Failure to adhere to laws, rules, ordinances, or orders.*

HHSC may terminate this Contract if a court of competent jurisdiction finds HMO failed to adhere to any laws, ordinances, rules, regulations or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of HMO's duties under this Contract. HHSC will provide at least thirty (30) days advance written notice of such termination.

(3) *Breach of confidentiality*.

HHSC may terminate this Contract at any time if HMO breaches confidentiality laws with respect to the Services and Deliverables provided under this Contract.

(4) *Failure to maintain adequate personnel or resources.*

HHSC may terminate this Contract if, after providing notice and an opportunity to correct, HHSC determines that HMO has failed to supply personnel or resources and such failure results in HMO's inability to fulfill its duties under this Contract. HHSC will provide at least thirty (30) days advance written notice of such termination.

(5) *Termination for gifts and gratuities*.

(i) HHSC may terminate this Contract at any time following the determination by a competent judicial or quasi-judicial authority and HMO's exhaustion of all legal remedies that HMO, its employees, agents or representatives have either offered or given any thing of value to an officer or employee of HHSC or the State of Texas in violation of state law.

(ii) HMO must include a similar provision in each of its Subcontracts and shall enforce this provision against a Subcontractor who has offered or given any thing of value to any of the persons or entities described in this Section, whether or not the offer or gift was in HMO's behalf.

(iii) Termination of a Subcontract by HMO pursuant to this provision will not be a cause for termination of the Contract unless:

(a) HMO fails to replace such terminated Subcontractor within a reasonable time; and

(b) Such failure constitutes cause, as described in this Subsection 12.03(b).

(iv) For purposes of this Section, a "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment, and charitable contributions. The term does not include contributions to holders of public office or candidates for public office that are paid and reported in accordance with State and/or Federal law.

(6) *Termination for non-appropriation of funds*.

Notwithstanding any other provision of this Contract, if funds for the continued fulfillment of this Contract by HHSC are at any time not forthcoming or are insufficient, through failure of any entity to appropriate funds or otherwise, then HHSC will have the right to terminate this Contract at no additional cost and with no penalty whatsoever by giving prior written notice documenting the lack of funding. HHSC will provide at least thirty (30) days advance written notice of such termination. HHSC will use reasonable efforts to ensure appropriated funds are available.

(7) *Judgment and execution.*

(i) HHSC may terminate the Contract at any time if judgment for the payment of money in excess of $500,000.00 that is not covered by insurance, is rendered by any court or governmental body against HMO, and HMO does not:

(a) Discharge the judgment or provide for its discharge in accordance with the terms of the judgment;

(b) Procure a stay of execution of the judgment within thirty (30) days from the date of entry thereof; or

(c) Perfect an appeal of such judgment and cause the execution of such judgment to be stayed during the appeal, providing such financial reserves as may be required under generally accepted accounting principles.

(ii) If a writ or warrant of attachment or any similar process is issued by any court against all or any material portion of the

property of HMO, and such writ or warrant of attachment or any similar process is not released or bonded within thirty (30) days after its entry, HHSC may terminate the Contract in accordance with this Section.

(8) Termination for insolvency.

(i) HHSC may terminate the Contract at any time if HMO:

(a) Files for bankruptcy;

(b) Becomes or is declared insolvent, or is the subject of any proceedings related to its liquidation, insolvency, or the appointment of a receiver or similar officer for it;

(c) Makes an assignment for the benefit of all or substantially all of its creditors; or

(d) Enters into a Contract for the composition, extension, or readjustment of substantially all of its obligations.

(ii) HMO agrees to pay for all reasonable expenses of HHSC including the cost of counsel, incident to:

(a) The enforcement of payment of all obligations of the HMO by any action or participation in, or in connection with a case or proceeding under Chapters 7, 11, or 13 of the United States Bankruptcy Code, or any successor statute;

(b) A case or proceeding involving a receiver or other similar officer duly appointed to handle the HMO's business; or

(c) A case or proceeding in a State court initiated by HHSC when previous collection attempts have been unsuccessful.

(9) Termination for HMO'S material breach of the Contract.

HHSC will have the right to terminate the Contract in whole or in part if HHSC determines, at its sole discretion, that HMO has materially breached the Contract. HHSC will provide at least thirty (30) days advance written notice of such termination.

(10) *Termination for Criminal Conviction*

HHSC will have the right to terminate the Contract in whole or in part, or require the replacement of a Material Subcontractor, if the HMO or a Material Subcontractor is convicted of a criminal offense in a state or federal court:

(i) Related to the delivery of an item or service;

(ii) Related to the neglect or abuse of patients in connection with the delivery of an item or service;

(iii) Consisting of a felony related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct, or

(iv) Resulting in a penalty or fine in the amount of $500,000 or more in a state or federal administrative proceeding.

Section 12.04 Termination by HMO.

(a) Failure to pay.

HMO may terminate this Contract if HHSC fails to pay the HMO undisputed charges when due as required under this Contract. Retaining premium, recoupment, sanctions, or penalties that are allowed under this Contract or that result from the HMO's failure to perform or the HMO's default under the terms of this Contract is not cause for termination. Termination for failure to pay does not release HHSC from the obligation to pay undisputed charges for services provided prior to the termination date.

If HHSC fails to pay undisputed charges when due, then the HMO may submit a notice of intent to terminate for failure to pay in accordance with the requirements of **Subsection 12.04(d)**. If HHSC pays all undisputed amounts then due within thirty (30)-days after receiving the notice of intent to terminate, the HMO cannot proceed with termination of the Contract under this Article.

(b) Change to HHSC Uniform Managed Care Manual.

HMO may terminate this agreement if the Parties are unable to resolve a dispute concerning a material and substantive change to the HHSC Uniform Managed Care Manual (a change that materially and substantively alters the HMO's ability to fulfill its obligations under the Contract). HMO must submit a notice of intent to terminate due to a material and substantive change in the HHSC Uniform Managed Care Manual no later than thirty (30) days after the effective date of the policy change. HHSC will not enforce the policy change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(c) Change to Capitation Rate.

If HHSC proposes an initial Capitation Rate or a modification to the Capitation Rate that is unacceptable to the HMO, the HMO may terminate the Contract. HMO must submit a written notice of intent to terminate due to a change in the Capitation Rate no later than thirty (30) days after HHSC's notice of the proposed change. HHSC will not enforce the rate change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(d) Notice of intent to terminate.

In order to terminate the Contract pursuant to this Section, HMO must give HHSC at least ninety (90) days written notice of intent to terminate. The termination date will be calculated as the last day of the month following ninety (90) days from the date the notice of intent to terminate is received by HHSC.

Section 12.05 Termination by mutual agreement.

This Contract may be terminated by mutual written agreement of the Parties.

Section 12.06 Effective date of termination.

Except as otherwise provided in this Contract, termination will be effective as of the date specified in the notice of termination.

Section 12.07 Extension of termination effective date.

The Parties may extend the effective date of termination one or more times by mutual written agreement.

Section 12.08 Payment and other provisions at Contract termination.

(a) In the event of termination pursuant to this Article, HHSC will pay the Capitation Payment for Services and Deliverables rendered through the effective date of termination. All pertinent provisions of the Contract will form the basis of settlement.

(b) HMO must provide HHSC all reasonable access to records, facilities, and documentation as is required to efficiently and expeditiously close out the Services and Deliverables provided under this Contract.

(c) HMO must prepare a Turnover Plan, which is acceptable to and approved by HHSC. The Turnover Plan will be implemented during the time period between receipt of notice and the termination date.

Section 12.09 Modification of Contract in the event of remedies.

HHSC may propose a modification of this Contract in response to the imposition of a remedy under this Article. Any modifications under this Section must be reasonable, limited to the matters causing the exercise of a remedy, in writing, and executed in accordance with **Article 8**. HMO must negotiate such proposed modifications in good faith.

Section 12.10 Turnover assistance.

Upon receipt of notice of termination of the Contract by HHSC, HMO will provide any turnover assistance reasonably necessary to enable HHSC or its designee to effectively close out the Contract and move the work to another vendor or to perform the work itself.

Section 12.11 Rights upon termination or expiration of Contract.

In the event that the Contract is terminated for any reason, or upon its expiration, HHSC will, at HHSC's discretion, retain ownership of any and all associated work products, Deliverables and/or documentation in whatever form that they exist.

Section 12.12 HMO responsibility for associated costs.

If HHSC terminates the Contract for Cause, the HMO will be responsible to HHSC for all reasonable costs incurred by HHSC, the State of Texas, or any of its administrative agencies to replace the HMO. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation that is reasonably attributable to HMO's failure to perform any Service in accordance with the terms of the Contract

Section 12.13 Dispute resolution.

(a) General agreement of the Parties.

The Parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the Parties employ all reasonable and informal means to resolve any dispute under this Contract. The Parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

(b) Duty to negotiate in good faith.

Any dispute that in the judgment of any Party to this Contract may materially or substantially affect the performance of any Party will be reduced to writing and delivered to the other Party. The Parties must then negotiate in good faith and use every reasonable effort to resolve such dispute and the Parties shall not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible. The resolution of any dispute disposed of by Contract between the Parties shall be reduced to writing and delivered to all Parties within ten (10) Business Days.

(c) Claims for breach of Contract.

(1) *General requirement.* HMO's claim for breach of this Contract will be resolved in accordance with the dispute resolution process established by HHSC in accordance with Chapter 2260, Texas Government Code.

(2) *Negotiation of claims*. The Parties expressly agree that the HMO's claim for breach of this Contract that the Parties cannot resolve in the ordinary course of business or through the use of all reasonable and informal means will be submitted to the negotiation process provided in Chapter 2260, Subchapter B, Texas Government Code.

(i) To initiate the process, HMO must submit written notice to HHSC that specifically states that HMO invokes the provisions of Chapter 2260, Subchapter B, Texas Government Code. The notice must comply with the requirements of Title 1, Chapter 392, Subchapter B of the Texas Administrative Code.

(ii) The Parties expressly agree that the HMO's compliance with Chapter 2260, Subchapter B, Texas Government Code, will be a condition precedent to the filing of a contested case proceeding under Chapter 2260, Subchapter C, of the Texas Government Code.

(3) *Contested case proceedings*. The contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be HMO's sole and exclusive process for seeking a remedy for any and all alleged breaches of contract by HHSC if the Parties are unable to resolve their disputes under Subsection (c)(2) of this Section.

The Parties expressly agree that compliance with the contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be a condition precedent to seeking consent to sue from the Texas Legislature under Chapter 107, Civil Practices & Remedies Code. Neither the execution of this Contract by HHSC nor any other conduct of any representative of HHSC relating to this Contract shall be considered a waiver of HHSC's sovereign immunity to suit.

(4) *HHSC rules.* The submission, processing and resolution of HMO's claim is governed by the rules adopted by HHSC pursuant to Chapter 2260, Texas Government Code, found at Title 1, Chapter 392, Subchapter B of the Texas Administrative Code.

(5) *HMO's duty to perform.* Neither the occurrence of an event constituting an alleged breach of contract nor the pending status of any claim for breach of contract is grounds for the suspension of performance, in whole or in part, by HMO of any duty or obligation with respect to the performance of this Contract. Any changes to the Contract as a result of a dispute resolution will be implemented in accordance with **Article 8** ("Amendments and Modifications").

Section 12.14 Liability of HMO.

(a) HMO bears all risk of loss or damage to HHSC or the State due to:

(1) Defects in Services or Deliverables;

(2) Unfitness or obsolescence of Services or Deliverables; or

(3) The negligence or intentional misconduct of HMO or its employees, agents, Subcontractors, or representatives.

(b) HMO must, at the HMO's own expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC and State employees, officers, directors, contractors and agents from and against any losses, liabilities, damages, penalties, costs, fees, including without limitation reasonable attorneys' fees, and expenses from any claim or action for property damage, bodily injury or death, to the extent caused by or arising from the negligence or intentional misconduct of the HMO and its employees, officers, agents, or Subcontractors. HHSC will not unreasonably withhold approval of counsel selected by HMO.

(c) HMO will not be liable to HHSC for any loss, damages or liabilities attributable to or arising from the failure of HHSC or any state agency to perform a service or activity in connection with this Contract.

Section 12.15 Pre-termination Process.

Section 12.15 Added by Version 1.2

The following process will apply when HHSC terminates the Agreement for any reason set forth in Section 12.03(b), "Termination for Cause," other than Subpart 6, "Termination for Non-appropriation of Funds." HHSC will provide the HMO with reasonable advance written notice of the proposed termination, as it deems appropriate under the circumstances. The notice will include the reason for the proposed termination, the proposed effective date of the termination, and the time and place where the parties will meet regarding the proposed termination. During this meeting, the HMO may present written information explaining why HHSC should not affirm the proposed termination. HHSC's Associate Commissioner for Medicaid and CHIP will consider the written information, if any, and will provide the HMO with a written notice of HHSC's final decision affirming or reversing the termination. An affirming decision will include the effective date of termination.

The pre-termination process described herein will not limit or otherwise reduce the parties' rights and responsibilities under Section 12.13, "Dispute Resolution;" however, HHSC's final decision to terminate is binding and is not subject to review by the State Office of Administrative Hearings under Chapter 2260, Texas Government Code.

Article 13. Assurances & Certifications

Section 13.01 Proposal certifications.

HMO acknowledges its continuing obligation to comply with the requirements of the following certifications contained in its Proposal, and will immediately notify HHSC of any changes in circumstances affecting these certifications:

(1) Federal lobbying;

(2) Debarment and suspension;

(3) Child support; and

(4) Nondisclosure statement.

Section 13.02 Conflicts of interest.

(a) Representation.

HMO agrees to comply with applicable state and federal laws, rules, and regulations regarding conflicts of interest in the performance of its duties under this Contract. HMO warrants that it has no interest and will not acquire any direct or indirect interest that would conflict in any manner or degree with its performance under this Contract.

(b) General duty regarding conflicts of interest.

HMO will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain. HMO will operate with complete independence and objectivity without actual, potential or apparent conflict of interest with respect to the activities conducted under this Contract with the State of Texas.

Section 13.03 Organizational conflicts of interest.

(a) Definition.

An organizational conflict of interest is a set of facts or circumstances, a relationship, or other situation under which a HMO, or a Subcontractor has past, present, or currently planned personal or financial activities or interests that either directly or indirectly:

(1) Impairs or diminishes the HMO's, or Subcontractor's ability to render impartial or objective assistance or advice to HHSC; or

(2) Provides the HMO or Subcontractor an unfair competitive advantage in future HHSC procurements (excluding the award of this Contract).

(b) Warranty.

Except as otherwise disclosed and approved by HHSC prior to the Effective Date of the Contract, HMO warrants that, as of the Effective Date and to the best of its knowledge and belief, there are no relevant facts or circumstances that could give rise to an organizational conflict of interest affecting this Contract. HMO affirms that it has neither given, nor intends to give, at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, at any time during the procurement process or in connection with the procurement process except as allowed under relevant state and federal law.

(c) Continuing duty to disclose.

(1) HMO agrees that, if after the Effective Date, HMO discovers or is made aware of an organizational conflict of interest, HMO will immediately and fully disclose such interest in writing to the HHSC project manager. In addition, HMO must promptly disclose any relationship that might be perceived or represented as a conflict after its discovery by HMO or by HHSC as a potential conflict. HHSC reserves the right to make a final determination regarding the existence of conflicts of interest, and HMO agrees to abide by HHSC's decision.

(2) The disclosure will include a description of the action(s) that HMO has taken or proposes to take to avoid or mitigate such conflicts.

(d) Remedy.

If HHSC determines that an organizational conflict of interest exists, HHSC may, at its discretion, terminate the Contract pursuant to **Subsection 12.03(b)(9).** If HHSC determines that HMO was aware of an organizational conflict of interest before the award of this Contract and did not disclose the conflict to the contracting officer, such nondisclosure will be considered a material breach of the Contract. Furthermore, such breach may be submitted to the Office of the Attorney General, Texas Ethics Commission, or appropriate State or Federal law enforcement officials for further action.

(e) Flow down obligation.

HMO must include the provisions of this Section in all Subcontracts for work to be performed similar to the service provided by HMO, and the terms "Contract," "HMO," and "project manager" modified appropriately to preserve the State's rights.

Section 13.04 HHSC personnel recruitment prohibition.

HMO has not retained or promised to retain any person or company, or utilized or promised to utilize a consultant that participated in HHSC's development of specific criteria of the RFP or who participated in the selection of the HMO for this Contract.

Unless authorized in writing by HHSC, HMO will not recruit or employ any HHSC professional or technical personnel who have worked on projects relating to the subject matter of this Contract, or who have had any influence on decisions affecting the subject matter of this Contract, for two (2) years following the completion of this Contract.

Section 13.05 Anti-kickback provision.

HMO certifies that it will comply with the Anti-Kickback Act of 1986, 41 U.S.C. §51-58 and Federal Acquisition Regulation 52.203-7, to the extent applicable.

Section 13.06 Debt or back taxes owed to State of Texas.

In accordance with Section 403.055 of the Texas Government Code, HMO agrees that any payments due to HMO under the Contract will be first applied toward any debt and/or back taxes HMO owes State of Texas. HMO further agrees that payments will be so applied until such debts and back taxes are paid in full.

Section 13.07 Certification regarding status of license, certificate, or permit.

Article IX, Section 163 of the General Appropriations Act for the 1998/1999 state fiscal biennium prohibits an agency that receives an appropriation under either Article II or V of the General Appropriations Act from awarding a contract with the owner, operator, or administrator of a facility that has had a license, certificate, or permit revoked by another Article II or V agency. HMO certifies it is not ineligible for an award under this provision.

Section 13.08 Outstanding debts and judgments.

HMO certifies that it is not presently indebted to the State of Texas, and that HMO is not subject to an outstanding judgment in a suit by State of Texas against HMO for collection of the balance. For purposes of this Section, an indebtedness is any amount sum of money that is due and owing to the State of Texas and is not currently under dispute. A false statement regarding HMO's status will be treated as a material breach of this Contract and may be grounds for termination at the option of HHSC.

Article 14. Representations & Warranties

Section 14.01 Authorization.

(a) The execution, delivery and performance of this Contract has been duly authorized by HMO and no additional approval, authorization or consent of any governmental or regulatory agency is required to be obtained in order for HMO to enter into this Contract and perform its obligations under this Contract.

(b) HMO has obtained all licenses, certifications, permits, and authorizations necessary to perform the Services under this Contract and currently is in good standing with all regulatory agencies that regulate any or all aspects of HMO's performance of this Contract. HMO will maintain all required certifications, licenses, permits, and authorizations during the term of this Contract.

Section 14.02 Ability to perform.

HMO warrants that it has the financial resources to fund the capital expenditures required under the Contract without advances by HHSC or assignment of any payments by HHSC to a financing source.

Section 14.03 Minimum Net Worth.

The HMO has, and will maintain throughout the life of this Contract, minimum net worth to the greater of (a) $1,500,000; (b) an amount equal to the sum of twenty-five dollars ($25) times the number of all enrollees including Members; or (c) an amount that complies with standards adopted by TDI. Minimum net worth means the excess total admitted assets over total liabilities, excluding liability for subordinated debt issued in compliance with Chapter 843 of the Texas Insurance Code.

Section 14.04 Insurer solvency.

(a) The HMO must be and remain in full compliance with all applicable state and federal solvency requirements for basic-service health maintenance organizations, including but not limited to, all reserve requirements, net worth standards, debt-to-equity ratios, or other debt limitations. In the event the HMO fails to maintain such compliance, HHSC, without limiting any other rights it may have by law or under the Contract, may terminate the Contract.

(b) If the HMO becomes aware of any impending changes to its financial or business structure that could adversely impact its compliance with the requirements of the Contract or its ability to pay its debts as they come due, the HMO must notify HHSC immediately in writing.

(c) The HMO must have a plan and take appropriate measures to ensure adequate provision against the risk of insolvency as required by TDI. Such provision must be adequate to provide for the following in the event of insolvency:

(1) continuation of Covered Services, until the time of discharge, to Members who are confined on the date of insolvency in a hospital or other inpatient facility;

(2) payments to unaffiliated health care providers and affiliated healthcare providers whose Contracts do not contain Member "hold harmless" clauses acceptable to the TDI;

(3) continuation of Covered Services for the duration of the Contract Period for which a capitation has been paid for a Member;

(4) provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI and the Contract.

Should TDI determine that there is an immediate risk of insolvency or the HMO is unable to provide Covered Services to its Members, HHSC, without limiting any other rights it may have by law, or under the Contract, may terminate the Contract.

Section 14.05 Workmanship and performance.

(a) All Services and Deliverables provided under this Contract will be provided in a manner consistent with the standards of quality and integrity as outlined in the Contract.

(b) All Services and Deliverables must meet or exceed the required levels of performance specified in or pursuant to this Contract.

(c) HMO will perform the Services and provide the Deliverables in a workmanlike manner, in accordance with best practices and high professional standards used in well-managed operations performing services similar to the services described in this Contract.

Section 14.06 Warranty of deliverables.

HMO warrants that Deliverables developed and delivered under this Contract will meet in all material respects the specifications as described in the Contract during the period following its acceptance by HHSC, through the term of the Contract, including any subsequently negotiated by HMO and HHSC. HMO will promptly repair or replace any such Deliverables not in compliance with this warranty at no charge to HHSC.

Section 14.07 Compliance with Contract.

HMO will not take any action substantially or materially inconsistent with any of the terms and conditions set forth in this Contract without the express written approval of HHSC.

Section 14.08 Technology Access

(a) HMO expressly acknowledges that State funds may not be expended in connection with the purchase of an automated information system unless that system meets certain statutory requirements relating to accessibility by persons with visual impairments. Accordingly, HMO represents and warrants to HHSC that this technology is capable, either by virtue of features included within the technology or because it is readily adaptable by use with other technology, of:

(1) Providing equivalent access for effective use by both visual and non-visual means;

(2) Presenting information, including prompts used for interactive communications, in formats intended for non-visual use; and

(3) Being integrated into networks for obtaining, retrieving, and disseminating information used by individuals who are not blind or visually impaired.

(b) For purposes of this Section, the phrase "equivalent access" means a substantially similar ability to communicate with or make use of the technology, either directly by features incorporated within the technology or by other reasonable means such as assistive devices or services that would constitute reasonable accommodations under the Americans with Disabilities Act or similar State or Federal laws. Examples of methods by which equivalent access may be provided include, but are not limited to, keyboard alternatives to mouse commands and other means of navigating graphical displays, and customizable display appearance.

(c) In addition, all technological solutions offered by the HMO must comply with the requirements of Texas Government Code §531.0162. This includes, but is not limited to providing technological solutions that meet federal accessibility standards for persons with disabilities, as applicable.

Article 15. Intellectual Property

Section 15.01 Infringement and misappropriation.

(a) HMO warrants that all Deliverables provided by HMO will not infringe or misappropriate any right of, and will be free of any claim of, any third person or entity based on copyright, patent, trade secret, or other intellectual property rights.

(b) HMO will, at its expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC, its employees, officers, directors, contractors, and agents from and against any losses, liabilities, damages, penalties, costs, fees, including without limitation reasonable attorneys' fees and expenses, from any claim or action against HHSC that is based on a claim of breach of the warranty set forth in the preceding paragraph. HHSC will promptly notify HMO in writing of the claim, provide HMO a copy of all information received by HHSC with respect to the claim, and cooperate with HMO in defending or settling the claim. HHSC will not unreasonably withhold, delay or condition approval of counsel selected by the HMO.

(c) In case the Deliverables, or any one or part thereof, is in such action held to constitute an infringement or misappropriation, or the use thereof is enjoined or restricted or if a proceeding appears to HMO to be likely to be brought, HMO will, at its own expense, either:

(1) Procure for HHSC the right to continue using the Deliverables; or

(2) Modify or replace the Deliverables to comply with the Specifications and to not violate any intellectual property rights.

If neither of the alternatives set forth in (1) or (2) above are available to the HMO on commercially reasonable terms, HMO may require that HHSC return the allegedly infringing Deliverable(s) in which case HMO will refund all amounts paid for all such Deliverables.

Section 15.02 Exceptions.

HMO is not responsible for any claimed breaches of the warranties set forth in Section 15.01 to the extent caused by:

(a) Modifications made to the item in question by anyone other than HMO or its Subcontractors, or modifications made by HHSC or its contractors working at HMO's direction or in accordance with the specifications; or

(b) The combination, operation, or use of the item with other items if HMO did not supply or approve for use with the item; or

(c) HHSC's failure to use any new or corrected versions of the item made available by HMO.

Section 15.03 Ownership and Licenses

(a) Definitions.

For purposes of this Section 15.03, the following terms have the meanings set forth below:

(1) "**Custom Software**" means any software developed by the HMO: for HHSC; in connection with the Contract; and with funds received from HHSC. The term does not include HMO Proprietary Software or Third Party Software.

(2) "**HMO Proprietary Software**" means software: (i) developed by the HMO prior to the Effective Date of the Contract, or (ii) software developed by the HMO after the Effective Date of the Contract that is not developed: for HHSC; in connection with the Contract; and with funds received from HHSC.

(3) "**Third Party Software**" means software that is: developed for general commercial use; available to the public; or not developed for HHSC. Third Party Software includes without limitation: commercial off-the-shelf software; operating system software; and application software, tools, and utilities.

(b) Deliverables.

The Parties agree that any Deliverable, including without limitation the Custom Software, will be the exclusive property of HHSC.

(c) Ownership rights.

(1) HHSC will own all right, title, and interest in and to its Confidential Information and the Deliverables provided by the HMO, including without limitation the Custom Software and associated documentation. For purposes of this Section 15.03, the Deliverables will not include HMO Proprietary Software or Third Party Software. HMO will take all actions necessary and transfer ownership of the Deliverables to HHSC, including, without limitation, the Custom Software and associated documentation prior to Contract termination.

(2) HMO will furnish such Deliverables, upon request of HHSC, in accordance with applicable State law. All Deliverables, in whole and in part, will be deemed works made for hire of HHSC for all purposes of copyright law, and copyright will belong solely to HHSC. To the extent that any such Deliverable does not qualify as a work for hire under applicable law, and to the extent that the Deliverable includes materials subject to copyright, patent, trade secret, or other proprietary right protection, HMO agrees to assign, and hereby assigns, all right, title, and interest in and to Deliverables, including without limitation all copyrights, inventions, patents, trade secrets, and other proprietary rights therein (including renewals thereof) to HHSC.

(3) HMO will, at the expense of HHSC, assist HHSC or its nominees to obtain copyrights, trademarks, or patents for all such Deliverables in the United States and any other countries. HMO agrees to execute all papers and to give all facts known to it necessary to secure United States or foreign country copyrights and patents, and to transfer or cause to transfer to HHSC all the right, title, and interest in and to such Deliverables. HMO also agrees not to assert any moral rights under applicable copyright law with regard to such Deliverables.

(d) License Rights

HHSC will have a royalty-free and non-exclusive license to access the HMO Proprietary Software and associated documentation during the term of the Contract. HHSC will also have ownership and unlimited rights to use, disclose, duplicate, or publish all information and data developed, derived, documented, or furnished by HMO under or resulting from the Contract. Such data will include all results, technical information, and materials developed for and/or obtained by HHSC from HMO in the performance of the Services hereunder, including but not limited to all reports, surveys, plans, charts, recordings (video and/or sound), pictures, drawings, analyses, graphic representations, computer printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the Services performed as a result of the Contract.

(e) Proprietary Notices

HMO will reproduce and include HHSC's copyright and other proprietary notices and product identifications provided by HMO on such copies, in whole or in part, or on any form of the Deliverables.

(f) State and Federal Governments

In accordance with 45 C.F.R. §95.617, all appropriate State and Federal agencies will have a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, translate, or otherwise use, and to

authorize others to use for Federal Government purposes all materials, the Custom Software and modifications thereof, and associated documentation designed, developed, or installed with federal financial participation under the Contract, including but not limited to those materials covered by copyright, all software source and object code, instructions, files, and documentation.

Article 16. Liability

Section 16.01 Property damage.

(a) HMO will protect HHSC's real and personal property from damage arising from HMO's, its agent's, employees' and Subcontractors' performance of the Contract, and HMO will be responsible for any loss, destruction, or damage to HHSC's property that results from or is caused by HMO's, its agents', employees' or Subcontractors' negligent or wrongful acts or omissions. Upon the loss of, destruction of, or damage to any property of HHSC, HMO will notify the HHSC Project Manager thereof and, subject to direction from the Project Manager or her or his designee, will take all reasonable steps to protect that property from further damage.

(b) HMO agrees to observe and encourage its employees and agents to observe safety measures and proper operating procedures at HHSC sites at all times.

(c) HMO will distribute a policy statement to all of its employees and agents that directs the employee or agent to promptly report to HHSC or to HMO any special defect or unsafe condition encountered while on HHSC premises. HMO will promptly report to HHSC any special defect or an unsafe condition it encounters or otherwise learns about.

Section 16.02 Risk of Loss.

During the period Deliverables are in transit and in possession of HMO, its carriers or HHSC prior to being accepted by HHSC, HMO will bear the risk of loss or damage thereto, unless such loss or damage is caused by the negligence or intentional misconduct of HHSC. After HHSC accepts a Deliverable, the risk of loss or damage to the Deliverable will be borne by HHSC, except loss or damage attributable to the negligence or intentional misconduct of HMO's agents, employees or Subcontractors.

Section 16.03 Limitation of HHSC's Liability.

HHSC WILL NOT BE LIABLE FOR ANY INCIDENTAL, INDIRECT, SPECIAL, OR CONSEQUENTIAL DAMAGES UNDER CONTRACT, TORT (INCLUDING NEGLIGENCE), OR OTHER LEGAL THEORY. THIS WILL APPLY REGARDLESS OF THE CAUSE OF ACTION AND EVEN IF HHSC HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

HHSC'S LIABILITY TO HMO UNDER THE CONTRACT WILL NOT EXCEED THE TOTAL CHARGES TO BE PAID BY HHSC TO HMO UNDER THE CONTRACT, INCLUDING CHANGE ORDER PRICES AGREED TO BY THE PARTIES OR OTHERWISE ADJUDICATED.

HMO's remedies are governed by the provisions in Article 12.

Article 17. Insurance & Bonding

Section 17.01 Insurance Coverage.

(a) Statutory and General Coverage

HMO will maintain, at the HMO's expense, the following insurance coverage naming the State of Texas, acting through HHSC, as an additional insured and loss payee.

(1) Business Automobile Liability Insurance for all owned, non-owned, and hired vehicles for bodily injury and property damage;

(2) Comprehensive General Liability Insurance of at least $1,000,000.00 per occurrence and $5,000,000.00 in the aggregate (including Bodily Injury coverage of $100,000.00 per each occurrence and Property Damage Coverage of $25,000.00 per occurrence); and

(3) if HMO's current Comprehensive General Liability insurance coverage does not meet the above stated requirements, HMO will obtain Umbrella liability insurance to compensate for the difference in the coverage amounts. If Umbrella Liability Insurance is provided, it shall follow the form of the primary coverage.

(b) Professional Liability Coverage.

(1) HMO must maintain at its own expense, or cause its Network Providers to maintain, Professional Liability Insurance for each Network Provider of $100,000.00 per occurrence and $300,000.00 in the aggregate, or the limits required by the hospital at which the Network Provider has admitting privileges.

(2) HMO must maintain an Excess Professional Liability (Errors and Omissions) Insurance Policy for the greater of $3,000,000.00 or an amount (rounded to the nearest $100,000.00) that represents the number of Members enrolled in the HMO in the first month of the applicable State Fiscal Year multiplied by $150.00, not to exceed $10,000,000.00.

(c) General Requirements for All Insurance Coverage

(1) Except as provided herein, all exceptions to the Contract's insurance requirements must be

approved in writing by HHSC. HHSC's written approval is not required in the following situations:

(i) An HMO or a Network Provider is not required to obtain the insurance coverage described in Section 17.01 if the HMO or Network Provider qualifies as a state governmental unit or municipality under the Texas Tort Claims Act, and is required to comply with, and subject to the provisions of, the Texas Tort Claims Act.

(ii) An HMO may waive the Professional Liability Insurance requirement described in Section 17.01(b)(1) for a Network Provider of Community-based Long Term Care Services. An HMO may not waive this requirement if the Network Provider provides other Covered Services in addition to Community-based Long Term Care Services, or if a Texas licensing entity requires the Network Provider to carry such Professional Liability coverage. An HMO that waives the Professional Liability Insurance requirement for a Network Provider pursuant to this provision is not required to obtain such coverage on behalf of the Network Provider.

(2) HMO or the Network Provider is responsible for any and all deductibles stated in the insurance policies.

(3) Insurance coverage must be issued by insurance companies authorized to conduct business in the State of Texas.

(4) Insurance coverage must name HHSC as an additional insured, with the exception of Professional Liability insurance maintained by Network Providers.

Insurance coverage must name HHSC as a loss payee, with the exception of Professional Liability insurance maintained by Network Providers, and Business Automobile Liability insurance.

(5) Insurance coverage kept by the HMO must be maintained in full force at all times during the Term of the Contract, and until HHSC's final acceptance of all Services and Deliverables. Failure to maintain such insurance coverage will constitute a material breach of this Contract.

(6) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must have extended reporting periods of two years. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, the Contract Effective Date.

(7) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must provide that prior written notice to be given to HHSC at least thirty (30) calendar days before coverage is reduced below minimum HHSC contractual requirements, canceled, or non-renewed. HMO must submit a new coverage binder to HHSC to ensure no break in coverage. Each policy must include the following provision: "It is a condition of this policy that the company shall furnish written notice to HHSC's designated contact at thirty (30) calendar days in advance of any reduction in, cancellation, or non-renewal of, this policy."

(8) The Parties expressly understand and agree that any insurance coverages and limits furnished by HMO will in no way expand or limit HMO's liabilities and responsibilities specified within the Contract documents or by applicable law.

(9) HMO expressly understands and agrees that any insurance maintained by HHSC will apply in excess of and not contribute to insurance provided by HMO under the Contract.

(10) If HMO, or its Network Providers, desire additional coverage, higher limits of liability, or other modifications for its own protection, HMO or its Network Providers will be responsible for the acquisition and cost of such additional protection. Such additional protection will not be an Allowable Expense under this Contract.

(11) HMO will require all insurers to waive their rights of subrogation against HHSC.

(d) Proof of Insurance Coverage

(1) Except as provided in Section 17.01(d)(2), the HMO must furnish the HHSC Project Manager original Certificates of Insurance evidencing the required insurance coverage on or before the Effective Date of the Contract. If insurance coverage is renewed during the Term of the Contract, the HMO must furnish the HHSC Project Manager renewal certificates of insurance, or such similar evidence, within five (5) Business Days of renewal. The failure of HHSC to obtain such evidence from HMO will not be deemed to be a waiver by HHSC and HMO will remain under continuing obligation to maintain and provide proof of insurance coverage.

(2) The HMO is not required to furnish the HHSC Project Manager proof of Professional Liability Insurance maintained by Network Providers on or before the Effective Date of the Contract, but must provide such information upon HHSC's request during the Term of the Contract.

Section 17.02 Performance Bond.

Beginning on the Operational Start Date of the Contract, the HMO must obtain a performance bond with a one (1) year term. The performance bond must be renewable and renewal must occur no later than the first day of each subsequent State

Fiscal Year. The performance bond must continue to be in effect for one (1) year following the expiration of the final renewal period. HMO must obtain and maintain the performance bonds in the form prescribed by HHSC and approved by TDI, naming HHSC as Obligee, securing HMO's faithful performance of the terms and conditions of this Contract. The performance bonds must comply with Chapter 843 of the Texas Insurance Code and 28 T.A.C. §11.1805. At least one performance bond must be issued. The amount of the performance bonds should total $100,000.00 for each Service Area that the HMO covers under this Contract. Performance bonds must be issued by a surety licensed by TDI, and specify cash payment as the sole remedy. HMO must deliver the initial performance bond to HHSC prior to the Operational Start Date of the Contract, and each renewal prior to the first day of the State Fiscal Year.

Section 17.03 TDI Fidelity Bond

The HMO will secure and maintain throughout the life of the Contract a fidelity bond in compliance with Chapter 843 of the Texas Insurance Code and 28 T.A.C. §11.1805. The HMO must promptly provide HHSC with copies of the bond and any amendments or renewals thereto.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	June 30, 2010	Initial version of Attachment B-1, Section 6 "Premium Payment, Incentives, and Disincentives" that includes all modifications negotiated by the Parties.
Revision	1.1	February 1, 2011	Contract amendment did not revise Attachment B-1, Section 6 "Premium Payment, Incentives, and Disincentives"
Revision	1.2	March 1, 2011	Section 6.3.2.8 is modified to remove "1% At-Risk Performance Indicator" from section name, and to clarify that nursing facility utilization will be measured in the Performance Based Capitation Rate and the Quality Challenge Award.
Revision	1.3	September 1, 2011	Section 6.3.2.2 is modified to add clarifying language regarding periods of data collection for the 1% at risk premium.
Revision	1.4	January 1, 2012	Contract amendment did not revise Attachment B-1, Section 6 "Premium Payment, Incentives, and Disincentives"
Revision	1.5	March 1, 2012	Section 6.3.2.2 is modified to conform to the language in the Uniform Managed Care Contract and to change the 1% at risk to 5%.

[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 in accordance 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 Payment, Incentives, and Disincentives

This section documents how the Capitation Rates are developed and describes performance incentives and disincentives related to HHSC's value-based purchasing approach. For further information, HMOs should refer to the HHSC **Uniform Managed Care Contract Terms and Conditions**.

Under the HMO Contracts, health care coverage for Members will be provided on a fully insured basis. The HMO must provide the Services and Deliverables, including Covered Services to enrolled Members, in order for monthly Capitation Payments to be paid by HHSC. **Section 8** includes the HMO's financial responsibilities regarding Out-of-Network Emergency Services and Medically Necessary Covered Services not available through Network Providers.

6.1 Capitation Rate Development

Refer to **Attachment A**, **HHSC Uniform Managed Care Contract Terms & Conditions, Article 10, "Terms & Conditions of Payment,"** for information concerning Capitation Rate development.

6.2 Financial Payment Structure and Provisions

HHSC will pay the HMO monthly Capitation Payments based on the number of eligible and enrolled Members. HHSC will calculate the monthly Capitation Payments by multiplying the number of Member Months times the applicable monthly Capitation Rate by Member Rate Cell. The HMO must provide the Services and Deliverables, including Covered Services to Members, described in the Contract for monthly Capitation Payments to be paid by HHSC.

The HMO must understand and expressly assume the risks associated with the performance of the duties and responsibilities under the Contract, including the failure, termination, or suspension of funding to HHSC, delays or denials of required approvals, cost of claims incorrectly paid by the HMO, and cost overruns not reasonably attributable to HHSC. The HMO must further agree that no other charges for tasks, functions, or activities that are incidental or ancillary to the delivery of the Services and Deliverables will be sought from HHSC or any other state agency, nor will the failure of HHSC or any other party to pay for such incidental or ancillary services entitle the HMO to withhold Services or Deliverables due under the Contract.

6.2.1 Capitation Payments

The HMO must refer to the **HHSC Uniform Managed Care Contract Terms & Conditions** for information and Contract requirements on the:

1) Time and Manner of Payment,
2) Adjustments to Capitation Payments,
3) Delivery Supplemental Payment and Bariatric Supplemental Payments, and
4) Experience Rebate.

6.3 Performance Incentives and Disincentives

HHSC introduces several financial and non-financial performance incentives and disincentives through this Contract. These incentives and disincentives are subject to change by HHSC over the course of the Contract Period. The methodologies required to implement these strategies will be refined by HHSC after collaboration with contracting HMOs through a new incentives workgroup to be established by HHSC. HMO is prohibited from passing down financial disincentives and/or sanctions imposed on the HMO to health care providers, except on an individual basis and related to the individual provider's inadequate performance.

6.3.1 Non-financial Incentives

6.3.1.1 Performance Profiling

HHSC intends to distribute information on key performance indicators to HMOs on a regular basis, identifying an HMO's performance, and comparing that performance to other HMOs, and HHSC standards and/or external Benchmarks. HHSC will recognize HMOs that attain superior performance and/or improvement by publicizing their achievements. For example, HHSC may post information concerning exceptional performance on its website, where it will be available to both stakeholders and members of the public. Likewise, HHSC may post its final determination regarding poor performance or HMO peer group performance comparisons on its website.

6.3.1.2 Auto-assignment Methodology for Medicaid HMOs

HHSC may also revise its auto-assignment methodology during the Contract Period for new Medicaid Members who do not select an HMO (Default Members). The new assignment methodology would reward those HMOs that demonstrate superior performance and/or improvement on one or more key dimensions of performance. In establishing the assignment methodology, HHSC will employ a subset of the performance indicators contained within the **Performance Indicator Dashboard**. At present, HHSC intends to recognize those HMOs that exceed the minimum geographic access standards defined within **Section 8 and the Performance Indicator Dashboard.** HHSC may also use its assessment of HMO performance on annual quality improvement goals (described in **Section 8**) in developing the assignment methodology.

The methodology would disproportionately assign Default Members to the HMO(s) in a given Service Area that performed favorably on the selected performance indicators.

HHSC anticipates that it will not implement a performance-based auto-assignment algorithm before September 1, 2011. HHSC will invite HMO comments on potential approaches prior to implementation of the new performance-based auto-assignment algorithm.

6.3.2 Financial Incentives and Disincentives

6.3.2.1 Experience Rebate Reward

HHSC historically has required HMOs to provide HHSC with an Experience Rebate (see the **Uniform Managed Care Contract Terms and Conditions, Article 10.08)** when there has been an aggregate excess of Revenues over Allowable Expenses. During the Contract Period, should the HMO experience an aggregate excess of Revenues over Allowable Expenses across the Service Areas, HHSC may allow the HMO to retain that portion of the aggregate excess of Revenues over Allowable Expenses that is equal to or less than 3.5 percent of the total Revenue for the period should the HMO demonstrate superior performance on selected performance indicators. The retention of 3.5 percent of revenue exceeds the retention of 3.0 percent of revenue that would otherwise be afforded to a HMO without demonstrated superior performance on these performance indicators relative to other HMOs. HHSC will develop the methodology for determining the level of performance necessary for an HMO to retain the additional 0.5 percent of revenue after consultation with HMOs. The finalized methodology will be added to the **Uniform Managed Care Manual**.

HHSC will calculate the Experience Rebate Reward after it has calculated the HMO's at-risk Capitation Rate payment, as described below in **Section 6.3.2.2**. HHSC will calculate whether a HMO is eligible for the Experience Rebate Reward prior to the 90-day Financial Statistical Report (FSR) filing.

HHSC anticipates that it will not implement the incentive for Rate Period 1 of the Contract. HHSC will invite HMO comments on potential approaches prior to implementation of the new performance-based Experience Rebate Reward.

6.3.2.2 Performance-Based Capitation Rate

Section 6.3.2.2 Modified by Versions 1.3 and 1.5

HHSC will place each HMO at risk for five percent (5%) of the Capitation Payment(s). HHSC retains the right to vary the percentage of the Capitation Payment placed at risk in a given Rate Period.

During the Rate Period, HHSC will pay the HMO the full monthly Capitation Payments as described in Section 6.2. Then, at the end of each Rate Period, HHSC will evaluate if the HMO has demonstrated that it has fully met the performance expectations for which the HMO is at risk. If the HMO falls short on some or all of the performance expectations, HHSC will adjust a future monthly Capitation Payment in accordance with Uniform Managed Care Manual Chapter 6.2, "Financial Incentive Methodology," by an

appropriate portion of the aggregate at risk amount. HHSC's objective is that all HMOs achieve performance levels that enable them to retain the full at-risk amount.

HHSC will determine the extent to which the HMO has met the performance expectations by assessing the HMO's STAR+PLUS performance relative to performance targets for the rate period.

HHSC will identify no more than ten (10) at-risk performance indicators for the STAR+PLUS Program.

Specific contractual requirements are set forth in the Uniform Managed Care Manual, Chapter 6.2, "Financial Incentive Methodology." Failure to timely provide HHSC with necessary data related to the calculation of the performance indicators will result in HHSC's assignment of a zero (0%) percent performance rate for each related performance indicator.

HMOs will report actual Capitation Payments received on the Financial Statistical Report (FSR) during the Rate Period that is at risk (i.e., the HMO will *not* report 95% of the payments received, leaving five percent (5%) as contingent). Actual Capitation Payments received include all of the at-risk Capitation Payment paid to the HMO. Any loss of the at-risk amount that may be realized in a subsequent Rate Period, via reduction to a monthly payment, will not be reported in the FSR as a reduced amount of capitation revenue, but will instead be reported below the income line, as an informational item, as described in the Uniform Managed Care Manual, Chapter 5.3.1, "Financial Statistical Report and Instructions." Any performance assessment based on performance for a contract period will appear on the second final (334-day) FSR for that contract period.

HHSC will evaluate the performance-based Capitation Rate methodology annually in consultation with HMOs. HHSC may then modify the methodology as it deems necessary and appropriate, in order to motivate, recognize, and reward HMOs for superior performance. The methodologies for all Rate Periods will be included in Uniform Managed Care Manual Chapter 6.2, "Financial Incentive Methodology."

6.3.2.3 Quality Challenge Award

Should one or more HMOs be unable to earn the full amount of the performance-based at-risk portion of the Capitation Rate, HHSC will reallocate all or part of the funds through the HMO Program's Quality Challenge Award. HHSC will use these funds to reward HMOs that demonstrate superior clinical quality, service delivery, access to care, and/or Member satisfaction. HHSC will determine the number of HMOs that will receive Quality Challenge Award funds annually based on the amount of the funds to be reallocated.

HHSC intends to evaluate HMO performance annually in order to determine which HMOs demonstrate superior performance. In no event will a distribution from the Quality Challenge Award, plus any other incentive payments made in accordance with the HMO

Contract, when combined with the Capitation Rate payments, exceed 105 percent of the Capitation Rate payments to an HMO.

HHSC anticipates that data collection for the Quality Challenge Award will begin on September 1, 2011. If Quality Challenge Award funds are available for a Rate Period, HHSC will distribute such funds to qualified HMOs during the following Rate Period. Information about the data collection period to be used and each indicator that will be considered for any specific time period will be included in the **HHSC Uniform Managed Care Manual**.

HHSC will calculate the HMOs' degree of compliance with the Quality Challenge Award indicators based on Encounter Data and other information supplied by the HMOs. Failure to provide timely and accurate information will result in HHSC's assignment of a zero percent performance rate for each applicable Quality Challenge Award indicator.

HHSC will evaluate the Quality Challenge Award methodology annually in consultation with HMOs. HHSC will make methodology modifications annually as it deems necessary and appropriate to motivate, recognize, and reward HMOs for superior performance based on available Quality Challenge Award funds and/or other performance incentives applicable to the award. HHSC will include the Quality Challenge Award methodology and any modifications in the **HHSC Uniform Managed Care Manual**.

6.3.2.4 Remedies and Liquidated Damages

All areas of responsibility and all requirements in the Contract will be subject to performance evaluation by HHSC. Any and all responsibilities or requirements not fulfilled may have remedies and HHSC will assess either actual or liquidated damages. Refer to **Attachment A, HHSC Uniform Managed Care Contract Terms and Conditions** and **Attachment B-5** for performance standards that carry liquidated damage values.

6.3.2.5 STAR+PLUS Hospital Inpatient Performance-Based Capitation Rate: Hospital Inpatient Stay Cost Incentives & Disincentives

Effective as of the Operational Start Date, HHSC will place at-risk a portion of the HMO's Medicaid-Only Capitation Rate. Settlements for Inpatient Stay costs will be calculated by the State after the end of each Rate Period using three (3) months of completed Hospital paid data for the preliminary settlement and 11 months of completed data for the final settlement. The SFY 2010 Fee-for-Service (FFS) Inpatient Hospital per-member-per-month (PMPM) rate will be projected for Rate Period 1 for the first settlement. Adjustments for the projection will include trending and risk adjustment. The base and final inpatient hospital PMPM rate will be calculated separately for each HMO, Service Area, and Rate Cell.

6.3.2.5.1 STAR+PLUS Hospital Inpatient Disincentive - Administrative Fee at Risk

For Rate Period 1, the STAR+PLUS HMOs must achieve a 22 percent reduction in projected FFS Hospital Inpatient Stay costs, for the Medicaid-Only population, through the implementation of the STAR+PLUS model. HMOs achieving savings beyond 22 percent will be eligible for the STAR+PLUS Shared Savings Award described in **Section 6.3.2.5.2**. The HMO will be at-risk for savings less than 22 percent.

The maximum risk to the HMO will be equal to 50 percent of the difference between 15 percent Hospital inpatient savings and 22 percent Hospital inpatient savings. The disincentive for savings above 15 percent, but still less than 22 percent will be equal to 50 percent of the difference between the level of achieved savings and 22 percent. HHSC retains the right to implement a hospital inpatient disincentive in subsequent Rate Periods by Contract amendment.

6.3.2.5.2 STAR+PLUS Hospital Inpatient Incentive – Shared Savings Award

HMOs that exceed the 22 percent reduction in Inpatient Stay costs incurred by Medicaid-Only STAR+PLUS Members specified in **Section 6.3.2.5.1** will be eligible to obtain a 20 percent share of the savings achieved beyond the 22 percent target. HHSC will determine the extent to which the HMO has met and exceeded the performance expectation in the manner described within **Section 6.3.2.5**. Should HHSC determine that the HMO exceeded the 22 percent target, HHSC will adjust a future monthly Capitation Payment upward by 20 percent of the calculated savings. This shared savings award is limited to 5 percent of the HMO's capitation in accordance with Federal Balance Budget Act requirements and is calculated off of total of STAR+PLUS Capitation Payment. An HMO will be subject to contractual remedies and determined ineligible for the award, if a HHSC audit reveals that the HMO has inappropriately averted Medically Necessary Inpatient Stay admissions and potentially endangered Member safety.

6.3.2.6 Additional Incentives and Disincentives

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

Information about the data collection period to be used, performance indicators selected or developed, or HMO ranking methodologies used for any specific time period will be found in the **HHSC Uniform Managed Care Manual**.

6.3.2.7 Frew Incentives and Disincentives

As required by the *Frew vs. Suehs Corrective Action Order: Managed Care*, this Contract includes a system of incentives and disincentives associated with the Medicaid Managed Care Texas Health Steps Medical Checkups Reports and Children of Migrant Farm Workers Reports. These incentives and disincentives apply to Medicaid HMOs.

The incentives and disincentives and corresponding methodology will be set forth in the Uniform Managed Care Manual.

6.3.2.8 Nursing Facility Utilization Disincentive

Section 6.3.2.8 Modified by Version 1.2

HHSC has developed the following disincentive to prevent inappropriate admission to nursing facilities. For SFY 2012, the rate of nursing facility admissions for Medicaid-only STAR+PLUS Members will be part of the Performance Indicator Dashboard (see **Section 6.3.2.2**).

In each of the HMO's STAR+PLUS Service Areas, HHSC will determine whether there has been a statistically significant increase in nursing facility admissions by comparing that HMO's rate of admission of Medicaid-only STAR+PLUS Members in SFY 2011 to that HMO's rate of admission of Medicaid-only STAR+PLUS Members in SFY 2012. Members who are admitted to a nursing facility and then discharged back into the community within 120 days of admission will not be included in the analysis.

HHSC reserves the right to include a nursing facility utilization measure in either the Performance Based Capitation Rate (see Section 6.3.2.2) or the Quality Challenge Award (see Section 6.3.2.3) for State Fiscal Years following 2012.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	June 30, 2010	Initial version of Attachment B-1, Section 7 "Transition Phase Requirements" that includes all modifications negotiated by the Parties.
Revision	1.1	February 1, 2011	Contract amendment did not revise Attachment B-1, Section 7 "Transition Phase Requirements".
Revision	1.2	March 1, 2011	Section 7.3.1.7 is modified to correct a contract reference.
Revision	1.3	September 1, 2011	Section 7.3.1.9 is modified to change "will" terminate the contract to "may".
Revision	1.4	January 1, 2012	Contract amendment did not revise Attachment B-1, Section 7 "Transition Phase Requirements".
Revision	1.5	March 1, 2012	Section 7.1 is modified to add termination of the contract to the list of remedies for failure to timely satisfy Transition Phase requirements. Section 7.3.1.6 is modified to reference the HMO's PBM and other Material Subcontractors. Section 7.3.1.7 is modified to reference the HMO's PBM and other Material Subcontractors, to require the HMOs to submit a written plan for providing pharmacy services, and to require an attestation from the PBM to comply with the requirements of SB 7.

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[2] Revisions should be numbered in accordance 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.
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7. Transition Phase Requirements

7.1 Introduction

Section 7.1 Modified by Version 1.5

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

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

If for any reason, a HMO 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 HMO's compliance with the applicable Readiness Review requirement, then HHSC shall impose remedies including actual or liquidated damages. Refer to **Attachment A** ("Uniform Managed Care Contract Terms and Conditions") and **Attachment B-5** ("Deliverables/Liquidated Damages Matrix") for additional information.

7.2 Transition Phase Scope for HMOs

STAR+PLUS HMOs must meet the Readiness Review requirements established by HHSC no later than 90 days prior to the Operational Start Date. HMO 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 Transition Phase must be completed no later than the Operational Start Date

7.3.1 Transition Phase Tasks

The HMO has overall responsibility for the timely and successful completion of each of the Transition Phase tasks. The HMO 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.

7.3.1.1 Contract Start-Up and Planning

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

- define project management and reporting standards;
- establish communication protocols between HHSC and the HMO;
- establish contacts with other HHSC contractors;
- establish a schedule for key activities and milestones; and
- clarify expectations for the content and format of Contract Deliverables.

The HMO 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 HMO must submit a detailed Transition/Implementation Plan to HHSC no later than 30 calendar days after the Contract's effective date.

The HMO's Transition/Implementation Plan must include a detailed description of the process it will use to ensure continued authorization of Community-based Long Term Care Services at the time of implementation. An HHS Agency will provide a file identifying these clients to the HMO for this purpose. The HMO's Transition/Implementation Plan must identify a designated HMO staff member responsible for the facilitation and oversight of this process. These requirements are further described in **Section 8.1.21 Continuity of Care and Out-of-Network Providers** and **Section 8.1.38.1 Community-based Long-Term Care Service Provider Training**.

7.3.1.2 Administration and Key HMO Personnel

No later than the Effective Date of the Contract, the HMO must designate and identify Key HMO Personnel that meet the requirements in **Attachment A** ("Uniform Managed Care Contract Terms and Conditions"). The HMO will supply HHSC with resumes of each Key HMO Personnel as well as organizational information that has changed relative to the HMO's Proposal, such as updated job descriptions and updated organizational charts, if applicable. If the HMO is using a Material Subcontractor(s), the HMO must also provide the organizational chart for such Material Subcontractor(s).

7.3.1.3 Organizational and Financial Readiness Review

In order to complete an organizational and financial Readiness Review and assess the most current corporate environment, HHSC will require that the HMO update the organizational and financial information submitted in its proposal. 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 HMO must update for Readiness Review.

7.3.1.4 System Testing and Transfer of Data

The HMO 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 8.1.18**. For example, the HMO's MIS system must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as indicated in **Section 8.1.18.4**.

During this Readiness Review task, the HMO will accept into its system any and all necessary data files and information available from HHSC or its contractors. The HMO will install and test all hardware, software, and telecommunications required to support the Contract. The HMO will define and test modifications to the HMO's system(s) required to support the business functions of the Contract.

The HMO will produce data extracts and receive all electronic data transfers and transmissions. The HMO must be able to demonstrate the ability to produce a STAR+PLUS encounter file and an 837- encounter file by the Operational Start Date.

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

7.3.1.5 System Readiness Review

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

The HMO must submit to HHSC, descriptions of interface and data and process flow for each key business processes described in **Section 8.1.18.3**, System-wide Functions.

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

1. Joint Interface Plan.
2. Disaster Recovery Plan
3. Business Continuity Plan
4. Risk Management Plan, and

5. Systems Quality Assurance Plan.

7.3.1.6 Demonstration and Assessment of System Readiness

Section 7.3.1.6 Modified by Version 1.5

The HMO must provide documentation on systems and facility security and provide evidence or demonstrate that it is compliant with HIPAA. The HMO shall also provide HHSC with a summary of all recent external audit reports, including findings and corrective actions, relating to the HMO's proposed systems, including any SAS70 audits that have been conducted in the past three years. The HMO shall promptly make additional information on the detail of such system audits available to HHSC upon request.

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

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

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

7.3.1.7 Operations Readiness

Section 7.3.1.7 Modified by Versions 1.2 and 1.5

The HMO 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+PLUS Services, including coordination with contractors. The HMO will be responsible for developing and documenting its approach to quality assurance.

HHSC or its designee will conduct a Readiness Review prior to the Operational Start Date. HMO 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, Section 12.02(e)**, "Damages."

During Readiness Review, the HMO shall, at a minimum:

1. Develop new, or revise existing, operations procedures and associated documentation to support the HMO's proposed approach to conducting operations activities in compliance with the contracted Scope of Work.
2. Submit to HHSC, a listing of all contracted and credentialed Providers, in a HHSC approved format including a description of additional contracting and credentialing activities scheduled to be completed before the Operational Start Date.
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 HMO will coordinate its business activities with those activities performed by HHSC contractors and the HMO'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 to HHSC the draft Member Handbook, draft Provider Manual, draft Provider Directory, and draft Member Identification Card for HHSC's review and approval. The materials must at a minimum meet the requirements specified in **Section 8.1.5** and include the Critical Elements to be defined in the **Uniform Managed Care Manual**.
6. Develop and submit to HHSC the HMO's proposed Member complaint and appeals processes.
7. Provide sufficient copies of the final Provider Directory to the HHSC Administrative Services Contractor in sufficient time to meet the enrollment schedule.
8. Demonstrate toll-free telephone systems and reporting capabilities for the Member Services Hotline, the Behavioral Health Hotline, and the Provider Services Hotline.
9. Submit a written Fraud and Abuse Compliance Plan to HHSC for approval no later than 30 days after the Contract Effective Date. See **Section 8.1.19**, Fraud and Abuse, for the requirements of the plan, including new requirements for special investigation units. As part of the Fraud and Abuse Compliance Plan, the HMO shall:
    - 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 HMO 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 HMO. The training will be conducted by the Office of Inspector General, HHSC, and will be provided free of charge. The HMO must schedule and complete training no later than 90 days after the Effective Date.

- designate an officer or director within the organization responsible for carrying out the provisions of the Fraud and Abuse Compliance Plan.
- The HMO is held to the same requirements and must ensure that, if this function is subcontracted to another entity, the subcontractor also meets all the requirements in this section and the Fraud and Abuse section as stated in **Section 8.1.19**.
- Complete hiring and training of STAR+PLUS Service Coordination staff, no later than 45 days prior to the STAR+PLUS Operational Start Date.

10. Submit a written plan for providing pharmacy services, including proposed policies and procedures for:

    - routinely updating formulary data following receipt of HHSC's daily files (no less frequently than weekly, and off-cycle upon HHSC's request);
    - prior authorization of drugs, including how HHSC's preferred drug lists (PDLs) will be incorporated into prior authorization systems and processes. The HMO 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;
    - implementing drug utilization review;
    - 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, etc.);
    - call center operations, including how the HMO will ensure that staff for all appropriate hotlines are trained to respond to prior authorization inquiries and other inquiries regarding pharmacy services, and
    - 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 HMO must include a written attestation by the PBM Subcontractor in the plan stating, in the three (3) 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 PMB 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 HMO certain operating procedures and updates to documentation to support the provision of STAR+PLUS Services. HHSC will assess the HMO's understanding of its responsibilities and the HMO's capability to assume the functions required under the Contract, based in part on the HMO's assurances of operational readiness, information contained in the Proposal, and in Transition Phase documentation submitted by the HMO.

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

7.3.1.8 Assurance of System and Operational Readiness

In addition to successfully providing the Deliverables described in **Section 7.3.1** ("Transition Phase Tasks"), the HMO 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 HMO must assure that Key HMO 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.

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

Section 7.3.1.9 modified by Version 1.3

The HMO must receive TDI licensure, certification or approval (as applicable) for all zip codes in the STAR+PLUS Service Areas in which the HMO proposes to provide STAR+PLUS Medicare services. In addition, the HMO must be contracted with the CMS to provide a Medicare Advantage Special Needs Plan for Dual Eligibles for all zip codes in the relevant STAR+PLUS Service Areas no later than January 1, 2012. If the HMO fails to receive licensure, certification, or approval from TDI, or if the HMO fails to contract with the CMS by this deadline, then HHSC may terminate the contract. The HMO must indemnify HHSC for all costs incurred by HHSC or its authorized representatives prior to termination. The HMO must also indemnify HHSC for all costs relating to replacing the HMO. Such costs include, without limitation, the cost of securing a replacement vendor, as well as the cost of any claim or litigation that is

reasonably attributable to the HMO's failure to receive the requisite contracts and approvals.

7.3.1.10 Post-Transition

The HMO 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 HMO is taking to resolve the problems.

If a HMO 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 pursuant to 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. freeze enrollment into the HMO's plan for the affected HMO Program(s) and Service Area(s);
2. freeze enrollment into the HMO's plan for all HMO Programs or for all Service Areas of an affected HMO Program;
3. impose contractual remedies, including liquidated damages; or
4. pursue other equitable, injunctive, or regulatory relief.

Refer to **Sections 8.1.1.2** and **8.1.18** for additional information regarding HMO Readiness Reviews during the Operations Phase.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	June 30, 2010	Initial version of Attachment B-1, Section 8 that includes all modifications negotiated by the Parties.
Revision	1.1	February 1, 2011	Section 8.1.24.2 is modified to change the title from "Former Recipients of Supplemental Payments for Physician Services" to "Network Access Assurance Fee" and to revise the requirements. Section 8.1.33.1 is modified to change the name from 'Community-based Long-Term Care Services Available to All Members' to "Community-based Long-Term Services and Supports Available to All Members" and to clarify that "Personal Assistance Services" is also called "Primary Home Care" for (b) Waiver Members. Section 8.1.33.2 is revised to change the name from "1915(c) Nursing Facility Waiver Services Available to Members Who Qualify for 1915(c) Nursing Facility Waiver Services" to "1915(c) STAR+PLUS Waiver Services Available to Members Who Qualify for 1915(c) STAR+PLUS Waiver Services" and to update the licensure and certification requirements. Section 8.2.1 "Medicaid Wrap-Around Services" is deleted and subsequent section is renumbered.
Revision	1.2	March 1, 2011	Section 8.1.1.1 is modified to change all "Performance Improvement Goals" references to "Performance Improvement Projects". Section 8.1.3.2 is revised to be consistent with the TDI requirement to allow pregnant Members past the 24th week of pregnancy to remain under the care of their current OB/GYN, even if provider is Out-of-Network. Section 8.1.4.8 is modified to prohibit Medicaid payments to entities located outside the U.S. in conformance with the Affordable Care Act. Section 8.1.5.6 is modified to change the word "dedicated" to "designated" regarding Member Hotline personnel. Section 8.1.19 is modified to require HMOs to designate a primary and secondary contact for all OIG requests and to outline the process and timeframes for responding to the OIG. Section 8.1.21 is revised to conform to the TDI requirement to allow pregnant Members past the 24th week of pregnancy to remain under the care of their

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			current OB/GYN, even if provider is Out-of-Network. Section 8.1.22.3 is modified to reorder requirements and add subsection headings. Additional training requirements are added to Section 8.1.22.3.5. Section 8.1.22.4 is amended to clarify that the 45 hour and 96 hour limits do not apply to neonatal care. Section 8.1.22.8 is amended to add "Texas Health Steps environmental lead investigation (ELI)". Remainder of list is renumbered. In addition, the section is amended to clarify disenrollment for utilizing DADS hospice services and to add Span of Coverage exceptions for STAR and STAR+PLUS members described in Attachment A, Section 5.05(a)(2). Immunization requirements from Section 8.1.22.3 "Texas Health Steps (EPSDT)" are moved to new Section 8.1.22.13 "Immunizations". Section 8.1.25.1 is revised to add the 98% standard for complaint resolution and to remove the 30 day request for extension requirement for complaints received directly by the HMO. Section 8.1.34.4 is modified to extend the timeframe for reviewing existing care plans from 90 days to 120 days after the Operational Start Date. Section 8.1.41 is added to require STAR+PLUS HMOs to contact Members at least once a year and to document that contact.
Revision	1.3	September 1, 2011	Section 8.1.1.1 is modified to remove redundant language. Section 8.1.4 is modified to require HMOs to contract with any willing ambulance provider that meets the HMO's credentialing requirements and agrees to the HMO's contract terms and rates. Section 8.1.4.8 is modified to add language for the ACA requirement regarding Healthcare Acquired Conditions (HAC) pursuant to the Patient Protection and Affordable Care Act of 2010 (Pubic Law 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA). Section 2702 of ACA prohibits federal payments to States for any amount expended under Medicaid for health care-acquired conditions. Section 8.1.4.8.1 is added pursuant to the Patient Protection and Affordable Care Act of 2010 (Pubic Law

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STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA). Section 2702 of ACA prohibits federal payments to States for any amount expended under Medicaid for health care-acquired conditions. Section 8.1.4.9 is modified to clarify compliance with 42 CFR 438.10(f)(5). Section 8.1.5.6 is modified to add clarification that the HMOs provide oral interpretive services free of charge, as required by 42 CFR 438.10(c)(4). Section 8.1.7.8 is modified to clarify current federal physician incentive plan requirements for Medicaid, and to add these requirements for CHIP. Section 8.1.8, Second Paragraph, is amended to refer to federal regulations regarding medical record content. Section 8.1.9 is modified to clarify the age requirements. Section 8.1.12.1 is modified to clarify that appropriate health care professionals must perform assessments, as required by 42 CFR 438.208(c)(2). Section 8.1.17.2 is modified to add the dates of service for which Bariatric Supplemental Reports are required. Section 8.1.18.5 is modified pursuant to the Patient Protection and Affordable Care Act of 2010 (Pubic Law 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA). Section 6401(b)(7) of the ACA requires the State to require all ordering or referring providers or other professionals to be enrolled in the program and that the national provider identifier (NPI) of any ordering or referring physician or other professional to be specified on the claims for payments for Medicaid and CHIP. Section 8.1.19 is modified to correct references to the Texas Government Code. Section 8.1.24.1 is modified to require the HMOs to pay FQHCs at the full encounter rate effective 9/1/11. Section 8.1.27.1 is modified to clarify that the HMO provide oral interpretive services free of charge, as required by 42 CFR 438.10(c)(4) . The section is also modified to clarify that the HMO must provide written notice of complaints resolutions that cannot be resolved

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			orally, in accordance with 42 CFR 438.408(d)(1). Section 8.1.27.2 is modified to clarify that the HMO provide oral interpretive services free of charge, as required by 42 CFR 438.10(c)(4). Section 8.1.36.1 is modified to clarify the SPW eligibility process. Section 8.1.36.2 is modified to clarify the MAO eligibility process. Section 8.1.37 is modified to add the new CDS benefits. Section 8.1.37.1 is modified to add the new CDS benefits and the section name is changed from "Self-Directed Model" to "Consumer Directed Option Model". Section 8.1.37.2 is modified to add the new CDS benefits and the section name is changed from "Agency Model, Self-Directed" to "Service Related Option Model". Section 8.1.37.3 is modified to add the new CDS benefits. Section 8.1.38.4 is deleted in its entirety.
Revision	1.4	January 1, 2012	Contract amendment did not revise Attachment B-1, RFP Section 8, "Operations Phase Requirements."
Revision	1.5	March 1, 2012	Section 8.1.1.1 is modified to clarify timelines, and to add language incorporating HHSC's PIPs templates (UMCM Chapters 10.2.4, 10.2.5, and 10.2.6) into the contract. Section 8.1.2.1 is modified to correct cross references and to add language incorporating HHSC's Value-Added Services template (UMCM Chapter 4.5) into the contract. Section 8.1.3 is modified to add a requirement regarding timely access to Network Providers, as required by 42 CFR §438.206(c)(1)(ii) and to add HHSC-specified copayments for Medicaid Members, where applicable. Section 8.1.3.2 is modified to add pharmacy access requirements. These standards are derived from Medicare Part D access standards, and the standards currently being met in the fee-for-service program. Section 8.1.4 is modified to require Provider contracts to include reasonable administrative and professional terms, to require that all Pharmacy Providers be enrolled with HHSC's Vendor Drug Program, and to clarify State Hospital and Pharmacy Provider contracting requirements. Section 8.1.4.6 is modified to add pharmacy training

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			requirements. Section 8.1.5.1 is modified to comply with SB & by adding a requirement to post Member Materials on the HMO's website. Section 8.1.5.5 is modified to require the HMOs to include a link to financial literacy information on the OCCC web page as required by HB 2615. Section 8.1.5.7 to require the HMO to develop health education initiatives addressing Medicaid Member copayment responsibilities, suicide prevention, identification and health education related to Obesity, and Case Management for Children and Pregnant Women (CPW). Section 8.1.8 is modified to add prior authorizations by pharmacists. Section 8.1.13 is modified to add Case Management for Children and Pregnant Women (CPW). Section 8.1.14 is modified to encourage HMOs to develop provider incentive programs for Designated Providers who meet the requirements for patient-centered medical homes, as required by SB 7. Section 8.1.17 is modified to remove the requirement to submit an accounting policy manual. Section 8.1.17.2 "Financial Disclosure Report" is renamed "MCO Disclosure Statement" and the submission date is updated. In addition "Report of Legal and other Proceedings" is added. Section 8.1.18 is modified to clarify that Subcontractor's MIS to comply with the requirements of this section. Section 8.1.18.1 is modified to require HMOs to submit pharmacy encounter data no later than 25 calendar days after the date of adjudication. Section 8.1.18.4 is modified to clarify claims transaction formats for pharmacy claims. Section 8.1.18.5 is modified to add requirement for HMO to file pharmacy claims in accordance with the timeframes specified in the Pharmacy Claims Manual (to be published on HHSC's website) and to add enforcement language. In addition, the section is modified to require HMOs to maintain a mechanism to receive claims in addition to the HHSC claims portal and to provide a web portal that supports Batch Processing.

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			Section 8.1.19 is modified to add a reference to the OAG, as required by Gov't Code §533.005(a)(10) (as modified by SB 7) and to add enforcement language. Section 8.1.20.2 "Fraudulent Practices Report" is modified to include additional required documentation and "Drug Utilization Review (DUR) Reports" is added. Section 8.1.22.3.4 is modified to require HMOs to use standard Texas Health Steps language in their Member Materials as provided in the UMCM. Section 8.1.22.8 is modified to clarify the requirements regarding non-capitated dental services, to add Case Management for Children and Pregnant Women (CPW), to remove audiology services and hearing aids from the list of non-capitated services, and to remove Inpatient Stays. These services are capitated. Section 8.1.22.11 is modified to clarify requirements for coordination with CPW. Section 8.1.22.13 is modified to clarify that HMOs must notify Medicaid and CHIP Providers of availability of vaccines through Texas Vaccines for Children Program and work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac Registry. Section 8.1.25.2 is modified to add a reference to Gov't Code §533.005(a)(19). Section 8.1.29 is modified to clarify that Medicaid is secondary when coordinating benefits with all other insurance coverage. Section 8.1.34 is modified to require the HMO to consider the availability of the PACE program when considering whether to refer a member to a nursing facility or other long-term care facility. Section 8.1.38.3 is modified to correct a cross-reference. Section 8.1.40 is modified to clarify the applicable waivers. Section 8.1.42 "Pharmacy Services" is added. Section 8.1.42.1 "Coverage Exclusions" is added. Section 8.1.42.4 "Pharmacy Rebate Program" is added. Section 8.1.42.5 "Drug Utilization Review Program" is added. Section 8.1.42.6 "Pharmacy Benefit Manager (PBM)" is

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			added. Section 8.1.42.7 “Financial Disclosures for Pharmacy Services” is added. Section 8.1.42.8 “Limitations Regarding Registered Sex Offenders” is added, as required by SB 7. Section 8.1.42.9 “Specialty Drugs” is added, as required by SB 7.

[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 in accordance according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

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8. OPERATIONS PHASE REQUIREMENTS

This Section is designed to provide the HMO with sufficient information to understand the responsibilities of a STAR+PLUS HMO. This Section describes scope of work requirements for the Operations Phase of the Contract.

Section 8.1 includes the scope of work that applies to the STAR+PLUS HMOs.

Section 8.2 includes additional scope of work requirements regarding qualified Dual Eligibles.

The Section does not include all of the STAR+PLUS Program requirements, such as the time frames and formats for all reporting requirements. HHSC has included this information in the **Uniform Managed Care Contract Terms and Conditions** (**Attachment A**) and the **Uniform Managed Care Manual**. HHSC reserves the right to modify these documents as it deems necessary using the procedures set forth in the **Uniform Managed Care Contract Terms and Conditions**.

8.1. General Scope of Work

In each STAR+PLUS Service Area, HHSC will select HMOs to provide health care services to Members. The HMO must be licensed by the Texas Department of Insurance (TDI) as an HMO or an ANHC in all zip codes in the respective Service Area(s). As set forth in **Sections 8.1**and **8.2**, the HMO also must be contracted with the CMS as a Medicare Advantage Dual Eligible Special Needs Plan (MA Dual SNP) in certain zip codes in the respective STAR+PLUS Service Area(s) no later than January 1, 2012. Additionally, no later than January 1, 2012, the HMO must contract with HHSC regarding payment of the Medicare cost sharing obligations for qualified STAR+PLUS Dual Eligibles.

Covered Services will be available to Members enrolled in the HMO on or after the Operational Start Date.

8.1.1. Administration and Contract Management

The HMO 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 waivers.

8.1.1.1. Performance Evaluation

Section 8.1.1.1 Modified by Versions 1.2, 1.3, and 1.5

Beginning in SFY 2013, by May 15$^{th\ t}$ each year, HHSC will establish two (2) overarching goals and negotiate a third goal suggested by the HMO for the following calendar year. The HMO must identify and propose annual HMO Performance Improvement Projects

(PIPs) relating to the overarching goals for the following calendar year no later than August 21st each year. The HMO is required to provide three (3) PIPs. At least one (1) PIP must be related to an overarching goal established by HHSC (see **Uniform Managed Care Manual** Chapter 10.2.7, "MMC/CHIP Performance Improvement Project Overarching Goals"). Once finalized, the overarching goals and HHSC-approved PIPs are incorporated into the Contract. If HHSC and the HMO cannot agree on the overarching goal or PIPs, HHSC will unilaterally select them.

PIPs will follow CMS protocol. The purpose of health care quality PIPs is to assess and improve processes, and thereby outcomes, of care. In order for such 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. (See **Uniform Managed Care Manual** Chapter 10.2.4, "Performance Improvement Project Submission Instructions" and 10.2.5, "Performance Improvement Project Template").

CMS protocol describes ten (10) steps to be undertaken 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 achieve sustained improvement.

The HMO must participate in semi-annual Contract Status Meetings (CSMs) with HHSC for the primary purpose of reviewing progress toward the achievement of annual PIPs and Contract requirements. HHSC may request additional CSMs, as it deems necessary, to address areas of noncompliance. HHSC will provide the HMO with reasonable advance notice of additional CSMs, generally at least five (5) business days.

The HMO must provide to HHSC, no later than14 business days prior to each semi-annual CSM, one electronic copy of a written update, detailing and documenting the HMO's progress toward meeting the annual PIPs or other areas of noncompliance.

HHSC will track HMO performance on PIPs. It will also track other key facets of HMO performance through the use of a **Performance Indicator Dashboard (see HHSC's Uniform Managed Care Manual)**. HHSC will compile the Performance Indicator Dashboard based on HMO submissions, data from the External Quality Review Organization (EQRO), and other data available to HHSC. HHSC will share the Performance Indicator Dashboard with the HMO on a quarterly basis.

8.1.1.2. Additional Readiness Reviews and Monitoring Efforts

As set forth in **Section 7**, HMOs must complete all Readiness Review requirements prior to the Operational Start Date. During the Operations Phase, HHSC may conduct desk and/or onsite reviews as part of its normal Contract monitoring efforts. Additionally, an HMO that chooses to make a change to any operational system or undergo any major transition may be subject to an additional Readiness Review(s). HHSC will determine whether the proposed changes will require a desk review and/or an onsite review. The HMO 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** for additional information regarding HMO Readiness Reviews. Refer to **Attachment A, Section 4.08(c)** for information regarding Readiness Reviews of the HMO's Material Subcontractors.

8.1.2. Covered Services

The HMO is responsible for authorizing, arranging, coordinating, and providing Covered Services in accordance with the requirements of the Contract. The HMO must provide Medically Necessary Covered Services to all Members beginning on the Member's date of enrollment regardless of pre-existing conditions, prior diagnosis, and/or receipt of any prior health care services. The HMO must also provide Functionally Necessary Community-based Long-Term Care Services to all Members beginning on the Member's date of enrollment regardless of pre-existing conditions, prior diagnosis, and/or receipt of any prior health care services. The HMO must not impose any pre-existing condition limitations or exclusions or require Evidence of Insurability to provide coverage to any Member.

The HMO must provide full coverage for Medically Necessary Covered Services to all Members and, for eligible Members, Functionally Necessary Community-based Long-Term Care Services, without regard to the Member's:

- Previous coverage, if any, or the reason for termination of such coverage;
- Health status;
- Confinement in a health care facility; or
- For any other reason.

Please Note:

A Member cannot change from one STAR+PLUS HMO to another STAR+PLUS HMO during an inpatient hospital stay. The Member's HMO is responsible for authorization and management of the inpatient hospital stay until the time of discharge, or until such

time as there is a loss of Medicaid eligibility. The HMO is responsible for professional charges during every month for which the HMO receives a full capitation for a Member.

A Member cannot change from one STAR+PLUS HMO to another STAR+PLUS HMO during a nursing facility stay.

The HMO 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 of the Contract (STAR+PLUS Covered Services)**. As noted in **Attachment B-2,** the HMO must provide Covered Services described in the most recent **Texas Medicaid Provider Procedures Manual (TMPPM)**, and in all **Texas Medicaid Bulletins**, which update the **TMPPM**, except for those services identified in **Section 8.1.22.8** as Medicaid Non-capitated Services.

8.1.2.1. Value-added Services

Section 8.1.2.1 Modified by Version 1.5

The HMO may propose additional services for coverage. These are referred to as "Value-added Services." Value-added Services may be actual Health Care Services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improved health outcomes among Members. Value-added Services that promote healthy lifestyles should target specific weight loss, smoking cessation, or other programs approved by HHSC. Temporary phones, cell phones, additional transportation benefits, and extra home health services may be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.

If offered, Value-added Services must be offered to all mandatory HMO Members within the Service Area. For Acute Care services, the HMO may distinguish between the Dual Eligible and non-Dual Eligible populations. Value-added Services do not need to be consistent across more than one Service Area. Value-added Services that are approved by HHSC during the contracting process will be included in the Contract's scope of services.

The HMO must provide Value-added Services at no additional cost to HHSC. The HMO must not pass on the cost of the Value-added Services to Providers. The HMO must specify the conditions and parameters regarding the delivery of the Value-added Services in the HMO's Marketing Materials and Member Handbook, and must clearly describe any limitations or conditions specific to the Value-added Services.

Transition Phase. During the Transition Phase, HHSC will offer a one-time opportunity for the HMO to propose two additional Value-added Services to its list of current, approved Value-added Services. (See **Uniform Managed Care Manual** 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 HMO 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 HMO's Contract will be amended to reflect the additional, approved Value-added Services.

The HMO 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 HMO to add Value-added Services. At no time during the Transition Phase will the HMO be allowed to delete, limit or restrict any of its current, approved Value-added Services.

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

Operations Phase. During the Operations Phase, Value-added Services can be added or removed only by written amendment of the Contract. HMOs 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. HMOs 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 HMO Comparison Charts for Members. An HMO's request to add, enhance, delete, or reduce a Value-added Service must be submitted to HHSC by April 1 of each year to be effective September 1 for the following contract period. A second request to add or enhance Value-added Services must be submitted to HHSC by October 1 each year to be effective March 1. See **Uniform Managed Care Manual** Chapter 4.5 "Physical and Behavioral Health Value-Added Services Template."

An HMO'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;
- Note any limits or restrictions that apply to the Value-added Service;
- Identify the Providers responsible for providing the Value-added Service;
- Describe how the HMO will identify the Value-added Service in administrative (Encounter) data;
- Propose how and when the HMO will notify Providers and mandatory Members about the availability of such Value-added Service;
- Describe how a Member may obtain or access the Value-added Service; and
- Include a statement that the HMO will provide such Value-added Service for at least 12 months from the Operational Start Date.

An HMO cannot include a Value-added Service in any material distributed to mandatory Members or prospective mandatory Members until the Parties have amended the Contract to include that Value-added Service. If a Value-added Service is deleted by amendment, the HMO must notify each mandatory Member that the service is no longer available through the HMO. The HMO must also revise all materials distributed to prospective mandatory Members to reflect the change in Value-added Services.

8.1.2.2. Case-by-Case Added Services

Except as provided below, the HMO may offer additional benefits that are outside the scope of services to individual Members on a case-by-case basis, based on Medical Necessity, cost-effectiveness, the wishes of the Member/Member's family, the potential for improved health status of the Member, and based on functional necessity.

8.1.3. Access to Care

Section 8.1.3 Modified by Version 1.5

All Covered Services must be available to Members on a timely basis in accordance with medically appropriate guidelines, and consistent with generally accepted practice parameters, and the requirements in this Contract. The HMO must comply with the access requirements as established by the Texas Department of Insurance (TDI) for all HMOs doing business in Texas, except as otherwise required by this Contract.

The HMO must provide coverage for Emergency Services to Members 24 hours a day and seven (7) days a week, without regard to prior authorization or the Emergency Service Provider's contractual relationship with the HMO. The HMO'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 HMO's Network or Out-of-Network. An HMO is not responsible for payment for unauthorized non-emergency services provided to a Member by Out-of-Network Providers.

The HMO must also have an emergency and crisis Behavioral Health Services Hotline available 24 hours a day, seven (7) a week, toll-free throughout the Service Area(s). The Behavioral Health Services Hotline must meet the requirements described in **Section 8.1.15.3**. An HMO must provide coverage for Emergency Services in compliance with 42 C.F.R. §438.114, and as described in more detail in **Section 8.1.22**. The HMO may arrange Emergency Services and crisis Behavioral Health Services through mobile crisis teams.

The HMO must require, and make best efforts to ensure, that PCPs are accessible to Members 24 hours a day, seven (7) days a week and that its Network Primary Care Providers (PCPs) have after-hours telephone availability that is consistent with **Section 8.1.4.2**. The HMO must ensure that Network Providers offer office hours to Members that are at least equal to those offered to the HMO'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 HMO must, upon the request of a Network physician or other

Provider, 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 five (5) business days after receipt of reasonably requested documentation, allow a referral to a non-network physician or Provider. The HMO must fully reimburse the non-network Provider in accordance with the Out-of-Network methodology for Medicaid as defined by HHSC.

The Member will not be responsible for any payment for Medically Necessary Covered Services, including Functionally Necessary Covered Services, other than the following:

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

(2) Members who qualify for 1915(c) Nursing Facility Waiver services and enter a 24-hour setting will be required to pay the Provider of care room and board costs and any income in excess of the personal needs allowance, as established by HHSC. If the HMO provides Members who do not qualify for the 1915(c) Nursing Facility Waiver services in a 24-hour setting as an alternative to nursing facility or hospitalization, the Member will be required to pay the Provider of care room and board costs and any income in excess of the personal needs allowance, as established by HHSC.

8.1.3.1. Waiting Times for Appointments

Through its Provider Network composition and management, the HMO must ensure that appointments for the following types of Covered Services are provided within the time frames specified below. In all cases below, “day” is defined as a calendar day.

- Emergency Services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities;
- Urgent care, including urgent specialty care, must be provided within 24 hours of request.
- Routine primary care must be provided within 14 days of request;
- Initial outpatient behavioral health visits must be provided within 14 days of request;
- Routine specialty care referrals must be provided within 30 days of request;
- Pre-natal 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 (5) days, or immediately, if an emergency exists;
- Preventive health services for adults, including annual adult well checks, must be offered to a Member within 90 days of request; and
- Preventive health services for children, including well-child checkups, should be offered to Members in accordance with the American Academy of Pediatrics (AAP) periodicity schedule. Please note that HMOs should use the Texas Health Steps Program modifications to the AAP periodicity schedule. For a New Member under age 21, overdue or upcoming well-child checkups, including Texas Health Steps medical checkups, should be offered as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 90 days of enrollment for all other eligible child Members. Effective September 1, 2010, 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 Chapter 12.4 of the Uniform Managed Care Manual.

8.1.3.2. Access to Network Providers

Section 8.1.3.2 Modified by Versions 1.2 and 1.5

The HMO's Network shall have network PCPs in sufficient numbers, and with sufficient capacity, to provide timely access to regular and preventive pediatric care and Texas Health Steps services to all child Members in accordance with the waiting times for appointments in **Section 8.1.3.1.**

PCP Access: At a minimum, the HMO must ensure that all Members have access to an age-appropriate PCP in the Provider Network with an Open Panel within 30 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 for a Member under age 21, and a pediatrician is not considered an age-appropriate choice for a Member age 21 and over.

OB/GYN Access: At a minimum, HMOs must ensure that all female Members have access to an OB/GYN in the Provider Network within 75 miles of the Member's residence. (If the OB/GYN is acting as the Member's PCP, the HMO must follow the access requirements for the PCP.) The HMO must allow female Members 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 HMO must ensure that all Members have access to an outpatient Behavioral Health Service Provider in the Network within 75 miles of the Member's residence. Outpatient Behavioral Health Service Providers must include Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient hospital departments. A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1~~)~~, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.

Other Specialist Physician Access: At a minimum, the HMO must ensure that all Members have access to a Network specialist physician within 75 miles of the Member's

residence for common medical specialties. For adult Members, common medical specialties shall include general surgery, cardiology, orthopedics, urology, and ophthalmology. For child Members, common medical specialties shall include orthopedics and otolaryngology. In addition, all Members must be allowed to: 1) select a Network ophthalmologist or therapeutic optometrist to provide eye Health Care Services, other than surgery, and 2) have access, without a PCP referral, to eye Health Care Services from a Network specialist who is an ophthalmologist or therapeutic optometrist for non-surgical services.

Hospital Access: The HMO must ensure that all Members have access to an Acute Care Hospital in the Provider Network within 30 miles of the Member's residence.

Pharmacy Access: Effective March 1, 2012, the HMO must meet the following minimum requirements. The HMO must ensure that all Members have access to at least one (1) Network Pharmacy within 15 miles of the Member's residence, and access to at least one (1) pharmacy with 24-hour coverage within 75 miles of the Member's residence. HMOs may request exceptions to this requirement on a case-by case basis.

Effective September 1, 2012, additional standards apply. 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 Service Area effective September 1, 2012:

- In urban counties, at least 80 percent of Members must have access to a Network Pharmacy within two (2) miles of the Members' residence;
- In suburban counties, at least 75 percent of Members must have access to a Network Pharmacy within five (5) miles of the Member's residence; and
- In rural counties, at least 90 percent of Members must have access to a Network Pharmacy within 15 miles of the Member's residence.

Note: HMOs 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, HMOs will be required to

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

All other Covered Services, except for services provided in the Member's residence: At a minimum, the HMO 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, but is not limited to: specialists, specialty Hospitals, psychiatric Hospitals, diagnostic and therapeutic services, and single or limited service health care physicians or Providers.

The HMO is not precluded from making arrangements with physicians or Providers outside the HMO's Service Area for Members to receive a higher level of skill or specialty than the level available within the Service Area, including but not limited to: treatment of cancer, burns, and cardiac diseases. HHSC may consider exceptions to the above access-related requirements when an HMO has established, through utilization data provided to HHSC, that a normal pattern for securing health care services within an area does not meet these standards, or when an HMO is providing care of a higher skill level or specialty than the level which is available within the Service Area such as, but not limited to: treatment of cancer, burns, and cardiac diseases.

8.1.3.3. Monitoring Access

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

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

8.1.4. Provider Network

Section 8.1.4 Modified by Versions 1.3 and 1.5

The HMO must enter into written contracts with properly credentialed Providers as described in this Section. The Provider contracts must comply with the **Uniform Managed Care Manual's** requirements, and include reasonable administrative and professional terms.

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

The Provider Network must be responsive to the linguistic, cultural, and other unique needs of any minority, elderly, or disabled individuals, or other special population in the Service Area(s) served by the HMO, 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 HMO must seek to obtain the participation in its Provider Network of qualified Providers currently serving Medicaid Members in the HMO's proposed Service Area(s). HMOs utilizing Out-of-Network Providers to render services to their Members must not exceed the utilization standards established in 1 T.A.C. §353.4. HHSC may modify this requirement for HMOs that demonstrate good cause for noncompliance, as set forth in §353.4(e)(3).

NOTE: The following Provider descriptions do not require HMOs to contract with Hospital Providers for Inpatient Stay services. HMOs are required, however, to contract with Hospitals for Outpatient Hospital Services, and with Hospital Providers for Inpatient Behavioral Health Services resulting from a behavioral health primary diagnosis.

All Providers: All Providers must be licensed in the State of Texas to provide the Covered Services for which the HMO is contracting with the Provider, and not be under sanction or exclusion from the Medicaid program. All Acute Care Providers serving Medicaid Members must be enrolled as Medicaid Providers and have a National Provider Identifier (NPI). All Pharmacy Providers must be enrolled with HHSC's Vendor Drug Program. Long-term Care Providers are not required to have an NPI, but must have a LTSS Provider number.

Inpatient hospital and medical services: The HMO must ensure that Acute Care Hospitals and specialty Hospitals are available and accessible 24 hours per day, seven (7) days per week, within the HMO's Network to provide Covered Services to Members throughout the Service Area(s). The HMO must enter into a Network Provider Agreement with any willing State Hospital that meets the HMO's credentialing requirements and agrees to the HMO's contract rates and terms.

Children's Hospitals/Hospitals with specialized pediatric services: The HMO 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, seven (7) days per week, to provide Covered Services to Members throughout the Service Area. The HMO must make a written reimbursement arrangement with an Out-of-Network designated Children's Hospital and/or hospital with specialized pediatric services in proximity to the Member's residence if the HMO does not include such 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 HMO must ensure Member access to Texas Department of State Health Services (TDSHS) designated Level I and Level II trauma centers within the state or Hospitals meeting the equivalent level of trauma care in the HMO's Service Area, or in close proximity to such Service Area. The HMO 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 HMO does not include such a trauma center in its Provider Network.

Transplant centers: The HMO must ensure Member access to HHSC-designated transplant centers or centers meeting equivalent levels of care. A list of HHSC-designated transplant centers can be found in the Procurement Library ("Transplant Facilities"). The HMO must make a written reimbursement arrangement with an Out-of-Network designated transplant center or a center meeting equivalent levels of care in proximity to the Member's residence if the HMO does not include such a center in its Provider Network.

Hemophilia centers: The HMO 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/hbd/htc_list.htm. The HMO must make written reimbursement arrangements with an Out-of-Network CDC-supported hemophilia center if the HMO does not include such a center in its Provider Network.

Physician services: The HMO must ensure that Primary Care Providers are available and accessible 24 hours per day, seven (7) days per week, within the Provider Network. The HMO 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 HMO 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, seven (7) days per week for each Acute Care Hospital in the Provider Network.

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

Laboratory services: The HMO must ensure that Network reference laboratory services must be of sufficient size and scope to meet the non-emergency and emergency needs of the enrolled population 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. Texas Health Steps requires that laboratory specimens obtained as part of a Texas Health Steps medical checkup visit must be sent to the DSHS Laboratory.

Pharmacy Providers: The HMO must ensure that all Pharmacy Network Providers are licensed with the Texas State Board of Pharmacy. These Providers must not be under

sanction or exclusion from the Medicaid and/or CHIP Programs. The HMO must enter into a Network Provider Agreement with any willing pharmacy provider that meets the HMO's credentialing requirements and agrees to the HMO's contract rates and terms. However, the HMO 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). Furthermore, if the selective contracts for specialty pharmacy services conflict with final rules promulgated by HHSC, then the HMO must terminate the contracts or amend them to comply with the rules.

Diagnostic imaging: The HMO 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 HMO must ensure that diagnostic imaging procedures that require the injection or ingestion of radiopaque chemicals are performed only under the direction of physicians qualified to perform those procedures.

Home health services: The HMO must have a sufficient number of contracts with home health Providers, so that all Members living within the HMO's Service Area will have access to at least one such Provider for home health Covered Services. (These services are provided as part of the Acute Care Covered Services, not the Community-based Long-Term Care Services.)

Community-based Long-Term Care Services: The HMO must have a sufficient number of contracts with Community-based Long-Term Care Service Providers, so that all Members living within the Contractor's Service Area will have access to Medically Necessary and Functionally Necessary Covered Services.

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

8.1.4.1. Provider Contract Requirements

The HMO is prohibited from requiring a Provider or Provider group to enter into an exclusive contracting arrangement with the HMO as a condition for participation in its Provider Network.

The HMO's contract with health care 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 **Uniform Managed Care Contract Terms and Conditions (Attachment A)** and **HHSC's Uniform Managed Care Manual**.

The HMO must submit model Provider contracts to HHSC for review during Readiness Review. HHSC retains the right to reject or require changes to any model Provider contract that does not comply with the STAR+PLUS Contract or Program requirements.

8.1.4.2. Primary Care Providers

The HMO's PCP Network may include Providers from any of the following practice areas: General Practice; Family Practice; Internal Medicine; Pediatrics; Obstetrics/Gynecology (OB/GYN); Advanced Practice Nurses (APNs) and Physician Assistants (PAs) (when APNs and PAs are practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP under this contract); Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and similar community clinics; and specialist physicians who are willing to provide a Medical Home to selected Members with special needs and conditions. Section 533.005(a)(13), Government Code, requires the HMO to use Advanced Practice Nurses practicing under the supervision of a physician as PCPs in its Provider Network.

An internist or other Provider who provides primary care to adults only is not considered an age-appropriate PCP choice for a Member under age 21. An internist or other Provider who provides primary care to adults and children may be a PCP for children if:

- the Provider agrees to perform all PCP duties required by the Contract for such Members in a specific age group under age 21,
- the Provider has a history of practicing as a PCP for the specified age group as evidenced by the Provider's primary care practice including an established patient population under age 21 and within the specified age range, and
- the Provider has admitting privileges to a local Hospital that includes admissions to pediatric units.

A pediatrician is not considered an age-appropriate choice for a Member age 21 and over.

The PCP for a Member with disabilities, Special Health Care Needs, or Chronic or Complex Conditions may be a specialist physician who agrees to provide PCP services to the Member. The specialty physician must agree to perform all PCP duties required in the Contract and PCP duties must be within the scope of the specialist's license. Any interested person may initiate the request through the HMO for a specialist to serve as a PCP for a Member with disabilities, Special Health Care Needs, or Chronic or Complex Conditions. The HMO shall handle such requests in accordance with 28 T.A.C. Part 1, Chapter 11, Subchapter J.

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.

The HMO must require, through contract provisions, that PCPs are accessible to Members 24 hours a day, seven (7) days a week. The HMO 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:

- 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;
- 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
- 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:

- The office telephone is only answered during office hours;
- The office telephone is answered after-hours by a recording that tells patients to leave a message;
- The office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; and
- Returning after-hours calls outside of 30 minutes.

The HMO must require PCPs, through Network Provider contract provisions or the HMO's Provider Manual, to provide children under the age of 21 with preventive services in accordance with the AAP recommendations, and the Texas Health Steps periodicity schedule published in the **Texas Medicaid Provider Procedures Manual.** The HMO must require PCPs, through Network Provider contract provisions or the HMO's Provider Manual, to provide adults with preventive services in accordance with the U.S. Preventive Services Task Force requirements. The HMO must make best efforts to ensure that PCPs follow these periodicity requirements for children and adult Members. Best efforts must include, but not be limited to: Provider education, Provider profiling, monitoring, and feedback activities.

The HMO 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 HMO must make best efforts to ensure that PCPs assess Member needs for referrals and make such referrals. Best efforts must include, but not be limited to: Provider education activities and review of Provider referral patterns.

8.1.4.3. PCP Notification

The HMO must furnish each PCP with a current list of enrolled Members assigned to that Provider no later than five (5) working days after the HMO receives the Enrollment File from the HHSC Administrative Services Contractor each month. The HMO may offer and provide such enrollment information in alternative formats, such as through access to a secure Internet site, when such format is acceptable to the PCP.

8.1.4.4. Provider Credentialing and Re-credentialing

The HMO must review, approve, and periodically recertify the credentials of all participating physician Providers and all other licensed Providers who participate in the HMO's Provider Network. The HMO may subcontract with another entity to which it delegates such credentialing activities if such 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 HMO's credentialing and re-credentialing processes must be consistent with recognized HMO industry standards, such as those provided by NCQA and relevant state and federal regulations including 28 T.A.C. §§11.1902 and 11.1402, relating to provider credentialing and notice, and as an additional requirement for Medicaid HMOs, 42 C.F.R. §438.12 and 42 C.F.R. §438.214(b). The initial credentialing process, including application and verification of information must be completed before the effective date of the initial contract with the physician or Provider. The re-credentialing process must occur at least every three (3) years.

The HMO 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. Additionally, if the HMO declines to include individual or groups of providers in its Network, it must give the affected providers written notice of the reasons for its decision.

The re-credentialing process must take into consideration Provider performance data including, but not limited to: Member Complaints and Appeals, quality of care, and utilization management.

HMOs must comply with the requirements of Texas Insurance Code Chapter 1452, Subchapter C, regarding expedited credentialing and payment of physicians who have joined medical groups that are already contracted with the HMO.

8.1.4.5. Board Certification Status

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

8.1.4.6. Provider Manual, Materials and Training

Section 8.1.4.6 Modified by Version 1.5

The HMO must prepare and issue a Provider Manual, including any necessary specialty manuals (e.g., behavioral health) to all existing Network Providers. For newly contracted Providers, the HMO must issue copies of the Provider Manual within five (5) working days from inclusion of the Provider into the Network. The Provider Manual must describe the special requirements of the STAR+PLUS Program and Members.

HHSC or its designee must approve the Provider Manual, and any substantive revisions to the Provider Manual, prior to publication and distribution to Providers. The Provider Manual must comply with the Contract's requirements and contain the critical elements defined in the **Uniform Managed Care Manual**. HHSC's initial review of the Provider Manual is part of the Operational Readiness Review described in **Section 7**.

The HMO must provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members. The HMO's training must be completed within 30 days of placing a newly contracted Provider on active status. The HMO must provide on-going training to new and existing Providers as required by the HMO or HHSC to comply with the Contract. The HMO 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.

The HMO must establish ongoing Provider training that includes, but is not limited to, the following issues:

1. Covered Services and the Provider's responsibilities for providing and/or coordinating such services. Special emphasis must be placed on areas that vary from commercial coverage rules (e.g., Early Intervention services, therapies and DME/Medical Supplies, referrals and coordination with Non-capitated Services), 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;
2. Relevant requirements of the Contract;
3. The HMO's quality assurance and performance improvement program and the Provider's role in such a program; and
4. The HMO's policies and procedures, especially regarding Network and Out-of-Network referrals.

Provider Materials must comply with state and federal laws governing STAR+PLUS and requirements of the **HHSC Uniform Managed Care Contract Terms and Conditions**. The HMO must make available any Provider Materials to HHSC upon request.

8.1.4.7. Provider Hotline

The HMO 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 Provider Hotline must be staffed with personnel who are knowledgeable about the STAR+PLUS Program, Covered Services, and Non-capitated Services.

The HMO 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 HMO 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 HMO and its Providers must not require such verification prior to providing Emergency Services.

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

- 99 percent of calls are answered by the fourth ring or an automated call pick-up system is used;
- No more than one (1) percent of incoming calls receive a busy signal;
- The average hold time is two (2) minutes or less; and
- The call abandonment rate is seven (7) percent or less.

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

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

If HHSC determines that it is necessary to conduct onsite monitoring of the HMO's Provider Hotline functions, the HMO is responsible for all reasonable costs incurred by HHSC or its authorized agent(s) relating to such monitoring.

8.1.4.8. Provider Reimbursement

Section 8.1.4.8 Modified by Versions 1.2 and 1.3

The HMO must make payment for all Medically Necessary Covered Services provided to all Members for whom the HMO is paid a capitation. The HMO must also make payment for all Functionally Necessary Covered Services provided to all Members for whom the HMO is paid a capitation. The HMO must ensure that claims payment is timely and accurate as described in **Section 8.1.18.5**. The HMO must require tax identification numbers from all participating Providers. The HMO 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 the requirements of Section 6505 of PPACA, entitled "Prohibition on Payments to Institutions or Entities Located Outside of the United States."

Provider payment must comply with the requirements of Section 2702 of PPACA, entitled "Payment Adjustment for Health Acquired Conditions."

8.1.4.8.1 Provider Preventable Conditions

Section 8.1.4.8 .1 Added by Version 1.3

STAR+PLUS HMOs must identify Present on Admission (POA) indicators as required in the **Uniform Managed Care Manual,** and must reduce or deny payments for Provider Preventable Conditions that were not POA using a methodology approved by HHSC in the **Uniform Managed Care Manual.**

8.1.4.9. Termination of Provider Contracts

Section 8.1.4.9 Modified by Version 1.3

The HMO 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 HMO must send notice to: (1) all Members in a PCP's panel, and (2) all Members who have had two (2) or more visits with the Network Provider for home-based or office-based care in the past 12 months. The HMO must notify HHSC of provider terminations in accordance with UMCM Chapter 5.4.1.1 "Provider Termination Report."

8.1.5. Member Services

The HMO must maintain a Member Services Department to assist Members and Members' family members or guardians in obtaining Covered Services for Members. The HMO must maintain employment standards and requirements (e.g., education, training, and experience) for Member Services Department staff and provide a sufficient number of staff for the Member Services Department to meet the requirements of this Section, including Member Hotline response times, and Linguistic Access capabilities, see 8.1.5.6 Member Hotline Requirements.

8.1.5.1. Member Materials

Section 8.1.5.1 Modified by Version 1.5

The HMO must design, print, and distribute Member identification (ID) cards and a Member Handbook to Members. Within five (5) business days following the receipt of an Enrollment File from the HHSC Administrative Services Contractor, the HMO 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 (2) or more new Members, the HMO is only required to send one Member Handbook. The HMO 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 available 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 HMO's Service Area, as specified by HHSC. HHSC will provide the HMO with reasonable notice when the population reaches the 10 percent threshold in the HMO's Service Area. All Member Materials must be available in a format accessible to the visually impaired, which may include large print, Braille, and audiotapes. Member Materials must comply with the requirements set forth in the **Uniform Managed Care Manual,** including required critical elements and marketing policies and procedures.

The HMO must submit Member Materials to HHSC for approval prior to use or mailing. HHSC will identify any required changes to the Member Materials within 15 business days. If HHSC has not responded to the Contractor by the fifteenth day, the Contractor may proceed to use the submitted materials. HHSC reserves the right to require the MCO to discontinue the use of any Member Materials that violate the terms of the **Uniform Managed Care Terms and Conditions**, including the **Uniform Managed Care Manual**.

If the HMO 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.

8.1.5.2. Member Identification (ID) Card

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

- The Member's name;
- The Member's Medicaid number;
- The effective date of the PCP assignment;
- The PCP's name, address (optional for all products), and telephone number;
- The name of the HMO;
- The 24-hour, seven (7) day a week toll-free Member services telephone number and BH Hotline number operated by the HMO; and
- Any other critical elements identified in the **Uniform Managed Care Manual**.

The HMO 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 HMO 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 **Uniform Managed Care Manual**.

The HMO 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 such change in Covered Services. In addition to modifying the Member Materials for new Members, the HMO 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 HMO is responsible for submitting draft Provider directory updates to HHSC for 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 HMO must develop and submit to HHSC the draft Provider Directory template for approval and must submit a final Provider Directory incorporating changes required by HHSC prior to the Operational Start Date. Such draft and final Provider Directories must be submitted according to the deadlines established in **Section 7**.

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 **Uniform Managed Care Manual**. The Provider Directory must include only Network Providers credentialed by the HMO in accordance with **Section 8.1.4.4**. If the HMO contracts with limited Provider Networks, the Provider Directory must comply with the requirements of 28 T.A.C. §11.1600(b)(11), relating to the disclosure and notice of limited Provider Networks.

The HMO must update the Provider Directory on a quarterly basis. The HMO must make such updates available to existing Members upon request, and must provide such updates to the HHSC Administrative Services Contractor at the beginning of each state fiscal quarter. HHSC will consult with the HMOs and the HHSC Administrative Services Contractors to discuss methods for reducing the HMO'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 HMO has not made major changes in its Provider Network, as determined by HHSC. HHSC will establish weight limits for the Provider Directories. Weight limits may vary by Service Area. HHSC will require HMOs that exceed the weight limits to compensate HHSC for postage fees in excess of the weight limits.

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

8.1.5.5. Internet Website

Section 8.1.5.5 Modified by Version 1.5

The HMO must develop and maintain, consistent with HHSC standards and Section 843.2015 of the Texas Insurance Code and other applicable state laws, a website to provide general information about the HMO, 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 HMO may develop a page within its existing website to meet the requirements of this section.

The HMO must maintain a Provider Directory for the STAR+PLUS Program on its website. The HMO must ensure that Members have access to the most current and accurate information concerning the HMO's Network Provider participation. To comply with this requirement, at least twice per month the HMO must update Provider information in either: (1) its online Provider Directory, or (2) its online Provider search functionality, if applicable. The online Provider Directory or online Provider search functionality must designate Providers with open versus closed panels. The online Provider Directory or online Provider search functionality must also identify Providers that provide Long-Term Services and Supports (LTSS). All HMOs must list Home Health Ancillary Providers on their websites, with an indicator for Pediatric services if provided.

The HMO's website must comply with HHSC's marketing policies and procedures, as set forth in the **Uniform Managed Care Manual**.

The website's STAR+PLUS content must be:

- 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 HMO's Service Area. HHSC will provide the HMO with reasonable notice when the population reaches the 10 percent threshold);
- Culturally appropriate;
- Written for understanding at the 6th grade reading level; and
- Be geared to the health needs of the enrolled population.

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

8.1.5.6. Member Hotline Requirements

Section 8.1.5.6 Modified by Versions 1.2 and 1.3

The HMO must operate a toll-free hotline that Members can call 24 hours a day, seven (7) days a week. The Member Hotline must be staffed with personnel designated solely to the STAR+PLUS Program. This staff must be properly trained, competent and knowledgeable about the STAR+PLUS Program, Covered Services, and Non-capitated Services. The Member Hotline must be fully operational between the hours of 8:00 a.m. to 5:00 p.m. local time for the Service Area, Monday through Friday, excluding state-approved holidays.

The HMO must ensure that after hours, on weekends, and on holidays the Member Services Hotline is answered by an automated system with the capability to provide callers with operating hours and instructions on what to do in cases of emergency. All recordings must be in English, Spanish, and the languages of any Major Population Groups. A voice mailbox must be available after hours for callers to leave messages.

The HMO's Member Services representatives must return Member calls received by the automated system on the next working day.

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

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

- Knowledgeable about the STAR+PLUS Program and Covered Services;
- Able to answer non-technical questions pertaining to the role of the PCP, as applicable;
- Able to answer non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services;
- Able to give information about Providers in a particular area;
- Knowledgeable about Fraud, Abuse, and Waste and the requirements to report any conduct that, if substantiated, may constitute Fraud, Abuse, or Waste;
- Trained regarding Cultural Competency;
- Trained regarding the process used to confirm the status of persons with Special Health Care Needs;
- Able to answer non-clinical questions pertaining to accessing Non-capitated Services;
- 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; and b) DME processes for obtaining services and how to address common problems.

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. To meet these requirements, the HMO must employ bilingual Spanish-speaking Member Services representatives and must secure the services of other contractors as necessary to meet these requirements. The HMO must provide such oral interpretation services to all Hotline callers free of charge.

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

- 99 percent of calls are answered by the fourth ring or an automated call pick-up system;
- No more than one (1) percent of incoming calls receive a busy signal;
- 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;

- The call abandonment rate is seven (7) percent or less; and
- The average hold time is two (2) minutes or less.

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

The Member Services Hotline may serve multiple HMO Programs and/or Service Areas if Hotline staff is knowledgeable about all of the HMO's Programs and Service Areas, including the Provider Network in each Service Area.

The HMO must monitor its performance regarding HHSC Member Hotline standards and submit performance reports summarizing call center performance for the Member Hotline as indicated in **Section 8.1.20** and the **Uniform Managed Care Manual.**

If HHSC determines that it is necessary to conduct onsite monitoring of the HMO's Member Hotline functions, the HMO is responsible for all reasonable costs incurred by HHSC or its authorized agent(s) relating to such monitoring.

8.1.5.6.1. Nurseline

The HMO is encouraged to train staff at its 24-hour nurse hotline about: a) the 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; and b) DME processes for obtaining services and how to address common problems. The 24-hour nurse hotline will attempt to respond immediately to problems concerning emergency medicines by means at its disposal, including explaining the rules to Members so that they understand their rights and, if necessary, by offering to contact the pharmacy that is refusing to fill the prescription to explain the 72-hour supply policy and DME processes.

8.1.5.7. Member Education

Section 8.1.5.7 Modified by Version 1.5

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

- How the HMO system operates, including the role of the PCP;
- Covered Services, and limitations and any Value-added Services offered by the HMO;
- The value of screening and preventive care, and
- How to obtain Covered Services, including:
    - Emergency Services;
    - Specialty care;
    - Behavioral Health Services;
    - Disease Management services;
    - Service Coordination;
    - Early Childhood Intervention (ECI) Services;
    - Screening and preventive services, including well-child care (Texas Health Steps medical checkups);

- Community-based Long-term Care Services;
- Consumer-Directed Services;
- Member copayment responsibilities (if HHSC implements Medicaid cost sharing after the Effective Date of the Contract);
- suicide prevention;
- identification and health education related to Obesity;
- Obtaining 72-hour supplies of emergency prescriptions from pharmacies enrolled with HHSC as Medicaid Providers; and
- Case Management for Children and Pregnant Women (CPW).

The HMO must provide a range of health promotion and wellness information and activities for Members in formats that meet the needs of all Members. The HMO must propose, implement, and assess innovative Member education strategies for wellness care and immunization, as well as general health promotion and prevention. The HMO must conduct wellness promotion programs to improve the health status of its Members. The HMO may cooperatively conduct health education classes for all enrolled Members with one or more HMOs also contracting with HHSC in the Service Area. The HMO must work with its Providers to integrate health education, wellness, and prevention training into the care of each Member.

The HMO also must provide condition and disease-specific information and educational materials to Members, including information on its Service Management and Disease Management programs described in **Section 8.1.14 and Section 8.1.** Condition- and disease-specific information must be oriented to various groups within the STAR+PLUS eligible population, such as children, the elderly, persons with disabilities and non-English speaking Members.

8.1.5.8. Cultural Competency Plan

The HMO must have a comprehensive written Cultural Competency Plan describing how the HMO will ensure culturally competent services, and provide Linguistic Access and Disability-related Access. The Cultural Competency Plan must describe how the individuals and systems within the HMO will effectively provide services to people of all cultures, 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 HMO 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 HMO's Provider Network.

8.1.5.9. Member Complaint and Appeal Process

The HMO must develop, implement and maintain a system for tracking, resolving, and reporting Member Complaints regarding its services, processes, procedures, and staff. The HMO must ensure that Member Complaints are resolved within 30 calendar days after receipt. The HMO 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 HMO. The state will refer Member Complaints that it receives

regarding the HMO to the HMO for resolution. Please see the **Uniform Managed Care Contract Terms & Conditions** and **B-4, Deliverables/Liquidated Damages Matrix.**

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

The HMO must ensure that Member Appeals are resolved within 30 calendar days of receipt, unless the HMO can document that the Member requested an extension or the HMO shows there is a need for additional information and the delay is in the Member's interest. The HMO 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 HMO. Please see the **Uniform Managed Care Contract Terms & Conditions** and **Attachment B-5, Deliverables/Liquidated Damages Matrix.**

The HMO must follow the Member Complaint and Appeal Process described in **Section 8.1.27**.

8.1.6. Marketing and Prohibited Practices

The HMO and its Subcontractors must adhere to the Marketing Policies and Procedures as set forth by HHSC in the Contract, and the **HHSC Uniform Managed Care Manual**.

8.1.7. Quality Assessment and Performance Improvement

The HMO 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 HMO 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 HMO must provide mechanisms for Members and Providers to offer input into the HMO's quality improvement activities.

8.1.7.1. QAPI Program Overview

The HMO must develop, maintain, and operate a quality assessment and performance improvement (QAPI) Program consistent with the Contract, and TDI requirements, including 28 T.A.C. §11.1901(a)(5) and §11.1902. The HMO must also meet the requirements of 42 C.F.R. §438.240.

The HMO must have on file with HHSC an approved plan describing its QAPI Program, including how the HMO will accomplish the activities required by this section. The HMO must submit a QAPI Program Annual Summary in a format and timeframe specified by HHSC or its designee. The HMO must keep participating physicians and other Network

Providers informed about the QAPI Program and related activities. The HMO must include a requirement securing cooperation with the QAPI in its Network Provider agreements.

The HMO 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:

- Evaluate performance using objective quality indicators;
- Foster data-driven decision-making;
- Recognize that opportunities for improvement are unlimited;
- Solicit Member and Provider input on performance and QAPI activities;
- Support continuous ongoing measurement of clinical and non-clinical effectiveness and Member satisfaction;
- Support programmatic improvements of clinical and non-clinical processes based on findings from on-going measurements; and
- 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 HMO must maintain a well-defined QAPI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. The HMO 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 HMO must ensure that the QAPI Program structure:

- Is organization-wide, with clear lines of accountability within the organization;
- 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;
- Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and
- Evaluates the effectiveness of clinical and non-clinical initiatives.

8.1.7.3. Clinical Indicators

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

8.1.7.4. QAPI Program Subcontracting

If the HMO subcontracts any of the essential functions or reporting requirements contained within the QAPI Program to another entity, the HMO 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 HMO 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 HMO must collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.

8.1.7.6. Clinical Practice Guidelines

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

The HMO may coordinate the development of clinical practice guidelines with other STAR+PLUS HMOs to avoid Providers in a Service Area receiving conflicting practice guidelines from different HMOs.

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

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

8.1.7.7. Provider Profiling

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

Provider profiling activities must include, but not be limited to:

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

8.1.7.8. Network Management

Section 8.1.7.8 Modified by Version 1.3

The HMO must:

- Use the results of its Provider profiling activities to identify areas of improvement for individual PCPs and Providers, and/or groups of Providers;
- Establish Provider-specific quality improvement goals for priority areas in which a Provider or Providers do not meet established HMO 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 such improvement goals.

If the HMO implements a physician incentive plan, the plan must comply with the requirements of 42 C.F.R. §438.6(h), §422.208 and §422.210. The HMO 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 HMO must ensure adequate stop-loss protection and conduct and submit annual Member surveys no later than five (5) Business Days after the HMO finalizes the survey results (refer to 42 C.F.R. §422.208 for information concerning "substantial financial risk" and "stop-loss protection").

The HMO must make information regarding physician incentive plans available to Members upon request, in accordance with the Uniform Managed Care Manual's requirements. The HMO must provide the following information to the Member:

1. whether the Member's PCP or other Providers are participating in the HMO's physician incentive plan;
2. whether the HMO 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 (5) Business Days prior to implementing or modifying a physician incentive plan, the HMO 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 HMO 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 HMO 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. Collaboration with the EQRO

The HMO 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 HMO improvement. To facilitate this process, the HMO will supply claims data to the EQRO in a format identified by HHSC in consultation with HMOs, and will supply medical records for focused clinical reviews conducted by the EQRO. The HMO 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.

8.1.8. Utilization Management

Section 8.1.8 Modified by Versions 1.3 and 1.5

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

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

The HMO 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 HMO must comply with the requirements of 42 C.F.R. §456.111 (Hospitals) and 42 CFR §456.211 (Mental Hospitals), as applicable.

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

- Within three (3) business days after receipt of the request for authorization of services;
- Within one (1) business day for concurrent hospitalization decisions; and
- Within one (1) hour for post-stabilization or life-threatening conditions, except that for Emergency Medical Conditions and Emergency Behavioral Health Conditions, the HMO must not require prior authorization.

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

- Consistent application of review criteria that are compatible with Members' needs and situations;
- Determinations to deny or limit services are made by physicians under the direction of the Medical Director;
- At the HMO's discretion, pharmacy prior authorization determinations may be made by pharmacists, subject to the limitations described in Attachment A, Section 4.04, "Medical Director;"
- 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 HMO must respond to calls within one business day;
- Confidentiality of clinical information; and
- Quality is not adversely impacted by financial and reimbursement-related processes and decisions.

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

The HMO UM Program must include polices and procedures to:

- Routinely assess the effectiveness and the efficiency of the UM Program;
- Evaluate the appropriate use of medical technologies, including medical procedures, drugs and devices;
- target areas of suspected inappropriate service utilization;
- Detect over- and under-utilization;
- Routinely generate Provider profiles regarding utilization patterns and compliance with utilization review criteria and policies;
- Compare Member and Provider utilization with norms for comparable individuals;
- Routinely monitor inpatient admissions, emergency room use, ancillary, and out-of-area services;
- Ensure that when Members are receiving Behavioral Health Services from the local mental health authority that the HMO 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

- Refer suspected cases of Provider or Member Fraud, Abuse, or Waste to the Office of Inspector General (OIG) as required by **Section 8.1.19**.

8.1.9. Early Childhood Intervention (ECI)

Section 8.1.9 Modified by Version 1.3

The HMO must ensure that Network Providers are educated regarding the federal laws on child find (e.g., 20 U.S.C. §1435 (a)(5); 34 C.F.R. §303.321(d)) and require Network Providers to identify and refer any Member birth through 35 months of age suspected of having a developmental disability or delay, or who is at risk of delay, to the designated ECI program for screening and assessment within two (2) working days from the day the Provider identifies the Member. The HMO 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. Eligibility for ECI services will be determined by the local ECI program using the criteria contained in 40 T.A.C. §108.25.

The HMO must contract with qualified ECI Providers to provide ECI services to Members birth through 35 months of age who have been determined eligible for ECI services. The HMO must permit Members to self refer to local ECI Service Providers without requiring a referral from the Member's PCP. The HMO's policies and procedures, including its Provider Manual, must include written policies and procedures for allowing such self-referral to ECI providers.

The HMO must coordinate and cooperate with local ECI programs in the development and implementation of the Individual Family Service Plan (IFSP), including on-going case management and other Non-capitated Services required by the Member's IFSP. The IFSP is an agreement developed by the interdisciplinary team that consists of the ECI Case Manager/Service Coordinator, the Member/family, and other professionals who participated in the Member's evaluation or are providing direct services to the Member, and may include the Member's Primary Care Physician (PCP) with parental consent. 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 shall be transmitted by the ECI Provider to the HMO and the PCP with parental consent to enhance coordination of the plan of care. The IFSP may be included in the Member's medical record.

Cooperation with the ECI program includes covering medical diagnostic procedures and providing medical records required to perform developmental assessments and developing the IFSP within the 45-day timeline established in federal rule (34 C.F.R. §303.342(a)). The HMO must require compliance with these requirements through Provider contract provisions. The HMO must not withhold authorization for the provision of such medical diagnostic procedures. The HMO must promptly provide to the ECI program, relevant medical records available to the HMO.

The interdisciplinary team will determine Medical Necessity for health and Behavioral Health Services as approved by the Member's PCP. The HMO must require, through contract provisions, that all Medically Necessary health and Behavioral Health Services

contained in the Member's IFSP are provided to the Member in the amount, duration, scope, and service setting established by the IFSP. The HMO must allow services to be provided by an Out-of-Network Provider if a Network Provider is not available to provide the services in the amount, duration, scope, and service setting as required by the IFSP. The HMO cannot modify the plan of care or alter the amount, duration, scope, or service setting required by the Member's IFSP. The HMO cannot create unnecessary barriers for the Member to obtain IFSP services, including requiring prior authorization for the ECI assessment or establishing insufficient authorization periods for prior authorized services.

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

The HMO 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 HMO must make referrals to WIC for Members potentially eligible for WIC. The HMO may use the nutrition education provided by WIC to satisfy certain health education requirements of the Contract.

8.1.11. Coordination with Texas Department of Family and Protective Services

The HMO must cooperate and coordinate with the Texas Department of Family and Protective Services (DFPS) for the care of a child who is receiving services from or has been placed in the conservatorship of DFPS.

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

- A court order (Order) entered by a Court of Continuing Jurisdiction placing a child under the protective custody of DFPS.
- A DFPS Service Plan entered by a Court of Continuing Jurisdiction placing a child under the protective custody of DFPS.
- A DFPS Service Plan voluntarily entered into by the parents or person having legal custody of a Member and DFPS.

The HMO cannot deny, reduce, or controvert the Medical Necessity of any Covered Service included in the court order, including Behavioral Health Services. The HMO may participate in the preparation of the medical and behavioral care plan prior to DFPS submitting the health care plan to the Court. Any modification or termination of court-ordered services must be presented and approved by the court having jurisdiction over the matter.

A Member or the parent or guardian whose rights are subject to an Order or Service Plan cannot use the HMO's Complaint or Appeal processes, or the HHSC Fair Hearing process to Appeal the necessity of the Covered Services.

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

- Providing medical records to DFPS;
- Scheduling medical and Behavioral Health Services appointments within 14 days unless requested earlier by DFPS; and
- Recognition of abuse and neglect, and appropriate referral to DFPS.

The HMO must continue to provide all Covered Services to a Member receiving services from, or in the protective custody of, DFPS until the Member has been; (1) disenrolled from the HMO due to loss of Medicaid managed care eligibility; or (2) enrolled in HHSC's managed care program for children in foster care, STAR Health.

8.1.12. Services for People with Special Health Care Needs

8.1.12.1. Identification

Section 8.1.12.1 Modified by Version 1.3

The HMO must develop and maintain a system and procedures for identifying Members with Special Health Care Needs (MSHCN), including people with disabilities or chronic or complex medical and behavioral health conditions and Children with Special Health Care Needs (CSHCN)[1].

The HMO must contact Members pre-screened by the HHSC Administrative Services Contractor as MSHCN to determine whether they meet the HMO's MSHCN assessment criteria, and to determine whether the Member requires special services described in this section. The HMO must implement mechanisms to assess each Member that has been pre-screened by the Administrative Services Contractor, or identified by the HMO as having special health care needs, in order to identify ongoing special conditions requiring a course of treatment or regular care monitoring. The HMO's assessment mechanisms must use appropriate health care professionals.

The HMO must provide information to the HHSC Administrative Services Contractor that identifies Members who the HMO has assessed to be MSHCN, including any Members pre-screened by the HHSC Administrative Services Contractor and confirmed by the HMO as an MSHCN. The information must be provided, in a format and on a timeline to be specified by HHSC in the **Uniform Managed Care Manual**, and updated with newly identified MSHCN by the 10th day of each month. In the event that an MSHCN changes HMOs, the HMO must provide the receiving contractor information concerning the results of the HMO's identification and assessment of that Member's needs, to prevent duplication of those activities.

[1] CSHCN is a term often used to refer to a services program for children with special health care needs administered by DSHS, and described in 25 TAC, Part 1, Section 38.1. Although children served through this program may also be served by Medicaid or CHIP, the reference to "CSHCN" in this Contract does not refer to children served through this program.

8.1.13. Access to Care and Service Management

Section 8.1.13 Modified by Version 1.5

Once identified, the HMO must have effective systems to ensure the provision of Covered Services to meet the special preventive, Acute Care, and specialty health care needs appropriate for treatment of the individual Member's condition(s). All STAR+PLUS Members are considered to be MSHCN.

The HMO must provide Members with access to identified PCPs and specialty care Providers with experience serving MSHCN. Such Providers must be board-qualified or board-eligible in their specialty. The HMO may request exceptions from HHSC for approval of traditional Providers who are not board-qualified or board-eligible but who otherwise meet the HMO's credentialing requirements.

For services to CSHCN, the HMO must have Network PCPs and specialty care Providers that have demonstrated experience with CSHCN in pediatric specialty centers such as children's Hospitals, teaching Hospitals, and tertiary care centers.

The HMO is responsible for working with MSHCN, their families, and legal guardians if applicable, and their health care Providers to develop a seamless package of care in which primary, Acute Care, and specialty service needs are met through a Service Plan that is understandable to the Member, or, when applicable, the Member's legal guardian.

The HMO is responsible for providing Service Management to develop a Service Plan and ensure MSHCN, including CSHCN, have access to treatment by a multidisciplinary team when the Member's PCP determines the treatment is Medically Necessary, or to avoid separate and fragmented evaluations and service plans. The team must include both physician and non-physician Providers determined to be necessary by the Member's PCP for the comprehensive treatment of the Member. The team must:

- Participate in Hospital discharge planning;
- Participate in pre-admission Hospital planning for non-emergency hospitalizations;
- Develop specialty care and support service recommendations to be incorporated into the Service Plan; and
- Provide information to the Member, or when applicable, the Member's legal guardian concerning the specialty care recommendations.

MSHCN, their families, or their health Providers may request Service Management from the HMO. The HMO must make an assessment of whether Service Management is needed and furnish Service Management when appropriate. The HMO may also recommend to an MSHCN, or to a CSHCN's family, that Service Management be furnished if the HMO determines that Service Management would benefit the Member.

The HMO must provide information and education in its Member Handbook and Provider Manual about the care and treatment available in the HMO's plan for Members with Special Health Care Needs, including the availability of Service Management.

The HMO must have a mechanism in place to allow MSHCN 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. The HMO must also provide MSHCN with access to non-primary care physician specialists as PCPs, as required by 28 T.A.C. §11.900 and **Section 8.1**.

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

- Community Resource Coordination Groups (CRCGs);
- Early Childhood Intervention (ECI) Program;
- Local school districts (Special Education);
- Texas Health and Human Services Commission (HHSC) Medical Transportation Program (MTP);
- Texas Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program;
- Texas Department of State Health (DSHS) services, including community mental health programs, the Title V Maternal and Child Health, and Children with Special Health Care Needs (CSHCN) Programs;
- Other state and local agencies and programs such as food stamps, the Women, Infants, and Children's (WIC) Program, and Case Management for Children and Pregnant Women (CPW);
- Civic and religious organizations and consumer and advocacy groups, such as United Cerebral Palsy, which also work on behalf of the MSHCN population.

8.1.14. Disease Management (DM)

Section 8.1.14 Modified by Version 1.5

The HMO must provide, or arrange to have provided to Members, comprehensive disease management services consistent with state statutes and regulations. Such DM services must be part of a person-based approach to DM and holistically address the needs of persons with multiple chronic conditions. The HMO must have a DM Program that addresses chronic conditions identified in HHSC's **Uniform Managed Care Manual**, 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 HMO must implement policies and procedures to ensure that Members that require DM services are identified and enrolled in a program to provide such DM services. The HMO must develop and maintain screening and evaluation procedures for the early detection, prevention, treatment, or referral of participants at risk for or diagnosed with the chronic conditions identified in the **Uniform Managed Care Manual**. The HMO 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 HMO and who require DM services, the HMO must evaluate and ensure continuity of care with any previous DM services in accordance with the requirements in the **Uniform Managed Care Manual**.

The HMO's DM Program must include:

- Patient self-management education;
- Provider education;
- Evidence-based models and minimum standards of care;
- Standardized protocols and participation criteria;
- Physician-directed or physician-supervised care;
- Implementation of interventions that address the continuum of care;
- Mechanisms to modify or change interventions that are not proven effective; and
- Mechanisms to monitor the impact of the DM Program over time, including both the clinical and the financial impact.

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

HHSC encourages HMOs 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 HMO must provide designated staff to implement and maintain the DM Program and to assist participating Members in accessing DM services. The HMO must educate Members and Providers about the HMO's DM Program and activities. Additional requirements related to the HMO's Disease Management Program and activities are found in the **HHSC Uniform Managed Care Manual**.

8.1.14.1. DM Services and Participating Providers

At a minimum, the HMO must:

- Implement a system for Providers to request specific DM interventions;
- Give Providers information, including differences between recommended prevention and treatment and actual care received by Members enrolled in a DM Program, and information concerning such Members' adherence to a service plan; and
- For Members enrolled in a DM Program, provide reports on changes in a Member's health status to their PCP.

8.1.14.2. HMO DM Evaluation

HHSC or its EQRO will evaluate the HMO's DM Program.

8.1.15. Behavioral Health (BH) Network and Services

STAR+PLUS Members in the Dallas Service Area will continue to be enrolled in NorthSTAR and will receive the applicable Behavioral Health Services from NorthSTAR. Services provided by NorthSTAR to Members in the Dallas Service Area are excluded from STAR+PLUS Covered Services. STAR+PLUS Members in the Tarrant Service Area will not be enrolled in NorthSTAR and will receive Behavioral Health Services from their STAR+PLUS HMO.

The HMO must provide, or arrange to have provided to Members all Medically Necessary Behavioral Health (BH) Services as described in **Attachment B-2**. All BH Services must be provided in conformance with the access standards included in **Section 8.1.3**. BH Services are described in more detail in the **Texas Medicaid Provider Procedures Manual** and the **Texas Medicaid Bulletins**. When assessing Members for BH Services, the HMO and its Network Behavioral Health Service Providers must use the DSM-IV multi-axial classification. HHSC may require use of other assessment instrument/outcome measures in addition to the DSM-IV. Providers must document DSM-IV and assessment/outcome information in the Member's medical record.

8.1.15.1. BH Provider Network

The HMO must maintain a Behavioral Health Services Provider Network that includes psychiatrists, psychologists, and other Behavioral Health Service Providers. To ensure accessibility and availability of qualified Providers to all Members in the Service Area, the Provider Network must include Behavioral Health Service Providers with experience serving special populations included in the STAR+PLUS program. Such special populations include children and adolescents, persons with disabilities, the elderly, and cultural or linguistic minorities.

8.1.15.2. Member Education and Self-referral for Behavioral Health Services

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

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

The HMO 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.

8.1.15.3. Behavioral Health Services Hotline

This Section includes Hotline functions pertaining to Members. Requirements for Provider Hotlines are found in **Section 8.1.4.7**. The HMO must have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel 24 hours a day, seven (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 HMO must operate a toll-free hotline as described in **Section 8.1.5.6** to handle Behavioral Health-related calls. The HMO may operate one hotline that handles emergency and crisis calls, as well as routine Member calls. The HMO 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 HMO Programs and/or Service Areas if the Hotline staff is knowledgeable about all of the HMO Programs and/or Service Areas, including the Behavioral Health Provider Network in each Service Area. The HMO must ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for all Service Areas:

- 99 percent of calls are answered by the fourth ring or an automated call pick-up system;
- No incoming calls receive a busy signal;
- 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;
- The call abandonment rate is seven (7) percent or less; and
- The average hold time is two (2) minutes or less.

The HMO must conduct on-going quality assurance to ensure these standards are met.

The HMO must monitor the HMO's performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated in **Section 8.1.20** and the **Uniform Managed Care Manual.**

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

8.1.15.4. Coordination between the BH Provider and the PCP

The HMO must require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or

suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice.

The HMO must provide training to network PCPs on how to screen for and identify behavioral health disorders, the HMO's referral process for Behavioral Health Services, and clinical coordination requirements for such services. The HMO 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 HMO shall develop and disseminate policies regarding clinical coordination between Behavioral Health Service Providers and PCPs. The HMO must require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement must be specified in all the Provider Manual.

The HMO must require that behavioral health Providers send initial and quarterly (or more frequently, if clinically indicated) summary reports of a Member's behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement must be specified in the Provider Manual.

8.1.15.5. Follow-up after Hospitalization for Behavioral Health Services

The HMO must require, through Provider contract provisions, that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. The HMO must ensure that Behavioral Health Service Providers contact Members who have missed appointments within 24 hours to reschedule appointments.

8.1.15.6. Chemical Dependency

The HMO must comply with 28 T.A.C. §3.8001 *et seq*., regarding utilization review for Chemical Dependency Treatment. Chemical Dependency Treatment must conform to the standards set forth in 28 T.A.C. Part 1, Chapter 3, Subchapter HH.

8.1.15.7. Court-Ordered Services

"Court-Ordered Commitment" means a commitment of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C.

The HMO must provide inpatient or outpatient psychiatric services to Members under the age of 21, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to Court-Ordered Commitments to psychiatric

facilities. The HMO is not obligated to cover placements as a condition of probation, authorized by the Texas Family Code.

The HMO cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric 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 the provisions of Chapter 573 or 574 of the Texas Health and Safety Code can only Appeal the commitment through the court system.

8.1.15.8. Local Mental Health Authority (LMHA)

The HMO 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 HMO 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 8.1.28**.

8.1.16. Financial Requirements for Covered Services

The HMO must pay for or reimburse Providers for all Medically Necessary Covered Services provided to all Members. The HMO 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 HMO. 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 HMO paid for such Covered Services, the HMO may obtain reimbursement from the responsible insurance entity not to exceed 100 percent of the value of Covered Services paid.

8.1.17. Accounting and Financial Reporting Requirements

Section 8.1.17 Modified by Version 1.5

The HMO'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 **Uniform Managed Care Manual**. The state will not recognize or pay services that cannot be properly substantiated by the HMO and verified by HHSC.

The HMO must:

- Maintain accounting records for STAR+PLUS separate and apart from other corporate accounting records;

- 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
- 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 HMO agrees to pay for all reasonable costs incurred by HHSC or its designee to perform an examination, review, or audit of the HMO's books pertaining to the Contract.

8.1.17.1. General Access to Accounting Records

The HMO 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 HMO must:

- Cooperate with the state and federal governments in their evaluation, inspection, audit, and/or review of accounting records and any necessary supporting information;
- 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. Such 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 HMO;
- 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 (7) Business Days, or as otherwise specified by HHSC, of receiving a written request from HHSC for specified records or information. If such documentation is not made available as requested, the HMO 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 such accounting records; and
- Pay any and all additional costs incurred by the state and federal governments that are the result of the HMO's failure to provide the requested accounting records or financial information within ten (10) business days of receiving a written request from the state or federal government.

8.1.17.2. Financial Reporting Requirements

HHSC will require the HMO to provide financial reports by Service Area to support Contract monitoring as well as state and federal reporting requirements. HHSC will consult with HMOs regarding the format and frequency of such reporting. All financial

Section 8.1.17.2 Modified by Versions 1.3 and 1.5

information and reports are the property of HHSC and will be public record, with the exception of any protected Member information contained within such 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 HMO 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 HMO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

HHSC's **Uniform Managed Care Manual** will govern the timing, format and content for the following reports.

(a) **Audited Financial Statement –**The HMO must provide the annual audited financial statement, for each year covered under the Contract, no later than June 30. The HMO 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 HMO must submit an Affiliate Report to HHSC if this information has changed since the last report submission. The report must contain the following:

- A list of all Affiliates, and
- 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 HMO by the Affiliate. Those should include financial terms, a detailed description of the services to be provided, and an estimated amount that will be incurred by the HMO for such services during the Contract Period.

(c) **BSP Report -** For dates of service from September 1, 2008 to August 31, 2011, the HMO must submit a monthly Bariatric Supplemental Payment (BSP) Report that includes the data elements specified in the **Uniform Managed Care Manual**. The BSP Report must include only bariatric surgeries that meet all of the following requirements:

- Unduplicated reports of bariatric surgeries;
- Bariatric surgeries that the HMO has paid under the group of procedure codes defined as allowable for bariatric reimbursement, as designated in the **Texas Medicaid Providers Procedures Manua**l, including the **Texas Medicaid Bulletins**; and
- Bariatric surgeries that were performed no earlier than 210 days prior to the date HHSC receives the BSP Report, or that were included in the BSP Report within 30 days from the date of discharge from the Hospital for the stay related to the bariatric surgery, whichever is later. If a medical service Provider does not submit a claim to the HMO by the deadline described herein, the HMO may request and exception to include the claim in the BSP Report. HHSC may, at its sole discretion, grant or deny the request.

(d) **Employee Bonus and/or Incentive Payment Plan –** If an HMO intends to include Employee Bonus or Incentive Payments as allowable administrative expenses, the HMO must furnish a written Employee Bonus and/or Incentive Payments Plan to HHSC so it may determine whether such payments are allowable administrative expenses in accordance with the Cost Principles Document in the **Uniform Managed Care Manual.** The written plan must include a description of the HMO's criteria for establishing bonus and/or incentive payments, the methodology to calculate bonus and/or incentive payments, and the timing of bonus and/or incentive payments. The Bonus and/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 HMO substantively revises the Employee Bonus and/or Incentive Payment Plan, the HMO must submit the revised plan to HHSC for prior review and approval.

(e) **Claims Lag Report -** The HMO 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 **Uniform Managed Care Manual Chapter 5, Section 5.6.2**. The report must disclose the amount of incurred claims each month and the amount paid each month.

(f) **DSP Report -** The HMO 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 **Uniform Managed Care Manual**. The DSP Report must include only unduplicated deliveries and only deliveries for which the HMO has made a payment, to either a Hospital or other Provider.

(g) **MCO Disclosure Statement -** The HMO must file:

1. an updated MCO Disclosure Statement by September 1^{s} of each Contract Year; and
2. a "change notification" abbreviated version of the report, no later than 30 days after any of the following events:
    a. entering into, renewing, modifying, or terminating a relationship with an affiliated party;
    b. after any change in control, ownership, or affiliations; or,
    c. after any material change in, or need for addition to, the information previously disclosed.

The MCO Disclosure Statement will include, at a minimum, a listing of the HMO'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/or CMS Program Integrity requirements. Minor quarterly adjustments in stock holdings for publicly-traded corporations are excluded from the reporting requirements. The reporting format is included in the Uniform Managed Care Manual.

(h) **FSR Reports –** The HMO 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 **Uniform Managed Care Manual**. The HMO 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 **Uniform Managed Care Manual**. 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.

(i) **HUB Reports –** Upon contract award, the HMO 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 HMO's good faith efforts to notify HUBs of subcontracting opportunities. The HMO must maintain its HUB Subcontracting Plan and submit monthly reports documenting the HMO's HUB program efforts and accomplishments to the HHSC HUB Office. The report must include a narrative description of the HMO's HUB program efforts and a financial report reflecting payments made to HUBs. HMOs must use the formats included in HHSC's **Uniform Managed Care Manual** for the HUB monthly reports. The HMO must comply with HHSC's standard Client Services HUB Subcontracting Plan requirements for all Subcontractors.

(j) **IBNR Plan -** The HMO must furnish a written incurred-but-not-reported (IBNR) Plan to manage IBNR expenses, and a description of the method of insuring against insolvency, including information on all existing or proposed insurance policies. The Plan must include the methodology for estimating IBNR. The plan and description must be submitted to HHSC no later than 60 days after the Effective Date of the Contract. Substantive changes to an HMO's IBNR plan and description must be submitted to HHSC no later than 30 days before the HMO implements changes to the IBNR plan.

(k) **Medicaid Disproportionate Share Hospital (DSH) Reports** – The HMO must file preliminary and final Medicaid DSH reports, required by HHSC to identify and reimburse Hospitals that qualify for Medicaid DSH funds. The preliminary and final DSH reports must include the data elements and be submitted in the form and format specified by HHSC in the **Uniform Managed Care Manual**. The preliminary DSH reports are due on or before March 1 of the year following the federal fiscal reporting year. The final DSH reports are due no later than April 1 of the year following the federal fiscal reporting year.

(l) **Out-of-Network Utilization Reports** – The HMO 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 **Uniform Managed Care Manual**. Quarterly reports are due 30 days after the end of each quarter.

(m) **TDI Examination Report -** The HMO 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 ten (10) days after receipt of the final report from TDI.

(n) **TDI Filings –** The HMO must submit annual figures to HHSC for controlled risk-based capital, as well as quarterly financial statements, both as required by TDI.

(o) **Registration Statement (also known as the "Form B") -** If the HMO is a part of an insurance holding company system, the HMO 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 such insurer with the insurance regulatory authority of its domiciliary jurisdiction.

(p) **Third Party Recovery (TPR) Reports -** The HMO must file TPR Reports in accordance with the format developed by HHSC in the **Uniform Managed Care Manual**. HHSC will require the HMO to submit TPR reports quarterly. TPR reports must include total dollars recovered from third party payors for services to the HMO's Members, and the total dollars recovered through coordination of benefits, subrogation, and worker's compensation.

(q) **Report of Legal and Other Proceedings and Related Events** - The HMO must comply with the **Uniform Managed Care Manual** Chapter 5.8, regarding the disclosure of certain matters involving either the HMO, its Affiliates, and/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.

8.1.18. Management Information System Requirements

Section 8.1.18 Modified by Version 1.5

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

- Enrollment/Eligibility Subsystem;
- Provider Subsystem;
- Encounter/Claims Processing Subsystem;
- Financial Subsystem;
- Utilization/Quality Improvement Subsystem;
- Reporting Subsystem;

- Interface Subsystem; and
- TPR Subsystem.

The MIS must enable the HMO 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 HMO administration.

HHSC will provide the HMO with pharmacy data on the HMO's Members on a weekly basis through the HHSC Vendor Drug Program, or, should these services be outsourced, through the Pharmacy Benefit Manager. HHSC will provide a sample format of pharmacy data to contract awardees.

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

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

The HMO 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 **Uniform Managed Care Terms and Conditions.** HHSC reserves the right to require a desk or on-site readiness review of the changes. HHSC retains the right to modify or waive the notification requirement contingent upon the nature of the request from the HMO.

The HMO must provide HHSC any updates to the HMO'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 HMO 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 HMO's ability to meet the MIS requirements as described in **Section 7**. The System Readiness Review may include a desk review and/or an onsite review and must be conducted for the following events:

- A new HMO is brought into the STAR+PLUS Program;
- An existing HMO begins business in a new Service Area;
- An existing HMO changes location;
- An existing HMO changes its processing system, including changes in Material Subcontractors performing MIS or claims processing functions; and
- An existing HMO in one or two HHSC HMO Programs is initiating a Contract to participate in any additional HMO Programs.

If HHSC determines that it is necessary to conduct an onsite review, the HMO is responsible for all reasonable travel costs associated with such 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 HMO does not fully meet the MIS requirements, the HMO must, upon request by HHSC, either correct such deficiency or submit to HHSC a Corrective Action Plan and Risk Mitigation Plan to address such deficiency 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 HMO's plan for any of its HMO Programs until such deficiency is corrected. Refer to **Attachment A, Article 12** and **Attachment B-5** for additional information regarding remedies and damages. **Refer to Section 7** and **Section 8.1.1.2** for additional information regarding HMO Readiness Reviews. Refer to **Attachment A, Section 4.08(c)** for information regarding Readiness Reviews of the HMO's Material Subcontractors.

8.1.18.1. Encounter Data

Section 8.1.18.1 Modified by Version 1.5

The HMO must provide complete Encounter Data for all Covered Services, including Value-added Services. Encounter Data must follow the format and data elements as described in the HIPAA-compliant 837 format. HHSC will specify the method of transmission, the submission schedule, and any other requirements in the **Uniform Managed Care Manual**. The HMO must submit Encounter Data transmissions monthly, and include all Encounter Data and Encounter Data adjustments processed by the HMO. 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 HMO. Encounter Data quality validation must incorporate assessment standards developed jointly by the HMO and HHSC. The HMO 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 HMO 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 HMO submit an Encounter Data file to HHSC's EQRO, in the format provided in the **Uniform Managed Care Manual**. 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 HMO 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 HMO requesting an exception. The HMO must also use the Provider numbers as directed by HHSC for both Encounter and fee-for-service claims submissions, as applicable.

8.1.18.2. HMO Deliverables Related to MIS Requirements

At the beginning of each State Fiscal Year (SFY), the HMO 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 HMO 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 HMO must submit plans and checklists to HHSC according to the format and schedule identified the HHSC **Uniform Managed Care Manual**. Additionally, if a Systems Readiness Review is triggered by one of the events described in Section 8.1.18, the HMO must submit all of the plans identified in this Section 8.1.18.2 in accordance with an HHSC-approved timeline.

The HMO 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 **Uniform Managed Care Manual**.

8.1.18.3. System-wide Functions

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

- Process electronic data transmission or media to add, delete, or modify membership records with accurate begin and end dates;
- Track Covered Services received by Members through the system, and accurately and fully maintain those Covered Services as HIPAA-compliant Encounter transactions;
- Transmit or transfer Encounter Data transactions on electronic media in the HIPAA format to the contractor designated by HHSC to receive the Encounter Data;
- Maintain a history of changes and adjustments and audit trails for current and retroactive data;

- Maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure;
- Employ industry standard medical billing taxonomies (procedure codes, diagnosis codes) to describe services delivered and Encounter transactions produced;
- Accommodate the coordination of benefits;
- Produce standard Explanation of Benefits (EOBs);
- Pay financial transactions to Providers in compliance with federal and state laws, rules and regulations;
- Ensure that all financial transactions are auditable according to GAAP guidelines.
- Relate and extract data elements to produce report formats (provided within the **Uniform Managed Care Manual)** or otherwise required by HHSC;
- Ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS;
- Maintain and cross-reference all Member-related information with the most current Medicaid Provider number; and
- 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 HMO's Member data.

8.1.18.4. Health Insurance Portability and Accountability Act (HIPAA) Compliance

Section 8.1.18.4 Modified by Version 1.5

The HMO's MIS system must comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, P.L. 104-191 (August 21, 1996), as amended or modified. The HMO must comply with HIPAA EDI requirements. The HMO'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 HMO must also be 5010 compliant by January 2012. The following website includes the final rules for 5010 Compliancy and ICD-10 Compliancy: www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp.

The HMO must provide its Members with a privacy notice as required by HIPAA. The HMO must provide HHSC with a copy of its privacy notice for filing.

8.1.18.5. Claims Processing Requirements

Section 8.1.18.5 Modified by Versions 1.3 and 1.5

The HMO must process and adjudicate all Provider claims for Medically Necessary health care Covered Services that are filed within the time frames specified in the **Uniform Managed Care Manual** Chapter 2.0, "Claims Manual," and pharmacy claims in that are filed in accordance with the timeframes specified in **Uniform Managed Care Manual** Chapter 2.2, "Pharmacy Claims Manual." The HMO is subject to remedies,

including liquidated damages and interest, if the HMO does not process and adjudicate claims in accordance with the procedures and the timeframes listed in the **Uniform Managed Care Manual.**

The HMO 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 **Uniform Managed Care Manual**. In addition, the HMO must be able to accept and process Provider claims in compliance with the **Texas Medicaid Provider Procedures Manual** and **Texas Medicaid Bulletins**.

The HMO 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 HMO's claims system must maintain online and archived files. The HMO must keep online automated claims payment history for the most current 18 months. The HMO 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 HMO 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 HMO to receive initial electronic claims through an HHSC-contracted vendor at a future date. This function will allow Providers to send claims to one location, which will then identify where the claim should be submitted. The HMO will be expected to have an interface that allows receipt of these electronic submissions. If HHSC implements this requirement, then the HMO must maintain a mechanism to receive claims in addition to the HHSC claims portal. Providers must be able to send claims directly to the HMO or its Subcontractor.

The HMO must provide a web portal that supports Batch Processing for Network Providers. 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.

The HMO 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 HMO may deny a claim submitted by a Provider for failure to file in a timely manner as provided for in the **Uniform Managed Care Manual**. The HMO must not pay any claim submitted by a provider based on an order or referral that excludes the National Provider Identifier (NPI) for the ordering or referring physician. The HMO must not pay any claim submitted by a Provider excluded or suspended from the Medicare, Medicaid, CHIP or CHIP Perinatal programs for Fraud, Abuse, or Waste. The HMO must not pay any claim submitted by a Provider that is on payment hold under the authority of HHSC or its authorized agent(s), or who has pending accounts receivable with HHSC.

The HMO is subject to the requirements related to coordination of benefits for secondary payors in the Texas Insurance Code Section 843.349 (e) and (f).

The HMO must notify HHSC of major claim system changes in writing no later than 180 days prior to implementation. The HMO 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 HMO 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 HMO/Provider contract. The HMO must make available to Providers claims coding and processing guidelines for the applicable Provider type. Providers must receive 90 days notice prior to the HMO's implementation of changes to claims guidelines.

The HMO'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.

8.1.18.6 National Correct Coding Initiative

Effective for claims filed on or after October 1, 2010, the HMO 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.

8.1.19. Fraud and Abuse

Section 8.1.19 Modified by Versions 1.2, 1.3, and 1.5

The HMO is subject to all state and federal laws and regulations relating to Fraud, Abuse, and Waste in health care and the Medicaid programs. The HMO must cooperate and assist HHSC and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected Fraud, Abuse, and Waste. The HMO must provide originals and/or copies of all records and information requested, allow access to premises, and provide records to the Inspector General for the Texas Health and Human Services System, HHSC or its authorized agent(s), the CMS, the U.S. Department of Health and Human Services (DHHS), the Federal Bureau of Investigation (FBI), the Office of the Attorney General, TDI, or other units of state government. The HMO must provide all copies of records free of charge.

Each HMO must designate one primary and one secondary contact person for all HHSC Office of Inspector General (OIG) records requests. HHSC OIG records requests will be sent to the designated HMO contact person(s) in writing via email, fax or regular mail, and will provide the specifics of the information being requested (see below). The HMO will respond to the appropriate HHSC OIG staff member within the timeframe designated in the request. If the HMO is unable to provide all of the requested information with in the designated timeframe, an extension may be granted and must be request in writing (email) by the HMO no less than two (2) Business Days prior to the due date. When a request for data is provided to the HMO, the HMO's response must include data for all data fields, as available. If any data field is left blank, an explanation must accompany the response. The data must be provided in the order and format requested. The HMO 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 will include:

- 1099 data and other financial information – five (5) Business Days.
- Claims data for sampling – 15 Business Days.
- Urgent claims data requests – 10 Business Days (with OIG manager's approval).
- Provider education information – 10 Business Days.
- Files associated with an HMO conducted investigation – 15 Business Day.
- Other time-sensitive requests – as needed.

The HMO must submit a written Fraud and Abuse compliance plan to the Office of Inspector General (OIG) at HHSC for approval each year. The plan must be submitted 90 days prior to the start of the State Fiscal Year. (See **Section 7** for requirements regarding timeframes for submitting the original plan.) If an HMO has not made any changes to its plan from the previous year, it may notify the HHSC OIG that: (1) no changes have been made to the previously-approved plan, (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 HMO that is responsible for carrying out the Fraud and Abuse compliance plan. Upon receipt of a written request from the HHSC OIG, the HMO must submit the complete Fraud and Abuse compliance plan.

The HMO is subject to and must meet all requirements in Section 531.113 of the Texas Government Code, Section 533.012 of the Texas Government Code, Title 1 Texas Administrative Code (TAC), Part 15, Chapter 353, Subchapter F, Rule 353.501-353.505, and Title 1 Texas Administrative Code (TAC), Part 15, Chapter 370, Subchapter F, Rule 370.501-370.505 as well as all laws specified in **Attachment A**, Section 7.02. Failure to comply with any requirement of 8.1.19 and 8.1.20.2(c) and (d) subjects the HMO to enforcement pursuant to 1 TEX. ADMIN. CODE Chapter 371 Subchapter G in addition to any other legal remedy.

Additional Requirements:

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

- Establish written policies for all employees, managers, officers, contractors, Subcontractors, and agents of the HMO 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 such laws, as described in Section 1902(a)(68)(A).
- Include as part of such written policies, detailed provisions regarding the HMO's or Subcontractor's policies and procedures for detecting and preventing Fraud, Abuse, and Waste.
- 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 HMO's or Subcontractor's policies and procedures for detecting and preventing Fraud, Abuse, and Waste.

8.1.20. Reporting Requirements

The HMO must provide and must require its Subcontractors to provide:

- 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
- 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 HMOs 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 HMO 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 HMO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

The HMO'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 HMO and is true and accurate to the best of their knowledge after reasonable inquiry.

8.1.20.1. HEDIS and Other Statistical Performance Measures

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

in consultation with the HMO. Such measures must be consistent with the Health Plan Employer Data and Information Set (HEDIS) or other externally based measures or measurement sets, and involve collection of information beyond that present in Encounter Data. The **Performance Indicator Dashboard** found in the **Uniform Managed Care Manual** provides additional information on the role of the HMO and the EQRO in the collection and calculation of HEDIS, CAHPS, and other performance measures.

8.1.20.2. Reports

Section 8.1.20.2 Modified by Version 1.5

The HMO must provide the following reports, in addition to the Financial Reports described in **Section 8.1.17** and those reporting requirements listed elsewhere in the Contract. The **HHSC Uniform Managed Care Manual** 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 HMO must submit quarterly Claims Summary Reports to HHSC by HMO 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/or professional services for Acute Care, Behavioral Health, Vision, and Community-based Long Term Care Services. 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 **Chapter 5, Section 5.6.1** of the **Uniform Managed Care Manual**.

(b) QAPI Program Annual Summary Report - The HMO must submit a QAPI Program Annual Summary in a format and timeframe as specified in the **Uniform Managed Care Manual**.

(c) Fraudulent Practices Report - Utilizing the HHSC Office of Inspector General (OIG) fraud referral form, the HMO's assigned officer or director must report and refer all possible acts of Fraud, Abuse, and Waste to the HHSC OIG within 30 working days of receiving the reports of possible acts of Fraud, Abuse, and Waste from the HMO's Special Investigative Unit (SIU). The report and referral must include:

- An investigative report identifying the allegation, statutes/regulations violated or considered, and the results of the investigation;
- Copies of program rules and regulations violated for the time period in question;
- Copies of any HMO contractual provisions, policies, published HMO program bulletins, policy notification letters, or provider policy or procedure manuals that apply to the alleged conduct for the time period in question;
- The estimated overpayment identified;
- A summary of the interviews conducted;
- The Encounter Data submitted by the Provider for the time period in question; and
- 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 **HHSC Uniform Managed Care Manual**.

(d) Provider Termination Report: - The HMO must submit a quarterly report that identifies any Providers who cease to participate in HMO'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 HMO must submit quarterly Member Complaints and Appeals reports. The HMO 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 HMO 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 **HHSC Uniform Managed Care Manual, Chapter 5.4.2**.

(f) Summary Report of Provider Complaints - The HMO must submit Provider complaint reports on a quarterly basis. The HMO 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 **HHSC Uniform Managed Care Manual, Chapter 5.4.2**.

(g) Hotline Reports - The HMO 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, 8.1.15.3, and 8.1.4.7**. The HMO shall submit such reports using a format to be prescribed by HHSC in consultation with the HMOs.

If the HMO is not meeting a hotline performance standard, HHSC may require the HMO to submit monthly hotline performance reports and implement corrective actions until the hotline performance standards are met. If an HMO has a single hotline serving multiple Service Areas, multiple HMO Programs, or multiple hotline functions, (i.e. Member, Provider, Behavioral Health Services hotlines), HHSC may request on an annual basis that the HMO submit certain hotline response information by HMO Program, by Service Area, and by hotline function, as applicable to the HMO. HHSC may also request this type of hotline information if an HMO is not meeting a hotline performance standard.

(h) Audit Reports – The HMO must comply with the **HHSC Uniform Managed Care Manual** requirements regarding notification and/or submission of audit reports.

(i) Medicaid Managed Care Texas Health Steps Medical Checkups Report – The HMO must submit reports that identify:

- The total number of New Members under the age of 21 who were enrolled continuously for 90 days or more with the HMO;
- The number of New Members under the age of 21 who were enrolled continuously for 90 days or more with the HMO who get medical checkups within 90 days of enrollment into the HMO;

- The total number of Existing Members under the age of 21 who were enrolled at the beginning of the reporting year and were continuously enrolled for 90 days or more with the HMO into the reporting year (excludes New Members reported in the same reporting year); and
- The number of Existing Members under the age of 21 who were enrolled at the beginning of the reporting year and were continuously enrolled for 90 days or more with the HMO into the reporting year (excludes New Members reported in the same reporting year) who got timely, age-appropriate medical checkups during the reporting year.

The HMO must also document and report those Members refusing to obtain the medical checkups. The documentation must include the reason the Member refused the check-up or the reason the check-up was not received.

The definitions, timeframe, format, and details of the report are contained and described in the **Uniform Managed Care Manual**.

(j) Children of Migrant Farm Workers Annual Report (FWC Annual Report) -- The HMO must submit an annual report, in the timeframe and format described in the **Uniform Managed Care Manual**, about the identification of and delivery of services to children of migrant farm workers (FWC). The report will include a description and results of the each of the following:

- The HMO's efforts to identify as many community and statewide groups that work with FWC as possible within each of its Service Areas;
- The HMO's efforts to coordinate and cooperate with as many of such groups as possible; and
- The HMO's efforts to encourage the community groups to assist in the identification of FWC.

The HMO will maintain accurate, current lists of all identified FWC Members.

(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 vs. Suehs* lawsuit. Medicaid HMOs 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 **Uniform Managed Care Manual**.

(l) Frew Health Care Provider Training Report -- Per the *Frew vs. Suehs* "Corrective Action Order: Health Care Provider Training," HHSC must compile a summary of the training health care providers receive throughout the year for the October Quarterly Monitoring Report for the court. Medicaid HMOs must report to HHSC health care provider training conducted throughout the year to be included in this report.

The timeframe, format, and details of the report are contained and described in the **Uniform Managed Care Manual**.

(m) Frew Provider Recognition Report - Per the Frew vs. Suehs' "Corrective Action Order: Health Care Provider Training," HHSC must recognize Medicaid enrolled healthcare providers who complete Frew and/or Texas Health Steps (THSteps) training. Medicaid HMOs must collect and track provider training recognition information for all Frew and/or THSteps trainings conducted and report the names of those Medicaid enrolled healthcare providers who consent to being recognized to HHSC quarterly.

The timeframe, format, and details of the report are contained and described in the **Uniform Managed Care Manual**.

(n) Drug Utilization Review (DUR) Reports – HMOs must submit the DUR reports in accordance with the requirements of HHSC's Uniform Managed Care Manual.

8.1.21. Continuity of Care and Out-of-Network Providers

Section 8.1.21 Modified by Version 1.2

The HMO must ensure that the care of newly enrolled Members is not disrupted or interrupted. The HMO must take special care to provide continuity in the care of newly enrolled Members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if Medically Necessary Covered Services are disrupted or interrupted. See **Section 8.1.14,** Disease Management, for specific requirements for New Members transferring to the HMO's DM Program.

The HMO is required to ensure that clients receiving Community-based Long Term Care Services at the time of implementation are guaranteed continued authorization of those services for up to six (6) months after the Operational Start Date, unless a new assessment has been completed and new authorizations issued as described in Section 8.1.34.4. During transition, an HHS Agency will provide a file identifying these clients to the HMO for this purpose. The HMO is required to work with HHSC and DADS to ensure that all necessary authorizations are in place within the HMO's system(s) for the continuation of Community-based Long Term Care Services on the Operational Start Date and for up to six (6) months following. The HMO must describe the process it will use to ensure continuation of current Community-based Long Term Care Services in its Transition/Implementation Plan as noted in **Section 7.3.1.1 Contract Start-Up and Planning**. The HMO is required to ensure that Community-based Long Term Care Services Providers are educated about and trained regarding this process prior to the Operational Start Date (see **Section 8.1.38.1**).

The HMO 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 HMO must pay a Member's existing Out-of-Network Providers for Medically Necessary Covered Services until the Member's records, clinical information, and care can be transferred to a Network Provider, or until such time as the Member is no longer enrolled in that HMO, whichever is shorter. Payment to Out-of-Network Providers must be made within the time period required for Network Providers. The HMO must comply with Out-of-Network Provider reimbursement rules as adopted by HHSC.

With the exception of pregnant Members who are past the 24th week of pregnancy, this Article does not extend the obligation of the HMO to reimburse the Member's existing Out-of-Network Providers for on-going care for:

- More than 90 days after a Member enrolls in the HMO, or
- For more than nine (9) months in the case of a Member who, at the time of enrollment in the HMO, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled in the HMO.

The HMO's obligation to reimburse the Member's existing Out-of-Network Provider for services provided to a pregnant Member past the 24th week of pregnancy extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six (6) weeks of delivery.

The HMO 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 HMO must provide Members with timely and adequate access to Out-of-Network services for as long as those services are necessary and covered benefits not available within the Network, in accordance with 42 C.F.R. §438.206(b)(4). The HMO will not be obligated to provide a Member with access to Out-of-Network services if such services become available from a Network Provider.

The HMO must ensure that each Member has access to a second opinion regarding the use of any Medically Necessary Covered Service. A Member must be allowed access to a second opinion from a Network Provider or Out-of-Network Provider if a Network Provider is not available, at no cost to the Member, in accordance with 42 C.F.R. §438.206(b)(3).The requirements in this **Section 8.1.21** regarding access to and payment of Out-of-Network providers apply only to Out-of-Network providers who are enrolled Texas Medicaid providers.

8.1.22. Provisions Related to Covered Services for Members

8.1.22.1. Emergency Services

HMO 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 HMO's Network or Out-of-Network. HMO 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 HMO 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, seven (7) days a week, rendered by either the HMO's Network or Out-of-Network Providers.

The HMO cannot require prior authorization as a condition for payment for an Emergency Medical Condition, an Emergency Behavioral Health Condition, or labor and delivery. The HMO cannot limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. The HMO cannot refuse to cover Emergency Services based on the emergency room Provider, Hospital, or fiscal agent not notifying the Member's PCP or the HMO of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services. The HMO 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 HMO 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 HMO must pay for the emergency medical screening examination, as required by 42 U.S.C. §1395dd. The HMO 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 HMO must pay for Emergency Services performed to stabilize the Member. The emergency physician must document these services in the Member's medical record. The HMO must reimburse for both the physician's and Hospital's emergency stabilization services including the emergency room and its ancillary services.

The HMO 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 HMO is financially responsible for Post-Stabilization Care Services obtained within or outside the Network that are not pre-approved by a Provider or other HMO representative, but administered to maintain, improve, or resolve the Member's stabilized condition if:

- The HMO does not respond to a request for pre-approval within one (1) hour;
- The HMO cannot be contacted; or
- The HMO 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 HMO 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 HMO'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 HMO 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.

8.1.22.2. Family Planning - Specific Requirements

The HMO 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 HMO must develop outreach programs to increase community support for family planning and encourage Members to use available family planning services.

The HMO 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 HMO 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 HMO must provide access to confidential family planning services.

The HMO must provide, at minimum, the full scope of services available under the Texas Medicaid program for family planning services. The HMO 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 HMO cannot require prior authorization for family planning services whether rendered by a Network or Out-of-Network provider.

The HMO 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 HMO 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 HMO 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 HMO must require,

through contractual provisions, that Subcontractors have mechanisms in place to ensure Member confidentiality for family planning services.

8.1.22.3. Texas Health Steps (EPSDT)

Section 8.1.22.3 Modified by Version 1.2

8.1.22.3.1 Medical Checkups

The HMO must develop effective methods to ensure that children birth through age 20 receive Texas Health Steps services when due and according to the recommendations established by the Texas Health Steps periodicity schedule for children. The HMO must arrange Texas Health Steps services for all eligible Members, except when a Member knowingly and voluntarily declines or refuses services after receiving sufficient information to make an informed decision.

For New Members birth through age 20, overdue or upcoming Texas Health Steps medical checkups should be offered as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 90 days of enrollment for all other eligible child Members. 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 within 365 calendar days after the child's birthday. For purposes of this requirement, the terms "New Member" and "Existing Member" are defined in Chapter 12.4 of the Uniform Managed Care Manual.

The HMO must have mechanisms in place to ensure that all newborn Members have an initial newborn checkup before discharge from the Hospital and in accordance with the Texas Health Steps periodicity schedule.

Section 8.1.22.3.1 renumbered to 8.1.22.3.2 by Version 1.2

8.1.22.3.2 Oral Evaluation and Fluoride Varnish

The HMO must educate Providers on the availability of the Oral Evaluation and Fluoride Varnish (OEVS) 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.

8.1.22.3.3 Lab

The HMO 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 Section 33.016 of the Health and Safety

Code for analysis. The HMO must educate Providers about Texas Health Steps Program requirements for submitting laboratory tests to the DSHS Laboratory Services Section.

8.1.22.3.4 Education/Outreach

Section 8.1.22.3.4 Modified by Version 1.5

The HMO must ensure that Members are provided information and educational materials about the services available through the Texas Health Steps Program, and when and how they may obtain the services. The information should tell the Member how they can obtain dental benefits, transportation services through the state's Medical Transportation Program, and advocacy assistance from the HMO. The UMCM includes required language for Texas Health Steps services, including medical, dental and case management services. Any additions to or deviations from the required language must be reviewed and approved by HHSC prior to publication and distribution to Members.

The HMO will encourage Network pharmacies to also become Medicaid-enrolled durable medical equipment (DME) Providers.

The HMO must provide outreach to Members to ensure they receive prompt services and are effectively informed about available Texas Health Steps services. Each month, the HMO must retrieve a list of Members who are due and overdue for Texas Health Steps services provided by the HHSC Administrative Services Contractor, posted to Tex Med Central. Using these lists and its own internally generated list, the HMO will contact such Members to obtain the service as soon as possible. The HMO outreach staff must coordinate with DSHS Texas Health Steps outreach unit and HHSC MTP staff to ensure that Members have access to the Medical Transportation Program, and that any coordination with other agencies is maintained.

The HMO 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 farm workers (FWC) and other migrant populations who may transition into and out of the HMO more rapidly and/or unpredictably than the general population.

The HMO 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 HMO 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.

8.1.22.3.5 Training

The HMO 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, etc., 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 HMO's process for acceleration of THSteps services for Children of Migrant Farm Workers;
8. missed appointment referrals and assistance provided by the THSteps Outreach and Informing Unit; and
9. administrative issues such as claims filing and services available to Members.

HMO must also educate and train Providers regarding the requirements imposed on HHSC and contracting HMOs under the Consent Decree and Corrective Action Orders entered in *Frew v. Suehs, et. al.*, Civil Action No. 3:93CV65, in the United States District Court for the Eastern District of Texas, Paris Division. Providers should be educated and trained to treat each Texas Health Steps visit as an opportunity for a comprehensive assessment of the Member.

8.1.22.3.6 Data Validation

The HMO 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 HMO. 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 HMO and/or Network Providers being investigated for potential Fraud, Abuse, or Waste without notice to the HMO or the Provider.

8.1.22.4. Perinatal Services

Section 8.1.22.4 Modified by Version 1.2

The HMO's perinatal health care services must ensure appropriate care is provided to women and infant Members of the HMO from the preconception period through the infant's first year of life. The HMO'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 T.A.C. Chapter 37, Subchapter M.

The HMO must have a perinatal health care system in place that, at a minimum, provides the following services:

- Pregnancy planning and perinatal health promotion and education for reproductive-age women;
- Perinatal risk assessment of non-pregnant women, pregnant, and postpartum women, and infants up to one year of age;
- Access to appropriate levels of care based on risk assessment, including emergency care;
- Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary;
- Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; and
- Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems.

The HMO 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 HMO 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 such care.

The HMO 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 HMO cannot deny claims based on a Provider's non-use of state-issued Medicaid ID number for a newborn Member. The HMO must accept Provider claims for newborn services based on mother's name and/or Medicaid ID number with accommodations for multiple births, as specified by the HMO.

The HMO must notify Providers involved in the care of pregnant/delivering women and newborns (including Out-of-Network Providers and Hospitals) of the HMO's prior authorization requirements. The HMO 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.

8.1.22.5. Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV)

The HMO must provide STD services that include STD/HIV prevention, screening, counseling, diagnosis, and treatment. The HMO is responsible for implementing procedures to ensure that Members have prompt access to appropriate services for STDs, including HIV. The HMO must allow Members access to STD services and HIV diagnosis services without prior authorization or referral by a PCP.

The HMO must comply with Texas Family Code Section 32.003, relating to a child's consent to treatment. The HMO 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 HMO must make education available to Providers and Members on the prevention, detection, and effective treatment of STDs, including HIV.

The HMO must require Providers to report all confirmed cases of STDs, including HIV, to the local or regional health authority according to 25 T.A.C. §§97.131 - 97.134, using the required forms and procedures for reporting STDs. The HMO 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 HMO 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 HMO 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 HMO must inform and require its Providers who provide STD/HIV services to comply with all state laws relating to communicable disease reporting requirements. The HMO must implement policies and procedures to monitor Provider compliance with confidentiality requirements.

The HMO must have policies and procedures in place regarding obtaining informed consent and counseling Members provided STD/HIV services.

8.1.22.6. Tuberculosis (TB)

The HMO must provide Members and Providers with education on the prevention, detection, and effective treatment of tuberculosis (TB). The HMO 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 8.1.22.8** as Medicaid Non-capitated Services. The HMO 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 HMO 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 HMO 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 HMO must provide access to Member medical records to DSHS and the local TB control program for all confirmed and suspected TB cases.

The HMO 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 HMO 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 HMO 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 HMO must have a mechanism for coordinating a post-discharge plan for follow-up DOT with the local TB program. The HMO 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.

8.1.22.7. Objection to Provide Certain Services

In accordance with 42 C.F.R. §438.102, the HMO 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 HMO 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 HMO and enrollment materials needing revision, and notifications to Members.

In order to meet the requirements of this section, the HMO 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.

8.1.22.8. Medicaid Non-capitated Services

Section 8.1.22.8 Modified by Versions 1.2 and 1.5

The following Texas Medicaid programs, services, or benefits have been excluded from HMO Covered Services. Members are eligible to receive these Non-capitated Services on a Fee-for-Service basis, or through a Dental HMO (for most dental services). HMOs should refer to relevant chapters in the **Texas Medicaid Provider Procedures Manual** and the **Texas Medicaid Bulletins** 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. DSHS targeted case management;
5. DSHS mental health rehabilitation;
6. Case Management for Children and Pregnant Women (CPW);

7. Texas School Health and Related Services (SHARS);
8. Department of Assistive and Rehabilitative Services Blind Children's Vocational Discovery and Development Program;
9. Tuberculosis services provided by DSHS-approved Providers (directly observed therapy and contact investigation);
10. Vendor Drug Program (out-of-office drugs);
11. Health and Human Services Commission's Medical Transportation Program;
12. DADS hospice services;
13. Nursing facility services are Non-capitated Services.
14. For Members who are enrolled in STAR+PLUS during an Inpatient Stay under one of the exceptions identified in Attachment A, Section 5.04(a)(2), Hospital facility charges associated with the Inpatient Stay are Non-Capitated Services under the circumstances described in Attachment A, Section 5.04(a)(2).

8.1.22.9. Referrals for Non-capitated Services

Although the HMO is not responsible for paying or reimbursing for Non-capitated Services, the HMO 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 HMO is responsible for informing Providers that bills for all Non-capitated Services must be submitted to HHSC's Claims Administrator for reimbursement.

8.1.22.10. Cooperation with Immunization Registry

The HMO must work with HHSC and health care Providers to improve the immunization rate of STAR+PLUS clients and the reporting of immunization information for inclusion in the Texas Immunization Registry, called "ImmTrac."

8.1.22.11. Case Management for Children and Pregnant Women

Section 8.1.22.11 Modified by Version 1.5

The HMO must coordinate services with CPW. This coordination includes, but is not limited to, client education, outreach, case collaboration and referrals to CPW. The HMO is required to follow referral procedures as outlined by the State. Referrals to CPW 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 HMO Care Coordination/Case Management Staff must complete the THSteps Online module titled: Case Management Services in Texas and maintain proof of completion.

8.1.22.12. Children of Migrant Farmworkers (FWC)

The HMO 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 timeframes in this Contract, to FWC Members and other migrant populations who may transition into and out of the HMO more rapidly and/or unpredictably than the general population.

The HMO must provide accelerated services to FWC Members. For purposes of this section, "accelerated services" are services that are provided to a child of a migrant farm worker prior to their leaving Texas to 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 health care needs.

The HMO must develop a plan annually for the process it will use to identify FWC and for the methods that will be used to provide accelerated services and submit an annual certification that the HMO will comply with the plan. The plan for SFY 2011 must be submitted for HHSC approval no later than 90 days after the Contract Effective Date. The plan must include at a minimum:

- Identification of community and statewide groups that work with FWC Members within the HMO's Service Areas;
- Participation of the community groups in assisting with the identification of FWC Members;
- Appropriate aggressive efforts to reach each identified FWC to provide timely medical checkups and follow up care if needed;
- Methods to maintain accurate, current lists of all identified FWC Members;
- Methods that the HMO and its Subcontractors will implement to maintain the confidentiality of information about the identity of FWC; and
- Methods to provide accelerated services to FWC.

8.1.22.13 Immunizations

Section 8.1.22.13 Added by Version 1.2 and Modified by Version 1.5

The HMO must educate Providers on the Immunization Standard Requirements set forth in Chapter 161, Health and Safety Code; the standards in the ACIP Immunization Schedule; the AAP Periodicity Schedule for CHIP Members; and the DSHS Periodicity Schedule for Medicaid Members. The HMO shall educate Providers that Members under the age of 21 must be immunized during the Texas Health Steps checkup according to the ACIP routine immunization schedule. The HMO shall also educate Providers that the screening Provider is responsible for administration of the immunization and should not refer children to Local Health Departments to receive immunizations.

The HMO must educate Providers about, and require Providers to comply with, the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac), to include parental consent on the Vaccine Information Statement.

The HMO must notify Providers that they may enroll, as applicable, as Texas Vaccines for Children Providers. In addition, the HMO must work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac Registry.

8.1.23. Medicaid Significant Traditional Providers

In the first three (3) years of Program Operations, the HMO must seek participation in its Network from all Medicaid Significant Traditional Providers (STPs) defined by HHSC in the applicable Service Area.

Medicaid STPs are defined as PCPs and Community-based Long-term Care 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 HMO is not required to contract with Hospitals for Inpatient Stays, but is required to contract with Hospitals for Outpatient Hospital Services. The HHSC website includes a list of Medicaid STPs by Service Area.

HHSC has developed an updated list for Long Term Care Providers. The list will be provided to HMOs and posted on HHSC's website.

The STP requirement will be in place for three years after the program has been implemented. During that time, Providers who believe they meet the STP requirements may contact HHSC request HHSC's consideration for STP status.

The HMO must give STPs the opportunity to participate in its Network for at least three (3) years commencing on the Operational Start Date for STAR+PLUS in the Service Areas. However, the STP Provider must:

- Agree to accept the HMO's Provider reimbursement rate for the Provider type; and
- Meet the standard credentialing requirements of the HMO, provided that lack of board certification or accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) is not the sole grounds for exclusion from the Provider Network.

8.1.24. Payments to Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Certain Physicians

8.1.24.1 FQHCs and RHCs

Section 8.1.24.1 is modified by Version 1.3

The HMO must make reasonable efforts to include FQHCs and RHCs (freestanding and Hospital-based) in its Provider Network. The HMO 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 Section 32.028, Human Resources Code, if the Member does not have a referral from their PCP.

HMOs are required to pay the full encounter rates to RHCs, as such rates are defined by HHSC. Therefore, cost settlements do not apply to RHCs, and the HMOs are not required to submit monthly RHC Encounter and payment reports for these providers.

Prior to September 1, 2011: HMOs are not required to pay the full encounter rates to FQHCs; therefore, cost settlement will apply to FQHCs. FQHCs must agree to accept initial payments from the HMO in an amount that is equal to or greater than the HMO's payment terms for other Providers providing the same or similar services.

On or after September 1, 2011: HMOs are required to pay the full encounter rates to FQHCs for claims accruing on or after September 1, 2011. HHSC cost settlements will not apply to FQHCs after that date.

During the claims run out period, the HMO must continue to submit monthly FQHC Encounter and payment reports to all contracted FQHCs, and FQHCs with which there have been encounters, not later than 21 days from the end of the month for which the report is submitted. The format for the reports is included in the **Uniform Managed Care Manual**. The FQHC must validate the Encounter and payment information contained in the report(s). The HMO and the FQHC must both sign the report(s) after each party agrees that it accurately reflects Encounters and payments for the month reported. The HMO must submit the signed FQHC Encounter and payment reports to HHSC not later than 45 days from the end of the reported month.

After the claims run out period there will be no need to submit encounter and payment reports. Encounter and payment reports will not be necessary for claims paid to FQHCs on or after September 1, 2011, because the HMO will pay the full encounter rates to FQHCs for this period of time.

8.1.24.2 Network Access Assurance Payments

Section 8.1.24.2 is modified by Version 1.1

For SFY 2011, the HMO will develop and implement a Network Access Assurance Program to continually improve Network access and quality. Under this program, the HMO will provide enhanced payments to qualified Network Providers in the HMO's Service Area. During Readiness Review, the HMO must submit a written description of its proposed Network Access Assurance Program to HHSC, and must receive HHSC's written approval before implementing the program.

Each month, HHSC will provide written notice to the HMO identifying the percent of the Capitation Payment that must be dedicated to enhanced payments to Network Providers. The percent may vary by month based on the availability of funding.

The Parties understand and agree that this program is contingent on the availability of funding, and that HHSC will equitably adjust the Capitation Payments if all or part of the funding is not received. The HMO's Network Provider Agreements also must include such a contingency.

In addition, HHSC will equitably adjust the Capitation Payments if the HMO's Network Provider agreements with qualified providers do not include enhanced payments as required by this Section, or if the HMO does not enter into Network Provider agreements with qualified providers.

HHSC may provide additional information concerning the Network Access Assurance Program in the Uniform Managed Care Manual.

8.1.25. Provider Complaints and Appeals

8.1.25.1. Provider Complaints

Section 8.1.25.1 Modified by Version 1.2

The HMO must develop, implement, and maintain a system for tracking and resolving all Provider Complaints. Within this process, the HMO 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 HMO must resolve Provider Complaints within thirty (30) days from the date the Complaint is received by the HMO. The HMO is subject to remedies, including liquidated damages, if at least 98 percent of Provider Complaints are not resolved within 30 days of receipt of the Complaint by the HMO. Please see the **Uniform Managed Care Contract Terms & Conditions** and **Attachment B-5, Deliverables/Liquidated Damages Matrix.**

HMOs must also resolve Provider Complaints received by HHSC no later than the due date indicated on HHSC's notification form. HHSC will generally provide HMOs ten (10) Business Days to resolve such Complaints. If an HMO 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 HMO demonstrates good cause.

Unless HHSC has granted a written extension as described above, the HMO is subject to remedies, including liquidated damages if Provider Complaints are not resolved by the timeframes indicated herein.

8.1.25.2. Appeal of Provider Claims

Section 8.1.25.2 Modified by Version 1.5

The HMO must develop, implement, and maintain a system for tracking and resolving all Provider appeals related to claims payment. Within this process, the HMO 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 HMO's process must comply with the requirements of Texas Government Code §533.005(a)(19).

The HMO 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 determination of the physician resolving the dispute must be binding on the HMO and the Provider. The physician resolving the dispute must 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.

8.1.26. Member Rights and Responsibilities

In accordance with 42 C.F.R. §438.100, all Medicaid HMOs 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 **Uniform Managed Care Manual**.

8.1.27. Member Complaint and Appeal System

The HMO 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 T.A.C. Chapter 357 relating to Medicaid managed care organizations.

HMOs also must resolve Member Complaints received by HHSC no later than the due date indicated on HHSC's notification form. HHSC will provide HMOs up to ten (10) Business Days to resolve such Complaints, depending on the severity and/or urgency of the Complaint. HHSC may, in its reasonable discretion, grant a written extension if the HMO demonstrates good cause.

Unless the HHSC has granted a written extension as described above, the HMO 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.

8.1.27.1. Member Complaint Process

Section 8.1.27.1 is modified by Version 1.3

The HMO 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 8.1.27**, 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 HMO must resolve Complaints within 30 days from the date the Complaint is received by the HMO. The HMO 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 HMO. Please see the **Uniform Managed Care Contract Terms & Conditions** and **Attachment B-5, 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 HMO must also inform Members how to file a Complaint directly with HHSC, once the Member has exhausted the HMO's Complaint process.

The HMO must designate an officer of the HMO who has primary responsibility for ensuring that Complaints are resolved in compliance with written policy and within the required timeframe. For purposes of **Section 8.1.27.2**, an "officer" of the HMO 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 HMO 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 HMO's Complaint procedures must be provided to Members in writing and through oral interpretive services. A written description of the HMO'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 HMO must include a written description of the Complaint process in the Member Handbook. The HMO must maintain and publish in the Member Handbook, at least one toll-free telephone number with TeleTypewriter/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capabilities for making Complaints. The HMO must provide such oral interpretive service to callers free of charge.

The HMO'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:

- Date;
- Identification of the individual filing the Complaint;
- Identification of the individual recording the Complaint;
- Nature of the Complaint;
- Disposition of the Complaint (i.e., how the HMO resolved the Complaint);
- Corrective action required; and
- Date resolved.

For Complaints that are received in person or by telephone, the HMO must provide Members or their representatives with written notice of resolution if the Complaint cannot be resolved within one working day of receipt.

The HMO 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, the HMO must give the Member information on the disenrollment process and direct the Member to the HHSC Administrative Services Contractor. 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 HMO will cooperate with the HHSC's Administrative Services Contractor and HHSC or its designee to resolve all Member Complaints. Such cooperation may include, but is not limited to, providing information or assistance to internal Complaint committees.

The HMO must provide designated Member Advocates to assist Members in understanding and using the HMO's Complaint system as described in **Section 8.1.27.9**. The HMO's Member Advocates must assist Members in writing or filing a Complaint and monitoring the Complaint through the HMO's Complaint process until the issue is resolved.

8.1.27.2. Standard Member Appeal Process

Section 8.1.27.2 is modified by Version 1.3

The HMO 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 HMO Action as defined in **HHSC's Uniform Contract Terms and Conditions**. The Appeal procedure must be the same for all Members. When a Member or his or her authorized representative expresses orally or in writing any dissatisfaction or disagreement with an Action, the HMO must regard the expression of dissatisfaction as a request to Appeal an Action.

A Member must file a request for an Appeal with the HMO within 30 days from receipt of the notice of the Action. The HMO 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 HMO. Please see the **Uniform Managed Care Contract Terms & Conditions and Attachment B-5, Deliverables/Liquidated Damages Matrix.** To ensure continuation of currently authorized services, however, the Member must file the Appeal on or before the later of ten (10) days following the HMO's mailing of the notice of the Action, or the intended effective date of the proposed Action. The HMO 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 Chapter 4201, Texas Insurance Code, relating to a Member's right to Appeal an Adverse Determination made by the HMO or a utilization review agent to an independent review organization, do not apply to a Medicaid recipient. Chapter 4201 is preempted by federal Fair Hearings requirements.

The HMO 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 HMO'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 HMO must provide designated Member Advocates, as described in **Section 8.1.27.9**, to assist Members in understanding and using the Appeal process. The HMO's Member Advocates must assist Members in writing or filing an Appeal and monitoring the Appeal through the HMO's Appeal process until the issue is resolved.

The HMO 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 HMO'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 HMO must include a written description of the Appeals process in the Member Handbook. The HMO 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 HMO must provide such oral interpretive service to callers free of charge.

The HMO'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:

- Date notice is sent;
- Effective date of the Action;
- Date the Member or his or her representative requested the Appeal;
- Date the Appeal was followed up in writing;
- Identification of the individual filing;
- Nature of the Appeal; and
- Disposition of the Appeal, and notice of disposition to Member.

The HMO must send a letter to the Member within five (5) business days acknowledging receipt of the Appeal request. Except for the resolution of an Expedited Appeal as provided in **Section 8.1.27.3**, the HMO 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 HMO 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 HMO must give the Member written notice of the reason for delay if the Member had not requested the delay. The HMO must designate an officer who has primary responsibility for ensuring that Appeals are resolved within these timeframes and in accordance with the HMO's written policies.

During the Appeal process, the HMO 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 HMO 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 HMO 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 HMO 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 HMO 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:

- The Member or his or her representative files the Appeal timely as defined in this Contract:
- The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized Provider;
- The original period covered by the original authorization has not expired; and
- The Member requests an extension of the benefits.

If, at the Member's request, the HMO continues or reinstates the Member's benefits while the Appeal is pending, the benefits must be continued until one of the following occurs:

- The Member withdraws the Appeal;
- Ten (10) days pass after the HMO mails the notice resolving the Appeal against the Member, unless the Member, within the ten (10)-day timeframe, has requested a Fair Hearing with continuation of benefits until a Fair Hearing decision can be reached; or
- 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 HMO's Action, then, to the extent that the services were furnished to comply with the Contract, the HMO may recover such costs from the Member.

If the HMO or state Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the HMO must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires.

If the HMO 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 HMO is responsible for the payment of services.

The HMO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making an Appeal.

8.1.27.3. Expedited Appeals

In accordance with 42 C.F.R. §438.410, the HMO must establish and maintain an expedited review process for Appeals, when the HMO 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 HMO must follow all Appeal requirements for standard Member Appeals as set forth in **Section 8.1.27.2**), except where differences are specifically noted. The HMO must accept oral or written requests for Expedited Appeals.

Members must exhaust the HMO's Expedited Appeal process before making a request for an expedited Fair Hearing. After the HMO 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 three (3) business days, except that the HMO 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 (1) 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 HMO 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 HMO 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 HMO must follow the procedures relating to the notice in **Section 8.1.27.5**. The HMO is responsible for notifying the Member of his or her right to access an expedited Fair Hearing from HHSC. The HMO 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 HMO is prohibited from discriminating or taking punitive action against a Member or his or her representative for requesting an Expedited Appeal. The HMO must ensure that punitive action is not taken against a Provider who requests an Expedited Appeal or supports a Member's request.

If the HMO denies a request for expedited resolution of an Appeal, it must:

- Transfer the Appeal to the timeframe for standard resolution, and
- Make a reasonable effort to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

8.1.27.4. Access to Fair Hearing for Medicaid Members

The HMO must inform Members that they have the right to access the Fair Hearing process at any time during the Appeal system provided by the HMO. In the case of an expedited Fair Hearing process, the HMO must inform the Member that he or she must first exhaust the HMO's internal Expedited Appeal process prior to filing an Expedited Fair Hearing. The HMO 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 HMO will complete the request for Fair Hearing, and submit the form via facsimile to the appropriate Fair Hearings office, within five (5) calendar days of the Member's request for a Fair Hearing.

Within five (5) calendar days of notification that the Fair Hearing is set, the HMO 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.

8.1.27.5. Notices of Action and Disposition of Appeals for Medicaid Members

The HMO must notify the Member, in accordance with 1 T.A.C. Chapter 357, whenever the HMO takes an Action. The notice must, at a minimum, include any information required by 1 T.A.C. Chapter 357 that relates to a managed care organization's notice of Action and any information required by 42 C.F.R. §438.404 as directed by HHSC, including but not limited to:

- The dates, types, and amount of service requested;
- The Action the HMO has taken or intends to take;
- The reasons for the Action (If the Action taken is based upon a determination that the requested service is not Medically Necessary, the HMO 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.);
- The Member's right to access the HMO's Appeal process.
- The procedures by which the Member may Appeal the HMO's Action;
- The circumstances under which expedited resolution is available and how to request it;
- 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;
- The date the Action will be taken;
- A reference to the HMO policies and procedures supporting the HMO's Action;
- 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;
- An explanation that Members may represent themselves, or be represented by a Provider, a friend, a relative, legal counsel, or another spokesperson;
- 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;
- A statement explaining that the HMO must make its decision within 30 days from the date the Appeal is received by the HMO, or three (3) business days in the case of an Expedited Appeal; and
- A statement explaining that the hearing officer must make a final decision within 90 days from the date a Fair Hearing is requested.

8.1.27.6. Timeframe for Notice of Action

In accordance with 42 C.F.R.§ 438.404(c), the HMO must mail a notice of Action within the following timeframes:

- 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;
- For denial of payment, at the time of any Action affecting the claim;
- For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R.§ 438.210(d)(1);
- If the HMO extends the timeframe in accordance with 42 C.F.R. §438.210(d)(1), it must:
    - 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
    - issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires;
- 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
- For expedited service authorization decisions, within the timeframes specified in 42 C.F.R. 438.210(d).

8.1.27.7. Notice of Disposition of Appeal

In accordance with 42 C.F.R.§ 438.408(e), the HMO 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 HMO'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 T.A.C. Chapter 357 that relates to a managed care organization's notice of disposition of an Appeal.

8.1.27.8. Timeframe for Notice of Resolution of Appeals

In accordance with 42 C.F.R.§ 438.408, the HMO 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

HMO 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 HMO denies a request for expedited resolution of an Appeal, the HMO 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 (2) calendar days with a written notice.

8.1.27.9. Member Advocates

The HMO must provide Member Advocates to assist Members. Member Advocates must be physically located within the Service Area unless an exception is approved by HHSC. Member Advocates must inform Members of the following:

- Their rights and responsibilities,
- The Complaint process,
- The Appeal process,
- Covered Services available to them, including preventive services, and
- Non-capitated Services available to them.

Member Advocates must assist Members in writing Complaints and are responsible for monitoring the Complaint through the HMO'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 HMO as Covered Services.

8.1.28. Additional Medicaid Behavioral Health Provisions

8.1.28.1. Local Mental Health Authority (LMH)

Assessment to determine eligibility for rehabilitative and targeted DSHS case management services is a function of the LMHA. Covered Services must be provided to Members with severe and persistent mental illness (SPMI) and severe emotional disturbance (SED), when Medically Necessary, whether or not the Members are also receiving targeted case management or rehabilitation services through the LMHA.

The HMO must enter into written agreements with all LMHAs in the Service Area that describe the process(es) that the HMO and LMHAs will use to coordinate services for Members with SPMI or SED. The agreements will:

- Describe the Behavioral Health Services indicated in detail in the **Texas Medicaid Provider Procedures Manual** and in the **Texas Medicaid Bulletins**, include the amount, duration, and scope of basic services, and the HMO's responsibility to provide these services;
- Describe Value-added Services, and the HMO's responsibility to provide these services;

- Describe criteria, protocols, procedures, and instrumentation for referral of Members to and from the HMO and the LMHA;
- Describe processes and procedures for referring Members with SPMI or SED to the LMHA for assessment and determination of eligibility for rehabilitation or targeted case management services;
- Describe how the LMHA and the HMO will coordinate providing Behavioral Health Services to Members with SPMI or SED;
- Establish clinical consultation procedures between the HMO and LMHA including consultation to effect referrals and on-going consultation regarding the Member's progress;
- Establish procedures to authorize release and exchange of clinical treatment records;
- Establish procedures for coordination of assessment, intake/triage, utilization review/utilization management, and care for persons with SPMI or SED;
- Establish procedures for coordination of inpatient psychiatric services (including Court-ordered Commitment of Members under 21) in state psychiatric facilities within the LMHA's catchment area;
- Establish procedures for coordination of emergency and urgent services to Members;
- Establish procedures for coordination of care and transition of care for new Members who are receiving treatment through the LMHA; and
- Establish that when Members are receiving Behavioral Health Services from the Local Mental Health Authority that the HMO is using the same UM guidelines as those prescribed for use by local mental health authorities by DSHS which are published at: http://www.dshs.state.tx.us/mhprograms/RDMUMProcess.shtm.

The HMO must offer licensed practitioners of the healing arts (defined in 25 T.A.C., Part 2, Chapter 419, Subchapter L), who are part of the Member's treatment team for rehabilitation services, the opportunity to participate in the HMO's Network. The practitioner must agree to accept the HMO's Provider reimbursement rate, meet the credentialing requirements, and comply with all the terms and conditions of the HMO's standard Provider contract.

HMOs must allow Members receiving rehabilitation services to choose the licensed practitioners of the healing arts who are currently a part of the Member's treatment team for rehabilitation services to provide Covered Services. If the Member chooses to receive these services from licensed practitioners of the healing arts who are part of the Member's rehabilitation services treatment team but are not part of the HMO's Network, the HMO must reimburse the Local Mental Health Authority through Out-of-Network reimbursement arrangements.

Nothing in this section diminishes the potential for the Local Mental Health Authority to seek best value for rehabilitative services by providing these services under arrangement, where possible, as specified is 25 T.A.C. §419.455.

8.1.29. Third Party Liability and Recovery

Section 8.1.29 Modified by Version 1.5

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 HMO, the HMO must pay the unpaid balance for Covered Services up to the agreed rates. For Out-of-Network providers with no written reimbursement arrangement, the HMO must pay the unpaid balance for Covered Services in accordance with HHSC's administrative rules regarding Out-of-Network payment (1 T.A.C. §353.4).

The HMO is responsible for establishing a plan and process for recovering costs for services that should have been paid through a third party in accordance with state and federal law and regulations. To recognize this requirement, capitation payments to the HMO are reduced by the projected amount of TPR that the HMO is expected to recover.

The HMO must provide required reports as stated in **Section 8.1.17.2,** Financial Reporting Requirements.

Beginning 120 days after the date of adjudication on any claim, Encounter, or other Medicaid-related payment by the HMO subject to Third Party Recovery, HHSC may attempt recovery independent of any HMO action. HHSC will retain, in full, all funds received as a result of the state-initiated recovery or subrogation action.

The HMO shall provide a Member quarterly file that contains the following information, if available to the HMO: 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 shall be used for the purpose of matching the Texas Medicaid eligibility file against the HMO Member file to identify clients enrolled in the HMO.

8.1.30. Coordination with Public Health Entities

8.1.30.1. Reimbursed Arrangements with Public Health Entities

The HMO 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:

- Sexually Transmitted Disease (STD) services;
- Confidential HIV testing;
- Immunizations;
- Tuberculosis (TB) care;
- Family planning services;
- Texas Health Steps medical checkups, and
- 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 HMO is unable to enter into a contract with Public Health Entities, the HMO must document efforts to contract with Public Health Entities, and make such documentation available to HHSC upon request.

HMO 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 HMO or PCP.

The HMO must:

- 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 HMO's Network; and
- 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.

8.1.30.2. Non-Reimbursed Arrangements with Local Public Health Entities

The HMO must coordinate with Public Health Entities in each Service Area regarding the provision of essential public health care services. In addition to the requirements listed above in **Section 8.1.22**, or otherwise required under state law or this contract, the HMO must meet the following requirements:

- Report to public health entities regarding communicable diseases and/or diseases that are preventable by immunization as defined by state law;
- Notify the local Public Health Entity, as defined by state law, of communicable disease outbreaks involving Members;
- Educate Members and Providers regarding WIC services available to Members; and
- Coordinate with local Public Health Entities that have a child lead program, or with DSHS regional staff 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.

8.1.31. Coordination with Other State Health and Human Services Programs

The HMO must coordinate with other state Health and Human Services (HHS) Programs in each Service Area regarding the provision of essential public health care services. In addition to the requirements listed above in **Section 8.1.22** or otherwise required under state law or this Contract, the HMO must meet the following requirements:

- Require Providers to use the DSHS Bureau of Laboratories for specimens obtained as part of a Texas Health Steps medical checkup, including Texas Health Steps newborn screens (see **Section 8.1.22.3** exception to DSHS Laboratory Services Section testing for newborn screens), lead testing, and hemoglobin/hematocrit tests;
- Notify Providers of the availability of vaccines through the Texas Vaccines for Children Program;
- Work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac Registry;
- Educate Providers and Members about the Department of State Health Services (DSHS) Case Management for Children and Pregnant Women (CPW) services available;
- Coordinate services with CPW specifically in regard to an HMO Member's health care needs that are identified by CPW and referred to the HMO;
- 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;
- Cooperate with activities required of state and local public health authorities necessary to conduct the annual population and community-based needs assessment;
- Report all blood lead results, coordinate and follow-up of suspected or confirmed cases of childhood lead exposure with the Childhood Lead Poisoning Prevention Program in DSHS; and
- Coordinate with Texas Health Steps.

8.1.32. Advance Directives

Federal and state law require HMOs 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 HMO's policies and procedures must include written notification to Members and comply with provisions contained in 42 C.F.R. § 489, Subpart I, relating to advance directives for all Hospitals, critical access Hospitals, skilled nursing facilities, home health agencies, Providers of home health care, Providers of personal care services and hospices, as well as the following state laws and rules:

- A Member's right to self-determination in making health care decisions;
- The Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:
    - 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;
    - A Member's right to make written and non-written out-of-hospital do-not-resuscitate (DNR) orders;

  - 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
- The Declaration for Mental Health Treatment, Chapter 137, Texas Civil Practice and Remedies Code, which includes a Member's right to execute a Declaration for Mental Health Treatment in a document making a declaration of preferences or instructions regarding mental health treatment.

The HMO must maintain written policies for implementing a Member's advance directive. Those policies must include a clear and precise statement of limitation if the HMO or a Provider cannot or will not implement a Member's advance directive.

The HMO cannot require a Member to execute or issue an advance directive as a condition of receiving health care services. The HMO cannot discriminate against a Member based on whether or not the Member has executed or issued an advance directive.

The HMO's policies and procedures must require the HMO and its Subcontractors to comply with the requirements of state and federal law relating to advance directives. The HMO 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 HMO 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.

8.1.33. Covered Community-based Long-Term Care Services

The HMO must ensure that Members needing Community-based Long-Term Care Services are identified and that services are referred and authorized in a timely manner. The HMO must ensure that Providers of Community-based Long-Term Care Services are licensed to deliver the service they provide.

Community-based Long-Term Care Services may be necessary as a preventative service to avoid more expensive hospitalizations, emergency room visits, or institutionalization. Community-based Long-Term Care Services should also be made available to Members to assure maintenance of the highest level of functioning possible in the least restrictive setting. A Member's need for Community-based Long-Term Care Services to assist with the activities of daily living must be considered as important as needs related to a medical condition. HMOs must provide Functionally Necessary Covered Services to Community-based Long-Term Care Service Members.

8.1.33.1. Community-based Long-Term Services and Supports Available to All Members

Section 8.1.33.1 Modified by Version 1.1

The HMO shall enter into written contracts with Providers of Personal Assistance Services (PAS) and Day Activity and Health Services (DAHS) to make them available to all Members. These Providers must, at a minimum, meet all of the following state licensure and certification requirements for providing the services in **Attachment B-2, Covered Services**.

Community-based Long-Term Services and Supports Available to All Members	
Service	**Licensure and Certification Requirements**
Personal Assistance Services/Primary Home Care	The Provider must be licensed by DADS Regulatory Services as a Home and Community Support Services Agency (HCSSA). The level of licensure required depends on the type of service delivered. NOTE: For Primary Home Care and Client Managed Personal Attendant Care, the agency may have only the Personal Assistance Services level of licensure.
Day Activity and Health Services (DAHS)	The Provider must be licensed by DADS Regulatory Services, as an adult day care Provider. To provide DAHS, the Provider must provide the range of services required for DAHS.

8.1.33.2. 1915(c) STAR+PLUS Waiver Services Available to Members Who Qualify for 1915(c) STAR+PLUS Waiver Services

Section 8.1.33.2 Modified by Version 1.1

The 1915(c) STAR+PLUS Waiver (SPW) provides Community-based Long-Term Care Services to Medicaid Eligibles who are elderly and to adults with disabilities as a cost-effective alternative to living in a nursing facility. These Members must be age 21 or older and be a Medicaid recipient or be otherwise financially eligible for waiver services. To be eligible for SPW Services, a Member must meet income and resource requirements for Medicaid nursing facility care, and receive a determination from HHSC on the medical necessity/level of care of the nursing facility care. The HMO must make available to Members who meet the eligibility requirements the array of services allowable through HHSC's CMS-approved SPW (see **Appendix B-2.1, STAR+PLUS Covered Services**).

Community-based Long-Term Services and Supports under the 1915(c) STAR+PLUS Waiver	
Service	**Licensure and Certification Requirements**
Personal Assistance Services	The Provider must be licensed by DADS Regulatory Services as a Home and Community Support Services Agency (HCSSA). The level of licensure required depends on the type of service delivered. For Primary Home Care and Client Managed Attendant Care, the agency may have only the Personal Assistance Services level of licensure.

Community-based Long-Term Services and Supports under the 1915(c) STAR+PLUS Waiver	
Service	**Licensure and Certification Requirements**
Assisted Living Services	The Provider must be licensed by the Texas Department of Aging and Disability Services, Long Term Care Regulatory Division in accordance with 40 T.A.C., Part 1, Chapter 92. The type of licensure determines what services may be provided.
Emergency Response Services	Licensed by the Texas Department of State Health Services as a Personal Emergency Response Services Agency under T.A.C., Title 25, Part 1, Chapter 140, Subchapter B.
Nursing Services	Licensed Registered Nurse by the Texas Board of Nursing under 22 T.A.C., Part 11, Chapter 217.
Adult Foster Care	Adult foster care homes serving three (3) or fewer participants must comply with requirements outlined in 40 TAC, Part 1, Chapter 48, Subchapter K. Adult foster care homes serving four (4) participants must be licensed by DADS as an assisted living facility under 40 TAC Part 1, Chapter 92.
Dental	Licensed by the Texas State Board of Dental Examiners as a Dentist under T.A.C., Title 22, Part 5, Chapter 101.
Respite Care	Licensed by DADS as a Home and Community Support Services Agency (HCSSA) under T.A.C., Title 40, Part 1, Chapter 97.
Home Delivered Meals	Providers must comply with requirements for providing home delivered meal services, which include requirements such as dietary requirements, food temperature, delivery times, and training of volunteers and others who deliver meals In accordance with T.A.C., Title 40, Part 1, Chapter 55.
Physical Therapy (PT) Services	Licensed Physical Therapist through the Texas Board of Physical Therapy Examiners, Chapter 453.
Occupational Therapy (OT) Services	Licensed Occupational Therapist through the Texas Board of Occupational Therapy Examiners, Chapter 454.
Speech, Hearing, and Language Therapy Services	Licensed Speech Therapist Through the Department of State Health Services under 22 TAC, Part 32, Chapter 741.
Consumer Directed Services (CDS)	No licensure or certification requirements. Must have completed required training by DADS. CDSAs contracted by DADS are assumed to have completed the training.
Transition Assistance Services (TAS)	The Provider must comply with the requirements for delivery of TAS, which include requirements such as allowable purchases, cost limits, and time frames for delivery. TAS providers must demonstrate knowledge of, and experience in, successfully serving individuals who require home and community-based services.

Community-based Long-Term Services and Supports under the 1915(c) STAR+PLUS Waiver	
Service	**Licensure and Certification Requirements**
Minor Home Modifications	No licensure or certification requirements.
Adaptive Aids and Medical Equipment/Supplies	No licensure or certification requirements.

8.1.34. Service Coordination

Section 8.1.34 Modified by Version 1.5

The HMO must furnish a Service Coordinator to all Members who request one. The HMO should also furnish a Service Coordinator to a Member when the HMO determines one is required through an assessment of the Member's health and support needs. The HMO must ensure that each Member has a qualified PCP who is responsible for overall clinical direction and, in conjunction with the Service Coordinator, serves as a central point of integration and coordination of Covered Services, including Acute Care, long-term care and Behavioral Health Services.

The Service Coordinator must work with the Member's PCP to coordinate all Covered Services and any applicable Non-capitated Services. This requirement applies regardless of whether the PCP is in the HMO's Network, particularly for Dual Eligible Members (dually eligible for both Medicare and Medicaid). 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. When considering whether to refer a Member to a nursing facility or other long-term care facility, the HMO must consider the availability of the Program of All-Inclusive Care for the Elderly (PACE) for that Member.

Members who are dually eligible for Medicare will receive most Acute Care services through Medicare, rather than Medicaid.

The HMO must identify and train Members or their families to coordinate their own care, to the extent of the Member's or the family's capability and willingness to coordinate care.

8.1.34.1. Service Coordinators

The HMO must employ as Service Coordinators persons experienced in meeting the needs of vulnerable populations who have Chronic or Complex Conditions. Such Service Coordinators are Key HMO Personnel as described in **Attachment A**, **HHSC's Uniform Managed Care Contract Terms and Conditions, Section 4.02,** and must meet the requirements set forth in **Section 4.04.1** of **HHSC's Uniform Managed Care Contract Terms and Conditions**.

8.1.34.2. Referral to Community Organizations

The HMO must provide information about and referral 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, but are not limited to:

- State/federal agencies (e.g., those agencies with jurisdiction over aging, public health, substance abuse, mental health/retardation, rehabilitation, developmental disabilities, income support, nutritional assistance, family support agencies, etc.);
- Social service agencies (e.g., Area Agencies on Aging, residential support agencies, independent living centers, supported employment agencies, etc.);
- City and county agencies (e.g., welfare departments, housing programs, etc.);
- Civic and religious organizations; and
- Consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning, etc.).

8.1.34.3. Discharge Planning

The HMO must have a protocol for quickly assessing the needs of Members discharged from a Hospital or other care or treatment facility.

The HMO's Service Coordinator must work with the Member's PCP, the Hospital discharge planner(s), the attending physician, the Member, and the Member's family to assess and plan for the Member's discharge. When long-term care is needed, the HMO must ensure that the Member's discharge plan includes arrangements for receiving community-based care whenever possible. The HMO 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.

8.1.34.4. Transition Plan for New STAR+PLUS Members

Section 8.1.34.4 Modified by Version 1.2

The HMO must provide a transition plan for Members who are enrolled in the STAR+PLUS Program. The state, and/or the Member's previous STAR+PLUS HMO contractor, will provide the HMO with detailed Care Plans, names of current Providers, etc., for newly enrolled Members already receiving long-term care services at the time of enrollment. The HMO must ensure that current Providers are paid for Medically Necessary Covered Services that are delivered in accordance with the Member's existing treatment/long-term care services plan after the Member has become enrolled in the HMO and until the transition plan is developed.

The transition planning process must include, but is not limited to, the following:

- Review of existing long-term care service plans;
- Preparation of a transition plan that ensures continuous care under the Member's existing Care Plan during the transfer into the HMO's Network while the HMO

conducts an appropriate assessment and development of a new long-term care service plan, if needed;
- If durable medical equipment or supplies had been ordered prior to enrollment but have not been received by the time of enrollment, coordination and follow-through to ensure that the Member receives the necessary supportive equipment and supplies without undue delay; and
- Payment to the existing Provider(s) of service under the existing authorization for up to six (6) months, until the HMO has completed the assessment and long-term care service plans and issued new authorizations.

Except as provided below, the HMO must review any existing care plan and develop a transition plan within 30 days of receiving the Member's enrollment. For all existing care plans received prior to the Operational Start Date, the HMO will have additional time to complete this process, not-to-exceed 120 days after the Member's enrollment. The transition plan will remain in place until the HMO contacts the Member and coordinates modifications to the Member's current treatment/long-term care service plan. The HMO must ensure that the existing services continue and that there are no breaks in service.

The HMO must ensure that: 1) the Member is involved in the assessment process and is fully informed about their options; 2) the Member is included in the development of their care plan; and 3) the Member is in agreement with the plan when completed.

8.1.34.5. Centralized Medical Record and Confidentiality

The Service Coordinator shall be responsible for maintaining a centralized record related to Member contacts, assessments, and service authorizations. The HMO shall ensure that the centralized Member record meets all applicable professional standards ensuring confidentiality of Member records, referrals, organization, and documentation of information.

The HMO must have a systematic process for generating and receiving referrals and sharing confidential medical, treatment, and planning information across Providers.

8.1.34.6. Nursing Facilities

There is frequently a significant period of time between a client's entry into a nursing facility and the state's determination of their eligibility for Medicaid. Many of the community supports usually open to these clients are not available while they are in a nursing facility. The state does not enroll clients who qualify for Medicaid via nursing facility residency in managed care, because such enrollments would require the HMO to maintain a Member in the nursing facility without all of the necessary options for managing their health.

The HMO must participate in the Texas Promoting Independence Initiative for such individuals. 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:

- the state's treatment professionals determine that such placement is appropriate;
- the affected persons do not oppose such treatment; and
- 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 HMO 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 1915(c) Nursing Facility Waiver services. To be eligible for this option, an individual must reside in a nursing facility until a written plan of care for safely moving back into a community setting has been developed and approved.

A STAR+PLUS Member who enters a nursing facility will remain an enrolled HMO Member for a total of four (4) months after entering the nursing facility. The nursing facility will bill the state directly for covered nursing facility services delivered while the Member is a resident of the facility. See **Section 8.1.34.7** for further information.

An HMO Service Coordinator must complete an assessment of the Member within 30 days of the HMO's notification that the member has entered the facility and develop a plan of care to transition the Member back into the community, if possible. If the initial review/assessment supports a return to the community, the Service Coordinator will work with the resident and family to return the Member to the community using 1915(c) Waiver Services.

If the initial review does not support a return to the community, the Service Coordinator will conduct a second assessment 90 days after the initial assessment to determine if the individual's condition or circumstances have changed that would allow a return to the community. If a return to the community is possible and appropriate, the Service Coordinator will develop and implement the transition plan with the resident and his/her family.

The HMO will provide these services as part of the Texas Promoting Independence Initiative. The HMO must maintain documentation of the assessments completed as part of this initiative and make them available for state review at any time.

It is possible that the HMO will be unaware of a Member's entry into a nursing facility. It is the responsibility of the nursing facility to review the Member's Medicaid card upon entry into the facility and notify the HMO of the Member's admission. The nursing facility is also required to notify HHSC of the entry of a new resident.

8.1.34.7. HMO Four (4)-Month Liability for Nursing Facility Care

A Member who enters a nursing facility will remain an enrolled Member with the HMO for a total of four months. The four months do not have to be consecutive. Upon completion of four months of nursing facility care, the individual will be disenrolled from the

STAR+PLUS Program. After managed care disenrollment, the Medicaid Fee-for-Service program will provide the client's Medicaid benefits. A STAR+PLUS Member may not change HMOs while in a nursing facility.

Tracking the four (4) months of liability is done through a counter system. The four (4)-month counter starts with the earlier of: (1) the date of the Medicaid admission to the nursing facility, or (2) on the 21st day of a Medicare stay, if applicable. A partial month's stay counts as a full month of liability. In other words, the month in which the Medicaid admission occurs or the month in which the 21st day of the Medicare stay occurs, is counted as one of the four (4) months of liability for the purpose of determining program disenrollment.

The HMO will not be liable for the cost of care provided in a nursing facility, but will be responsible for providing other Covered Services to Medicaid-only Members for the four (4)-month period described above. For Medicaid-only Members, the cost of all other Covered Services will be included in the capitation payment analysis. The HMO will not maintain nursing facilities in its Provider Network, and will not reimburse nursing facilities for Covered Services provided in such facilities. Nursing facilities will use the traditional Fee-for-Service (FFS) system of billing HHSC rather than billing the HMO.

8.1.34.8. Coordination of Services for Dual Eligibles

The STAR+PLUS program is intended to coordinate program services for Dual Eligible recipients. In order to achieve this goal, the HMO must be contracted with the CMS and operating as a MA Dual SNP no later than January 1, 2012. The HMO is encouraged to contract with the CMS in all counties and zip codes in the Service Area(s); however, at a minimum, the HMO must be an MA Dual SNP in all zip codes in Tarrant and Denton Counties (if the HMO operates as a STAR+PLUS HMO in the Tarrant Service Area) and in all zip codes in Dallas and Collin Counties (if the HMO operates as a STAR+PLUS HMO in the Dallas Service Area). After January 1, 2012, the HMO must maintain its status as an MA DUAL SNP contractor throughout the term of the STAR+PLUS Contract. Failure to do so may result in HHSC's assessment of contractual remedies, including Contract termination. Additional requirements regarding certain categories of Dual Eligibles are described in **Section 8.2**.

8.1.34.9. Prioritization Plan

Prior to the Operational Start Date, HHSC and DADS will provide the HMO a plan that outlines a priority of populations and special handling procedures that the HMO must implement to help ensure timely assessments for potential enrollees and incoming Members as well as continuity of care for incoming Members. The populations that will be part of the priority list will include but are not limited to Money Follows the Person (MFP); Medically Dependent Children Program (MDCP), Comprehensive Care Program -Personal Care Services (CCP-PCS) and Comprehensive Care Program-Private Duty Nursing (CCP-PDN) aging out consumers; Medical Assistance Only (MAO) Interest List consumers; and Supplemental Security Income (SSI) consumer. HHSC and/or DADS will also provide the HMO with information concerning Members who will be enrolled through manual processes and will need expedited access to services.

8.1.35. Assessment Instruments

The HMO must have and use functional assessment instruments to identify Members with significant health problems, Members requiring immediate attention, and Members who need or are at risk of needing long-term care services. The HMO, a Subcontractor, or a Provider may complete assessment instruments, but the HMO remains responsible for the data recorded.

HMOs must use the DADS Consumer Needs Assessment Questionnaire and Task/Hour Guide, Form 2060, as amended or modified, to assess a Member's need for Functionally Necessary Personal Assistance Services. The HMO may adapt the form to reflect the HMO's name or distribution instructions, but the elements must be the same and instructions for completion must be followed without amendment.

The DADS Form 2060 must be completed if a need for or a change in Personal Assistance Services is warranted at the initial contact, at the annual reassessment, and anytime a Member requests the services or requests a change in services. The DADS Form 2060 must also be completed at any time the HMO determines the Member requires the services or requires a change in the Personal Assistance Services that are authorized.

HMOs must use the Texas Medicaid Personal Care Assessment Form (PCAF Form) in lieu of the DADS Form 2060 for children under the age of 21 when assessing the Member's need for Functionally Necessary Personal Care Services. HMOs may adapt the PCAF Form to reflect the HMO's name or distribution instructions, but the elements must be the same and instructions for completion must be followed without amendment. Reassessments using the PCAF Form must be completed every twelve months and as requested by the Member's parent or other legal guardian. The PCAF Form must also be completed at any time the HMO determines the Member may require a change in the number of authorized Personal Care Service hours.

For Members and applicants seeking or needing the 1915(c) Nursing Facility Waiver services, the HMO must use the Community Medical Necessity and Level of Care (MN/LOC) Assessment Instrument, as amended or modified, to assess Members and to supply current medical information for Medical Necessity determinations. The HMO must also complete the Individual Service Plan (ISP), Form 3671, for each Member receiving 1915(c) Nursing Facility Waiver Services. The ISP is established for a one-year period. After the initial ISP is established, the ISP must be re-evaluated on an annual basis for the next 12-month period, as described in **Section 8.1.36.3**. An Initial Community Medical Necessity and Level of Care determination will expire 120 days after it is approved by the HHSC Claims Administrator.

8.1.36. 1915(c) Nursing Facility Waiver Service Eligibility

Recipients of 1915(c) Nursing Facility Waiver services must meet nursing facility criteria for participation in the waiver and must have a plan of care at initial determination of eligibility in which the annualized cost of the Member's care is equal to or less than 200

percent of the annualized cost of care if the individual were to enter a nursing facility. If the HMO determines that the recipient's cost of care will exceed the 200 percent limit, the HMO will submit a request to HHSC Health Plan Operations to consider the use of state General Revenue Funds to cover costs over the 200 percent allowance, as per HHSC's policy and procedures related to use of General Revenue for 1915(c) Nursing Facility Waiver participants. If HHSC approves the use of General Revenue Funds, the HMO will be allowed to provide waiver services as per the Individual Service Plan, and non-waiver services (services in excess of the 200 percent allowance) utilizing state General Revenue Funds. Non-waiver services are not Medicaid Allowable Expenses, and may not be reported as such on the FSRs. The HMO will submit reports documenting expenses for non-waiver services in accordance with the requirements of the **Uniform Managed Care Manual**. HHSC will reimburse the HMO for such expenses in accordance with the procedures set forth in the **Uniform Managed Care Manual**.

8.1.36.1. For Members

Section 8.1.36.1 Modified by Version 1.3

Members can request to be tested for eligibility into the 1915(c) STAR+PLUS Waiver (SPW). The HMO can also initiate SPW eligibility testing on a STAR+PLUS Member, if the HMO determines that the Member would benefit from the SPW services.

To be eligible for the SPW, the Member must meet risk criteria, Medical Necessity/Level of Care, the cost of the Individual Service Plan (ISP) cannot exceed 202% of cost of providing the same services in a nursing facility, and the HMO must be able to demonstrate that that Member has a minimum of one (1) unmet need for at least one (1) SPW service. The HMO must apply risk criteria as illustrated in Section 3242.3 of the STAR+PLUS Handbook, "Risk Assessment."

If the HMO determines that a Member does not meet the risk criteria for SPW eligibility, the HMO must notify HHSC's Administrative Services Contractor. The Administrative Services Contractor will notify the Member that he or she did not meet the eligibility criteria for the SPW, and the right to Appeal the Adverse Determination.

If the HMO determined that the Member meets risk criteria for SPW eligibility, the HMO must complete the Community Medical Necessity and Level of Care Assessment Instrument for Medical Necessity/Level of Care determination, and submit the form to HHSC's Administrative Services Contractor. The HMO is also responsible for completing the assessment documentation, and preparing a 1915(c) STAR+PLUS Waiver ISP for identifying the needed SPW services. The ISP is submitted to the State to ensure that the total cost does not exceed the 202% cost limit. The HMO must complete these activities within 45 days of receiving the State's authorization form for eligibility testing.

HHSC will notify the Member and the HMO of the eligibility determination, which will be based on results of the assessments and the information provided by the HMO. If the STAR+PLUS Member is eligible for SPW services, HHSC will notify the Member of the effective date of their eligibility. If the Member is not eligible for SPW services, HHSC will provide the Member information on right to Appeal the Adverse Determination.

Regardless of the SPW eligibility determination, HHSC will send a copy of the Member notice to the HMO.

8.1.36.2. For Medical Assistance Only (MAO) Non-Member Applicants

Section 8.1.36.2 Modified by Version 1.3

Non-Member persons who are not eligible for Medicaid in the community may apply for participation in the 1915(c) STAR+PLUS Waiver (SPW) program under the financial and functional eligibility requirements for MAO. HHSC will inform the non-member applicant that services are provided through an HMO and allow the applicant to select the HMO. HHSC will provide the selected HMO an authorization form to initiate pre-enrollment assessment services required under the SPW for the applicant. The HMO's initial home visit with the applicant must occur within 14 days of the receipt of the referral. To be eligible for SPW, the applicant must meet financial eligibility, risk criteria, Medical Necessity/Level of Care, the cost of the Individual Service Plan (ISP) cannot exceed 202% of cost of providing the same services in a nursing facility, and the HMO must be able to demonstrate that the applicant has a minimum of one (1) unmet need for at least one (1) SPW service. The HMO must apply risk criteria as illustrated in Section 3242.3 of the STAR+PLUS Handbook, "Risk Assessment."

If the HMO determines that the applicant does not meet the risk criteria for SPW eligibility, the HMO must notify HHSC's Administrative Services Contractor. The Administrative Services Contractor will notify the applicant that he or she did not meet the eligibility criteria for the SPW, and the right to Appeal the Adverse Determination.

If the HMO determined that the applicant meets risk criteria for SPW eligibility, the HMO must complete the Community Medical Necessity and Level of Care Assessment Instrument for Medical Necessity/Level of Care determination, and submit the form to HHSC's Administrative Services Contractor. The HMO is also responsible for completing the assessment documentation, and preparing a 1915(c) STAR+PLUS ISP for identifying the needed SPW services. The ISP is submitted to the State to ensure that the total cost does not exceed the 202% cost ceiling. The HMO must complete these activities within 45 days of receiving the State's authorization form for eligibility testing.

HHSC will notify the applicant and the HMO of the results of its eligibility determination. If the applicant is eligible, HHSC will notify the applicant and the HMO of the effective date of their eligibility, which will be the first day of the month following the determination of eligibility. The HMO must initiate the Individual Service Plan (ISP) on the date of the Member's enrollment.

If the applicant is not eligible, the HHSC notice will provide information on the applicant's right to Appeal the Adverse Determination. HHSC will also send notice to the HMO if the applicant is not eligible for 1915(c) Nursing Facility Waiver services.

8.1.36.3. Annual Reassessment

Prior to the end date of the annual ISP, the HMO must initiate an annual reassessment to determine and validate continued eligibility for 1915(c) Nursing Facility Waiver

services for each Member receiving such services. The HMO will be expected to complete the same activities for each annual reassessment as required for the initial eligibility determination, including the MN/LOC and Form 3671.

8.1.37. Consumer Directed Services Options

Section 8.1.37 Modified by Version 1.3

There are three (3) options available to Members desiring to self-direct the delivery of Primary Home Care (PHC) for Members in the 1915(b) waiver; and personal attendant services (PAS), in-home or out-of-home respite, nursing, physical therapy (PT), occupational therapy (OT), and/or speech/language therapy (SLT) for Members in the 1915(c) STAR+PLUS Waivers (SPW). These three (3) options are:

- Consumer–Directed;
- Service-Related; and
- Agency.

The HMO must provide information concerning the three (3) CDS options to all eligible Members:

1. who meet the functional requirements for PHC Services in the 1915(b) Waiver, and the requirements for PAS in the SPW (the functional criteria for these services are described in the Form 2060),
2. who are eligible for in-home or out-of-home respite services in the SPW; and
3. who are eligible for nursing, PT, OT and/or SLT in the SPW.

In addition to providing information concerning the three (3) options, the HMO must provide Member orientation in the option selected by the Member. The HMO must provide the information to any Member receiving PHC/PAS and/or in-home or out-of-home respite:

- at initial assessment;
- at annual reassessment or annual contact with the Member;
- at any time when a Member receiving PAS requests the information; and
- in the Member Handbook.

The HMO must contract with Providers who are able to offer PHC/PAS, in-home or out-of-home respite, nursing, PT, OT, and/or SLT and must also educate/train the HMO Network Providers regarding the three PAS options. Network Providers must meet licensure/certification requirements as indicated in Attachment B-1, Sections 8.1.33.1 and 8.1.33.2 of the Uniform Managed Care Contract.

In all three (3) options, the Service Coordinator and the Member work together in developing the Individual Service Plan.

A more comprehensive description of Consumer Directed Services is found in the STAR+PLUS Handbook:
http://www.dads.state.tx.us/handbooks/sph/8000/8000.htm#sec8120

8.1.37.1. Consumer-Directed Option Model

Section 8.1.37.1 Modified by Version 1.3

In the Consumer-Directed Model, the Member or the Member's legal guardian is the employer of record and retains control over the hiring, management, and termination of an individual providing PHC/PAS; in-home or out-of-home respite; nursing, PT, OT, and/or SLT. The Member is responsible for assuring that the employee meets the requirements for PHC/PAS; in-home or out-of-home respite; nursing, PT, OT, and/or SLT, including the criminal history check. The Member uses a Consumer Directed Services agency (CDSA), a fiscal/employer agent, to handle such functions as processing payroll, withholding taxes and filing tax-related reports to the Internal Revenue Service and the Texas Workforce Commission for the PHC/PAS; in-home or out-of-home respite; nursing, PT, OT, and/or SLT. The CDSA must be qualified to perform these services, by completing the mandatory CDSA enrollment training and obtaining a DADS CDSA contract. CDSAs are no longer required to be HCSSAs (as of 2007).

8.1.37.2. Service Related Option Model

Section 8.1.37.2 Modified by Version 1.3

In the Service Related Option Model, the Member or the Member's legal guardian is actively involved in choosing their personal attendant, respite provider, nurse, physical therapist, occupational therapist and/or speech/language therapist but is not the employer of record. The Home and Community Support Services Agency (HCSSA) in the HMO'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 and/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 PHC/PAS, and/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 PHC/PAS and/or in-home or out-of-home respite. The HMO is the employer or contractor of record for the nurse, physical therapist, occupational therapist, and/or speech/language therapist. In this model, the Member selects the nurse, physical therapist, occupational therapist, and/or speech/language therapist from the HMO's Provider Network. The nurse, physical therapist, occupational therapist, and/or speech/language therapist's schedule is set up based on the Member's input, and the Member manages the nursing, PT, OT, and/or SLT services. The Member retains the right to supervise and train the nurse, physical therapist, occupational therapist, and/or speech/language therapist. The Member may request a different nurse, physical therapist, occupational therapist, and/or speech/language therapist and the HMO must honor the request as long as the nurse, physical therapist, occupational therapist, and/or speech/language therapist is a Network Provider. The HMO establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of nursing, PT, OT, and/or SLT services.

8.1.37.3. Agency Model

Section 8.1.37.3 Modified by Version 1.3

In the Agency Model, the HMO contracts with a Home and Community Support Services agency (HCSSA) for the delivery of waiver services. The HCSSA is the employer of record for the personal attendant,-respite provider, nurse, physical therapist, occupational therapist, and speech language therapist. The HCSSA establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of PHC/PAS and/or in-home or out-of home respite.

8.1.38. Community-based Long-Term Care Service Providers

8.1.38.1. Training

The HMO must comply with **Section 8.1.4.6** regarding Provider Manual and Provider training specific to the STAR+PLUS Program. The HMO must train all Community-based Long-Term Care Service Providers regarding the requirements of the Contract and special needs of STAR+PLUS Members. The HMO must establish ongoing Provider training addressing the following issues at a minimum:

- Covered Services and the Provider's responsibilities for providing such services to Members and billing the HMO for such services. The HMO must place special emphasis on Community-based Long-Term Care Services and STAR+PLUS requirements, policies, and procedures that vary from Medicaid Fee-for-Service and commercial coverage rules, including payment policies and procedures.
- The transition process of up to six (6) months for the continuation of Community-based Long Term Care Services for Members receiving those services at the time of program implementation, including provider billing practices for these services and who to contact at the HMO for assistance with this process.
- Inpatient Stay Hospital services and the authorization and billing of such services for STAR+PLUS Members.
- Relevant requirements of the STAR+PLUS Contract, including the role of the Service Coordinator;
- Processes for making referrals and coordinating Non-capitated Services;
- The HMO's quality assurance and performance improvement program and the Provider's role in such programs; and
- The HMO's STAR+PLUS policies and procedures, including those relating to Network and Out-of-Network referrals.

8.1.38.2. 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 HMO must make accommodations to the claims processing system for such Providers to allow for a smooth transition from traditional Fee-for-Service Medicaid to Managed Care Medicaid. HHSC also encourages HMOs 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+PLUS HMOs are required to utilize the standardized method of long-term care billing described in the **HHSC Uniform Managed Care Manual**.

8.1.38.3. Rate Enhancement Payments for Agencies Providing Attendant Care

Section 8.1.38.3 Modified by Version 1.5

All HMOs participating in the STAR+PLUS program must allow their LTC Providers to participate in the STAR+PLUS Attendant Care Enhancement Program.

Uniform Managed Care Manual Chapter 2.1.3, "STAR+PLUS Attendant Care Enhanced Payment Methodology" explains the methodology that the HMO will use to implement and pay the enhanced payments, including a description of the timing of the payments, in accordance with the requirements in the **Uniform Managed Care Manual** and the intent of the 2000-01 General Appropriations Act (Rider 27, House Bill 1, 76th Legislature, Regular Session, 1999) and T.A.C. Title 1, Part 15, Chapter 355.

Section 8.1.38.4 Deleted in its Entirety by Version 1.3

8.1.39. Substance Abuse Benefit

Substance Abuse and Dependency Treatment Services

The requirements in this subsection apply to STAR+PLUS HMOs in all Service Areas except the Dallas Service Area. Members in the Dallas Service Area receive Behavioral Health Services through the NorthSTAR Program.

Benefits related to the treatment of substance use disorder must be available to Medicaid Members by the later of September 1, 2010, or the effective date(s) noted in the Medicaid State Plan, 1915(b) STAR+PLUS waiver and 1915(b) STAR waiver for "Mental Health and Substance Use Disorder Treatment Services." Substance use disorder includes substance abuse and dependence as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

Providers

Providers for this benefit include: hospitals, chemical dependency treatment facilities licensed by the Department of State Health Services, and licensed practitioners of the healing arts.

Medicaid HMOs must include Significant Traditional Providers (STPs) of these benefits in its Network, and provide STPs with expedited credentialing. Medicaid HMOs must enter into provider agreements with any willing Significant Traditional Provider (STP) of these benefits that meets the Medicaid enrollment requirements, HMO credentialing requirements and agrees to the HMO'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.

Medicaid HMOs must maintain a provider education process to inform substance abuse treatment Providers in the HMO's Network on how to refer Members for treatment.

Service Management

Medicaid HMOs shall ensure service management is provided to Members with a substance use disorder. Medicaid HMOs 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. Medicaid HMOs must also coordinate services with the DSHS, DFPS, and their designees for Members requiring Non-Capitated Services. Non-Capitated Services includes, without limitation, services that are not available for coverage under the Contract, State Plan or Waiver that are available under the Federal Substance Abuse and Prevention and Treatment block grant when provided by a DSHS-funded provider or covered by the DFPS under direct contract with a treatment provider. Medicaid HMOs 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.

Member Education and Self-Referral for Substance Abuse Treatment Services

Medicaid HMOs 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.

8.1.40. STAR+PLUS Handbook

Section 8.1.40 Modified by Version 1.5

The STAR+PLUS Handbook contains HHSC-approved policies and procedures related to the STAR+PLUS Program, including policies and procedures relating to the 1915(b), 1915(c), or 1115 waivers. The STAR+PLUS Handbook includes additional requirements regarding the STAR+PLUS Program and guidance for the HMOs, the STAR+PLUS Support Units at DADS, and HHSC staff for administrating and managing STAR+PLUS Program operations. The STAR+PLUS Handbook is incorporated by reference into this Contract.

8.1.41. Required Contact with STAR+PLUS Members

Section 8.1.41 Added by Version 1.2

The HMO is required to contact each STAR+PLUS Member a minimum of two (2) times per calendar year. This contact can be done telephonically, written, or as an onsite visit to the Member's residence, contingent upon the Member's level of need. The HMO must document the mechanisms, number and method of contacts, and outcomes within the HMO's Service Coordination system.

8.1.42. Pharmacy Services

Section 8.1.42 Added by Version 1.5

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

The HMO must allow Members access to prescribed drugs though formularies and a preferred drug list (PDL) developed by HHSC. HHSC will maintain separate Medicaid and CHIP formularies, and a Medicaid PDL. The HMO must administer the PDL in a way

that allows access to all non-preferred drugs that are on the formulary through a structured prior authorization process.

The following information must be submitted to HHSC for review and approval during Readiness Review, then after the Operational Start Date prior to any changes: pharmacy clinical guidelines; and prior authorization policies and procedure. In determining whether to approve these materials, HHSC will review factors such as the clinical efficacy and Members' needs.

The HMO may include mail-order pharmacies in their Networks, but must not require Members to use them. Members who opt to use this service may not be charged fees, including postage and handling fees.

HHSC will provide the HMO daily formulary and PDL files. The HMO must update its formulary and PDL files, or ensure that its Pharmacy Benefits Manager (PBM) has updated its formulary and PDL files, at least weekly. At HHSC's direction, the HMO or PBM must be able perform off-cycle formulary and PDL file updates. Such updates must be completed within one (1) Business Day.

The HMO must ensure that prescribers have the ability to utilize real time e-prescribing, which at a minimum will allow for: eligibility confirmation, PDL benefit confirmation, identification of "alternative" (i.e., preferred) drugs that can be used in place of non-preferred drugs, medication history, and prescription routing.

The HMO must allow pharmacies to fill prescriptions for covered drugs ordered by any licensed provider regardless of Network participation.

The HMO will encourage Network pharmacies to also become Medicaid-enrolled durable medical equipment (DME) providers.

The HMO must educate Network Providers about how to access the Medicaid formulary and PDL on HHSC's website, and how to use HHSC's free subscription service for accessing such information through the internet or hand-held devices.

The HMO is responsible for negotiating reasonable pharmacy provider reimbursement rates, including individual HMO maximum allowable cost (MAC) rates. The HMO must ensure that, as an aggregate, rates comply with 42 C.F.R. Part 50, Subpart E, regarding upper payment limits.

The HMO must comply with the requirements of Section 8.1.21.

8.1.42.1 Prior Authorization for Prescription Drugs

Section 8.1.42.1 Added by Version 1.5

The HMO must adopt prior authorization policies and procedures that comply with state and federal laws, including 42 U.S.C. §1369r-8 and Texas Government Code §531.073 and §533.005.

The HMO must adhere to HHSC's PDL for Medicaid. Preferred drugs must adjudicate as payable without prior authorization, unless they are subject to Clinical Edits. HHSC approval is required for all Clinical Edit policies and any revisions thereto.

HHSC's Medicaid prior authorization policies, and the Medicaid PDL, are available on HHSC's website at http://www.txvendordrug.com/index.shtml. HHSC will provide the HMO written notice of changes to website information, and will identify Clinical Edits that are mandatory for HMOs on its Vendor Drug Program website.

HHSC's website 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 prior authorization.

The HMO may require that the prescriber's office request prior authorization as a condition of coverage or payment for a prescription drug provided that: 1) a decision whether to approve or deny the prescription is made within 24 hours of the prior authorization request, and 2) if a Member's prescription for a medication is not filled when a prescription is presented to the pharmacist due to a prior authorization requirement, the HMO must instruct the pharmacist to dispense a 72 hour emergency supply of the prescribed medication if the provider cannot be reached. The pharmacy may fill consecutive 72 hour supplies if the prescriber remains unavailable. The HMO must reimburse the pharmacy for dispensing the temporary supply of medication. The HMO may not charge pharmacies for prior authorization transaction costs or for any software costs related to processing prior authorizations.

The HMO must provide access to a toll-free call center for prescribers to call to request a prior authorization for non-preferred drugs or drug that are subject to Clinical Edits. The HMO must allow prescribers to submit automated prior authorization requests, as well as requests by phone or fax. If the HMO or its PBM operates a separate call center for prior authorization requests, the prior authorization call center must meet the provider hotline performance standards set forth in Section 4.1.4.11, "Provider Hotline."

The HMO may not require a prior authorization for any drug exempted from prior authorization requirements by federal law.

For drug products purchased by a pharmacy through the Health Resources Services Administration (HRSA) 340B discount drug program, the HMO may only impose Clinical Edit prior authorization requirements. These drugs must be exempted from all PDL prior authorization requirements.

The HMO must notify the prescriber's office of a prior authorization approval or denial within 24 hours of the prior authorization request. In the event that the HMO cannot make a prior authorization determination within 24 hours, the HMO must have procedures in place so as to permit the Member to receive a supply of the new medication such that the supply will not be exhausted prior to receipt of the notice.

The requirement that the Member be given at least a 72-hour supply for a new medication does not apply when the dispensing pharmacist determines that the taking of

the prescribed medication would jeopardize the health or safety of the Member. In such event, the HMO must require that its participating pharmacist make good faith efforts to contact the prescriber.

A provider may appeal prior authorization denials on a Member's behalf, in accordance with Section 4.1.31 "Member Complaint and Appeal System."

8.1.42.2 Coverage Exclusions

Section 8.1.42.2 Added by Version 1.5

In accordance with Section 1927 of the Social Security Act, 42 U.S.C.A. §1396r-8, the HMO must exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program. The HMO 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.

8.1.42.3 DESI Drugs

Section 8.1.42.3 Added by Version 1.5

The HMO must not provide coverage under any circumstances for drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI).

8.1.42.4 Pharmacy Rebate Program

Section 8.1.42.4 Added by Version 1.5

Under the provisions of Section 1927 of the Social Security Act, 42 U.S.C.A. §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.

The HMO is not authorized to negotiate rebates with drug companies for preferred pharmaceutical products. HHSC or its designee will negotiate rebate agreements. If the HMO 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 HMO must implement a process to timely support HHSC's Medicaid rebate dispute resolution processes.

a. The HMO 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 HMO must establish a single point of contact where the HHSC's designee can send information on claims needing correction.

HHSC will notify the HMO of claims submitted with incorrect information. The HMO must correct this information on the next scheduled pharmacy encounter data transmission.

8.1.42.5 Drug Utilization Review Program

Section 8.1.42.5 Added by Version 1.5

The HMO 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 should take place at the dispensing pharmacy's point-of-sale (POS). The prospective review at the POS should compare the prescribed medication against previous drug history for drug-to-drug, ingredient duplication, therapeutic duplication, and high dose situations. The HMO's retrospective review should monitor prescriber and contracted pharmacies for outlier activities. Retrospective reviews should also determine whether services were delivered as prescribed and consistent with the HMO's payment policies and procedures.

When a HMO receives a new Member with recent Medicaid eligibility, HHSC will transmit a file with up to one year of medication history.

8.1.42.6 Pharmacy Benefit Manager (PBM)

Section 8.1.42.6 Added by Version 1.5

The HMO must use a PBM to process prescription claims. The PBM must pay claims in accordance with §843.339 of the Texas Insurance Code. This law requires PBMs to pay clean claims: (1) submitted electronically no later than 18 days after adjudication, and (2) not electronically submitted no later than 21 days after adjudication.

The HMO 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 HMO 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 HMO must provide a plan documenting how it will monitor such 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.

8.1.42.7 Financial Disclosures for Pharmacy Services

Section 8.1.42.7 Added by Version 1.5

The HMO must disclose all financial terms and arrangements for remuneration of any kind that apply between the HMO and any prescription drug manufacturer or labeler, including, without limitation, formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and any other fees. Article 9 of Attachment A, "Uniform Managed Care Contract Terms and Conditions," provides HHSC with the right to audit such information at any time. HHSC agrees to maintain the confidentiality of information disclosed by the HMO pursuant to this section, to the extent that such information is confidential under Texas or federal law.

8.1.42.8 Limitations Regarding Registered Sex Offenders

Section 8.1.42.8 Added by Version 1.5

As of the Effective Date of this Contract, HHSC's Medicaid formulary does not include sexual performance enhancing medications. If such medications are added to the

Medicaid formulary after the Effective Date of this Contract, then HMO must comply with the requirements of Texas Government Code §531.071. This law prohibits the provision of sexual performance enhancing medication to persons required to register as sex offenders under Chapter 62, Texas Code of Criminal Procedure.

8.1.42.9 Specialty Drugs

Section 8.1.42.9 Added by Version 1.5

HHSC will adopt rules concerning specialty pharmacy services. Once HHSC adopts these rules, the HMO must develop policies and procedures for reclassifying prescription drugs from retail to specialty drugs. The HMO's policies and procedures must be consistent with HHSC's rules, and include processes for notifying Network Pharmacy Providers.

As set forth in Section 8.1.4, the HMO may enter into selective contracts for specialty pharmacy services prior to HHSC's adoption of rules concerning specialty pharmacy services, subject to the following conditions. These arrangements must comply with Texas Government Code §533.005(a)(23)(G). Furthermore, if these specialty pharmacy services contracts conflict with final rules promulgated by HHSC, then the HMO must terminate the contracts or amend them to comply with the rules.

8.2. Additional Requirements Regarding Dual Eligibles

One of HHSC's goals for this Contract is to provide integrated Acute Care and long term care services to Dual Eligible Members enrolled in STAR+PLUS. To meet this goal, HHSC is adding new features to the STAR+PLUS Program, as described in this Section.

Section 8.2.1 is deleted & subsequent section is renumbered by Version 1.1

8.2.1. MA Dual SNP Agreement

As set forth in **Section 8.1.34.8**, the HMO must contract with the CMS as a MA Dual SNP, and operate as such in applicable zip codes beginning on January 1, 2012. At a minimum, the HMO must be contracted as an MA Dual SNP in all zip codes in Tarrant and Denton Counties (if the HMO operates as a STAR+PLUS HMO in the Tarrant Service Area) and in all zip codes in Dallas and Collin Counties (if the HMO operates as a STAR+PLUS HMO in the Dallas Service Area). After January 1, 2012, the HMO must maintain its status as an MA DUAL SNP contractor throughout the term of the STAR+PLUS Contract. Failure to do so may result in HHSC's assessment of contractual remedies, including Contract termination.

In addition, as part of the integrated care initiative for Dual Eligible STAR+PLUS Members, the HMO must maintain a separate capitation agreement with HHSC whereby the HMO's MA Dual SNP plan reimburses Medicare providers for the cost-sharing obligations that the State would otherwise be required to pay on behalf of qualified STAR+PLUS Dual Eligible Members. The final Texas MA Dual SNP Agreement, as amended or modified, will be incorporated by reference into the STAR+PLUS Contract as **Attachment B-9**, and must be executed on or before January 1, 2012. The HMO will be required to provide all enrolled

STAR+PLUS Dual Eligible Members with the coordinated care and other services described in the Texas MA Dual SNP Agreement, and any violations of the Texas MA Dual SNP Agreement with respect to STAR+PLUS Members will also be a violation of the STAR+PLUS Contract. Note that, for STAR+PLUS Members who are also enrolled in the MA Dual SNP's Medicare plan, the Parties may develop alternative methods for verifying Member eligibility and submitting encounter data. Any modifications to these processes or other scope of work requirements identified in the Texas MA Dual SNP Agreement will be included in the Texas MA Dual SNP Agreement.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	June 30, 2010	Initial version of Attachment B-1, Section 9 "Turnover Requirements" that includes all modifications negotiated by the Parties.
Revision	1.1	February 1, 2011	Contract amendment did not revise Attachment B-1, Section 9 "Turnover Requirements".
Revision	1.2	March 1, 2011	Contract amendment did not revise Attachment B-1, Section 9 "Turnover Requirements".
Revision	1.3	September 1, 2011	Contract amendment did not revise Attachment B-1, Section 9 "Turnover Requirements".
Revision	1.4	January 1, 2012	Contract amendment did not revise Attachment B-1, Section 9 "Turnover Requirements".
Revision	1.4	March 1, 2012	Contract amendment did not revise Attachment B-1, Section 9 "Turnover Requirements".

[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 in accordance 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

This section presents the Turnover requirements. "Turnover" is defined as the activities that the HMO is required to perform prior to or upon termination of the Contract, in situations where the HMO will transition data and documentation to HHSC or a subsequent contractor.

9.2 Turnover Plan

Twelve months after the start of the Contract, the HMO 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 must be approved by HHSC.

9.3 Transfer of Data and Information

The HMO must transfer to HHSC or a subsequent contractor all data and information necessary to transition operations, including: data and reference tables; data entry software; third-party software and modifications; 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 HMO must provide the documentation in the formats in which such documentation exists at the expiration or termination of the Contract. See **Attachment A, Uniform Managed Care Contract Terms and Conditions, Section 15** for additional information concerning intellectual property rights.

In addition, the HMO will provide to HHSC the following:

1. Data, information and services necessary and sufficient to enable HHSC to map all HMO Program data from the HMO's system(s) to the replacement system(s) of HHSC or a successor contractor, including a comprehensive data dictionary as defined by HHSC.
2. All necessary data, information and services will be provided in the format defined by HHSC, and must be HIPAA compliant.
3. All of the data, information and services mentioned in this section shall be provided and performed in a manner by the HMO 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 pursuant to this section shall be provided at no additional cost to HHSC.

All relevant data and information must be received and verified by HHSC or the subsequent contractor. 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 reasonable cost of providing these services will be the responsibility of the HMO.

9.4 Turnover Services

Six months prior to the end of the Contract Period, including any extensions, the HMO must update their Turnover Plan. If HHSC terminates the Contract prior to the expiration of the Contract Period, then HHSC may require the HMO to update the Turnover Plan sooner. In such 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 describes the HMO's policies and procedures that will assure:

1. The least disruption in the delivery of Health Care Services to Members who are enrolled with the HMO during the transition to a subsequent vendor.
2. Cooperation with HHSC and the subsequent contractor 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 in transferring information to the subsequent contractor, as requested and in the form required or approved by HHSC.

The Turnover Plan must be approved by HHSC, and include at a minimum:

1. The HMO's approach and schedule for the transfer of data and information, as described above.
2. The quality assurance process that the HMO will use to monitor Turnover activities.
3. The HMO'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 HMO or modify the Turnover Plan as necessary.

9.5 Post-Turnover Services

30 days following Turnover of operations, the HMO must provide HHSC with a Turnover Results Report documenting the completion and results of each step of the Turnover Plan. Turnover will not be considered complete until this document is approved by HHSC.

If the HMO does not provide the required data or information necessary for HHSC or the subsequent contractor to assume the operational activities successfully, the HMO agrees to reimburse HHSC for all reasonable costs and expenses, including, but not limited to: transportation, lodging, and subsistence to carry out inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such 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

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	June 30, 2010	Initial version of Attachment B-2, "STAR+PLUS Covered Services" that includes all modifications negotiated by the Parties.
Revision	1.1	February 1, 2011	Contract amendment did not revise Attachment B-2, "STAR+PLUS Covered Services".
Revision	1.2	March 1, 2011	Services included under the HMO capitation payment is modified to remove the services effective prior to the effective dates of the State Plan and 1915(b) STAR Waiver. Services included under the HMO capitation payment is modified to add a reference to "Cancer screening, diagnostic, and treatment services". These services are already 1905(a) covered services, therefore adding this reference does not impact the HMOs' rates.
Revision	1.3	September 1, 2011	Attachment B-2.1 is modified to remove the waiver of the 30-day spell of illness for physical health in conformance with the 1915(b) waiver. In addition, effective September 1, 2011 and subject to CMS approval, the waiver of the three prescription limit for adults is removed.
Revision	1.4	January 1, 2012	Contract amendment did not revise Attachment B-2, "STAR+PLUS Covered Services".
Revision	1.5	March 1, 2012	Acute Care Services is modified to reinstate the waiver of the three prescription limit for adults language and to clarify the waiver of the $200,000 individual annual limit on inpatient services. Services included under the HMO capitation payment is modified to clarify the requirements regarding services provided in free-standing psychiatric hospitals and chemical dependency treatment facilities in lieu of the acute care hospital setting; to clarify the requirements for "Prenatal care services rendered in a birthing center"; and to add inpatient hospital services. Community Based Long Term Care Services is modified to change the name of the "1915(c) Nursing Facility Waiver" to "1915(c) STAR+PLUS Waiver."

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			"Wrap-around Medicaid Services for SLMB Plus and QMB Plus Dual Eligible Members" is deleted.

[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 in accordance 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+PLUS Covered Services

Acute Care Services

Acute Care Services Modified by Versions 1.3 and 1.5

The following is a non-exhaustive, high-level listing of Acute Care Covered Services included under the STAR+PLUS Medicaid managed care program.

Medicaid HMO Contractors are responsible for providing a benefit package to STAR+PLUS 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 HMO capitation and listed in **Section 8.1.22.8** of the RFP. In accordance with **Section 8.1.22.8** of the RFP, Hospital Inpatient Stays and Nursing Facility Services are examples of services that are excluded from the capitation payment to STAR+PLUS HMOs and are paid through HHSC's Administrative Contractor responsible for payment of Traditional Medicaid fee-for-service claims. The HMO must coordinate care for STAR+PLUS Members for these Non-capitated Services so that STAR+PLUS Members have access to a full range of medically necessary Medicaid services, both capitated and non-capitated. A Contractor may elect to offer additional Acute Care Value-added Services.

Adult STAR+PLUS Members receive three (3) enhanced benefits compared to the traditional, fee-for-service Medicaid coverage:

1) waiver of the three-prescription per month limit, for members not covered by Medicare;
2) waiver of the 30-day spell-of-illness limit; and
3) waiver of the $200,000 individual annual limit on inpatient services.

Prescription drug benefits to Members are provided outside of the HMO capitation.

The HMO should refer to the current **Texas Medicaid Provider Procedures Manual** and the bi-monthly **Texas Medicaid Bulletin** for a more inclusive listing of limitations and exclusions that apply to each Medicaid benefit category. (These documents 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 program policy updates.

Services included under the HMO capitation payment

Services Under the Capitation Payment Modified by Versions 1.2 and 1.5

- Ambulance services;
- Audiology services, including hearing aids, for adults and children
- (These services are not subject to the quantitative treatment limitations that apply under traditional, fee-for-service Medicaid coverage. The services may be subject to the HMO's non-quantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008.) Behavioral Health Services, including:
  - Inpatient mental health services for Adults and Children (Effective 6/01/07 in the Harris Service Area; and effective 9/01/07 in the Bexar, Nueces and Travis Service Areas.) The HMO may provide these services in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting.

  - Outpatient mental health services for Adults and Children
  - Psychiatry services
  - Counseling services for adults (21 years of age and over)
  - Substance use disorder treatment services, including
    - Outpatient services, including:
      - 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;
- Durable medical equipment and supplies;
- Emergency Services;
- Family planning services ;
- Home health care services;
- Hospital services, inpatient and outpatient;
- Laboratory;
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
  - 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 for children (under the age of 21) through the Texas Health Steps Program;
- 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;
- Podiatry;
- Prenatal care;

- Preventive services including an annual adult well check for patients 21 years of age and over;
- Primary care services;
- Radiology, imaging, and X-rays;
- Specialty physician services;
- Therapies – physical, occupational and speech;
- Transplantation of organs and tissues; and
- Vision services.

Community-based Long-Term Care Services

The following is a non-exhaustive, high-level listing of Community-based Long-Term Care Covered Services included under the STAR+PLUS Medicaid managed care program.

Community-based Long-Term Care Services Modified by Version 1.5

- Community-based Long-Term Care Services for all Members
  - Personal Assistance Services – All Members may receive medically and functionally necessary Personal Assistance Services (PAS).
  - Day Activity and Health Services (DAHS) – All Members may receive medically and functionally necessary Day Activity and Health Services (DAHS).
- 1915 (c) STAR+PLUS Waiver Services for those Members who qualify for such services
  The state provides an enriched array of services to clients who would otherwise qualify for nursing facility care through a Home and Community-based Medicaid Waiver. In traditional Medicaid, this is known as the Community-based Alternatives (CBA) waiver. The HMO must also provide medically necessary services that are available to clients through the CBA waiver in traditional Medicaid to those clients that meet the functional and financial eligibility for 1915 (c) Nursing Facility Waiver Services.
  - Personal Assistance Services (including the three service delivery options: Self-Directed; Agency Model, Self-Directed; and Agency Model);
  - In-Home or Out-of-Home Respite Services;
  - Nursing Services (in home);
  - Emergency Response Services (Emergency call button);
  - Home Delivered Meals;
  - Dental services;
  - Respite Care;
  - Minor Home Modifications;
  - Adaptive Aids and Medical Equipment;
  - Medical Supplies not available under the Texas Medicaid State Plan/1915(b) Waiver;
  - Physical Therapy, Occupational Therapy, Speech Therapy;
  - Adult Foster Care;
  - Assisted Living;
  - Consumer Directed Services;
  - Transition Assistance Services (These services are limited to a maximum of $2,500.00. If the HMO determines that no other resources are available to pay for the basic services/items needed to assist a Member who is leaving a nursing facility with setting up a household, the HMO may authorize up to $2,500.00 for Transition Assistance Services (TAS). The $2,500.00 TAS benefit is part of the expense ceiling when determining the Total Annual Individual Service Plan (ISP) Cost.)

Wrap-around Medicaid Deleted by Version 1.5

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	June 30, 2010	Initial version of Attachment B-5, "Deliverables/Liquidated Damages Matrix" that includes all modifications negotiated by the Parties.
Revision	1.1	February 1, 2011	Contract amendment did not revise Attachment B-5, "Deliverables/Liquidated Damages Matrix".
Revision	1.2	March 1, 2011	Contract amendment did not revise Attachment B-5, "Deliverables/Liquidated Damages Matrix".
Revision	1.3	September 1, 2011	Item 11 is modified to clarify liquidated damages for failing to submit timely HMO response to Provider complaints. Item 22 is modified to clarify liquidated damages for timely HMO response to complaints.
Revision	1.4	January 1, 2012	Contract amendment did not revise Attachment B-5, "Deliverables/Liquidated Damages Matrix".
Revision	1.5	March 1, 2012	Item 8 is added to require MCOs to submit or comply with the requirements of the HHSC-approved Fraud and Abuse Compliance Plan. All subsequent items are renumbered. Item 23 is added to require that MCOs must respond to Office of Inspector General request for information in the manner and format requested.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Item 26 is added to require MCOs to submit a Fraudulent Practices Report within 30 days of receiving a report of possible Waste, Abuse, or Fraud and to submit quarterly SIU Reports.

[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 in accordance 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
1.	General Requirement: Failure to Perform an Administrative Service Contract Attachment A HHSC Uniform Managed Care Contract Terms and Conditions, RFP §§ 6, 7, 8 and 9	The HMO fails to timely perform an Administrative Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, such failure either: (1) results in actual harm to a Member or enrollee or places him/her at risk of imminent harm; or (2) materially affects HHSC's ability to administer the STAR+PLUS 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 Contract Attachment A HHSC Uniform Managed Care Contract Terms	The HMO 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, such 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 Contract or HHSC's **Uniform Managed Care Manual**.
[2] Standard specified in the Contract. Note: Where the due date states 30 days, the HMO 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 HMO is to 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
	and Conditions, RFP §§ 6, 7, 8 and 9				
3.	Contract Attachment A HHSC Uniform Managed Care Contract Terms and Conditions, Section 4.08 Subcontractors	The MCO must notify HHSC in writing: (i) three (3) 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 HMO Administrative Services; and (iv) 30 calendar days prior to the termination date of any other Material Subcontract.	Transition, Measured 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	All reports and deliverables as specified in Sections 6, 7, 8 and 9 of the RFP must be submitted according to the timeframes and requirements stated in the Contract (including all attachments) and HHSC's Uniform Managed Care Manual. (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 late, inaccurate, or incomplete.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
5.	RFP §7.3 -- Transition Phase Schedule RFP §7.3.1 -- Transition Phase Tasks RFP §8.1 -- General Scope	The HMO must be operational no later than the agreed upon Operational Start Date. HHSC, or its agent, will determine when the HMO is considered to be operational based on the requirements in Section 7 and 8 of the RFP.	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 HMO is not operational until the day that the HMO is operational, including all systems.
6.	RFP §7.3.1.5 -- Systems Readiness Review	The HMO must submit to HHSC or to the designated Readiness Review Contractor the following plans for review: • Joint Interface Plan; • Disaster Recovery Plan; • Business Continuity Plan; • Risk Management Plan; and • 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 late, inaccurate, or incomplete.
7.	RFP §7.3.1.7 – 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 late, inaccurate, or incomplete.
8.	Attachment B-1, RFP Sections 7.2.8.1 and	The HMO must submit or comply with the requirements of the HHSC-approved Fraud and Abuse	Transition, Operations, and Turnover	Each incident of noncompliance, per HMO Program	HHSC may assess up to $250 per calendar day for each incident of noncompliance, per HMO Program.

RFP §§7.2.8.1 and 8.1.19 Fraud and Abuse is Added by Version 1.5

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
	8.1.19	Compliance Plan.			
9.	RFP §8.1.4 Provider Network UMCM Chapter 5.38 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.	Measured Quarterly beginning March 1, 2010.	Per incident of non-compliance, per Medicaid HMO, per Service Area.	HHSC may assess up to $25,000 per quarter, per Medicaid HMO, per Service Area.
10.	RFP §8.1.4.7 – Provider Hotline	A. The HMO 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. B. Performance Standards: 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. Call abandonment rate—Call abandonment rate is seven (7) percent or less.	Operations and Turnover	A. Each incident of non-compliance per SA. B. Each percentage point below the standard for 1 and each percentage point above the standard for 2 per SA. C. Per month, for each 30 second time increment, or portion thereof, by which the average hold time exceeds the maximum	HHSC may assess: A. Per SA, up to $100 for each hour or portion thereof 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. B. Up to $100 per SA for each percentage point for each standard that the HMO fails to meet the requirements for a monthly reporting period for any

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
		C. Average hold time is two (2) minutes or less.		acceptable hold time.	HMO operated toll-free lines. C. Up to $100 may be assessed for each 30 second time increment, or portion thereof, by which the MCO's average hold time exceeds the maximum acceptable hold time.
11.	RFP §8.1.5.6 – Member Services Hotline	A. The HMO must operate a toll-free hotline that Members can call 24 hours a day, seven (7) days a week. B. Performance Standards. 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. Call hold rate—At least 80 percent of calls must be answered by toll-free line staff within 30 seconds; 3. Call abandonment rate—Call abandonment rate is seven (7) percent or less. C. Average hold time is two (2) minutes or less.	Ongoing during Operations and Turnover	A. Each incident of non-compliance per SA. B. Each percentage point below the standard for 1 and 2 and each percentage point above the standard for 3 per SA. C. Per month, for each 30 second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time.	HHSC may assess: A. Per SA, up to $100 for each hour or portion thereof that 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. B. Per SA, up to $100 for each percentage point for each standard that the HMO fails to meet the requirements for a monthly reporting period for any HMO operated toll-free lines. C. Up to $100 may be assessed for each 30 second time increment, or portion thereof, by which the MCO's average hold time exceeds the maximum acceptable hold time.

RFP §8.1.5.9 Member Complaint and Appeal Process is Modified by Version 1.3

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
12.	RFP §8.1.5.9-- Member Complaint and Appeal Process RFP §8.1.25.1 Provider Complaints	The HMO must resolve at least 98 percent of Member and Provider Complaints within 30 calendar days from the date the Complaint is received by the HMO.	Measured Quarterly during the Operations Period	Per reporting period, per SA.	HHSC may assess up to $250 per reporting period if the HMO fails to meet the performance standard.
13.	RFP §8.1.5.9— Member Complaint and Appeal Process	The HMO must resolve at least 98 percent of Member Appeals within 30 calendar days from the date the Appeal is filed with the HMO.	Measured Quarterly during the Operations Period	Per reporting period, per SA.	HHSC may assess up to $500 per reporting period if the HMO fails to meet the performance standard.
14.	RFP §8.1.6 -- Marketing & Prohibited Practices Uniform Managed Care Manual	The HMO may not engage in prohibited marketing practices.	Transition, Measured Quarterly during the Operations Period	Per incident of non-compliance.	HHSC may assess up to $1,000 per incident of non-compliance.
15.	RFP §8.1.15.3 – Behavioral Health Services Hotline	A. The HMO must have an emergency and crisis Behavioral Health services Hotline available 24 hours a day, seven (7) days a week, toll-free throughout the SA(s). B. Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess behavioral health emergencies.	Operations and Turnover	A. Each incident of non-compliance per SA. B. Each incident of non-compliance per SA. C. Per SA, per month, each percentage point below the standard for 1 and 2 and each	HHSC may assess: A. Up to $100 for each hour or portion thereof 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
		C. The HMO must ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for the STAR+PLUS Program: 1. Call pick-up rate: 99 percent of calls are answered by the fourth ring, or by an automated call pick-up system; 2. Call hold rate: At least 80 percent of calls must be answered by toll-free line staff within 30 seconds; 3. Call abandonment rate: The call abandonment rate is seven (7) percent or less. D. Average hold time is two (2) minutes or less.		percentage point above the standard for 3. D. Per month, for each 30 second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time.	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. C. Up to $100 for each percentage point for each standard that the HMO fails to meet the requirements for a monthly reporting period for any HMO-operated toll-free lines. D. Up to $100 may be assessed for each 30 second time increment, or portion thereof, during which the MCO's average hold time exceeds the maximum acceptable hold time.
16.	RFP §8.1.17.2 -- Financial Reporting Requirements Uniform Managed Care Manual – Chapter 5	Financial Statistical Reports (FSR**)**: For each SA, the HMO 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	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 late, inaccurate, or incomplete.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
		Contract Year.			
17.	RFP §8.1.17.2 -- Financial Reporting Requirements: Uniform Managed Care Manual – Chapter 5	Medicaid Disproportionate Share Hospital (DSH) Reports: The HMO must submit, on an annual basis, preliminary and final DSH Reports. The Preliminary report is due no later than June 1st after each reporting year, and the final report is due no later than July 1st after each reporting year. Any claims added after July 1st shall include supporting claim documentation for HHSC validation.	Measured during 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 late, incorrect, inaccurate, or incomplete.
18.	RFP §8.1.18 – Management Information System (MIS) Requirements	The HMO's MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan.	Measured 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.
19.	RFP §8.1.18.1 – Encounter Data	The HMO must submit Encounter Data transmissions and include all Encounter Data and Encounter Data adjustments processed by the HMO on a monthly basis, not later than the 30th calendar day after the last day of the month in which the claim(s) are adjudicated. Additionally, the HMO 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	Measured Quarterly during Operations Period.	Per incidence of non-compliance.	If the MCO falls below the 98% match standard in a SA. HHSC may assess up to $5,000 per Quarter, per SA for each additional Quarter that the MCO falls below the 98% match standard.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
		the appropriate paid dollars reported in the Texas Encounter Data (TED) Warehouse) includes more than a 2 percent variance (i.e., less than a 98 percent match).			
20.	RFP §8.1.18.3 – Management Information System (MIS) Requirements: System-Wide Functions	The HMO's MIS system must meet all requirements in Section 8.1.18.3 of the RFP.	Measured 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.
21.	RFP §8.1.18.5 -- Claims Processing Requirements Uniform Managed Care Manual Chapter 2	The HMO must adjudicate all provider Clean Claims within 30 days of receipt by the HMO. The HMO must pay providers interest at an 18 percent per annum, calculated daily for the full period in which the Clean Claim remains unadjudicated beyond the 30-day claims processing deadline. Interest owed the provider must be paid on the same date that the claim is adjudicated.	Measured Quarterly during the Operations Period	Per incident of non-compliance.	HHSC may assess up to $1,000 per claim if the HMO fails to timely pay interest.
22.	RFP §8.1.18.5 -- Claims Processing Requirements Uniform Managed Care	The HMO must comply with the claims processing requirements and standards as described in Section 8.1.18.5 of the RFP and in Chapter 2 of the Uniform Managed Care Manual.	Measured Quarterly during the Operations Period	Per quarterly reporting period, per SA, per claim type.	HHSC may assess liquidated damages of up to $5,000 for the first quarter that an HMO's Claims Performance percentages by claim type, and by SA, fall below the performance standards. HHSC may assess up to $25,000 per quarter for each additional quarter that the

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
	Manual – Chapter 2				Claims Performance percentages by claim type, and by SA, fall below the performance standards.
23.	Attachment B-1, RFP Section 8.1.19	The HMO 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, per HMO Program.	HHSC may assess up to $250 per calendar day, per HMO Program, that the report is late, inaccurate, or incomplete.
24.	RFP §8.1.20 Reporting Requirements RFP §8.1.25.1 Provider Complaints RFP §8.1.27 Member Complaint and Appeal System	The HMO fails to submit a timely response to an HHSC Member or Provider Complaint received by HHSC and referred to the HMO by the specified due date. The HMO response must be submitted according to the timeframes and requirements stated within the HMO Notification Correspondence (letter, email, etc).	Measured on a Quarterly Basis	Each incident of non-compliance per HMO Program and SA	HHSC may assess up to $250 per calendar day for each day beyond the due date specified within the HMO Notification Correspondence.
25.	RFP §8.1.20.2--Reporting Requirements Uniform Managed Care Manual Chapters 2 & 5	Claims Summary Report: The HMO must submit quarterly Claims Summary Reports to HHSC by SA, and by claim type, by the 30th day following the reporting period unless otherwise specified.	Measured 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 late, inaccurate, or incomplete.
26.	Attachment B-1, RFP Section 8.1.20.2, UMCM Chapter 5.5	The HMO must submit a Fraudulent Practices Report to the HHSC-OIG within 30 Business Days of receiving a report of possible Waste, Abuse, or Fraud from the	Transition, Operations, and Turnover	Each calendar day of noncompliance, per HMO Program.	HHSC may assess up to $250 per calendar day, per HMO Program, that the report is late, inaccurate, or incomplete.

RFP §8.1.19 Fraud and Abuse Added by Version 1.5

RFP §8.1.20 Reporting Requirements Modified by Version 1.3

RFP §8.1.20 Reporting Requirements Added by Version 1.5

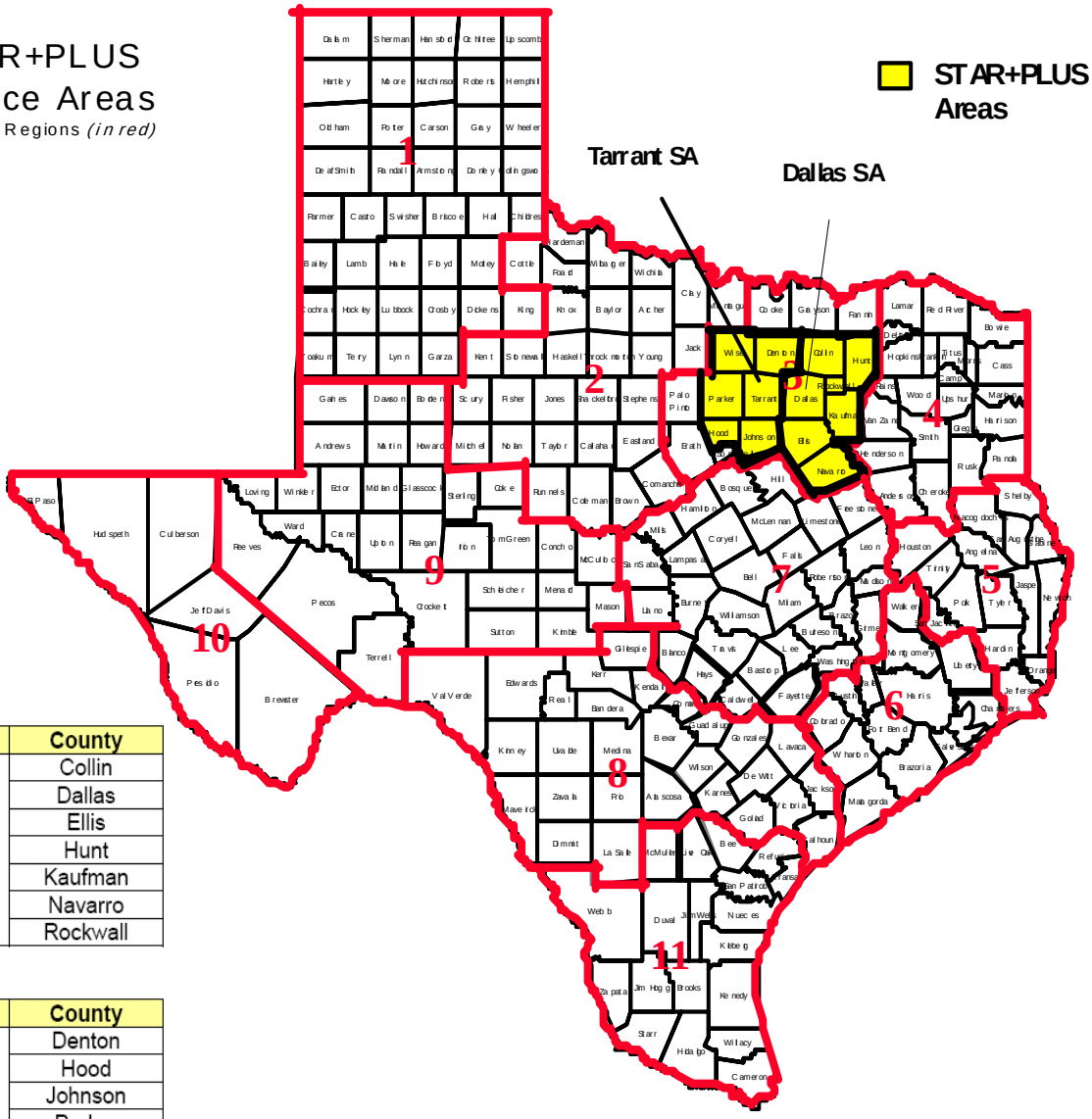
#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
		HMO's Special Investigative Unit (SIU). The HMO must submit quarterly SIU Reports.			
27.	RFP §8.1.35 – STAR+PLUS Assessment Instruments RFP §8.1.36.1 – For Members RFP §8.1.36.2 – For Medical Assistance Only (MAO) Non-Member Applicants	The Community Medical Necessity and Level of Care (MN LOC) Assessment Instrument must be completed and electronically submitted via the TMHP portal in the specified format within 45 days: 1) from the date of referral for 1915(c) Waiver services for MAO applicants; 2) from the date of the Member's request for 1915(c) Waiver services for current Members requesting an upgrade; or 3) prior to the annual ISP expiration date for all Members receiving 1915(c) Waiver services as specified in Section 8.1.35.	Operations, Turnover	Per calendar day of non-compliance, per SA.	HHSC may assess up to $500 per calendar day per SA, for each day a report is late, inaccurate, or incomplete.
28.	RFP §9.3 -- Transfer of Data	The HMO must transfer all data regarding the provision of Covered Services to Members to HHSC or a new HMO, at the sole discretion of HHSC and as directed by HHSC. All transferred data must comply with the Contract requirements, including HIPAA.	Measured 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 and/or failure to provide data in required format), per SA.	HHSC may assess up to $10,000 per calendar day the data is late, inaccurate, or incomplete.
29.	RFP §9.4 -- Turnover	Six (6) months prior to the end of the contract period or any extension	Measured at Six Months prior to the	Each calendar day of non-compliance, per	HHSC may assess up to $1,000 per calendar day the Plan is late,

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
	Services	thereof, the HMO must propose a Turnover Plan covering the possible turnover of the records and information maintained to either the State (HHSC) or a successor HMO.	end of the contract period or any extension thereof and ongoing until satisfactorily completed	SA.	inaccurate, or incomplete.
30.	RFP §9.5 -- Post-Turnover Services	The HMO must provide the State (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.	Measured 30 days after the Turnover of Operations	Each calendar day of non-compliance, per SA.	HHSC may assess up to $250 per calendar day the report is late, inaccurate, or incomplete.

Attachment B-6

STAR+PLUS Service Areas

With HHSRegions *(in red)*



Service Area	County
Dallas (7 counties)	Collin
	Dallas
	Ellis
	Hunt
	Kaufman
	Navarro
	Rockwall

Service Area	County
Tarrant (6 counties)	Denton
	Hood
	Johnson
	Parker
	Tarrant
	Wise

HHSC, Health Plan Operations
May 2009