Part 1: Parties to the Contract:

This Contract Amendment ("Amendment Seven") is entered into between the **Texas Health and Human Services Commission (HHSC)**, an administrative agency within the executive department of the State of Texas, having its principal office at 4900 North Lamar Boulevard, Austin, Texas 78751, and **Banker's Reserve Life Insurance Company of Wisconsin (d.b.a. Superior HealthPlan Network) (EPO)** a corporation organized under the laws of the State of Wisconsin, having its principal place of business at 2100 South IH-35, Suite 202, Austin, Texas 78704. HHSC and EPO may be referred to in this Amendment individually as a "Party" and collectively as the "Parties."

The Parties hereby agree to amend their original contract, HHSC contract number 529-04-036, and all prior amendments (collectively the "Agreement") as set forth herein. The Parties agree that the terms of the Agreement will remain in effect and continue to govern except to the extent modified in this Amendment Seven.

This Amendment Seven is executed by the Parties in accordance with the authority granted in Attachment A to the HHSC Managed Care Contract document, "HHSC Uniform Managed Care Contract Terms & Conditions," Article 8, "Amendments and Modifications."

Part 2: Effective Date of Amendment:	**Part 3: Contract Expiration Date**	**Part 4: Operational Start Date:**
September 1, 2009	August 31, 2010	CHIP EPO Program: September 1, 2004 CHIP Perinatal Program: January 1, 2007

Part 5: Project Managers:

HHSC Project Manager:

Scott Schalchlin
Director, Health Plan Operations
11209 Metric Boulevard, Building H
Austin, Texas 78758
Phone: 512-491-1866
Fax: 512-491-1969
Email: scott.schalchlin@hhsc.state.tx.us

EPO Project Manager:

Tom Wise
2100 IH 35 South, Suite 202
Austin, Texas 78701
Office: (512) 692-1465
Fax: (512) 692-1474
Email: twise@centene.com

Part 6: Deliver Legal Notices to:

HHSC:

HHSC General Counsel
4900 North Lamar Boulevard, 4th Floor
Austin, Texas 78751

EPO:

Barry Senterfitt
Greenberg Traurig, LP.
One American Center, Suite 300
Austin, Texas, 78701

Part 7: EPO Service Areas, Premium Rates and Operational Start Dates:

The EPO is responsible for providing Covered Services to Members in the identified Service Areas*:*

Service Area: CHIP Program Service Area (170 Counties)							
	Rate Cell (Member Age Group)	Rate Period 1 (September 1, 2004 – August 31, 2005) Premium Rate	Rate Period 2 (September 1, 2005 – August 31, 2006) Premium Rate	Rate Period 3 (September 1, 2006 – August 31, 2007) Premium Rate	Rate Period 4 (September 1, 2007 – August 31, 2008) Premium Rate	Rate Period 5 (September 1, 2008 – August 31, 2009) Premium Rate	Rate Period 6 (September 1, 2009 – August 31, 2010) Premium Rate
1	< age 1	$453.45	$435.29	$124.90	$85.52	$144.50	$148.97
2	Ages 1 through 5	$92.38	$88.68	$90.14	$89.16	$104.15	$108.29
3	Ages 6 through 14	$60.38	$57.96	$70.85	$71.87	$75.55	$76.34
4	Ages 15 through 18	$119.55	$114.76	$93.69	$99.85	$93.17	$93.74

Service Area: CHIP Perinatal Program Service Area (170 Counties)								
	Rate Cell	Rate Period 1 (September 1, 2004 – August 31, 2005) Premium Rate	Rate Period 2 (September 1, 2005 – August 31, 2006) Premium Rate	Rate Period 3 (September 1, 2006 – August 31, 2007) Premium Rate	Rate Period 4 (September 1, 2007 – August 31, 2008) Premium Rate	Rate Period 5 (September 1, 2008 – February 28, 2009) Premium Rate	Rate Period 5 (March 1, 2009 – August 31, 2009) Premium Rate	Rate Period 6 (September 1, 2009 – August 31, 2010) Premium Rate
5	Perinate Newborn 0% - 185% of FPL	NA	NA	$325.92	$385.87	$406.88	$229.00	$238.36
6	Perinate Newborn Above 185% - 200% of FPL	NA	NA	$663.20	$725.15	$764.63	$539.67	$408.55
7	Perinate 0% - 185% of FPL	NA	NA	$417.19*	$539.19	$548.95	$203.70	$291.08
8	Perinate Above 185% - 200% of FPL	NA	NA	$152.35	$175.04	$184.79	$176.18	$309.57

* This rate was effective April 1, 2007 in accordance with Attachment A-2, Section 10.05(d).

Delivery Supplemental Payment: See Attachment A, “HHSC Uniform Managed Care Contract Terms and Conditions,” Article 10, for a description of the Delivery Supplemental Payment for the CHIP EPO Program and the CHIP Perinatal Program. For Rate Period 6, CHIP EPO Program, the Delivery Supplement Payment is $3,100.00. For Rate Period 6, the CHIP Perinatal Program, the Delivery Supplement Payment is $3,100.00, and applies only to Perinates between Above 185% and 200% of the Federal Poverty Level.

Optional Service Areas: At its option, HHSC may direct the EPO to provide Covered Services to EPO Program and CHIP Perinatal Program Members in the Corpus, Laredo and/or Travis Service Areas at the rates identified above for Rate Period 6. The Parties will negotiate the Operational Start Date for such optional Service Areas.

Part 8: Contract Attachments:

Modifications to Part 8 of the HHSC EPO Care Contract document, "Contract Attachments," are italicized below:

A: EPO Terms & Conditions

A-1: Agreed Modifications to the RFP, EPO Managed Care Contract Terms & Conditions, and EPO's Proposal

A-2: HHSC's EPO Managed Care Contract Terms & Conditions, V*ersion 1.6 replaced with Version 1.7*

B: Scope of Work/Performance Measures - V*ersion 1.6 is replaced with Version 1.7 for all attachments, except if noted.*

B-1: HHSC RFP 529-04-272, Sections 6.5 through 9

B-2: CHIP EPO Program Covered Services

B-2.1: CHIP Perinatal Program Covered Services

B-3: Value-added Services

B-4: Tailored Remedies Matrix

B-5: County Listing for CHIP EPO Program and CHIP Perinatal Program Service Area

B-6: CHIP EPO Program Cost Sharing, V*ersion 1.3 is deleted, effective September 1, 2007*

C: EPO's Proposal

D: Guarantee of Centene Corporation

Part 9: Signatures:

The Parties have executed this Amendment Seven in their capacities as stated below with authority to bind their organizations on the dates set forth by their signatures. By signing this Amendment Seven, the Parties expressly understand and agree that this Amendment is hereby made part of the Agreement as though it were set out word for word in the Agreement.

Texas Health and Human Services Commission	**EPO**
By: ______________________________ Name: Albert Hawkins Title: Executive Commissioner Date: ______________________________	By: ______________________________ Name: Holly Munin Title: Vice President, Banker's Reserve Life Insurance Company of Wisconsin Date: ______________________________

Texas Health & Human Services Commission

Exclusive Provider Organization (EPO) Managed Care Contract Terms & Conditions

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	August 19, 2004	Initial version of the HHSC EPO Managed Care Contract Terms & Conditions
Revision	1.1	September 1, 2005	Contract Amendment 1 revised the HHSC EPO Managed Care Contract Terms & Conditions as follows: 1. Added Section 4.12, “EPO Agreements with Third Parties.” 2. Modified Section 10.01, “Calculation of Monthly Premium Payment.”
Revision	1.2	March 1, 2006	Contract Amendment 2 did not revise the HHSC EPO Managed Care Contract Terms & Conditions.
Revision	1.3	September 1, 2006	Contract Amendment 3 revised the HHSC EPO Managed Care Contract Terms & Conditions as follows: 1. Modified or added the following sections to include provisions applicable to the CHIP Perinatal Program: 1.05, 3.07, 3.14, 4.02, 4.03, 4.04, 5.01, 5.02, 5.03, 5.03.1, 5.04, 10.05, 10.07, 10.13. 2. Article 2, “Definitions,” added or modified the following: CHIP Perinate, CHIP Perinate Newborn, CHIP Perinatal Program, Covered Services, Delivery Supplemental Payment, Default Enrollment, Eligibles, EPO, EPO Service Area, Exclusive Provider Benefit Plan, Expansion Area, HHSC Administrative Services Contractor, Major Population Group, Medical Home, Member, Member Materials, Provider Network, Service Area, Service Management. 3. Modified Section 4.04, “Medical Director,” to change the name of the “State Board of Medical Examiners” to “Texas Medical Board.” 4. Modified Section 6.01, “Performance Measurement.” 5. Modified Section 7.02(a)(4) to correct a C.F.R. reference. 6. Modified Section 9.01, “Financial Records Retention and Audit.” 7. Modified Section 9.03(d), regarding errors and overcharges. 8. Deleted Section 9.06, “Audit Software.” 9. Added Section 10.14, “Federal Disallowance.” 10. Modified Section 15.03, “Ownership and Licenses.” 11. Modified Section 17.01, “Insurance Coverage,” to clarify that HHSC will not be named as an additional insured on Standard Workers’ Compensation Insurance. 12. Modified Section 17.02, “Performance Bond.”
Revision	1.4	September 1, 2007	Contract Amendment 4 revised the HHSC EPO Managed Care Contract Terms & Conditions as follows: 1. Article 2 definition of “Clean Claim” modified to align with the UMCM’s definition. 2. Article 2 definition of “Value-added Services” modified to reflect legislative changes required by SB 10, 80th Regular Session of the Texas Legislature. 3. Section 4.08(c) modified to add a cross-reference to new Attachment B-1, Sections 8.3.1.3.10. 4. Section 5.03(a) amended to revise the CHIP coverage period, effective 9/1/07, resulting from HB 109, 80th Regular Session of the Texas Legislature. 5. Section 5.03.1(e) added to clarify the process for a CHIP Perinatal Newborn to move into CHIP at the end of the 12-month CHIP Perinatal Program eligibility. 6. Section 10.05(a) amended to correct the FPL percentages for CHIP Perinates and CHIP Perinate Newborns. 7. Section 10.05(b-c) modified to clarify that the provisions are applicable to the CHIP Program.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			8. Section 10.05(d) added CHIP Perinatal Program premium development provisions. 9. Section 10.05(f) added to clarify that Value-added Services are not considered in premium development. 10. Section 10.07 modified to include treatment of disincentives (within the Experience Rebate determination); additionally, several clarifications are added with respect to the continuing accrual of any unpaid interest, etc. 11. Section 10.15 added to include a pass-through requirement for physician rate increases, effective 9/1/07. 12. Section 17.01 amended to clarify the insurance requirements for the EPO and Network Providers, and to remove the insurance requirements for Subcontractors. 13. Section 17.02(b) added to clarify that a separate Performance Bond is not needed for the CHIP Perinatal Program.
Revision	1.5	September 1, 2008	Contract Amendment 5 revised the HHSC EPO Managed Care Contract Terms & Conditions as follows: 1. Article 2 is modified to remove the “Pediatric and Family” qualifier from Advanced Practice Nurses in the definition for PCP. 2. Section 5.04(c) is modified to clarify the span of coverage for CHIP Perinate Newborns who are in the hospital on the effective date of disenrollment. 3. Section 09.06 is added to require the EPO to notify HHSC of legal and other proceedings, and related events. 4. Section 10.07 (e) is modified to clarify the settlement process. 5. Section 10.07 (f) is modified to require the payment of interest on any Experience Rebate unpaid 35 days after the due date for the 90-day FSR Report. 6. Section 10.07.1 is added to institute the EPO Administrative Expense Cap. 7. Section 10.08 (a) is modified to address federal CHIP regulations. 8. Section 11.07 is modified to remove an extraneous word.
Revision	1.6	April 1, 2009	Contract Amendment 6 revised the HHSC EPO Managed Care Contract Terms & Conditions as follows: 1. Article 2 is modified to add the definition for TP 13. 2. Section 5.04 is modified to clarify item (c) regarding effective date of disenrollment for CHIP Perinates and add item (d) regarding effective date of SSI status. These clarifications to existing policies and processes will be effective 9/1/08. 3. Section 10.05(a) is modified to accurately reflect the percentage breakdown. 4. Section 10.13(b) is modified to reflect the percentage breakdown used in rate setting.
Revision	1.7	September 1, 2009	Contract Amendment 7 revised the HHSC EPO Managed Care Contract Terms & Conditions as follows: 1. Article 2 definition for Affiliate is modified to conform to the definition in the Uniform Managed Contract. 2. Article 2 definition for Allowable Expenses is modified to remove the word “Administrative” from the UMCM’s “Cost Principles for Expenses” to conform to the definition in the Uniform Managed Contract. 3. Article 2 is modified to add definitions for Discharge and Transfer to conform to the Uniform Managed Contract. 4. Article 2 definition for PCP is modified to conform to the Uniform Managed Contract. 5. Article 2 is modified to add definitions for Rate Periods 4-6.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			6. Section 7.05 is modified to conform to requirements in the Uniform Managed Care Contract 7. Section 10.07(b) is amended to reflect the change in the SFY 2010 sharing tier structure for the Experience Rebate and to change the heading in the table from “Experience Rebate as a % of Allowable Revenues” to “Pre-tax Income as a % of Revenues” to conform to the Uniform Managed Contract. 8. Section 10.07 (c) (1) is modified to remove the word “administrative” from the title of UMCM chapter reference. 9. Section 10.07(d) is amended to clarify the two year loss carry forward. 10. Section 10.07(e) is amended to clarify the required documentation for non-scheduled payments. 11. Section 10.08 is modified to include CHIP enrollees in prohibition against liability for payment (Balance Billing). 12. Section 12.15 is added to establish a pre-termination process. 13. Section 17.01(a) is modified to provide clarification of required insurance coverage, including deletion of Standard Worker’s 14. Section 17.01(b) is modified to correctly identify the type of professional liability coverage required. 15. Section 17.01(c)(4) is modified to require that HHSC is named as loss payee of insurance coverage. 16. Section 17.01(c)(5) is modified to require continuous coverage during Term of Contract. 17. Section 17.01(c)(6) is modified to require notification prior to reduction in coverage and to add provision to insurance policy requiring 30-day notice prior to reduction in, cancellation, or non-renewal of, the policy. 18. Section 17.02(a) is modified to align the performance bond requirements with insurance practices by requiring one bond per MCO with a defined term and amount and to require annual renewal of the bond. 19. Section 17.02(c) is added to establish a process for release of previous performance bonds received by HHSC.

[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.

TABLE OF CONTENTS

Article 1. Introduction 1

Section 1.01 Purpose. 1
Section 1.02 Risk-based contract. 1
Section 1.03 Inducements. 1
Section 1.04 Construction of the Contract. 1
Section 1.05 No implied authority. 2
Section 1.06 Legal Authority. 2

Article 2. Definitions 2

Article 3. General Terms & Conditions 12

Section 3.01 Contract elements. 12
Section 3.02 Term of the Contract. 12
Section 3.03 Funding. 12
Section 3.04 Delegation of authority. 12
Section 3.05 No waiver of sovereign immunity. 12
Section 3.06 Force majeure. 12
Section 3.07 Publicity. 13
Section 3.08 Assignment. 13
Section 3.09 Cooperation with other vendors and prospective vendors. 13
Section 3.10 Renegotiation and reprocurement rights. 13
Section 3.11 RFP errors and omissions. 13
Section 3.12 Attorneys' fees. 14
Section 3.13 Preferences under service contracts. 14
Section 3.14 Time of the essence. 14
Section 3.15 Notice 14
Section 3.16 Guarantee. 14

Article 4. Contract Administration & Management 14

Section 4.01 Qualifications, retention and replacement of EPO employees. 14
Section 4.02 EPO's Key Personnel. 14
Section 4.03 Executive Director. 15
Section 4.04 Medical Director. 15
Section 4.05 Responsibility for EPO personnel and Subcontractors. 15
Section 4.06 Cooperation with HHSC and state administrative agencies. 16
Section 4.07 Conduct of EPO personnel. 16
Section 4.08 Subcontractors. 16
Section 4.09 HHSC's ability to contract with Subcontractors. 17
Section 4.10 Retention of critical third-party providers 17
Section 4.11 Third-party consents for termination assistance 17

Article 5. Member Eligibility & Enrollment 18

Section 5.01 Eligibility Determination 18
Section 5.02 Member Enrollment & Disenrollment. 18
Section 5.03 CHIP EPO Program eligibility and enrollment. 18
Section 5.03.1 *CHIP Perinatal eligibility, enrollment, and disenrollment.* 18
Section 5.04 Span of Coverage. 19

Article 6. Service Levels & Performance Measurement 19

Section 6.01 Performance measurement. 19

Article 7. Governing Law & Regulations 20

Section 7.01 Governing law and venue. 20
Section 7.02 EPO responsibility for compliance with laws and regulations. 20
Section 7.03 TDI licensure and solvency requirements 20
Section 7.04 Immigration Reform and Control Act of 1986. 21
Section 7.05 Compliance with State and Federal anti-discrimination laws. 21
Section 7.06 Environmental protection laws. 21
Section 7.07 HIPAA. 22

Article 8. Amendments & Modifications 22

Section 8.01 Mutual Agreement. 22
Section 8.02 Changes in law or contract. 22
Section 8.03 Modifications as a remedy. 22
Section 8.04 Modifications upon renewal or extension of Contract. 22
Section 8.05 Modification of HHSC Uniform Managed Care Manual. 22
Section 8.06 Required compliance with amendment and modification procedures. 23

Article 9. Audit & Financial Compliance 23

Section 9.01 Financial record retention and audit. 23
Section 9.02 Access to records, books, and documents. 23
Section 9.03 Audits of Services, Deliverables and inspections. 23
Section 9.04 SAO Audit 24
Section 9.05 Response/compliance with audit or inspection findings. 24

Article 10. Terms & Conditions of Payment 24

Section 10.01 Calculation of monthly Premium Payment. 24
Section 10.02 Time and Manner of Payment. 25
Section 10.03 Certification of Premium Rates. 25
Section 10.04 Modification of Premium Rates. 25
Section 10.05 CHIP Premium Rates Structure. 25
Section 10.06 Adjustments to Premium Payments. 25
Section 10.07 Experience Rebate. 26
Section 10.08 Payment by Members. 29
Section 10.09 Restriction on assignment of fees. 30
Section 10.10 Liability for taxes. 30
Section 10.11 Liability for employment-related charges and benefits. 30
Section 10.12 No additional consideration. 31
Section 10.13 Delivery Supplemental Payment. 31
Section 10.14 Federal disallowance. 31
Section 10.15 Required pass-through of physician rate increases. 31

Article 11. Disclosure & Confidentiality of Information 32

Section 11.01 Confidentiality. 32
Section 11.02 Disclosure of HHSC's Confidential Information. 32
Section 11.03 Member Records 33
Section 11.04 Requests for public information. 33
Section 11.05 Privileged Work Product. 33
Section 11.06 Unauthorized acts. 33
Section 11.07 Legal action. 34

Article 12. Remedies & Disputes 34

Section 12.01 Understanding and expectations. 34
Section 12.02 Tailored remedies. 34
Section 12.03 Termination by HHSC. 36
Section 12.04 Termination by EPO. 38
Section 12.05 Termination by mutual agreement. 38
Section 12.06 Effective date of termination. 38
Section 12.07 Extension of termination effective date. 38
Section 12.08 Payment and other provisions at Contract termination. 38
Section 12.09 Modification of Contract in the event of remedies. 38
Section 12.10 Turnover assistance. 38
Section 12.11 Rights upon termination or expiration of Contract. 38
Section 12.12 EPO responsibility for associated costs. 38
Section 12.13 Dispute resolution. 39
Section 12.14 Liability of EPO. 39
Section 12.15 Pre-termination Process. 40

Article 13. Assurances & Certifications 40

Section 13.01 Proposal certifications. 40
Section 13.02 Conflicts of interest. 40
Section 13.03 Organizational conflicts of interest. 40
Section 13.04 HHSC personnel recruitment prohibition. 41
Section 13.05 Anti-kickback provision. 41
Section 13.06 Debt or back taxes owed to State of Texas. 41
Section 13.07 Certification regarding status of license, certificate, or permit. 41
Section 13.08 Outstanding debts and judgments. 41

Article 14. Representations & Warranties 41

Section 14.01 Authorization. 41
Section 14.02 Ability to perform. 41
Section 14.03 Minimum Capital & Surplus. 41
Section 14.04 Insurer solvency. 41
Section 14.05 Workmanship and performance. 42
Section 14.06 Warranty of deliverables. 42
Section 14.07 Compliance with Contract. 42
Section 14.08 Technology Access 42

Article 15. Intellectual Property 42

Section 15.01 Infringement and misappropriation. 42
Section 15.02 Exceptions. 43
Section 15.03 Ownership and Licenses 43

Article 16. Liability 44

Section 16.01 Property damage. 44
Section 16.02 Risk of Loss. 44
Section 16.03 Limitation of HHSC's Liability. 44

Article 17. Insurance & Bonding 44

Section 17.01 Insurance Coverage. 44
Section 17.02 Performance Bond. 46
Section 17.03 Fidelity Bond 46

Article 1. Introduction

Section 1.01 Purpose.

The purpose of this Contract is to set forth the terms and conditions for the EPO's participation as an Exclusive Provider Benefit Plan for CHIP. Under the terms of this Contract, the EPO will provide comprehensive Health Care Services to qualified CHIP recipients through a managed care delivery system.

Section 1.02 Risk-based contract.

This is a risk-based health insurance contract.

Section 1.03 Inducements.

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

(1) EPO is an established health insurance provider, is currently licensed as such in the State of Texas, and is fully authorized to arrange for the delivery of Health Care Services and conduct business in the Service Areas;

(2) EPO and the EPO's Administrative Services Subcontractors have the skills, qualifications, expertise, financial resources and experience necessary to provide the Services and Deliverables described in the RFP, EPO'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) EPO 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) EPO 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, EPO currently has the capability to perform in accordance with the terms and conditions of this Contract;

(5) EPO also has reviewed and understands the risks associated with the Children's Health Insurance 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 EPO 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.

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. Such provisions may nevertheless be used in the interpretation of this Contract if and to the extent they may assist in clarifying the Parties' intent with respect to HHSC's purposes and objectives under this Contract and the appropriate scope of the Parties' obligations in light of those purposes and objectives.

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 CHIP, provided, however, that no provision will be interpreted to include any entity other than HHSC as the contracting agency.

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.

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.

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.

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.

Section 1.05 modified by Version 1.3

The authority delegated to EPO by HHSC is limited to the terms of this Contract. HHSC is the state agency designated by the Texas Legislature to administer CHIP, and no other agency of the State grants EPO any authority related to this program unless directed through HHSC. EPO 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 CHIP; or

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

EPO 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 this Contract and the CHIP EPO Program or CHIP Perinatal Program, as directed by HHSC.

Section 1.06 Legal Authority.

(a) HHSC is authorized to enter into this Contract under Chapters 531, Texas Government Code; Section 2155.144, Texas Government Code; and Chapters 62 and 63, Texas Health & Safety Code. EPO 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:

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).

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

Additional Service Area(s) means the Service Areas identified in **Attachment B-5** to the **EPO Managed Care Contract** that may be added to this Contract at HHSC's option.

Adjudicate means to deny or pay a clean claim.

Administrative Services see EPO Administrative Services.

Administrative Services Contractor see HHSC Administrative Services Contractor.

Adverse Determination means a determination by an EPO 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.

Definition of Affiliate modified by Version 1.7

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 EPO (either directly, or through one or more intermediaries); 2) in which the EPO 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 EPO, regardless of the organizational structure of the entity; 4) any entity that has a common parent with the EPO (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 EPO; 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.

Definition of Allowable Expenses modified by Version 1.7

Allowable Expenses means all expenses related to the Contract between HHSC and the EPO 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**."

Allowable Revenue means all managed care revenue received by the EPO pursuant to this

Contract during the Contract Period, including retroactive adjustments made by HHSC. This would include any funds earned on CHIP EPO managed care funds such as investment income, earned interest, or third party administrator earnings from services to delegated Networks.

AAP means the American Academy of Pediatrics.

Appeal means the formal process by which a Utilization Review agent addresses Adverse Determinations.

Auxiliary Aids and Services includes qualified interpreters or other effective methods of making aurally delivered materials understood by persons with hearing impairments; and, taped texts, large print, Braille, or other effective methods to ensure visually delivered materials are available to individuals with visual impairments. Auxiliary aids and services also include effective methods to ensure that materials (delivered both aurally and visually) are available to those with cognitive or other Disabilities affecting communication.

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, but is not limited to, 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.

Care Management is an administrative service performed by the EPO to facilitate development of a Care Plan and coordination of services among a Member's PCP, specialty providers and non-medical providers to ensure Members with Special Health Care Needs and/or Members needing high-cost treatment have access to, and appropriately utilize, Medically Necessary Covered Services and other services and supports.

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.

Definition of CHIP Perinate added by Version 1.3

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

Definition of CHIP Perinate Newborn added by Version 1.3

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

Definition of CHIP Perinatal Program added by Version 1.3

CHIP Perinatal Program means the State of Texas CHIP program in which HHSC contracts with the EPO to provide, arrange for, and coordinate covered services for enrolled CHIP Perinate and CHIP Perinate Newborn Members.

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.

Definition of Clean Claim modified by Version 1.4

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 EPO or a 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 EPO 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 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 any dissatisfaction, expressed by a Complainant, orally or in writing to the EPO, with any aspect of the EPO's operation, including, but not limited to, dissatisfaction with:

(1) plan administration;

(2) procedures related to review or Appeal of an Adverse Determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G;

(3) the denial, reduction, or termination of a service for reasons not related to medical necessity;

(4) the way a service is provided; or

(5) disenrollment decisions.

The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP Member.

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 EPO'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 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 EPO, or participating State agencies for the purpose of fulfilling a duty or obligation under this Contract and that has not been disclosed publicly.

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 **EPO** means the contractor that is a party to this Contract, and is an insurance company licensed by the TDI and authorized to do business in the State of Texas as an Exclusive Provider Benefit Plan in accordance with 28 T.A.C. §3.9201 *et seq.*

Copayment means the amount that a Member is required to pay when utilizing certain benefits within the health care plan. Once the copayment is made, further payment may not be required by the Member.

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

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 EPO must arrange to provide to Members,

Definition of Covered Services modified by Version 1.3

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, and B-3** of the **HHSC EPO Managed Care Contract** relating to "Covered Services" and "Value-added Services"). Covered Services include Behavioral Health 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 EPO receives payment for a Member.

Day means a calendar day unless specified otherwise.

Definition of Default Enrollment added by Version 1.3

Default Enrollment means the process established by HHSC to assign a mandatory CHIP Perinate who has not selected an MCO to an MCO.

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

Definition of Delivery Supplemental Payment added by Version 1.3

Delivery Supplemental Payment means a one-time per pregnancy supplemental payment for the CHIP Perinatal Program.

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 EPO that outlines details for the restoration of the MIS in the event of an emergency or disaster.

Definition of Discharge added by Version 1.7

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.

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.

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.

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 EPO Managed Care Contract.

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

Definition of Eligibles modified by Version 1.3

Eligibles means CHIP EPO Program or CHIP Perinatal Program eligibles residing in one of the Service Areas and eligible to enroll in the CHIP EPO Program or CHIP Perinatal Program.

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 EPO in accordance with HHSC's MCO Encounter Data Claims Submission requirements in the **HHSC Uniform Managed Care Manual** and in accordance with HHSC's required format for CHIP managed care organizations.

Enrollment Report/Enrollment File means the daily or monthly list of Eligibles that are enrolled with an EPO 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.

Definition of EPO or Contractor modified by Version 1.3

EPO or Contractor means the contractor that is a party to this Contract for CHIP EPO Program and CHIP Perinatal Program services, and is an insurance company licensed by TDI and authorized to do business in the State of Texas as an Exclusive Provider Benefit Plan in accordance with 28 T.A.C. §3.9201 *et seq.*

EPO 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; or MIS operation and reporting.

EPO Program means the State of Texas CHIP program in which HHSC contracts with a contractor to provide, arrange for, and coordinate Covered Services to EPO Program Members.

Definition of EPO Service Area modified by Version 1.3

EPO Service Area means all the geographic regions included in the EPO Program and CHIP Perinatal Program Service Area, including the Rural Service Area and any Additional Service Areas added to the scope of this Contract at HHSC's option.

Definition Exclusive Provider Benefit Plan modified by Version 1.3

Exclusive Provider Benefit Plan means the type of managed care health care plan, offered by the EPO pursuant to this Contract, that arranges for or provides group health insurance coverage to CHIP EPO Program or CHIP Perinatal Program Members.

Exclusive Provider Services means medical, surgical and supplementary Health Care Services that are covered under a group contract only when rendered by an exclusive provider.

Expansion Area means a county or Service Area where HHSC has not previously operated the CHIP EPO Program or CHIP Perinatal Program.

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 EPO's net income before taxes that is returned to the State in accordance with **Section 10.07** ("Experience Rebate").

Expiration Date means the expiration date of this Contract, as specified in HHSC's EPO 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 EPO and HMO Programs.

FSR means Financial Statistical Report.

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 and 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.

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.

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.

Health Care Services means the Acute Care, behavioral health care and health-related services, which an enrolled population might reasonably require in order to be maintained in good health, including, at a minimum, emergency services and inpatient and out patient services.

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 Texas Health and Human Services Agencies.

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

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.

Definition of HHSC Administrative Services Contractor modified by Version 1.3

HHSC Administrative Services Contractor means an entity under contract with HHSC performing EPO administrative services functions, including member enrollment functions, for the CHIP EPO Program and the CHIP Perinatal Program.

HHSC Uniform Managed Care Manual means the manual published by or on behalf of HHSC that contains policies and procedures required of all managed care organizations participating in the HHSC Programs.

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

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.

Initial Contract Period means the Effective Date of the Contract through August 31, 2007.

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

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 EPO's interfaces required to conduct business under this Contract. The JIP must address the coordination with each of the EPO'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 EPO Personnel means the critical management and technical positions identified by the EPO 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 of Major Population Group modified by Version 1.3

Major Population Group means any population, which represents at least 10% of CHIP EPO Program and CHIP Perinatal Program population in any of the counties in the Service Area served by the EPO.

Material Subcontractor or **Major Subcontractor** means any entity that contracts with the EPO for all or part of the EPO Administrative Services, where the value of the subcontracted EPO Administrative Service(s) exceeds $100,000. Providers in the EPO's Provider Network are not Material Subcontractors.

Marketing means any communication from the EPO to a Medicaid or CHIP Eligible who is not enrolled with the EPO that can reasonably be interpreted as intended to influence the Eligible to enroll in the EPO, or either to not enroll in, or to disenroll from another HMO or EPO.

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

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 or STAR+PLUS.

Definition of Medical Home modified by Version 1.3

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

CHIP EPO Program and CHIP Perinate Newborn Members participating in the CHIP Perinatal Program.

Medically Necessary means:

(1) 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 diagnoses of the conditions;

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

(2) 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 any child who has met CHIP eligibility criteria, and is enrolled with the EPO under the CHIP EPO Program or the CHIP Perinatal Program.

Definition of Member modified by Version 1.3

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

Definition of Member Materials modified by Version 1.3

Member Month means one Member enrolled with the EPO 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.

MHMR or TDMHMR means the Texas Department of Mental Health and Mental Retardation, or its successor agency.

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 Allowable Revenues over Allowable Expenses.

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

Non-provider Subcontracts means contracts between the EPO and a third party that performs a function, excluding delivery of Health Care Services, that the EPO is required to perform under its Contract with HHSC.

OB/GYN means obstetrician-gynecologist.

Open Panel means Providers who are accepting new patients for the Service Area.

Operational Start Date means the first day on which the EPO is responsible for providing Covered Services to Members in a Service Area in exchange for a Premium Payment under the Contract. The Operational Start Date may vary per Service Area. The Operational Start Date(s) applicable to this

Contract are set forth in the HHSC EPO Managed Care Contract document.

Operations Phase means the period of time when EPO 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 Service Area.

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

Parties means HHSC and EPO, collectively.

Party means either HHSC or EPO, individually.

Pediatric Specialists means physicians who are board eligible/board certified in pediatrics by the American Board of Pediatrics.

Pediatric Subspecialists and Pediatric Surgical Specialists means physicians who are board eligible/board certified and/or have pediatric qualifications under their respective American Boards of Pediatrics, Surgery, or Psychiatry/Neurology.

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

Premium Rate means a fixed predetermined fee paid by HHSC to the EPO each month in accordance with the Contract, for each enrolled Member in a defined Rate Cell, in exchange for the EPO 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.

Premium Payment means the aggregate amount paid by HHSC to the EPO on a monthly basis for the provision of Covered Services to enrolled Members in accordance with the Premium Rates in the EPO Managed Care Contract document.

Definition of PCP modified by Versions 1.5 and 1.7

Primary Care Physician or Primary Care Provider (PCP) means a physician or provider who is licensed to practice medicine in the State of Texas; has contracted with the EPO 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, pediatrics, internal medicine, Obstetrics/Gynecology (OB/GYN), Advanced Practice Nurses (APNs) and Physician Assistants (when practicing under the supervision of a physician specializing in Family Practice, Pediatrics, Internal Medicine 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.

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

Provider means an appropriately credentialed individual, facility, agency, institution, organization or other entity, licensed to practice medicine in the State of Texas that has a contract with the EPO for the delivery of Covered Services to the EPO's Members.

Provider Contract means a contract entered into by a direct provider of Health Care Services and the EPO or an intermediary entity.

Definition of Provider Network modified by Version 1.3

Provider Network or Network means all Providers that have contracted with the EPO for the CHIP EPO Program or CHIP Perinatal 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 TDH 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 Premium Rate has been determined.

Rate Period 1 means the period of time beginning on the Operational Start Date and ending on August 31, 2005.

Rate Period 2 means the period of time beginning on September 1, 2005 and ending on August 31, 2006.

Rate Period 3 means the period of time beginning on September 1, 2006 and ending on August 31, 2007.

Definition of Rate Period 4 added by Version 1.13

Rate Period 4 means the period of time beginning on September 1, 2007 and ending on August 31, 2008.

Definition of Rate Period 5 added by Version 1.13

Rate Period 5 means the period of time beginning on September 1, 2008 and ending on August 31, 2009.

Definition of Rate Period 6 added by Version 1.13

Rate Period 6 means the period of time beginning on September 1, 2009 and ending on August 31, 2010.

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 EPO and the examination conducted by HHSC, or its agents, of EPO'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.

Risk means the potential for loss as a result of expenses and costs of the EPO 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 Service Area means the 170 counties identified in **Attachment B-5** of the **EPO Managed Care Contract** as the primary EPO CHIP Service Area.

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.

Scope of Work means the description of Services and Deliverables specified in this Contract, the RFP, the EPO'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.

Definition of Service Area modified by Version 1.3

Service Area means the defined geographic area within which Covered Services are available to CHIP EPO Program or CHIP Perinatal Program Members who reside within such geographic area.

Definition of Service Management added by Version 1.3

Service Management is an administrative service in the CHIP EPO Program and CHIP Perinatal Program performed by the EPO to facilitate development of a Service Plan and coordination of services among a Member's PCP, specialty providers and non-medical providers to ensure Members with Special Health Care Needs and/or Members needing high-cost treatment have access to, and appropriately utilize, Medically Necessary Covered Services, Non-capitated Services, and other services and supports.

Services means the tasks, functions, and responsibilities assigned and delegated to the EPO under this Contract.

Significant Traditional Provider or STP (for CHIP) means contracted health care providers serving the CHIP population in the Service Area prior to July, 2003.

Software means all operating system and applications software used by the EPO 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 or STAR Program stands for the State of Texas Access Reform, and means the State of Texas Medicaid managed care program in which HHSC contracts with HMOs to provide, arrange for, and coordinate preventive, primary, and acute care Covered Services to non-disabled children and families, and pregnant women.

STAR HMOs means HMOs participating in the STAR Program. Requirements for STAR HMOs apply to the HMO's STAR HMO operations and STAR Members.

STAR+PLUS or STAR+PLUS Program means the State of Texas Medicaid managed care program in which HHSC contracts with HMOs to provide 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 SSI/MAO.

STAR+PLUS HMOs means HMOs participating in the STAR+PLUS Program. Requirements for STAR+PLUS HMOs apply to the HMOs' STAR+PLUS HMO operations and STAR+PLUS Members.

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

Subcontract means any written Contract between the EPO and other party to fulfill the requirements of the Contract.

Subcontractor means any individual or entity that has entered into a Subcontract with EPO.

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

T.A.C. means Texas Administrative Code.

TANF means Temporary Assistance for Needy Families

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

TDH means the Texas Department of Health, or its successor agency.

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 Network (THN) is the name of the Medicaid primary care case management program in Texas.

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 TAC, Chapter 33 (relating to Early and Periodic Screening, Diagnosis and Treatment).

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 EPO from an individual or entity with the legal responsibility to pay for the Covered Services.

Definition of TP 13 Added by Version 1.6

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.

Definition of Transfer Added by Version 1.7

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.

Transition Phase includes all activities the EPO is required to perform between the Contract award and the Operational Start Date for a Service Area.

Turnover Phase includes all activities the EPO 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 EPO, approved by HHSC, to be employed during the Turnover Phase. The Turnover Plan describes EPO'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 EPO during the transition to a substitute health plan; and

(2) Cooperation with HHSC and the substitute health plan provider in transferring information to a substitute health plan, as well as 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.

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 themselves or others and the Member is able to cooperate with treatment.

Urgent Condition means a health condition, including an Urgent Behavioral Health Situation, which 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 means the system for prospective or concurrent review of the medical necessity and appropriateness of Health Care Services being provided or proposed to be provided to a Member. The term does not include elective requests for clarification of coverage.

Definition of Value-Added Services modified by Version 1.4

Value-added Services means additional services for coverage beyond those specified in Attachments B-2 and B-2.1. 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 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.

Contract documentation.

The Contract between the Parties will consist of the HHSC Managed Care Contract and all attachments and amendments thereto, and the HHSC Uniform Managed Care Manual and all attachments and amendments thereto.

Order of documents.

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

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

(2) Contract **Attachment A** – “EPO Terms and Conditions” and all amendments thereto;

(3) 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; and

(5) Contract **Attachment C** – “EPO’s Proposal.”

Applicable portions of the HHSC Uniform Managed Care Manual.

With the following exceptions, all portions of the HHSC Uniform Managed Care Manual that apply to the CHIP Program apply to this Contract. The following provisions do not apply to this Contract:

(1) all provisions that apply only to the Medicaid STAR or STAR+PLUS Programs, including provisions relating to Medicaid provider directories, member handbooks, identification cards, marketing policies and procedures, CBA policies and procedures, and long-term care; and

(2) all provisions relating to performance indicators, measurements, and financial incentives for HMOs.

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 a period or periods, but the Contract Term may not exceed a total of six (6) 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. EPO 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 EPO to resolve any EPO 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 EPO 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 EPO 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 Bays of the existence of a force majeure event or otherwise waive this right as a defense.

Section 3.07 Publicity.

Section 3.07(a) modified by Version 1.3

(a) EPO may use the name of HHSC, the State of Texas, any HHS Agency, and the name of the HHSC CHIP EPO Program or CHIP Perinatal 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 EPO submits the information to HHSC for review and comment. If HHSC has not responded within seven (7) calendar days, the EPO 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 EPO's performance under the Contract. .

(b) EPO will provide HHSC at least three (3) copies of any information described in Subsection 3.07(a) prior to public release. EPO will provide additional 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:

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

(b) that the EPO is otherwise required by law to disclose; and

(3) Member Materials (the EPO 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 EPO.

EPO 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 EPO from its obligations pursuant to the Contract. HHSC-approved Material Subcontracts will not be considered to be an assignment or delegation for purposes of this section.

Assignment by HHSC.

EPO 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.

Assumption.

Each party to whom a transfer is made (an "Assignee") must assume all or any part of EPO'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 contracts for work related to the Contract, or any portion thereof. EPO 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.

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 EPO that HHSC has elected to renegotiate certain terms of the Contract. Upon EPO's receipt of any notice pursuant to this Section, EPO 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.**

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 EPO'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 Services covered by the Contract or services similar or comparable to the Services performed by EPO under the Contract.

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.

EPO will not take advantage of any errors and/or omissions in the RFP that the EPO should have been aware of or errors and/or omissions in the resulting Contract. EPO must promptly notify HHSC of any such errors and/or omissions.

Section 3.12 Attorneys' fees.

In the event of any litigation, appeal, or other legal action to enforce any provision of the Contract, EPO 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.

EPO 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.

Section 3.14 modified by Version 1.3

In consideration of the need to ensure uninterrupted and continuous CHIP EPO Program or CHIP Perinatal Program services, time is of the essence in the performance of the Services 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 Contract. In addition, legal notices must be sent to the Legal Contact identified in the Contract.

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

Section 3.16 Guarantee.

EPO's performance of the Services provision of the Deliverables is guaranteed by the EPO's parent corporation, as specified in the Guarantee, **Attachment D** to the **HHSC EPO Managed Care Contract**.

Article 4. Contract Administration & Management

Section 4.01 Qualifications, retention and replacement of EPO employees.

EPO agrees to maintain the organizational and administrative capacity and capabilities to carry out all duties and responsibilities under this Contract. The personnel EPO 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, EPO 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 EPO's Key Personnel.

Section 4.02(a) modified by Version 1.3

Designation of Key Personnel.

EPO 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 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) Executive Director as defined in **Section 4.03** ("Executive Director"); and

(11) Medical Director as defined in **Section 4.04** ("Medical Director").

Support and Replacement of Key Personnel.

The EPO 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 EPO 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 EPO must maintain the overall level of expertise, experience, and skill reflected in the EPO's staffing plan (see **Attachment B-1, RFP Section 8.2.3.1**).

Notification of replacement of Key Personnel.

EPO 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 EPO in writing. Upon receipt

of HHSC's notice, HHSC and EPO will attempt to resolve HHSC's concerns on a mutually agreeable basis. HHSC reserves the right to require the replacement of Key Personnel found unacceptable by HHSC, in accordance with **Section 4.07**.

Section 4.03 Executive Director.

Section 4.03(a) modified by Version 1.3

(a) The EPO must employ a qualified individual to serve as the Executive Director for its HHSC Program. Such Executive Director must be employed full-time by the EPO or its parent company, be primarily dedicated to the HHSC CHIP EPO Program and CHIP Perinatal Program, and must hold a Senior Executive or Management position in the EPO's organization or its parent company's organization. The EPO 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 EPO regarding all matters pertaining to the Contract prior to such representation. The Executive Director must act as liaison between the EPO and the HHSC and must have responsibilities that include, but are not limited to, the following:

(1) ensuring the EPO'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 EPO to establish time frames and formats reasonably acceptable to the Parties;

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

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

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

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

Section 4.04 Medical Director.

Section 4.04(a) modified by Version 1.3.

(a) The EPO must have a qualified individual to serve as the Medical Director for its HHSC EPO Program(s). 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 physician designee meeting the same Contract qualifications that apply to the Medical Director, 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 physician designee meeting the same Contract qualifications that apply to the Medical Director, must be authorized and empowered to represent the EPO regarding clinical issues, Utilization Review and quality of care inquiries. The Medical Director, or his or her physician designee, must exercise independent medical judgment in all decisions relating to medical necessity. The EPO 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.

Section 4.05 Responsibility for EPO personnel and Subcontractors.

(a) EPO'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 EPO's employees or its Subcontractor's employees, as applicable.

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

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

(d) EPO agrees that any claim on behalf of any person arising out of employment or alleged employment by the EPO (including, but not limited to, claims of discrimination against EPO, its officers, or its agents) is the sole responsibility of EPO and not the responsibility of HHSC. EPO 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 EPO. EPO understands that any person who alleges a claim arising out of employment or alleged employment by EPO 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) EPO agrees to be responsible for the following in respect to its employees:

(1) Damages incurred by EPO'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 EPO's employees.

(f) EPO 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 EPO pursuant to this Contract or any judgment rendered against the EPO. HHSC's liability to the EPO'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 §101.001 et seq.).

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

Section 4.06 Cooperation with HHSC and state administrative agencies.

Cooperation with HHSC EPOs.

EPO agrees to reasonably cooperate with and work with the State's EPOs, 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 EPO and to use its best efforts to ensure that other HHSC contractors reasonably cooperate with the EPO.

Cooperation with State and Federal administrative agencies.

EPO must ensure that EPO 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 EPO personnel.

(a) While performing the Services, EPO'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 EPO with notice and documentation concerning such conduct. Upon receipt of such notice, EPO 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 EPO, 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 EPO, are unable to work effectively with the members of the HHSC's staff. In such event, EPO 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) EPO agrees that anyone employed by EPO to fulfill the terms of the Contract remains under EPO's sole direction and control.

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

Section 4.08 Subcontractors.

(a) EPO 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 EPO'S employees, and for purposes of this Contract such work will be deemed work performed by EPO. 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) EPO must:

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

(2) notify HHSC in writing at least 60 days prior to reprocurement of services provided by any Material Subcontractor;

(3) provide written notification to HHSC within three (3) Business Days after making a decision to terminate a Subcontract with a Material Subcontractor or upon receiving notification from the Material Subcontractor of its intent to terminate such Subcontract;

(4) notify HHSC in writing within one (1) Business Day of making a decision to enter into a subcontract with a new Material Subcontractor, or a new subcontract for newly procured services of an existing Material Subcontractor; and

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

Section 4.08(c) modified by Version 1.4.

(c) During the Contract Period, proposed new Material Subcontractors, or newly procured services of an existing Material Subcontractor, may be subject to Readiness Reviews by HHSC or its designated agent prior to implementation at HHSC's discretion. The EPO must submit information required by HHSC for each proposed Material Subcontractor as specified in the **HHSC Uniform Managed Care Manual**. Refer to **Attachment B-1, Sections 8.3.1.3.10** for additional information regarding HMO Readiness Reviews during the Contract Period.

(d) EPO 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 EPO under this Contract.

(e) EPO must identify any Subcontractor that is a newly-formed subsidiary or entity, whether or not an affiliate of EPO, 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 EPO will assume responsibility for all contractual responsibilities whether or not the EPO performs them. Further, HHSC considers the EPO to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the Contract.

(f) All Subcontracts executed in connection with the requirements or functions of this Contract must be in writing and provide HHSC the right to examine all Subcontractor records relating to those requirements.

(g) EPO must submit a copy of the all EPO Administrative Services Subcontracts to HHSC.

(h) Network Provider contracts must include the mandatory provisions set forth in the **HHSC Uniform Managed Care Manual**.

(i) 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.

Section 4.09 HHSC's ability to contract with Subcontractors.

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

Section 4.10 Retention of critical third-party providers

Subject to Section 4.08, EPO must use commercially reasonable efforts to continue to use existing Material Subcontractors and Network Providers who are believed by HHSC to have knowledge, either technical or business, not easily replaceable and critical to EPO in providing the Services and Deliverables to HHSC. HHSC will identify such Subcontractors, if any, at least 180 days prior to the expiration of the Contract Term. Upon making a determination that continued use of any Subcontractors is not in the best interest of the State, subject to prior written consent by HHSC, EPO may eliminate such Subcontractor or diminish the Subcontractor's level of effort.

Section 4.11 Third-party consents for termination assistance

EPO must ensure that all consents or approvals to allow the EPO and the EPO's Subcontractors to provide Transition Assistance, as required by the Contract, have been obtained, on a contingent basis, in advance and will be provided by applicable third parties at no cost or delay to HHSC.

Section 4.12 added by Version 1.1

Section 4.12 ***EPO Agreements with Third Parties***

(a) An agreement between EPO and a third party (including affiliates or other related entities) whereby the third party receives all or a portion of the Capitation Payment or other payment made to EPO, pursuant to or related to the execution of this contract, must be in writing.

(b) An agreement between EPO and a third party (including affiliates or other related entities) whereby the third party receives payment or other consideration (whether a lump sum or series of payments or services) totaling $10,000 or more in any

fiscal year, pursuant to or related to the execution of this contract, must be in writing.

(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 is being paid to the third party.

(d) All agreements whereby EPO receives rebates, recoupments, discounts, payments, or other consideration from a third party (including affiliates or other related entities), pursuant to or related to the execution of this contract, must be in writing.

(e) All agreements described in subsection (d) must show the dollar amount, the percentage of money, or the value of any consideration that EPO is receiving from the third party.

(f) Copies of agreements described in subsections (a), (b), and (d) valued at less than $100,000 for the fiscal year must be maintained and available for review by HHSC.

(g) Copies of agreements described in subsections (a), (b), and (d) valued at $100,000 or more for the fiscal year must be submitted to HHSC by September 30, 2005. Copies of agreements that are entered into after the effective date of this contract must be submitted to HHSC no later than 30 days prior to the date of execution of the agreement.

(h) This section shall not apply to those agreements that are covered under Section 4.08 (Subcontractors).

Article 5. Member Eligibility & Enrollment

Section 5.01 modified by Version 1.3

Section 5.01 Eligibility Determination

The State or its designee will make eligibility determinations for the CHIP EPO Program or CHIP Perinatal Program.

Section 5.02 modified by Version 1.3

Section 5.02 Member Enrollment & Disenrollment.

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

(b) HHSC makes no guarantees or representations to the EPO regarding the number of eligible Members who will ultimately be enrolled into the EPO or the length of time any such enrolling Members remain enrolled with the EPO beyond the minimum mandatory enrollment periods established for each HHSC Program.

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

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

(e) Upon implementation of the Comprehensive Healthcare Program for Foster Care, CHIP Members taken into conservatorship by the Department of Family and Protective Services (DFPS) will be disenrolled from the EPO effective the date of DFPS conservatorship.

Section 5.03 modified by Versions 1.3 and 1.4

Section 5.03 CHIP EPO Program eligibility and enrollment.

Term of coverage.

The Administrative Services Contractor determines CHIP eligibility on behalf of HHSC. The Administrative Services Contractor will enroll and disenroll eligible individuals into and out of CHIP. CHIP Members with an Effective Date of Coverage on or after September 1, 2007 will have twelve (12) months of coverage. CHIP Members with an Effective Date of Coverage prior to September 1, 2007 will be required to re-enroll in CHIP at the end of their six (6) month coverage, at which point they will have a new Effective Date of Coverage and twelve (12) months of CHIP Coverage.

Pregnant Members and Infants.

The HHSC Administrative Contractor will refer pregnant CHIP Members, with the exception of Legal Permanent Residents and other legally qualified aliens barred from Medicaid due to federal eligibility restrictions, to Medicaid for eligibility determinations. Those CHIP Members who are determined to be Medicaid Eligible will be disenrolled from EPO's CHIP plan. Medicaid coverage will be coordinated to begin after CHIP eligibility ends to avoid gaps in health care coverage.

In the event the EPO remains unaware of a Member's pregnancy until delivery, the delivery will be covered by CHIP. Newborns are automatically enrolled in the mother's CHIP health plan at birth with CHIP eligibility and re-enrollment following the timeframe as that of the mother. The HHSC Administrative Services Contractor will then set the Member's eligibility expiration date at the later of (1) the end of the second month following the month of the baby's birth or (2) the Member's original eligibility expiration date.

Section 5.03.1 added Version 1.3 and modified by Version 1.4

Section 5.03.1 ***CHIP Perinatal eligibility, enrollment, and disenrollment.***

(a)The HHSC Administrative Contractor will electronically transmit to the EPO new CHIP Perinatal Program Member information based on the appropriate CHIP Perinate or CHIP Perinate Newborn

Rate Cell. There is no waiting period for CHIP Perinatal Program Members.

(b) CHIP Perinate Newborns are eligible for 12 months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

(c) If only one CHIP Perinatal MCO operates in a service area, HHSC will automatically enroll a prospective member in that CHIP Perinatal MCO. If multiple CHIP Perinatal MCOs offer coverage in the service area, HHSC will send an enrollment packet to the prospective Member's household. If the household of a prospective member does not make a selection within 15 calendar days, the HHSC Administrative Services Contractor will notify the household that the prospective member has been assigned to a CHIP Perinatal MCO ("Default Enrollment"). When this occurs, the household has 30 calendar days to select another CHIP Perinatal MCO for the Member.

HHSC's Administrative Services Contractor will assign prospective members to CHIP Perinatal MCOs in a service area in a rotational basis. Should HHSC implement one or more administrative rules governing the Default Enrollment processes, such administrative rules will take precedence over the Default Enrollment process set forth herein.

(d) When a member of a household enrolls in the CHIP Perinatal Program, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal Program Member's health plan. All members of the household must remain in the same health plan through the end of the CHIP Perinatal Program Member's enrollment period.

(e) In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Program Members' information. Once the child's CHIP Perinatal Program coverage expires, the child will be added to his or her siblings' existing CHIP program case.

Section 5.04 Span of Coverage

(a) Members participating in the EPO Program prior to the Operational Start Date.

This provision applies only to Members who are already enrolled in HHSC's EPO Program prior to the Operational Start Date who transfer to the EPO from another contractor. If the Members' Effective Date of Coverage occurs while the Member is confined in a Hospital: (1) EPO is responsible for the CHIP Member's costs of Covered Services for professional charges beginning on the Effective Date of Coverage, and (2) the EPO is not responsible for the cost of Covered Services for Hospital facility charges that occur between the Effective Date of Coverage and the date of discharge from the Hospital. If a Member is disenrolled while the Member is confined in a Hospital, EPO's responsibility for the Member's costs of Covered Services terminates on the Date of Disenrollment.

(b) Members enrolled in the EPO Program after the Operational Start Date.

This provision applies to all Members enrolled in the EPO's Service Area after the Operational Start Date for the Service Area. If a Member's Effective Date of Coverage occurs while the Member is confined in a Hospital, EPO is responsible for the CHIP Member's costs of Covered Services beginning on the Effective Date of Coverage. If a Member is disenrolled while the Member is confined in a Hospital, EPO's responsibility for the Member's costs of Covered Services terminates on the Date of Disenrollment.

(c) CHIP Perinates.

Section 5.04(c) added by Version 1.3 and modified by Versions 1.5 and 1.6

If a CHIP Perinate's Effective Date of Coverage occurs while the CHIP Perinate is confined in a Hospital, EPO is responsible for the CHIP Perinate's costs of Covered Services beginning on the Effective Date of Coverage. If a CHIP Perinate is disenrolled while confined in a Hospital, EPO's responsibility for the CHIP Perinate's costs of Covered Services terminates on the Date of Disenrollment. If a CHIP Perinate Newborn is disenrolled while confined in a Hospital, the EPO's responsibility for the CHIP Perinate Newborn's costs of Covered Services terminates on the Date of Disenrollment.

(d) Effective Date of SSI Status.

Section 5.04(d) Added by Version 1.6

SSI status is effective on the date the State's eligibility system identifies a CHIP or CHIP Perintal 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 CHIP or CHIP Perinatal Program Member as TP13, following standard eligibility cut-off rules, HHSC will allow the Member to prospectively move to Medicaid.

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

Article 6. Service Levels & Performance Measurement

Section 6.01 modified by Version 1.3.

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 Appendix 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 EPO and HHSC and as modified from time to time by written Contract 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 EPO 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 EPO responsibility for compliance with laws and regulations.

(a) EPO must comply, to the satisfaction of HHSC, with all provisions set forth in this Contract, and all applicable provisions of State and Federal laws, rules, regulations, federal waivers, policies and guidelines that govern the administration of the Contract and the performance of the Services including, but not limited to:

(1) Title XXI of the Social Security Act;

(2) Chapters 62, 63, and 109, Texas Health and Safety Code;

(3) Chapter 531, Texas Government Code;

Section 7.02(a)(4) modified by Version 1.3.

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

(5) 45 C.F.R. Part 74;

(6) 45 C.F.R. Part 92;

(7) 48 C.F.R. Part 31 or OMB Circular A-122, as applicable;

(8) 1 T.A.C. Chapters 361, 370, 391, 392;

(9) 28 T.A.C. §3.9201 *et seq.*; and

(10) 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 that affect the performance of the Services may change from time to time or be added, judicially interpreted, or amended by competent authority. EPO acknowledges that the Programs will be subject to continuous change during the term of the Contract and, except as provided in **Section 8.02**, EPO 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 EPO 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 Services. In keeping with HHSC's reliance on this knowledge and expertise, EPO is responsible for identifying the impact of changes in applicable Federal or state legislative enactments and regulations that affect the performance of the Services or the State's use of the Services. EPO 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.

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

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

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

Section 7.03 TDI licensure and solvency requirements

Licensure.

EPO must be licensed by the TDI as an insurance company in all counties for the Operational Service Areas included within the scope of the Contract.

Solvency.

EPO must maintain compliance with the Texas Insurance Code and rules promulgated and administered by the TDI requiring a fiscally sound operation.

EPO 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 Premium 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.

EPO 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.

Section 7.05 modified by Version 1.7

(a) EPO 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.

EPO 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) EPO 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. EPO 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. EPO 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) EPO 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, EPO will provide HHSC Civil Rights Office with copies of all of the EPO's civil rights policies and procedures.

(e) EPO 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.

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

Pro-Children Act of 1994.

EPO 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.

National Environmental Policy Act of 1969.

EPO 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").

Clean Air Act and Water Pollution Control Act regulations.

EPO 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").

State Clean Air Implementation Plan.

EPO 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.*).

Safe Drinking Water Act of 1974.

EPO 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.

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

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 EPO will specify those modifications to the Scope of Work, the Contract pricing terms, or other Contract terms and conditions.

(b) EPO must respond to HHSC's proposed modification within the timeframe specified by HHSC, generally within thirty (30) days of receipt. Upon receipt of EPO's response to the proposed modifications, HHSC may enter into negotiations with EPO 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 EPO 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 EPO 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 EPO's obligations under the Contract). The Uniform Managed Care Manual, and all modifications thereto, are incorporated by reference into this Contract. HHSC will provide EPO 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 EPO's response deadline, and such changes will be incorporated into the HHSC Uniform Managed Care Manual. If the EPO 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 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. EPO 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 Version 1.3.

EPO agrees to maintain, and require its Subcontractors to maintain, supporting financial information and documents that are adequate to ensure that payment is made and the Experience Rebate is calculated in accordance with this Contract and applicable Federal and State requirements, and are sufficient to ensure the accuracy and validity of EPO invoices. Such documents, including all original claims forms, will be maintained and retained by EPO 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.

(a) Upon reasonable notice, EPO 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) EPO 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) Program personnel from HHSC or its designee;

(4) The Office of Inspector General;

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

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

(7) A State or Federal law enforcement agency;

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

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

(d) EPO agrees to provide the access described wherever EPO maintains such books, records, and supporting documentation. EPO 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. EPO will require its Subcontractors to provide comparable access and accommodations.

Section 9.03 Audits of Services, Deliverables and inspections.

(a) Upon reasonable notice from HHSC, EPO 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) EPO service locations, facilities, or installations; and

(2) EPO Software and Equipment.

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

(1) EPO'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) EPO must provide, as part of the Services, any assistance that such auditors and inspectors reasonably may require to complete such audits or inspections.

Section 9.03(d) modified by Version 1.3.

(d) If, as a result of an audit or review of payments made to the EPO, HHSC discovers a payment error or overcharge, HHSC will notify the EPO of such error or overcharge. HHSC will be

entitled to recover such funds as an offset to future payments to the EPO, or to collect such funds directly from the EPO. EPO 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 EPO have resulted in errors in payments to the EPO or errors in the calculation of the Experience Rebate, the EPO will indemnify HHSC for any losses resulting from such errors, including the cost of audit.

Section 9.04 SAO Audit

The EPO 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 EPO 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 EPO will ensure that this clause concerning the authority to audit funds received indirectly by Subcontractors through EPO and the requirement to cooperate is included in any Subcontract it awards.

Section 9.05 Response/compliance with audit or inspection findings.

(a) EPO 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 EPO'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) EPO 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 EPO's business;

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

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

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

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

Section 9.06 Audit Software deleted by Version 1.3 Section 9.06 Notification of Legal and Other Proceedings, and Related Events added by Version 1.5

The EPO 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 Premium Payment.

Section 10.01 (c-e) added by Amendment 1.

(a) This is a risk-based health insurance contract. HHSC will pay the EPO monthly Premium Payments set forth in **HHSC's EPO Managed Care Contract, Part 6**, based on the number of eligible and enrolled Members in each Service Area. HHSC will calculate the monthly Premium Payments by multiplying the number of Members by the applicable monthly Member Rate Cell. In consideration of the Monthly Premium Payment(s), the EPO agrees to provide the Services and Deliverables described in this Contract.

(b) The monthly Premium 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 EPO's risk margin.

(c) EPO 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.

(d) EPO will be required to provide in a timely manner financial and statistical information necessary in the capitation rate determination process. Encounter data provided by EPO must conform to all HHSC requirements. Encounter data containing non-compliant information, including, but not limited to, inaccurate member identification numbers, inaccurate provider identification numbers, or diagnosis or procedure codes insufficient to adequately describe the diagnosis or medical procedure performed, will not be considered in the EPO experience for rate-setting purposes.

(e) Information or data, including complete and accurate encounter data, as requested by HHSC for rate-setting purposes, must be provided by EPO 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.

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 Premium Payments by the 10th Business Day of each month.

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

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

(d) HHSC's payment of monthly Premium Payments is subject to availability of appropriations. If appropriations are not available to pay the full monthly Premium Payment, HHSC may equitably adjust Premium Payments and reduce scope of service requirements as appropriate and in accordance with **Article 8**, or HHSC may terminate the Contract in accordance with **Article 12** ("Remedies and Disputes").

Section 10.03 Certification of Premium Rates.

For Rate Period 1, the EPO employed or retained a qualified actuary that certified the actuarial soundness of the Premium Rates contained in the Contract.

Section 10.04 Modification of Premium Rates.

The Parties expressly understand and agree that the agreed Premium 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 EPO notice of a modification to the Premium Rates 60 days prior to the effective date of the change, unless HHSC determines that circumstances warrant a shorter notice period. If the EPO does not accept the rate change, either Party may terminate the Contract in accordance with **Article 12** ("Remedies and Disputes").

Section 10.05 CHIP Premium Rates Structure.

Section 10.05(a) modified by Versions 1.3, 1.4, and 1.6

(a) CHIP Rate Cells.

CHIP Premium Rates are defined on a per Member per month basis by the Rate Cells applicable to a Service Area. CHIP EPO Program Rate Cells are based on the Member's age group as follows:

(1) under age one (1);

(2) ages one (1) through five (5);

(3) ages six (6) through fourteen (14); and

(4) ages fifteen (15) through eighteen (18).

(b) CHIP Perinatal Program Rate Cells are:

(1) CHIP Perinate 0% - 185% of FPL;

(2) CHIP Perinate Above 185% - 200% of FPL;

(3) CHIP Perinate Newborn 0% - 185% of FPL;

(4) CHIP Perinate Newborn Above 185% - 200% of FPL.

These Rate Cells are subject to change after Rate Period 2.

(c) CHIP Program Premium Rates for Rate Period 1.

The CHIP Premium Rates for Rate Period 1 are included in the negotiated HHSC EPO Managed Care Contract.

(d) CHIP Program Premium Rate development: subsequent Rate Terms.

HHSC will establish Premium Rates for subsequent Rate Periods by analyzing Encounter Data and financial data for the Service Area. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information.

(e) CHIP Perinatal Program Premium Rates for Rate Period 3.

(1) The CHIP Premium Rates for Rate Period 3 are included in the negotiated HHSC EPO Managed Care Contract.

(2) Effective 4/1/07, on a prospective basis, the monthly premium rate for Perinatal expectant mothers at or below 185% of FPL has been increased. The rate increase is to be passed on to all physicians involved in the labor with delivery for members at or below 185% FPL. The average increase for the fee schedule for the procedure codes related to labor with delivery is 26.1%.

(f) CHIP Perinatal Program Premium Rate development: subsequent Rate Terms

Until such time as adequate encounter data is available to set rates, CHIP Perinatal Program capitation rates will be established based on experience from comparable populations in the Medicaid Fee-for-Service and STAR programs. This analysis will include: a review of historical enrollment and claims experience information; changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information. HHSC may modify the Service Area based Capitation Rate using diagnosis-based risk adjusters to yield the final Capitation Rates.

(g) Value-added Services will not be included in the rate-setting process.

Section 10.06 Adjustments to Premium Payments.

(a) Recoupment.

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

(1) the Member is enrolled into the EPO in error, and the EPO provided no Covered Services to the

Member for the period of time for which the payment was made;

(2) the Member moves outside the United States, and the EPO has not provided Covered Services to the Member for the period of time for which the payment has been made; or

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

Appeal of recoupment.

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

Section 10.07 Experience Rebate.

Section 10.07 modified by Versions 1.3, 1.4, 1.5, and 1.7

(a) EPO's duty to pay.

Should the EPO experience at the end of a Contract Rate Year a Net Income before Taxes greater than 3% of total Allowable Revenues, the EPO must pay an Experience Rebate to HHSC. 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 EPO Programs included within the scope of this Contract, as measured by any positive amount on the Financial-Statistical Report (FSR) as reviewed and confirmed by HHSC. If the EPO participates in any other HHSC managed care program(s) by separate agreement, expenses and losses incurred in such programs will not be factored into the Experience Rebate calculations under this Contract.

(b) Graduated Experience Rebate Sharing Method.

(1) Rate Periods 1 through 5.

Pre-tax Income as a % of Revenues	EPO Share	HHSC Share
≤ 3%	100%	0%
> 3% and ≤ 7%	75%	25%
> 7% and ≤ 10%	50%	50%
> 10% and ≤ 15%	25%	75%
> 15%	0%	100%

For Rate Periods 1 through 5, HHSC and the EPO will share the Net Income before Taxes as follows:

(i) The EPO will retain all Net Income before Taxes that are equal to or less than 3% of the total Allowable Revenues received by the EPO.

(ii) HHSC and the EPO will share that portion of the Net Income before Taxes that is over 3% but less than or equal to 7% of the total Allowable Revenues received with 75% to the EPO and 25% to HHSC.

(iii) HHSC and the EPO will share that portion of the Net Income before Taxes that is over 7% but less than or equal to 10% of the total Allowable Revenues received with 50% to the EPO and 50% to HHSC.

(iv) HHSC and the EPO will share that portion of Net Income before Taxes that is over 10% but less than or equal to 15% of the total Allowable Revenues received with 25% to the EPO and 75% to HHSC.

(v) HHSC will be paid the entire portion of the Net Income before Taxes that exceeds 15% of the total Allowable Revenues.

(2) Rate Period 6 and after.

Pre-tax Income as a % of Revenues	EPO 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 6 and thereafter, HHSC and the EPO will share the Net Income before Taxes as follows:

(i) The EPO will retain all the Net Income before Taxes that is equal to or less than 3% of the total Allowable Revenues received by the EPO.

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

(iii) HHSC and the EPO will share that portion of the Net Income before Taxes that is over 5% and less than or equal to 7% of the total Allowable Revenues received, with 60% to the HMO and 40% to HHSC.

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

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

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

(c) Net Income before Taxes.

(1) EPO must compute the Net Income before Taxes in accordance with **Uniform Managed Care Manual's, "Cost Principles for Expenses"** 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"** found in **HHSC's Uniform Managed Care Manual** in accordance with the process specified in **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; and

(iii) financial disincentives, including without limitation: the liquidated damages described in Attachment B-5.

(3) 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 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.

(1) *Losses Incurred in Rate Year 1.*

Notwithstanding any provisions in the Contract to the contrary, losses incurred by the EPO during Rate Year 1 may be carried forward up to two (2) Rate Years, and applied as an offset against the pre-tax income when calculating the Experience Rebate. The EPO may only carry forward unapplied losses from Rate Year 1 to Rate Year 3 if the aggregate Allowable Expenses exceed the aggregate Allowable Revenues in Rate Year 2.

(2) *Losses incurred after Rate Year 1.*

Losses incurred by EPO for a Rate Year occurring after Rate Year 1 may be carried forward to the next Rate Year, and applied as an offset against pre-tax income when calculating the potential Experience Rebate. Prior losses may be carried forward for only one Rate Year for this purpose.

(e) Settlements for payment.

(1) There may be one or more EPO payment(s) of the State share of the Experience Rebate on income generated for a given State Fiscal Year under the EPO 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 the EPO may tender a payment. For example, the EPO 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 EPO to HHSC. Section 10.07(f) describes the interest expenses associated with any payment after the Primary Settlement.

The EPO may make non-scheduled payments at any time to reduce the accumulation of interest under Section 10.07(f). For any nonscheduled payments prior to the 334-day FSR, the EPO is not required to submit a revised FSR, but is required to submit an Experience Rebate calculation form and an adjusted summary page of the FSR. The FSR summary page is labeled "Summary Income Statements (Dollars), All Coverage Groups Combined (FSR, Part I)."

(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 EPO 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 EPO of any interest payment obligation that may exist under Section 10.07(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 EPO. HHSC may adjust the Experience Rebate if HHSC determines the EPO 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 Section 10.07(e)(1). 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 EPO 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 EPO.

(3) Any interest obligations that are incurred pursuant to Section 10.07 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 10.07 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 10.07 (f) will not stop during any period of dispute. If a dispute is resolved in the EPO's favor, then interest will only be assessed on the revised unpaid amount.

(5) If the EPO incurs an interest obligation pursuant to Section 10.07 for an Experience Rebate payment due on or after September 1, 2008, 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 10.07 is not an Allowable Expense for reporting purposes on the FSR.

<u>Section 10.07.1</u> EPO Administrative Expense Cap.

Section 10.07.1 added by Version 1.5

(a) General requirement

Effective with SFY 2009, the calculation methodology of Experience Rebates described in Section 10.07 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.

Commencing with the Primary Settlement for SFY 2009, and for all pre and post-audit FSRs thereafter, the calculation of any corresponding 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 the EPO Program prior to each applicable Rate Period. At the conclusion of a Rate Period, HHSC will apply that predetermined administrative expense component against the EPO's actually incurred number of Member Months and aggregate premiums received by the EPO (the monthly Capitation Payments plus Delivery Supplemental Payments), to determine the specific Admin Cap, in aggregate dollars, for a given FSR.

For SFY 2009 only, the Admin Cap methodology will include the application of an adjustment factor of 1.05. This factor will have the effect of increasing the Admin Cap. Section 10.07.1(d) demonstrates how HHSC will apply the adjustment factor.

(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 EPO 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 EPO), 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 earned by the EPO (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 EPO 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 EPO. 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 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.

The EPO will have a single Admin Cap for the Service Area. This will require calculating a separate Admin Cap corresponding to each FSR (for annual, or complete period, versions of FSRs only). CHIP and CHIP-Perinatal Programs will then be combined. 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 period.

By way of example only, HHSC will calculate the Admin Cap for a given FSR 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 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 by the EPO during the Rate Period (for example, $6,000,000).

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

(3) For SFY 2009, add the totals of items 1-2 and multiply the sum by the adjustment factor of 1.05. To this product, add applicable premium taxes and maintenance taxes (for example, $112,000), to determine the Admin Cap for the Program and Service Area:

- 1.05($770,000 + $345,000) + $112,000 = $1,282,750.

In this example, $1,282,750 would be the Admin Cap for the SFY 2009 Rate Period.

(4) For SFY 2010 and after, 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 FSR:

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

In this example, $1,227,000 would be the EPO's Admin Cap for the Rate Period.

(e) Impact on Loss carry-forward.

For Experience Rebate calculation purposes, the calculation of any loss carry-forward, as described in Section 10.07(d), will be based on the allowable pre-tax loss as determined under the Admin Cap.

(f) Unforeseen events.

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

Section 10.08 Payment by Members.

Section 10.08 modified by Versions 1.5 and 1.7

(a) CHIP EPO Program

(1) In the CHIP EPO Program, families that meet the enrollment period cost share limit requirement must report it to the HHSC Administrative Services Contractor. The HHSC Administrative Service

Contractor notifies the EPO that a family's cost share limit has been reached. Upon notification from the HHSC Administrative Services Contractor that a family has reached its cost-sharing limit for the term of coverage, the EPO will generate and mail to the CHIP Member a new Member ID card within five days, showing that the CHIP Member's cost-sharing obligation for that term of coverage has been met. No cost-sharing may be collected from these CHIP Members for the balance of their term of coverage.

(2) Providers are responsible for collecting all CHIP Member co-payments at the time of service. Co-payments that families must pay vary according to their income level.

(3) Co-payments do not apply, at any income level, to Covered Services that qualify as well-baby and well-child care services, as defined by 42 C.F.R. §457.520.

(4) Except for costs associated with unauthorized non-emergency services provided to a Member by Out-of-Network providers and for non-covered services, the co-payments outlined in the CHIP Cost Sharing Table in **the HHSC Uniform Managed Care Manual** are the only amounts that a provider may collect from a CHIP-eligible family. As required by 42 C.F.R. §457.515, this includes, without limitation, Emergency Services that are provided at an Out-of-Network facility. Cost sharing for such Emergency Services is limited to the co-payment amounts set forth in the CHIP Cost Sharing Table.

(5) Federal law prohibits charging premiums, deductibles, coinsurance, co-payments, or any other cost-sharing to CHIP Members of Native American Tribes or Alaskan Natives. The HHSC Administrative Services Contractor will notify the EPO of CHIP Members who are not subject to cost-sharing requirements. The EPO is responsible for educating Providers regarding the cost-sharing waiver for this population.

(6) EPO's monthly Premium Payment will not be reduced for a family's failure to make its CHIP premium payment. There is no relationship between the per Member/per month amount owed to a EPO for coverage provided during a month and the family's payment of its CHIP premium obligation for that month.

(7) With the exception of copayments authorized by the CHIP State Plan, the EPO, Network Providers, and Out-of-Network Providers are prohibited from billing or collecting any amount from a CHIP Member for Covered Services. MCO must inform CHIP Members of costs for non-covered services, and must require its Network Providers to:

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

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

(b) CHIP Perinatal Program

(1) Cost-sharing does not apply to CHIP Perinatal Program Members. The exemption from cost-sharing applies through the end of the original 12-month enrollment period.

(2) The EPO, Network Providers, and Out-of-Network Providers are prohibited from billing or collecting any amount from a CHIP Perinatal Program Member for Covered Services. MCO must inform CHIP Perinatal Program Members of costs for non-covered services, and must require its Network Providers to:

(a) inform CHIP Perinatal Program Members of costs for non-covered services prior to rendering such services; and

(b) obtain a signed Private Pay form from such CHIP Perinatal Program Members.

Section 10.09 Restriction on assignment of fees.

During the term of the Contract, EPO may not, directly or indirectly, assign to any third party any beneficial or legal interest of the EPO 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 10.10 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 EPO's performance of this Contract. EPO 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 EPO or any taxes levied on employee wages.

Section 10.11 Liability for employment-related charges and benefits.

EPO will perform work under this Contract as an independent contractor and not as agent or representative of HHSC. EPO 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 10.12 No additional consideration.

(a) EPO 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 EPO to withhold Services and Deliverables due under the Agreement.

(c) EPO 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 10.13 Delivery Supplemental Payment.

Section 10.13 Added by Version 1.3 and Modified by Version 1.6

(a) The Delivery Supplemental Payment (DSP) is a function of the average delivery cost in the Service Area. Delivery costs include facility and professional charges.

(b) The EPO will receive a Delivery Supplemental Payment (DSP) from HHSC for each live or stillbirth by a Member in the CHIP EPO Program. The EPO will receive a DSP from HHSC for each live or stillbirth by a mother of a CHIP Perinatal Program Member in the Above 185% to 200% FPL (measured at the time of enrollment in the CHIP Perinatal Program). CHIP Perinatal EPO will not receive a DSP from HHSC for a live or stillbirth by the mother of a CHIP Perinatal Program Member in the 0%-185% FPL. The one-time DSP payment is made in the amount identified in the **HHSC Managed Care Contract** document regardless of whether there is a single birth or there are multiple births at time of delivery. A delivery is the birth of a live born infant, regardless of the duration of the pregnancy, or a stillborn (fetal death) infant of twenty (20) weeks or more of gestation. A delivery does not include a spontaneous or induced abortion, regardless of the duration of the pregnancy.

(c) The EPO must submit a monthly DSP Report in the format prescribed in **HHSC's Uniform Managed Care Manual**.

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

(e) The EPO will not be entitled to Delivery Supplemental Payments for deliveries that are not reported to HHSC within 210 days after the date of delivery, or within thirty (30) days from the date of discharge from the hospital for the stay related to the delivery, whichever is later.

(f) The EPO must maintain complete claims and adjudication disposition documentation, including paid and denied amounts for each delivery. The EPO must submit the documentation to HHSC within five (5) Business Days after receiving a request for such information from HHSC.

Section 10.14 Federal disallowance.

Section 10.14 added by Version 1.3.

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

Section 10.15 Required pass-through of physician rate increases.

Section 10.15 added by Version 1.4.

(a) Effective September 1, 2007, the EPO is required to adjust its physician fee schedules for the CHIP and CHIP Perinatal Programs to reflect the physician rate increases funded through Legislative Appropriations during the 80th Regular Legislative Session. The EPO is required to pass on all appropriated targeted physician rate increases to physicians serving their Members.

(b) The Medicaid Fee Schedule in effect on September 1, 2007 (the "updated Medicaid Fee Schedule") will include 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.

(c) If, under the terms of a Network Provider contract in place prior to September 1, 2007, the EPO pays for physician services based on the Medicaid Fee Schedule, then the EPO must pay for physician services provided on or after September 1, 2007 based on the updated Medicaid Fee Schedule.

(d) If, under the terms of a Network Provider contract in place prior to September 1, 2007, the EPO pays for physician services based on a percentage of the Medicaid Fee Schedule, then the EPO must pay for physician services provided on or after September 1, 2007 based on the same percentage of the updated Medicaid Fee Schedule. By way of example only, if prior to September 1, 2007, the EPO paid for physician services at 110% of the Medicaid Fee Schedule, then the EPO will pay for physician

services provided on or after September 1, 2007 at 110% of the updated Medicaid Fee Schedule.

(e) If, under the terms of a Network Provider contract in place prior to September 1, 2007, the EPO uses benchmarks other than the Medicaid Fee Schedule (e.g. rates that are a percentage of Medicare) to pay for physician services, then for physician services provided on or after September 1, 2007, the EPO must increase its rates by 25% for services to Members under 21 and by 10% for Members age 21 and over. The EPO must provide HHSC with a copy of both the prior and new Network Provider agreements and demonstrate how the new rates are 125% or 110%, depending on the age of the Member, of the former rates.

(f) The EPO's Chief Executive Officer will attest that the EPO has appropriately increased physician reimbursements as required above. HHSC will perform sample audits to verify payments to physicians are in accordance with this Contract requirement.

Article 11. Disclosure & Confidentiality of Information

Section 11.01 Confidentiality.

(a) EPO 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) EPO 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) EPO 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) EPO 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 EPO, including information required by HHSC, will be in accordance with applicable law. If the EPO receives a request for information deemed confidential under this Contract, the EPO 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, EPO must comply with any policy, rule, or reasonable requirement of HHSC that relates to the safeguarding or disclosure of information relating to Members, EPO'S operations, or EPO'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 EPO shall be returned to HHSC or, at HHSC's option, erased or destroyed. EPO shall provide HHSC certificates evidencing such destruction.

(g) The obligations in this Section shall not restrict any disclosure by the EPO pursuant to any applicable law, or by order of any court or government agency, provided that the EPO 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) EPO 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. EPO 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 EPO, 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 EPO all damages and liabilities caused by or arising from EPO's, its Subcontractors', consultants', or agents' failure to protect HHSC's Confidential Information. EPO 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 EPO'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 EPO.

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

Section 11.03 Member Records

(a) EPO 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 EPO, to another entity as consistent with federal and state laws.

(c) The term "Member Record" for this Section means only those administrative, enrollment, case management and other such records maintained by EPO 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 EPO 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 EPO'S confidential information, including without limitation, information or data to which EPO has a proprietary or commercial interest. HHSC will deliver a copy of the request for public information to EPO.

(b) With respect to any information that is the subject of a request for disclosure, EPO 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. EPO 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 EPO that the EPO believes to be confidential information. EPO 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) EPO acknowledges that HHSC asserts that privileged work product may be prepared in anticipation of litigation and that EPO 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 EPO of any privileged work product to which EPO has or may have access. After the EPO is notified or otherwise becomes aware that such documents, data, database, or communications are privileged work product, only EPO personnel, for whom such access is necessary for the purposes of providing the Services, may have access to privileged work product.

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

(1) Immediately notify HHSC; and

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

(d) If EPO 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 EPO in such resistance;

(2) to retain counsel to represent EPO; or

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

(e) If a court of competent jurisdiction orders EPO 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, EPO 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 EPO 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 of such information.

Section 11.07 Legal action.

Section 11.07 is modified by Version 1.5

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 EPO as confidential or proprietary, which action or proceeding identifies the other Party or such information without Party's consent.

Article 12. Remedies & Disputes

Section 12.01 Understanding and expectations.

The remedies described in this Section are directed to EPO'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 EPO 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 the remedies set forth in the Contract.

Section 12.02 Tailored remedies.

Understanding of the Parties.

EPO 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.

Notice and opportunity to cure for non-material breach.

(1) HHSC will notify EPO in writing of specific areas of EPO 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) EPO 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:

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

(B) If EPO disagrees with HHSC's findings, its reasons for disagreeing with HHSC's findings.

(3) EPO's proposed cure of a non-material deficiency is subject to the approval of HHSC. EPO'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.

Corrective action plan.

(1) At its option, HHSC may require EPO 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:

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

(B) EPO's assessment or diagnosis of the cause; and

(C) 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 EPO in writing of HHSC's final disposition of HHSC's concerns. If HHSC accepts EPO's proposed Corrective Action Plan, HHSC may:

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

(B) Disapprove portions of EPO's proposed Corrective Action Plan; or

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

Notwithstanding the submission and acceptance of a Corrective Action Plan, EPO remains responsible for achieving all written performance criteria. HHSC reserves the right to prohibit the EPO from incurring additional obligations of funds during investigation of an alleged breach and pending corrective action or a decision by HHSC to terminate the Contract.

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

(A) Excuse EPO's prior substandard performance;

(B) Relieve EPO of its duty to comply with performance standards; or

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

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:

(A) Assess liquidated damages in accordance with **Attachment B-4** to the **HHSC Managed Care Contract**, "Tailored Remedies Matrix;"

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

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

(D) Decline to renew or extend the Contract;

(E) Appoint temporary management;

(F) Initiate disenrollment of a Member or Members;

(G) Suspend enrollment of Members;

(H) Withhold or recoup payment to EPO;

(I) Require forfeiture of all or part of the EPO's bond; or

(J) 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 EPO that:

(A) Violates a material provision of the Contract;

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

(C) Represents a failure of EPO 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 EPO 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 EPO 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.

Damages.

(1) HHSC will be entitled to actual and consequential damages resulting from the EPO'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 EPO'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 EPO 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-4** to the **HHSC EPO Managed Care Contract**, "Tailored Remedies Matrix." Liquidated damages will be assessed if HHSC determines such failure is the fault of the EPO (including the EPO'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 EPO 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 EPO's nonperformance, including financial loss as a result of project delays. Accordingly, in the event EPO fails to perform in accordance with the Contract, HHSC may assess liquidated damages as provided in this Section.

(3) If EPO 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:

(A) Through direct assessment and demand for payment delivered to EPO; or

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

Equitable Remedies

(1) EPO acknowledges that, if EPO 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 an equitable remedy.

(2) If a court of competent jurisdiction finds that EPO breached (or attempted or threatened to breach) any such obligations, EPO 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 EPO and restraining it from any further breaches (or attempted or threatened breaches).

Suspension of Contract

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

(A) HHSC determines that EPO has committed a material breach of the Contract;

(B) HHSC has reason to believe that EPO has committed, assisted in the commission of Fraud, Abuse, Waste, malfeasance, misfeasance, or nonfeasance by any party concerning the Contract;

(C) HHSC determines that the EPO knew, or should have known of, Fraud, Abuse, Waste, malfeasance, misfeasance, or nonfeasance by any party concerning this Contract, and the EPO failed to take appropriate action; or

(D) 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 EPO in writing of its intention to suspend the Contract in whole or in part. Such notice will:

(A) Be delivered in writing to EPO;

(B) Include a concise description of the facts or matter leading to HHSC's decision; and

(C) Unless HHSC is suspending the contract for convenience, request a Corrective Action Plan from EPO or describe actions that EPO may take to avoid the contemplated suspension of the Contract.

<u>Section 12.03</u> Termination by HHSC.

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:

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 at least thirty (30) days advance written notice of such termination, unless in its sole discretion it determines that less than (30) days notice is required. In such cases, the termination will be effective on the date specified in HHSC's notice of termination.

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 EPO:

(A) Makes an assignment for the benefit of its creditors;

(B) Admits in writing its inability to pay its debts generally as they become due; or

(C) Consents to the appointment of a receiver, trustee, or liquidator of EPO 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 EPO 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 EPO'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 if EPO breaches confidentiality laws with respect to the Services and Deliverables provided under this Contract. HHSC will provide at least thirty (30) days advance written notice of such termination, unless in its sole discretion it determines that less than (30) days notice is required. In such cases, the termination will be effective on the date specified in HHSC's notice of termination.

(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 EPO has failed to supply personnel or resources and such failure results in EPO'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.*

(A) HHSC may terminate this Contract at any time following the determination by a

competent judicial or quasi-judicial authority and EPO's exhaustion of all legal remedies that EPO, 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.

(B) EPO 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 EPO's behalf.

(C) Termination of a Subcontract by EPO pursuant to this provision will not be a cause for termination of the Contract unless:

(1) EPO fails to replace such terminated Subcontractor within a reasonable time; and

(2) Such failure constitutes cause as described in Subsection 12.03(b).

(D) 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 reasonable advance written notice of the termination, as it deems appropriate under the circumstances. HHSC will use reasonable efforts to ensure appropriated funds are available.

(7) *Judgment and execution.*

(A) 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 EPO, and EPO does not:

(1) Discharge the judgment or provide for its discharge in accordance with the terms of the judgment;

(2) Procure a stay of execution of the judgment within thirty (30) days from the date of entry thereof; or

(3) 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.

(B) 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 EPO, 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.*

(A) HHSC may terminate the Contract at any time if EPO:

(1) Files for bankruptcy;

(2) 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;

(3) Makes an assignment for the benefit of all or substantially all of its creditors; or

(4) Enters into an Contract for the composition, extension, or readjustment of substantially all of its obligations.

(B) EPO agrees to pay for all reasonable expenses of HHSC including the cost of counsel, incident to:

(1) The enforcement of payment of all obligations of the EPO 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;

(2) A case or proceeding involving a receiver or other similar officer duly appointed to handle the EPO's business; or

(3) A case or proceeding in a State court initiated by HHSC when previous collection attempts have been unsuccessful.

(9) *Termination for EPO'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 EPO has materially breached the Contract. HHSC will provide at least thirty (30) days advance written notice of such termination.

Section 12.04 Termination by EPO.

(a) Failure to pay.

EPO may terminate this Contract if HHSC fails to pay the EPO 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 EPO's failure to perform or the EPO'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 EPO may submit a notice of intent to terminate for failure to pay in accordance with the requirements of **Section 12.04(d).** If HHSC pays all undisputed amounts then due within thirty (30)-days after receiving the notice of intent to terminate, the EPO cannot proceed with termination of the Contract under this Article.

Change to HHSC Uniform Managed Care Manual.

EPO 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 EPO's obligations under the Contract). EPO must submit a notice of intent to terminate (see **Section 12.04(d)**) 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.

Change to Premium Rate.

If HHSC proposes a modification to the Premium Rate that is unacceptable to the EPO, the EPO may terminate the Contract. EPO must submit a written notice of intent to terminate due to a change in the Premium 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.

Notice of intent to terminate.

In order to terminate the Contract pursuant to this Section, EPO 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 Premium 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) EPO 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) EPO 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. EPO must negotiate such proposed modifications in good faith.

Section 12.10 Turnover assistance.

Upon receipt of notice of termination of the Contract by HHSC, EPO 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 EPO responsibility for associated costs.

If HHSC terminates the Contract for Cause, the EPO 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 EPO. 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 EPO's failure to perform any Service in accordance with the terms of the Contract

Section 12.13 Dispute resolution.

(a) General Contract 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.

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.

Claims for breach of Contract.

(1) *General requirement.* EPO'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 EPO'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.

(A) To initiate the process, EPO must submit written notice to HHSC that specifically states that EPO 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.

(B) The Parties expressly agree that the EPO'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 EPO'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 EPO'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) *EPO'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 EPO 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 EPO.

(a) EPO bears all risk of loss or damage due to:

(1) Defects in products, Services or Deliverables;

(2) Unfitness or obsolescence of products, Services or Deliverables; or

(3) The negligence or intentional misconduct of EPO or its employees, agents, Subcontractors, or representatives.

(b) EPO must, at the EPO'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 EPO and its employees, officers, agents, or Subcontractors. HHSC will not unreasonably withhold approval of counsel selected by EPO.

(c) EPO 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 1.13

The following process will apply when HHSC terminates the Agreement for any reason set forth in Section 12.03, "Termination by HHSC," 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.

EPO 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.

Representation.

EPO 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. EPO 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.

General duty regarding conflicts of interest.

EPO 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. EPO 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 EPO, 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 EPO's or Subcontractor's ability to render impartial or objective assistance or advice to HHSC; or

(2) Provides the EPO or Subcontractor an unfair competitive advantage in future HHSC procurements (excluding the award of this Contract).

Warranty.

Except as otherwise disclosed and approved by HHSC prior to the Effective Date of the Contract, EPO 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. EPO 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.

Continuing duty to disclose.

(1) EPO agrees that, if after the Effective Date, EPO discovers or is made aware of an organizational conflict of interest, EPO will immediately and fully disclose such interest in writing to the HHSC project manager. In addition, EPO must promptly disclose any relationship that might be perceived or represented as a conflict after its discovery by EPO or by HHSC as a potential conflict. HHSC reserves the right to make a final determination regarding the existence of conflicts of interest, and EPO agrees to abide by HHSC's decision.

(2) The disclosure will include a description of the action(s) that EPO has taken or proposes to take to avoid or mitigate such conflicts.

Remedy.

If HHSC determines that an organizational conflict of interest exists, HHSC may, at its discretion, terminate the Contract pursuant to Section 12.03(b)(9). If HHSC determines that EPO 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.

Flow down obligation.

EPO must include the provisions of this Section in all Subcontracts for work to be performed similar to the service provided by EPO, and the terms "Contract," "EPO," and "project manager" modified appropriately to preserve the State's rights.

Section 13.04 HHSC personnel recruitment prohibition.

EPO 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 EPO for this Contract.

Unless authorized in writing by HHSC, EPO 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.

EPO 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, EPO agrees that any payments due to EPO under the Contract will be first applied toward any debt and/or back taxes EPO owes State of Texas. EPO 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. EPO certifies it is not ineligible for an award under this provision.

Section 13.08 Outstanding debts and judgments.

EPO certifies that it is not presently indebted to the State of Texas, and that EPO is not subject to an outstanding judgment in a suit by State of Texas against EPO 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 EPO'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 EPO and no additional approval, authorization or consent of any governmental or regulatory agency is required to be obtained in order for EPO to enter into this Contract and perform its obligations under this Contract.

(b) EPO 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 EPO's performance of this Contract. EPO will procure, pay for, and maintain all required certifications, licenses, permits, and authorizations during the term of this Contract.

Section 14.02 Ability to perform.

EPO 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 Capital & Surplus.

The EPO has, and will maintain throughout the life of this Contract, minimum capital and surplus that is the greater of (a) $2,000,000; (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 the Wisconsin Department of Insurance. Minimum net worth means the excess total admitted assets over total liabilities, excluding liability for subordinated debt issued in compliance with the Wisconsin Insurance Code.

Section 14.04 Insurer solvency.

(a) The EPO must be and remain in full compliance with all applicable State and Federal solvency requirements for accident and health insurance companies, including but not limited to, all reserve requirements, capital and surplus standards, debt-to-equity ratios, or other debt limitations. In the event the EPO 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 EPO 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 EPO must notify HHSC immediately in writing.

(c) The EPO 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 payment 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 EPO 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) EPO 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.

EPO 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 EPO and HHSC. EPO 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.

EPO 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) EPO 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, EPO represents and warrants to HHSC that the technology provided to HHSC for purchase 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 EPO 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) EPO warrants that all Deliverables provided by EPO 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) EPO 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 EPO in writing of the claim, provide EPO a copy of all information received by HHSC with respect to the claim, and cooperate with EPO in defending or settling the claim. HHSC will not unreasonably withhold, delay or condition approval of counsel selected by the EPO.

(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 EPO to be likely to be brought, EPO 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 EPO on commercially reasonable terms, EPO may require that HHSC return the allegedly infringing Deliverable(s) in which case EPO will refund all amounts paid for all such Deliverables.

Section 15.02 Exceptions.

EPO is not responsible for any claimed breaches of the warranties set forth in **Section 15.01** to the extent caused by:

(1) Modifications made to the item in question by anyone other than EPO or its Subcontractors, or modifications made by HHSC or its contractors working at EPO's direction or in accordance with the specifications; or

(2) The combination, operation, or use of the item with other items if EPO did not supply or approve for use with the item; or

(3) HHSC's failure to use any new or corrected versions of the item made available by EPO.

Section 15.03 Ownership and Licenses

Section 15.03 modified by Version 1.3.

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 EPO: for HHSC; in connection with the Contract; and with funds received from HHSC. The term does not include EPO Proprietary Software or Third Party Software.

(2) "**EPO Proprietary Software**" means software: (i) developed by the EPO prior to the Effective Date of the Contract, or (ii) software developed by the EPO 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.

Deliverables.

The Parties agree that any Deliverable, including without limitation the Custom Software, will be the exclusive property of HHSC.

Ownership rights.

(1) HHSC will own all right, title, and interest in and to its Confidential Information and the Deliverables provided by the EPO, including without limitation the Custom Software and associated documentation. For purposes of this Section 15.03, the Deliverables will not include EPO Proprietary Software or Third Party Software. EPO 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) EPO 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, EPO 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) EPO 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. EPO 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. EPO also agrees not to assert any moral rights under applicable copyright law with regard to such Deliverables.

License Rights

HHSC will have a royalty-free and non-exclusive license to access the EPO 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 EPO under or resulting from the Contract. Such data will include all results, technical information, and materials developed for and/or obtained by HHSC from EPO 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.

Proprietary Notices

EPO will reproduce and include HHSC's copyright and other proprietary notices and product identifications provided by EPO on such copies, in whole or in part, or on any form of the Deliverables.

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) EPO will protect HHSC's real and personal property from damage arising from EPO's, its agent's, employees' and Subcontractors' performance of the Contract, and EPO will be responsible for any loss, destruction, or damage to HHSC's property that results from or is caused by EPO'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, EPO 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) EPO agrees to observe and encourage its employees and agents to observe safety measures and proper operating procedures at HHSC sites at all times.

(c) EPO 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 EPO any special defect or unsafe condition encountered while on HHSC premises. EPO 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 EPO, its carriers or HHSC prior to being accepted by HHSC, EPO 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 EPO'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 EPO UNDER THE CONTRACT WILL NOT EXCEED THE TOTAL CHARGES TO BE PAID BY HHSC TO EPO UNDER THE CONTRACT, INCLUDING CHANGE ORDER PRICES AGREED TO BY THE PARTIES OR OTHERWISE ADJUDICATED.

Article 17. Insurance & Bonding

Section 17.01 Insurance Coverage.

Section 17.01 modified by Versions 1.3, 1.4, and 1.7

(a) Statutory and General Coverage.

EPO will maintain, at the EPO'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.oo per each occurrence and Property Damage Coverage of $25,000.00 per occurrence); and

(3) If EPO's current Comprehensive General Liability insurance coverage does not meet the above stated requirements, EPO 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) EPO must maintain, 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) EPO 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 EPO 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.

(A) The EPO or a Network Provider is not required to obtain the insurance coverage described in Section 17.01 because the EPO 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.

(2) EPO 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 and loss payee with the following exceptions: Standard Workers' Compensation Insurance maintained by the EPO, and Professional Liability Insurance maintained by Network Providers.

(5) Insurance coverage kept by the EPO 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. EPO 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 EPO will in no way expand or limit EPO's liabilities and responsibilities specified within the Contract documents or by applicable law.

(9) EPO expressly understands and agrees that any insurance maintained by HHSC will apply in excess of and not contribute to insurance provided by EPO under the Contract.

(10) If EPO, or its Network Providers, desire additional coverage, higher limits of liability, or other modifications for its own protection, EPO 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) EPO 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 EPO 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 EPO 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 EPO will not be deemed to be a waiver by HHSC and EPO will remain under continuing obligation to maintain and provide proof of insurance coverage.

(2) The EPO 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 modified by Versions 1.4 and 1.7

Section 17.02 Performance Bond.

(a) Beginning on the Operational Start Date of the Contract, the EPO must obtain a performance bond with a one 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 year following the expiration of the final renewal period. EPO must obtain and maintain the performance bond in the form prescribed by HHSC and approved by TDI, naming HHSC as Obligee, securing EPO's faithful performance of the terms and conditions of this Contract. The performance bond(s) must comply with the requirements of Chapter 843 of the Texas Insurance Code, and 28 T.A.C. §11.1805. At least one EPO performance bond must be issued. The amount of the EPO Performance bond(s) should total $100,000 Performance bond(s) must be issued by a surety licensed by TDI, and specify cash payment as the sole remedy. EPO must deliver the initial performance bond to HHSC-prior to the Operational Start Date of the EPO Contract, and each renewal prior to the first day of the State Fiscal Year.

(b) Since the CHIP Perinatal Program is a sub-program of the CHIP Program, neither a separate performance bond for the CHIP Perinatal Program nor a combined performance bond for the CHIP and CHIP Perinatal Programs is required. The same bond that the EPO obtains for its CHIP Program will cover the EPO's CHIP Perinatal Program.

(c) Prior performance bonds received for a specific SFY will be released upon completion of the audit of the 334-day FSR for the corresponding SFY.

Section 17.03 Fidelity Bond

EPO will obtain and maintain a fidelity bond in its own name for its officers, directors, and employees to insure against criminal conduct or fraud. The bond must:

(1) Be issued by a surety or other entity duly licensed and authorized to conduct business in the State of Texas and rated "A" or better by a rating agency acceptable to HHSC;

(2) Be in an amount not less than $100,000.00;

(3) Indemnify HHSC and the State against any financial loss caused by the wrongful, fraudulent, or criminal conduct of EPO's employees, officers or directors;

(4) Name HHSC as an additional insured or beneficiary;

(5) Be tendered to HHSC within ten (10) Business Days from the Effective Date of this Contract. Any applicable renewals of the fidelity bond must be tended to HHSC within ten (10) Business Days of issuance.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	August 19, 2004	Initial version of Attachment B-1, Section 6.
Revision	1.1	September 1, 2005	Contract Amendment 1 did not revise Attachment B-1, Section 6.
Revision	1.2	March 1, 2006	Contract Amendment 2 did not revise Attachment B-1, Section 6
Revision	1.3	September 1, 2006	Revised version of Attachment B-1, Section 6, to include the provisions applicable to the CHIP Perinatal Program. Modified Sections 6.5.5 and 6.5.5.2 to include CHIP Perinatal Program reporting requirements. Modified Section 6.6.1.1 to clarify available remedies.
Revision	1.4	September 1, 2007	Section 6.5.5.2, FRC-11, modified to provide that HHSC will post all FSRs on its website. Section 6.5.5.2, FRC-20, modified to include a reference the UMCM's reporting format for the Claims Lag Report and to remove the requirement that the report separate claims by service categories. Section 6.6.1.1 is modified to clarify that the EPO may not pass financial remedies or disincentives imposed by HHSC to health care providers, except on an individual basis and due to the individual's inadequate performance.
Revision	1.5	September 1, 2008	Contract Amendment did not revise Attachment B-1, Section 6.
Revision	1.6	April 1, 2009	Contract Amendment did not revise Attachment B-1, Section 6.
Revision	1.7	September 1, 2009	Section 6.5.5.2 FRC-23 is modified to clarify the third party recovery requirements. Section 6.6.1.2 is added to clarify the third party recovery requirements for CHIP EPO.

[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.

6.5 Financial: Accounting and Reporting Requirements

6.5.1 Overview

This section presents State and EPO responsibilities for recording and reporting Contract transactions.

6.5.2 Business Objectives

The business objectives include:

- Accumulating and reporting accounting data in accordance with the Generally Accepted Accounting Principles and the cost principles contained in the Cost Principles for Administrative Expenses in the Uniform Managed Care Manual.

- Providing authorized State and Federal governments with full access to all financial and accounting records related to the performance of this Contract.

6.5.3 Financial Accounting Requirements

The EPO's accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with Generally Accepted Accounting Principles (GAAP) and the cost principles contained in the Cost Principles for Administrative Expenses in the Uniform Managed Care Manual. The State will not recognize or pay services that cannot be properly substantiated by the EPO and verified by HHSC.

6.5.3.1 (Intentionally left blank).

6.5.3.2 EPO Responsibilities

The EPO must:

FRC-01 Maintain records for all claims payments, refunds and adjustment payments to providers, premium payments, interest income and payments for administrative fees, charges, and payments;

FRC-02 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.

FRC-03 Within 60 days after Contract execution, submit an accounting policy manual that includes all proposed policies and procedures the EPO must follow during the duration of the Contract. Any modifications to the accounting policy manual must be approved in writing by the HHSC prior to any change.

FRC-04 The EPO agrees to pay for all costs incurred by HHSC to perform an examination, agreed upon procedures, review or audit of the EPO's books pertaining to the Contract.

6.5.4 General Access to Accounting Records

The EPO must provide authorized representatives of the State and Federal governments full access to all financial and accounting records related to the performance of the Contract.

6.5.4.1 EPO Responsibilities

The EPO must:

FRC-05 Cooperate with the State and Federal governments in their evaluation, inspection, audit, and/or review of accounting records and any necessary supporting information.

FRC-06 Permit authorized representatives of the State and Federal governments full access, during normal business hours, to the accounting records that the State and the Federal government determine are relevant to this Contract. Such access is guaranteed at all times during the performance and retention period of this Contract, and will include both announced and unannounced inspections, on-site audits, and the review, analysis, and reproduction of reports produced by the EPO.

FRC-07 Make copies of any accounting records or supporting documentation relevant to the Contract available to the State or its agents within ten business days of receiving a written request from the State for specified records or information. If such documentation is not made available as requested, the EPO agrees to reimburse the State 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.

FRC-08 Pay any and all additional costs incurred by the State that are the

result of the EPO's failure to provide the requested accounting records or financial information within ten business days of receiving a written request from the State for specified accounting records or information.

FRC-09 Maintain and retain financial records and supporting documents relating to the Contract 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 the Contract, whichever is longer. The EPO agrees to repay any valid audit exceptions taken by HHSC in any audit of the Contract.

6.5.5 Financial Report Requirements

The State will require the EPO to provide financial reports by EPO Service Area to support contract monitoring as well as State and Federal reporting requirements. All financial information and reports provided by the EPO will be the property of HHSC, and the portions of such information and reports that do not reveal confidential Member information will be public record. This includes but is not limited to, FSRs, Claims Summary Lag Reports, IBNR Plan, and TPR Reports. HHSC's Uniform Managed Care Manual will govern the timing, format and content for the reports listed in this Section.

Section 6.5.5 modified by Version 1.3

CHIP Perinatal Program data must be reported, and the data will be integrated into existing EPO Program financial reports. Except for the Financial Statistical Report, no separate CHIP Perinatal Program reports are required. For all other CHIP financial reports, where appropriate, HHSC will designate specific attributes within the EPO Program financial reports that the EPO must complete to allow HHSC to extract financial data particular to the CHIP Perinatal Program.

6.5.5.1 State Responsibilities

The State reserves the right to waive the review and approval of EPO work products. State approval of the EPO's work product will not relieve the EPO of liability for errors and omissions in the work product.

The State will:

FRS-01 Monitor EPO compliance for providing the specified reports on or before the specified times.

FRS-02 Review reports provided by the EPO for accuracy and completeness.

FRS-03 Assess applicable remedies/liquidated damages for any late reports, incorrect reports, or additional expenses incurred by the State, authorized representatives, or agents of the State.

6.5.5.2 EPO Responsibilities

The EPO must:

FRC-10 **Audited Financial Statement** - The EPO must provide the annual audited financial statement for each year covered under the Contract, no later than June 30. The EPO must provide the most recent annual financial statements, as required by the Texas Department of Insurance for each year covered under the contract, no later than March 1.

Section 6.5.5.2, FRC-11, modified by Versions 1.3 and 1.4

FRC-11 FSR Reports - The EPO must file quarterly and annual Financial-Statistical Reports (FSR) for each Program in the format and timeframe specified by HHSC. HHSC will include FSR format and directions in the Uniform Managed Care Manual. The FSR reports must include complete financial and statistical information. The report must provide information for the current month and a year-to-date report through the current month. The FSR Report must be submitted for each claims processing subcontractor in accordance with this document. The EPO must incorporate financial and statistical data of its delegated networks, (e.g., IPAs, ANHCs, Limited Provider Networks), if any, in its FSR Report. Administrative expenses reported in the FSRs must be reported in accordance with the Cost Principles for Administrative Expenses in the Uniform Managed Care Manual. Quarterly FSR reports must provide information for the current quarter and a year-to-date report through the current quarter. The first annual FSR Report must reflect expenses incurred through the 90th day after the end of the Contract Year. The first annual report must be filed on or before the 120th day after the end of each Contract Year and accompanied by an actuarial opinion by a qualified actuary who is in good standing with the American Academy of Actuaries. Subsequent annual reports must reflect data completed through the 334th day after the end of each Contract Year and must be filed on or before the 365th day following the end of each Contract Year. HHSC will post all FSRs on the HHSC website.

FRC-13 Affiliate Report – The EPO must submit an Affiliate Report to the HHSC if this information has changed since the last report was submitted. The report must contain the following:

- A list of all Affiliates;
- For HHSC's prior review and approval, a schedule of all transactions with Affiliates which, under the provisions of the Contract, will be allowable as expenses in the FSR Report for services provided to the EPO 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 EPO for such services during the Contract period.

FRC-14 Form CMS-1513 - The EPO must file an original CMS-1513 prior to beginning operations regarding the EPO's control, ownership, or affiliations. An updated Form CMS-1513 must also be filed no later than 30 days after any change in control, ownership, or affiliations.

FRC-15 Section 1318 Financial Disclosure Report - The EPO must file an original CMS Public Health Service (PHS) Section 1318 Financial Disclosure Report prior to the Start of Operations and an updated CMS PHS Section 1318 Financial Disclosure Report no later than 30 days after entering into, renewing, or terminating a relationship with an affiliated party.

FRC-16 Registration Statement also known as the Form B – If the EPO is a part of an insurance holding company system, the EPO must submit 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.

FRC-17 TDI Examination Report - The EPO must submit to TDI examinations to ensure compliance with all applicable statutes and regulations, including TDI regulations concerning Exclusive Provider Benefit Plans at Title 28 Texas Administrative Code, Sections 3.9201 – 3.9212. EPO must furnish a copy of any TDI Examination Report, including both the financial, market conduct, target exam, complaint, quality of care components, and corrective action plans and responses no later than 10 days after receipt of the final report from TDI.

FRC-18 HUB Reports – The EPO must maintain its HUB Subcontracting Plans and submit monthly reports documenting the EPO's Historically Underutilized Business (HUB) program efforts and accomplishments. The report must include a narrative description of the EPO's program efforts and a financial report reflecting payments made to HUBs. EPOs must use the format included in HHSC's Uniform Managed Care Manual for the HUB monthly reports. The EPO must comply with HHSC's standard HUB Subcontracting Plan (HSP) requirements for all Material Subcontractors, and HHSC's Client Services HUB Subcontracting Plan requirements for all Network Providers.

FRC-19 **Bonus and/or Incentive Payment Plan –** If a EPO intends to include Bonus or Incentive Payments as allowable administrative expenses, the EPO must furnish a written Bonus and/or Incentive Payments Plan to HHSC so it may determine whether such payments are allowable administrative expenses in accordance with Cost Principles for Administrative Expenses in the **Uniform Managed Care Manual.** The written plan must include a description of the EPO'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 EPO substantively revises the Bonus and/or Incentive Payment Plan, the EPO must submit the revised plan to HHSC for prior review and approval.

Section 6.5.5.2, FRC-20, modified by Version 1.4

FRC-20 **Claims Summary Lag Report -** The EPO must submit an Incurred Claims Summary 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 in the **Uniform Managed Care Manual**. The report must at a minimum disclose the amount of incurred claims each month and the amount paid each month.

FRC-21 **IBNR Plan -** The EPO must furnish a written IBNR Plan to manage incurred-but-not-reported (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 the EPO's IBNR plan and description must be submitted to HHSC no later than 30 days before the EPO implements changes to the IBNR plan.

FRC-22 **TDI Filings –** The EPO must submit annual figures for controlled risk-based capital, as well as its quarterly financial statements, both as required by TDI.

Section 6.5.5.2, FRC-23, modified by Versions 1.3 and 1.7

FRC-23 **Third Party Recovery (TPR) Reports** The EPO must file TPR Reports in accordance with the format developed by HHSC in the **Uniform Managed Care Manual**. HHSC will require the EPO to submit TPR reports no more often than quarterly. TRP reports must include total dollars recovered from third party payers for the EPO Program and CHIP Perinatal Program for services to the EPO's Members, and the total dollars recovered through coordination of benefits, subrogation, and worker's compensation.

6.6 Additional Financial Components

6.1.1.1 Remedies and Liquidated Damages

All areas of responsibility and all requirements in the Contract will be subject to performance evaluation by the State. Any and all responsibilities or requirements not

Section 6.6.1.1 modified by Versions 1.3 and 1.4

fulfilled may have remedies, which may include liquidated damages. Refer to **Attachment B-4,** Exclusive Provider Organization Tailored Remedies Matrix, for performance standards and liquidated damage values. The EPO is prohibited from passing down financial disincentives or remedies imposed by HHSC to health care providers, except on an individual basis and related to that individual provider's inadequate performance.

6.1.1.2 Third Party Liability and Recovery

Section 6.6.1.2 added by Version 1.7

CHIP EPO is authorized to engage in Third Party Recovery (TPR) actions for claims resulting from the care and/or treatment of CHIP Members, CHIP Perinatal Members, and CHIP Perinatal Newborn Members. CHIP EPO 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 applicable State and Federal laws and regulations, including State insurance laws and regulations. HHSC may reduce capitation payments to CHIP EPO by the projected amount of TPR that the EPO is expected to recover.

CHIP EPO must provide required reports as stated in **Section 6.5.5,** Financial Reporting Requirements.

After 120-days from the date of service on any claim, encounter, or other CHIP related payment by the EPO subject to TPR, HHSC may attempt recovery independent of any EPO action. HHSC will retain, in full, all funds received as a result of the state initiated recovery or subrogation action.

CHIP EPO shall provide a Member quarterly file, which contains the following information if available to the EPO: 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 CHIP eligibility file against the EPO Member file to identify CHIP Members enrolled in the EPO who may have TPL information not known to the CHIP Program or the CHIP Perinatal Program.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	August 19, 2004	Initial version of Attachment B-1, Section 7.
Revision	1.1	September 1, 2006	Contract Amendment 1 did not revise Attachment B-1, Section 7.
Revision	1.2	March 1, 2006	Contract Amendment 2 did not revise Attachment B-1, Section 7.
Revision	1.3	September 1, 2006	Contract Amendment 3 did not revise Attachment B-1, Section 7.
Revision	1.4	September 1, 2007	Contract Amendment 4 did not revise Attachment B-1, Section 7.
Revision	1.5	September 1, 2008	Contract Amendment did not revise Attachment B-1, Section 7.
Revision	1.6	April 1, 2009	Contract Amendment did not revise Attachment B-1, Section 7.
Revision	1.7	September 1, 2009	Contract Amendment did not revise Attachment B-1, Section 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.

7 Turnover Requirements

7.1 Introduction

This section presents the Turnover requirements to which the EPO must agree. Turnover is defined as those activities that are required for the EPO to perform in order to transition contract operations to a subsequent vendor.

7.2 Transfer of Data

The EPO must transfer all data regarding the provision of Covered Services to Members to HHSC or a new vendor, at the sole discretion of HHSC and as directed by HHSC. All transferred data must be compliant with the Health Insurance Portability and Accountability Act of 1996, (HIPAA).

If HHSC determines that not all of the data regarding the provision of Covered Services to Members was transferred to HHSC or the subsequent vendor, as required, or the data is not HIPAA compliant, HHSC reserves the right to hire an independent contractor to assist HHSC in obtaining and transferring all the required data and in to ensure that all the data is HIPAA compliant. The cost of providing these services will be the responsibility of the EPO. This agreement is necessary to ensure that all data is updated on required systems and all records and information is received and verified by HHSC or the subsequent vendor in the format required.

7.3 Turnover Services

The State must ensure that program stakeholders do not experience any adverse impact from the transfer of the responsibility of providing Covered Services to Members from the EPO to either the State or to a successor vendor. Six months prior to the end of the initial contract period or any extension thereof, the EPO must propose a Turnover Plan covering the possible turnover of the records and information maintained to either the State or a successor vendor. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. HHSC reserves the right to review and approve the Turnover Plan. HHSC's approval of the Turnover Plan will not relieve the EPO of liability for errors and omissions in the work product. As part of the Turnover Plan, the EPO must provide the State with copies of all relevant data, documentation, or other pertinent information necessary, as determined by the State, for HHSC or a subsequent vendor to assume the

operational activities successfully. This includes correspondence, documentation of ongoing outstanding issues, and other operations support documentation. The plan will describe the EPO's approach and schedule for transfer of all data and operational support information, as applicable. The information must be supplied in media and format specified by the State and according to the schedule approved by the State.

HHSC is not limited or restricted in the ability to require additional information from the EPO or modify the turnover schedule as necessary.

7.3.1 Post-Turnover Services

Following turnover of operations, the EPO must provide the State 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 the State.

If the EPO does not provide the required relevant Member and Service data, documentation, or other pertinent information necessary for the subsequent EPO to assume the operational activities successfully, the EPO agrees to reimburse the State 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, reproduction and transfer functions at the location(s) of such records.

The EPO also agrees to pay any and all additional costs incurred by the State that are the result of the EPO's failure to provide the requested records, data or documentation within the time frames agreed to in the Turnover Plan.

The State or its representatives, or agents, are authorized to obtain from the EPO all required information and in the format needed. This includes relevant Member and Service data, correspondence, documentation of ongoing outstanding issues, and other operations support documentation.

The EPO must maintain all files and records related to the CHIP Members and providers for three years and 90 days after the date of final payment under the Contract or until the resolution of all litigation, claim, financial management review or audit pertaining to the Contract, whichever is longer. The EPO agrees to repay any valid, undisputed audit exceptions taken by HHSC in any audit of the Contract.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	August 19, 2004	Initial version of Attachment B-1, Section 8.
Revision	1.1	September 1, 2006	Amendment 1 did not revise Attachment B-1, Section 8.
Revision	1.2	March 1, 2006	Amendment 2 modified the following provisions of Attachment B-1, Section 8: 1. revised 8.2.1.5.3, PSC-7, regarding quarterly call center summary reports; added 8.2.1.5.3, PSC-16, regarding lists of Members for PCPs; 2. revised 8.2.1.5.5, ¶4, regarding Behavioral Health Services Hotline; 3. revised 8.2.1.6.1, ¶6, regarding processing Clean Claims; 4. revised 8.2.1.7, MSC-20, regarding quarterly call center summary reports; 5. deleted 8.2.3.7.1 as redundant; revised 8.2.3.7.1, RRC-9, regarding Member and Provider hotline reports; and 6. revised 8.3.1.3.9, ¶2, regarding Encounter Data submission.
Revision	1.3	September 1, 2006	Revised version of Attachment B-1, Section 8,as follows: 1. added or modified the following Sections to include provisions applicable to the CHIP Perinatal Program: 8.1, 8.1.1.1, 8.1.1.5, 8.2.1.3, 8.2.1.5, 8.2.1.5.1, 8.2.1.5.3, 8.2.1.5.4, 8.2.1.5.5, 8.2.1.7, 8.2.3.7.1, 8.3.1.3.7; 2. modified Section 8.1.1.1 to clarify the CHIP EPO eligibility provisions; 3. modified Sections 8.1.1.5 and 8.2.1.5 to update references to the Cost Sharing Appendix for the EPO Program; 4. modified Section 8.2.1.5.3, regarding call center performance standards and provider Complaints and Appeals resolution; 5. modified Section 8.2.1.5.6; regarding Disease Management.
Revision	1.4	September 1, 2007	Revised version of Attachment B-1, Section 8, as follows: 1. modified Section 8.1 to specify that HHSC may post information concerning the EPO's performance on its website; 2. modified Section 8.1.1.1 to refer to Attachment A-2's eligibility and enrollment requirements; 3. modified Section 8.1.1.3 to reflect changes in the CHIP term of coverage; 4. modified Section 8.1.1.5 regarding CHIP Cost-Sharing; 5. modified the call hold standard in Section 8.2.1.5.3, PSC-3; 6. modified Section 8.2.1.5.4 to included changes required by SB 10, 80th Regular Session of the Texas Legislature,

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			regarding eye Health Care Services; 7. modified Section 8.2.1.6.1 to refer to the UMCM's claims processing and adjudication requirements and to remove 15 day requirement and associated liquidated damages for processing of unclean claims; 8. modified Section 8.2.1.7, MSC-12, to update references to applicable policies and laws for the internet website, and add a requirement that the EPO list Home Health Ancillary Providers on its website as an indicator for Pediatric services; 9. modified Section 8.2.1.7, MSC-18, to revise the maximum call abandonment rate; 10. modified Section 8.2.3.7.1, RRC-2, to include a reference to the UMCM's reporting format for the All Claims Summary Report, and to require that the report be submitted by claim type; and 11. added Section 8.3.1.3.10, "Additional EPO Readiness Reviews."
Revision	1.5	September 1, 2008	Revised version of Attachment B-1, Section 8, as follows: 1. Section 8.2.1.5.3 is modified to require the EPO to pay all reasonable costs for HHSC to conduct onsite monitoring of the EPO's Provider Hotline functions. 2. Section 8.2.1.5.5 is modified to require the EPO to pay all reasonable costs for HHSC to conduct onsite monitoring of the EPO's Behavioral Health Services Hotline functions. 3. Section 8.2.1.5.6 is modified to require the HMO to coordinate continuity of care for Members in Disease Management who change plans. 4. Section 8.2.1.7 is modified to require the EPO to pay all reasonable costs for HHSC to conduct onsite monitoring of the EPO's Member Hotline functions. 5. Section 8.2.1.8 is added to provide guidelines related to ECI. 6. Section 8.2.3.7.1 is modified to require the EPO to submit copies of all internal and external audit reports. 7. Section 8.3.1.3.9 is modified to clarify encounter data submission requirements.
Revision	1.6	April 1, 2009	Revised version of Attachment B-1, Section 8, as follows: 1. Section 8.2.1.5.3, Item PSC-1 is modified to remove the word "separate" to make the language consistent with the language in the Uniform Managed Care Contract. 2. Section 8.2.1.7, MSC-12 is modified to bring it into conformance with the Uniform Managed Care Contract.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			3. Section 8.2.1.7, MSC-14 is modified to bring it into conformance with the Uniform Managed Care Contract. 4. Section 8.2.1.7, MSC-18 is modified to bring it into conformance with the Uniform Managed Care Contract. 5. Section 8.2.3.6 is modified to clarify that a written Fraud and Abuse compliance plan must be submitted annually and to list the legal citations.
Revision	1.7	September 1, 2009	Revised version of Attachment B-1, Section 8, as follows: 1. Section 8.2.1.5.9 is added to clarify that the dental coverage requirements applicable to CHIP Members also apply to CHIP Perinate Newborns. 2. Section 8.2.1.5.10 is added to require CHIP EPO to pay full encounter rates. 3. Section 8.3.1.3.9 is modified in compliance with HB 1218 to require the EPO to submit encounter data not later than the 30th day after the last day of the month in which the claim was adjudicated.

[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.

Table of Contents

8 Operations Scope of Work 8-6

8.1 Introduction 8-6

8.1.1 Background Overview of CHIP Member Eligibility, Enrollment, Disenrollment and Cost Sharing 8-8

8.1.1.1 CHIP Member Eligibility 8-8
8.1.1.2 Enrollment 8-8
8.1.1.3 Re-enrollment 8-8
8.1.1.4 Disenrollment due to loss of eligibility 8-9
8.1.1.5 Cost Sharing 8-9

8.2 Operations Requirements 8-9

8.2.1 General Operations Requirements 8-9

8.2.1.1 Overview 8-9
8.2.1.2 Business Objective 8-10
8.2.1.3 System Support Requirements 8-10
8.2.1.4 State Responsibilities 8-10
8.2.1.5 EPO Responsibilities 8-10
8.2.1.5.1 Case Management Services for Children with Special Health Care Needs 8-12
8.2.1.5.2 Network Oversight and Key Personnel 8-14
8.2.1.5.3 Provider Services 8-14
8.2.1.5.4 Network Requirements 8-16
8.2.1.5.5 Behavioral Health (BH) Network and Services 8-19
8.2.1.5.6 Disease Management (DM) 8-22
8.2.1.5.7 Provider Contract Requirements 8-23
8.2.1.5.8 Provider Reimbursement 8-23
8.2.1.5.9 Dental Coverage for CHIP Members and CHIP Perinate Newborn Members 8-24
8.2.1.5.10 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) 8-24
8.2.1.6 Claims Processing Requirements 8-24
8.2.1.6.1 EPO Responsibilities 8-24
8.2.1.7 Member Services 8-25
8.2.1.8 Early Childhood Intervention (ECI) 8-29

8.2.2 Marketing and Community Outreach 8-30

8.2.3 Additional Operations Requirements 8-31

8.2.3.1 Key Personnel 8-31
8.2.3.2 Provider Medical Record Audit and Reports 8-31
8.2.3.3 Quality Assurance 8-31
8.2.3.4 Utilization 8-32
8.2.3.5 Right to Audit 8-32
8.2.3.6 Fraud and Abuse Compliance Plan 8-32
8.2.3.7 Administrative Performance Requirements 8-33
8.2.3.8 Performance Reporting 8-33
8.2.3.8.1 Required Plans and Reports 8-33

8.2.3.8.2 Records Management 8-36

8.3 Management Information Systems 8-37

8.3.1 Systems development, maintenance and operation 8-38

8.3.1.1 General responsibilities 8-38
8.3.1.2 General management information system functions 8-39
8.3.1.2.1 General data storage and handling requirements 8-39
8.3.1.2.2 Data override capability 8-40
8.3.1.2.3 Data security and confidentiality 8-40
8.3.1.2.4 Back-up 8-40
8.3.1.2.5 Disaster recovery 8-40
8.3.1.3 System-wide functions 8-41
8.3.1.3.1 Enrollment Subsystem 8-41
8.3.1.3.2 Provider Subsystem 8-42
8.3.1.3.3 Claims/Services Data Subsystem. 8-43
8.3.1.3.4 Financial Subsystem 8-44
8.3.1.3.5 Utilization/Quality Improvement Subsystem 8-44
8.3.1.3.6 Report Subsystem 8-45
8.3.1.3.7 Data Interface Subsystem 8-46
8.3.1.3.8 Additions or changes to the requirements set out in this section 8-48
8.3.1.3.9 Encounter Data 8-48
8.3.1.3.10 Additional EPO Readiness Reviews 8-48

8 Operations Scope of Work

8.1 Introduction

Section 8.1 modified by Versions 1.3 and 1.4

The EPO will provide comprehensive exclusive provider health insurance coverage to CHIP EPO Program and CHIP Perinatal Program Members in a cost effective, customer service-focused, and quality-driven manner. Coverage for benefits will be available on the Operational Start Date for each Program. The Operational Start Date is September 1, 2004 for the EPO Program, and January 1, 2007 for CHIP Perinatal Program.

The EPO will provide health care services for Texas CHIP EPO Program and CHIP Perinatal Program Members through an "Exclusive Provider Plan". An "Exclusive Provider Plan," commonly referred to as an Exclusive Provider Organization (EPO), is group health benefit plan that provides benefits for medical, surgical and supplemental expenses incurred as a result of a health condition, accident or sickness. Such a plan may only be offered by an EPO that is licensed by the Texas Department of Insurance (TDI). An "exclusive provider" means an institution or health care professional that renders exclusive provider services to covered persons under a group contract pursuant to a contract with an EPO to provider such services at alternative rates.

This section presents the operational requirements to support the provision of health care services in the Texas CHIP EPO Program and CHIP Perinatal Program. The business requirements include the following:

- Provide the minimum level of health care Benefits described in Attachments B-2 and B-2.1. The benefits described in Attachments B-2 and B-2.1 should be considered programmatic requirements. The EPO may propose additional value-added services at no additional cost to HHSC.
- Provide Case Management Services for Children with Special Health Care Needs. In the CHIP Perinatal Program, this requirement does not apply to CHIP Perinates.
- Network Oversight - The EPO is responsible for the development, approval, implementation and enforcement of administrative, operational, personnel and patient care policies and procedures.
- Operate separate toll-free Member and Provider telephone hotlines from 8:00 A.M. to 5:00 P.M., Monday through Friday in the time zone of the Service Area(s) where the EPO provides Covered Services. Develop and make available to all Providers a Provider's Manual which provides instructions to the Providers including how they are to obtain authorizations for selected benefits, conditions under which its Medical Director is available for medical necessity determinations, performance measures for timely responses and the provider appeals process.

- Require all Network Providers to be licensed and in good standing in the State of Texas to provide services. The EPO must enter into a written contract with licensed Providers, including third-party billing vendors who submit claims on behalf of one or more provider of services. (See the Network Requirements Section for additional requirements.)
- Process and pay or reimburse for all covered benefits provided to CHIP Members for whom the EPO is paid a premium. The EPO must administer an effective, accurate, and efficient claims payment process.
- Meet accessibility and availability requirements in the RFP and provide covered services to CHIP Members on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted practice parameters.
- Maintain key contract personnel.
- Cooperate with and work with the state's contractors, subcontractors and third-party representatives as requested by HHSC.
- Develop, maintain, and operate or arrange for the development, maintenance, and operation of an automated information system that will be utilized by the EPO in the performance of the Services as stated in the RFP.
- Maintain records as required by HHSC.
- Ensure the safety and security of all information, data, procedures, methods and funds involved in the performance authorized under the contract.
- Meet with HHSC and related administrative contractors and Health Maintenance Organizations, if necessary, at least semi-annually, unless HHSC determines otherwise.
- Maintain quality control procedures, utilization management, and programs designed to prevent fraud, abuse, waste, or misuse by Providers or Members.
- Furnish regular performance reports and other required reports, including Ad Hoc Reports as specified by the State.
- Design, print and distribute Member identification cards, provider directories and certificates of coverage in English and in Spanish and the languages of other major population groups making up 10% or more of the enrolled CHIP population, as specified by HHSC.
- Develop, implement and maintain a system for tracking and resolving Member Complaints and Appeals regarding its services, processes, procedures, and staff.
- Develop, implement and maintain a system for tracking and resolving provider Complaints and Appeals including those involving payment denial.
- Engage in marketing within the marketing guidelines set out in the RFP and with the goal of increasing the number of applications for health insurance. The EPO must comply with all state insurance law and TDH regulations regarding restrictions on marketing.
- The following categories describe each operations business function.

- Overview – Provides a high-level overview of the business function.
- Business Objectives – Defines the objectives for the business function.
- State/EPO Responsibilities – Separately describes the State's operational responsibilities for the business function and the State's requirements for performance of the EPO's operational responsibilities for the business function, including coordination activities with other vendors.

Vendors are encouraged to propose innovative and efficient methods for providing health care services to CHIP Members in a cost effective manner. Proposals that include additional value over and above the requirements stated in this section of the RFP or in current CHIP health care services policy are encouraged.

HHSC may post information concerning the EPO's 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 peer group performance comparisons, on its website.

8.1.1 Background Overview of CHIP Member Eligibility, Enrollment, Disenrollment and Cost Sharing

8.1.1.1 CHIP Member Eligibility

Section 8.1.1.1 modified by Amendment 2 and Versions 1.3 and 1.4

Refer to Attachment A-2, "HHSC EPO Managed Care Contract Terms and Conditions," Article 5, "Member Eligibility and Enrollment," for a description of the Member eligibility requirements for the EPO Program and the CHIP Perinatal Program.

In both the EPO Program and the CHIP Perinatal Program, a potential member's permanent legal residence must be located within the EPO's service area. Any interpretation of membership eligibility and effective dates is made by the Administrative Services Contractor with administrative review by HHSC on appeal and may include retroactive membership and effective date determinations because of administrative error, reversed appeals or other administrative action. There are rare instances when an emancipated minor may qualify for CHIP.

8.1.1.2 Enrollment

HHSC makes no guarantees or representations to the EPO regarding the number of eligible Members who will ultimately be enrolled into the EPO health services plan. The Administrative Services Contractor will electronically transmit to the EPO new Member information and change information applicable to active Members on the Cut-off Date. The EPO must accept all CHIP-enrolled persons without regard to the Member's health status or any other factor. There is no retroactive enrollment in CHIP.

8.1.1.3 Re-enrollment

Section 8.1.1.3 modified by Version 1.4

At the beginning of the tenth month of coverage, the Administrative Services Contractor will send a notice to the family outlining the next steps for renewal or continuation of coverage. To promote continuity of care for children eligible for re-enrollment, the EPO

may facilitate re-enrollment through reminders to Members and other appropriate means. Failure of the family to respond to the Administrative Services Contractor's renewal notice will result in disenrollment from the plan and from CHIP.

8.1.1.4 Disenrollment due to loss of eligibility

For those Members who are disenrolled because they are no longer eligible for CHIP, the EPO will receive from the Administrative Services Contractor notice informing the EPO that the Members' coverage will end on a particular date. Disenrollment due to loss of eligibility includes, but is not limited to:

- "Aging-out" when a child turns nineteen.
- Failure to re-enroll at the conclusion of the six-month eligibility period.
- Change in health insurance status, such as a child enrolling in the CHIP Premium Assistance Program.
- An employer-sponsored health plan.
- Failure to meet monthly cost-sharing obligation.
- Death of a child.
- The child permanently moves out of the state.
- Data match with the Medicaid system indicates dual enrollment in Medicaid and CHIP.
- Data match conducted under authority of states indicates third party-coverage.

If a child is disenrolled from CHIP, the child loses his or her CHIP eligibility and must re-apply for a determination of CHIP eligibility in the future.

Regardless of the reason for retroactive disenrollment, recoupment of premium payments by HHSC shall be in accordance with the Contract.

8.1.1.5 Cost Sharing

Section 8.1.1.5 modified by Versions 1.3 & 1.4

The CHIP administrative contractor notifies health plans of enrolled families who are no longer subject to cost sharing requirements to ensure the co-payment obligation is suspended.

Cost-Sharing does not apply to the CHIP Perinatal Program.

8.2 Operations Requirements

8.2.1 General Operations Requirements

8.2.1.1 Overview

This subsection presents the operations responsibilities for providing the covered health care benefits.

- **Pharmacy Carve-out** - In general, pharmacy benefits are not the responsibility of the EPO. These benefits are provided through the Medicaid Vendor Drug Program. The EPO should consult Attachment B-2 and the attached list of durable medical equipment benefits for clarification.

8.2.1.2 Business Objective

To provide health care services to all CHIP Members as stated in the RFP to the satisfaction of the State.

8.2.1.3 System Support Requirements

The EPO will ensure all hardware and software used to support operations under this RFP complies with all requirements associated with the Health Insurance Portability and Accountability Act (HIPAA), as amended.

Section 8.2.1.3 modified by Version 1.3

The EPO must be capable of exchanging CHIP EPO Program and CHIP Perinatal Program Member data with the Administrative Services Contractor, the External Quality Review Organization, the Third Party Liability (TPL) contractor, and the Office of Inspector General at HHSC.

8.2.1.4 State Responsibilities

The State reserves the right to waive the review and approval of EPO work products. State approval of the EPO's work product will not relieve the EPO of liability for errors and omissions in the work product.

The State, will:

GOS –1 Collect from Members any contributory portion of the Premium and pay to the EPO the monthly Premiums specified in the contract for all enrolled Members, as reported to the EPO.

GOS –2 The State or the Administrative Services Contractor will furnish the EPO with enrollment information and all data necessary to accurately pay Benefits.

GOS-3 Approve all Member Materials prior to use by the EPO, including the Certificate of Coverage.

8.2.1.5 EPO Responsibilities

The EPO must:

GOC-1 Not impose any pre-existing condition limitations or exclusions or require Evidence of Insurability to provide coverage to any CHIP-eligible child.

GOC-2 The EPO must provide full coverage for each Member beginning the first day of the month following the child's enrollment unless enrollment occurs after the monthly cut-off date, in which case coverage begins the first day of the

following month. Full coverage must be provided 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
- any other reason.

The EPO is not liable for cost incurred in connection with health care rendered prior to the date of the Member's enrollment in the EPO.

GOC-4 The EPO must indemnify and hold harmless CHIP Members, HHSC, and the State of Texas from and against any and all damages, claims, lawsuits, settlements, judgments, costs, penalties, and expenses, including attorney's fees, for injury (including death) or damage to any person resulting or alleged to result from the refusal or inability of the EPO or any health care provider to provide health care services or from the negligent provision of such health care services by the EPO or any health care provider.

GOC-5 The EPO must not practice discriminatory selection, or encourage segregation, among the total group of eligible CHIP Members by excluding, seeking to exclude, or otherwise discriminating against any group or class of individuals.

GOC-6 **Subrogation of Benefits (TPR**) - To be eligible for CHIP, a child must not be covered by creditable health insurance for at least 90 days. However, a CHIP-eligible child 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 CHIP Member is entitled to coverage for specific services payable under another insurance plan and the Member's EPO paid for the services, the EPO may obtain reimbursement not to exceed 100% of the value of benefits paid.

GOC-7 Pay for or reimburse for all Covered Services provided to Members for whom the EPO is paid a premium.

Section 8.2.1.5, GOC-8 modified by Version 1.3

GOC-8 Covered benefits are subject to change due to changes in federal law, changes in CHIP policy, and responses to changes in medical practice, clinical protocols, or technology. If covered benefits change, the change will be the subject of a change order as provided in Section 10 of the RFP. Any proposed change in the scope of covered benefits will be made through a Change Order as described in Section 10 of the RFP. Any change in benefits that affects the **Attachment B-6** will not become effective until approved by the Texas Department of Insurance.

GOC-9 Coverage for benefits will be available to enrolled Members through the selected EPO effective on the mutually agreed upon Operations Start Date.

GOC-10 The EPO must have a policy, subject to HHSC approval, that prohibits the employment of or contracting with individuals or entities who have been convicted of a criminal offense related to health care, who have been excluded from the Medicare or Medicaid program, or who are listed as ineligible to participate in Federally or State funded health care programs.

Section 8.2.1.5, GOC-11 modified by Version 1.3

GOC-11 A description of CHIP EPO Program Covered Services and exclusions is provided in Attachment B-2. A description of CHIP Perinatal Program Covered Services and exclusions is provided in **Attachment B-2.1 of the Contract**.

8.2.1.5.1 Case Management Services for Children with Special Health Care Needs

The EPO must:

Section 8.2.1.5.1, CMC-1 modified by Version 1.3

- CMC – 1 For the CHIP EPO Program, develop a documented plan for identifying and tracking the services of CHIP-eligible children with special health care needs (CSHCN), identifying methods and data sources. This plan must be approved by HHSC. The EPO must revise the plan for the CHIP Perinatal Program, to document how it will document and track services provided to CHIP Perinate Newborns. Such revised plan must be approved by HHSC.

  A child, a child's family, a health care provider, the CHIP administrative contractor, or the EPO may identify a CSHCN with a potential need for enhanced case management. EPO must contact the family of a child identified as potentially needing enhanced case management within 20 days. The purpose of the contact is to initiate outreach to identify families wanting enhanced case management and/or other EPO services as available (such as disease management programs). Outreach methods can include HHSC-approved surveys, needs assessments, or other methods. EPO can contact families through telephone or mail, and must follow up within 30 days with families not responding to initial contact. Documentation on outreach activities must be available to HHSC upon request. Documentation must include the following:

  - Number and percent of Members contacted
  - Number and percent responding to contact
  - Number and percent completing outreach tool
  - Number and percent accepting case management
  - Number and percent referred to other health plan programs (such as disease management)

  CSHCN are eligible for case management services beyond the scope normally provided to other CHIP-eligible children. The EPO must provide the following enhanced case management services, as appropriate, if the family wants the services:

  - Outreach and Informing - The EPO must discuss covered services,

including specialty services, the family's right to select a specialist as a primary care provider, out-of-network emergency services, the availability of enhanced care management, and community referrals.

- Enhanced Care Management - CSHCNs, their families, or their health providers may request enhanced care management from the EPO. The EPO must furnish a care coordinator when requested. The EPO may also recommend to the CSHCN's family that a care coordinator be furnished if the plan determines that care management would benefit the child. Care coordinators are responsible for working with CSHCN, their families and their health care providers to develop a seamless package of care in which primary, acute and specialty service needs are met through a single, understandable and rational plan. If the family agrees, a written plan must be updated at least annually. The care coordinator will coordinate all services with a provider and, as necessary, with the child's pediatric specialty care physician. The care coordinator also makes referrals for other community services provided on a value-added basis.
- Community Referrals - The EPO must make a best effort to implement a systematic process to enlist the involvement of community organizations that may not be providing CHIP covered services but are otherwise important to the health and well being of CHIP Members. The EPO also must make a best effort to establish relationships with these community organizations in order to make referrals for CSHCN and other children who need community services. These organizations may include, but are not limited to:
    - Early Childhood Intervention Program (512/424-6745).
    - Department of Mental Health and Mental Retardation (MHMR) (512/206-4830).
    - Texas Department of Health (TDH) Title V Program (512/458-7321)
    - Local School District (Special Education).
    - Other state and local agencies and programs with jurisdiction over children's services, including food stamps, Women, Infants, and Children's (WIC) Program.
    - Texas Information and Referral Network.
    - Texas Commission for the Blind (TCB).
    - Child-serving civic and religious organizations and consumer and advocacy groups, such as United Cerebral Palsy, that also work on behalf of the CSHCN population.

8.2.1.5.2 Network Oversight and Key Personnel

The EPO is responsible for the development, approval, implementation and enforcement of administrative, operational, personnel and patient care policies and procedures. The Vendor must provide a full time chief executive officer or operations officer and at least one full time medical director unless approved by HHSC. The Vendor must:

- demonstrate to TDI the ability to provide continuity, accessibility, availability and quality of services.
- provide a complete physician and provider listing for all CHIP Members eligible for benefits

The EPO must comply with Article 4 of the HHSC EPO Managed Care Contract Terms and Conditions, regarding Key Personnel requirements.

8.2.1.5.3 Provider Services

The EPO must:

Section 8.2.1.5.3, PSC-1, modified by Versions 1.3 and 1.6

PSC-1 Operate a toll-free provider hotline staffed with personnel who are knowledgeable about CHIP EPO Program and CHIP Perinatal Program and the covered health care services. The phone line must be available for Providers from 8:00 AM to 5:00 PM Monday through Friday, (in the time zone of the Service Area(s) where the EPO provides Covered Services), excluding State-approved holidays.

PSC-2 Ensure that after hours and on weekends and holidays the line is answered by an automated system with the capability to provide callers with operating hours. The calls received must be returned the next working day.

PSC-3 Ensure that the toll-free line meets the following minimum performance requirements:

Section 8.2.1.5.3, PSC-3, modified by Versions 1.3 & 1.4.

- 99% of calls are answered by the fourth ring or an automated call pick up system is used.
- No more than one percent of incoming calls receive a busy signal.
- The average hold time is 2 minutes or less.
- Call abandonment rate is 7% or less.
- EPO staff is knowledgeable and helpful.
- EPO conducts ongoing call quality assurance.
-

PSC-4 Annual traffic studies are completed to assess the need for additional lines.

PSC-5 The provider hotline must have an automated response option in which Providers may enter a child's unique Member ID number and receive the following information:

- Verification of a child's membership in CHIP.

- The child's begin and end dates of coverage.
- This information must also be available through a fax-back capability.

PSC-6 EPO staff answering provider calls must be able to search for eligibility and enrollment information by a variety of fields. The staff must be able to answer questions about the health care claims process and confirm the status of a pending claim. The staff must be able to answer questions about enrollment as a health care claims provider and facilitate that enrollment process.

Section 8.2.1.5.3, PSC-7, modified by Version 1.2

PSC-7 Submit a quarterly report to HHSC summarizing call center performance for the provider toll-free line, in accordance with the requirements set forth in Attachment B-1 to the EPO Managed Care Contract, §8.2.3.7.1, Task RRC-9.

Section 8.2.1.5.3, PSC-7.5, added by Version 1.5

PSC-7.5 If HHSC determines that it is necessary to conduct onsite monitoring of the EPO's Provider Hotline functions, the EPO is responsible for all reasonable costs incurred by HHSC or its authorized agent(s) relating to such monitoring.

PSC-8 The EPO agrees to make its best efforts to recruit and maintain an adequate provider base throughout the CSA and these best efforts will be ongoing through the term of the Contract. HHSC agrees that no provider quota, either in the aggregate or in relation to a particular area of the state, will be imposed through the Contract.

Section 8.2.1.5.3, PSC-9, modified by Version 1.3

PSC-9 The EPO must develop, implement and maintain a system for tracking and resolving provider Complaints and Appeals related to the denial of payment. Within this process, any contractor must respond fully and completely to each appeal and establish a tracking mechanism to document the status and final disposition of each appeal. The EPO must resolve provider complaints or appeals within 30 days from the date the complaint or appeal is received. Provider Complaints and Appeals are subject to disposition consistent with any applicable insurance law or Texas Department of Insurance regulations.

PSC-10 Maintain a provider services program consistent with the needs of the Texas CHIP professional health care providers and HHSC.

PSC-11 Develop and submit the initial provider directory template to HHSC for approval 60 days prior to implementation. If the EPO divides the state into more than one area for the purpose of publishing separate provider directories, HHSC must approve the coverage stipulated in each provider directory.

PSC-12 Provider directories will be updated quarterly, unless there are more than 300 additions and/or deletions to the directories.

PSC-13 At any time, if the update exceeds 300 additions and/or deletions, a revised directory will be printed.

PSC-14 Three months post-implementation, the EPO will mail a revised directory to all current Members and new Members that reflects the Network as it exists 15 days prior to the mailing date. Thereafter, EPO will publish quarterly directories. These directories will be provided to all new Members. Additionally, directories will be sent to existing members upon request.

PSC-15 The EPO must meet the weight limit requirements established by HHSC for the mailing of the directories by the Administrative Services Contractor. If the EPO exceeds the weight limit, the EPO will be subject to actual damages of the extra expense for the Administrative Contractor to mail the directories.

8.2.1.5.4 Network Requirements

Section 8.2.1.5.4 modified by Versions 1.3 and 1.4

All Network Providers must be licensed in the State of Texas to provide services and must be in good standing and have no restrictions on their license. Network Providers must not have been excluded or be under sanction status by the Medicaid or Medicare program. The written provider contract may be through an intermediary group or groups, such as an Independent Physicians Association (IPA) or Approved Non-Profit Health Corporations 5.01(a)s. The EPO must comply with the following Network requirements:

Access and Availability

An EPO is required to meet the accessibility and availability requirements described below. Out–of-network emergency services must be provided consistent with the requirements of Texas Insurance Code art. 20A.04(16). Other out-of-network standards are described below. An EPO that complies with these requirements meets the CHIP minimal standards. An EPO is not responsible for payment for unauthorized non-emergency services provided to a Member by out-of-network providers.

Network Services

In general, all covered services must be available to the EPO's enrolled CHIP Members on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted practice parameters.

PHYSICIAN SERVICES. There shall be a sufficient number of participating physicians, pediatricians and pediatric specialists to meet the needs of CHIP Members.

The CHIP EPO also must seek to obtain the participation of Providers for CHIP Perinate Members. The CHIP EPO is encouraged to obtain the participation of Obstetricians/Gynecologists (OB/GYNs), Family Practice Physicians with experience in prenatal care, or other qualified health care providers as CHIP Perinate Providers.

An adequate number of participating physicians shall have admitting privileges at one or more participating general hospitals located within the EPO's Network to assure that necessary admissions are made.

The EPO must contract with physicians so that Primary Care Providers are available and accessible 24 hours per day, seven days per week, within the EPO's Network. There shall be a sufficient number of specialists with appropriate hospital admitting privileges that are available and accessible 24 hours per day, seven days per week, to meet the needs of the EPO's enrolled CHIP Members. For the CHIP Perinatal Program, the EPO is not required to establish PCP Networks for CHIP Perinates, and Perinatal Newborns are assigned PCPs that are part of the CHIP EPO Program PCP Network.

The EPO shall develop a method by which the enrolled CHIP Members may secure health care services after hours, which shall be clearly communicated in writing to CHIP

enrolled Members in the languages predominantly spoken in the service area.

All Members must be allowed to (1) select an in-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.

SPECIAL NEEDS CHILDREN'S SERVICES. The EPO must ensure that children with special health care needs (CSHCN) have access to treatment by a multidisciplinary team when determined to be medically necessary for effective treatment, or to avoid separate and fragmented evaluations and service plans. The teams must include both physician and non-physician Providers.

The EPO must assure adequate access of all Members to children's hospitals and pediatric health care centers with recognized special expertise in the care of CSHCN to meet patients' health care needs as documented in their medical records. TDH-approved pediatric transplant centers and federally qualified hemophilia centers are examples. The EPO may be required to make out-of-network reimbursement arrangements for treatment in these hospitals or centers if the Covered Services are not available through Network Providers.

POLICIES AND PROCEDURES. The EPO must require that physicians and other Providers under contract with the EPO who employ physician assistants, advanced practice nurses, and individuals other than physicians to assess the health care needs of CHIP Members to have written policies which are implemented and enforced and describe the duties of all such Providers in accordance with statutory requirements for licensure, delegation, collaboration, and supervision as appropriate.

APPOINTMENTS. Waiting times to obtain appointments for the following types of care must be provided as follows:

- Routine care within two weeks of appointment request
- Urgent care shall be provided within 24 hours of contact by the CHIP Member or a person acting on behalf of the CHIP Member;
- Preventive health services shall be offered to a child within two months.

INPATIENT HOSPITAL AND MEDICAL SERVICES. EPO must contract with hospitals so that:

- General hospitals are available and accessible 24 hours per day, seven days per week, within the EPO Network;
- Special hospitals, and, if necessary, other general hospitals are available and accessible 24 hours per day, seven days per week, within the Vendor's EPO Network.

General and special hospitals, under contract with an EPO must have current licenses by the State of Texas, unless exempt from licensure requirements.

DIAGNOSTIC AND THERAPEUTIC SERVICES. Laboratories under contract with the EPO must meet the requirements of Federal Public Law 100-578, Clinical Laboratory Improvement Amendments of 1988 (CLIA 1988). CLIA 1988 applies to all laboratories that examine human specimens for the diagnosis, prevention or treatment of any disease

or impairment of, or the assessment of the health of, human beings. Laboratories under contract with the EPO must be in good standing with licensing entities in the state and must not have any restrictions on their licenses or be under sanction or exclusion from the Medicaid program.

The reference laboratory services shall be of sufficient size and scope to meet the non-emergency and emergency needs of the enrolled population. Reference laboratory specimen procurement services shall facilitate the provision of clinical diagnostic services for physicians, Providers, CHIP Members through the use of convenient reference satellite labs, strategically located specimen collection areas, and the use of a courier system under the management of the reference lab.

Pathology laboratory services shall be available and accessible.

The EPO must contract with providers so that diagnostic imaging services shall be available and accessible to all CHIP EPO Members and such Providers must meet the following standards:

Diagnostic imaging procedures that require the injection or ingestion of radiopaque chemicals must be performed only under the direction of physicians qualified to perform those procedures.

Diagnostic imaging machines must be registered and inspected according to state law.

Technicians, physicians, and other personnel who work with imaging machines must comply with state law regarding monitoring.

The EPO must contract with providers so that services involving therapeutic/oncological radiology shall be available and accessible to all CHIP EPO Members.

The EPO must contract with providers so that other covered diagnostic and therapeutic services shall be available and accessible to all CHIP EPO Members.

OTHER SERVICES. The EPO must contract with providers so that the following services shall be available and accessible to the enrolled population within the EPO Program and CHIP Perinatal Program Network.

HOME HEALTH CARE. Contracts with licensed home and community support services agencies or their licensed branches may provide one or a combination of the following services:

- licensed and certified home health services;
- licensed home health services;
- licensed home health services with home dialysis designation; and
- personal assistance services.

TRAUMA. The EPO must assure access to Texas Department of Health (TDH) designated Level I and Level II trauma centers within the State or hospitals meeting the equivalent level of trauma care. The EPO may make out-of-network reimbursement arrangements with the TDH-designated Level I and Level II trauma centers.

EMERGENCY SERVICES. For the CHIP EPO Program, refer to Attachment B-2 for a description of emergency services for Members. For the CHIP Perinatal Program, refer

to Attachment B-2.1 for description of emergency services for CHIP Perinates and CHIP Perinate Newborns.

Out-of-Network Services

The EPO must provide in its policy or certificate that if medically necessary covered services are not available through Network physicians or Providers, the EPO must, upon the request of a Network physician or 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 business days after receipt of reasonably requested documentation, allow a referral to a non-network physician or provider and must fully reimburse the non-network provider at the usual and customary or an agreed upon rate. The covered child will not be responsible for any payment other than stated co-payments or deductibles.

Each policy or certificate must further provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the EPO may deny such a referral.

Access Standards

MONITORING ACCESS. The EPO is required to systematically and regularly verify that health care services furnished by physicians and Providers are available and accessible to EPO Members without unreasonable periods of delay.

REPORTING. The EPO must develop and maintain a statistical reporting system which allows for compiling, developing, evaluating, and reporting statistics relating to the cost of operation, the pattern of utilization of Providers of covered benefits, and the availability and accessibility of Providers.

TELEMEDICINE. Each policy or certificate delivered or issued for delivery by an EPO may provide the EPO Members the option to access covered health care services through telemedicine.

Before providing telemedicine services to an EPO Member, the EPO shall provide the EPO Member with the option to select a physician or provider within the EPO's Network to provide the covered health care services, or to elect to receive telemedicine services. In order to provide covered health care services to any EPO Member by telemedicine, the EPO must satisfy the criteria specified above.

Special Providers

The EPO must seek to obtain the participation in its Provider Network of:

- Significant traditional providers, defined by the Texas Health and Human Services Commission as contracted providers currently serving the CHIP population (a list of STPs will be posted to the HHSC website in a timely manner after the release of this RFP);
- The tribal health clinics located near El Paso, Eagle Pass, and Livingston.

8.2.1.5.5 Behavioral Health (BH) Network and Services

Section 8.2.1.5.5 modified by Versions 1.2, 1.3, and 1.5

The EPO must provide, or arrange to have provided to Members except CHIP Perinates 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 this RFP. When assessing Members for BH Services, the EPO 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.

BH Provider Network

The EPO must maintain a Behavioral Health Services Provider Network that includes psychiatrists, psychologists and other Behavioral Health Service Providers. The Provider Network must include Behavioral Health Service Providers with experience serving special populations among the EPO Program's enrolled population to ensure accessibility and availability of qualified Providers to all Members in the Service Area.

Member Education and Self-referral for Behavioral Health Services

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

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

The EPO 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 in-Network Providers with relevant experience.

Behavioral Health Services Hotline

The EPO must have an emergency and crisis Behavioral Health Services Hotline available 24 hours a day, 7 days a week, toll-free throughout the Service Area as described in **Section 8.2.1.12** of this RFP. 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 EPO 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 EPO must ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for the CHIP EPO Program:

- 99% 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% of calls must be answered by toll-free line staff within 30 seconds~~;~~ after being initially answered by an automated call pick-up system;

- the call abandonment rate is 7% or less; and
- the average hold time is 2 minutes or less.

The EPO must conduct on-going quality assurance to ensure these standards are met.

The EPO must monitor its performance against the Behavioral Health Services Hotline standards and submit quarterly performance reports summarizing call center performance, in accordance with the requirements set forth in the **Uniform Managed Care Manual** and Attachment B-1 to the EPO Managed Care Contract, §8.2.3.7.1, Task RRC-9.

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

Coordination between the BH Provider and the PCP

The EPO 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 EPO must provide training to Network PCPs on how to screen for and identify behavioral health disorders, the EPO's referral process for Behavioral Health Services and clinical coordination requirements for such services. The EPO 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 EPO shall develop and disseminate policies regarding clinical coordination between Behavioral Health Service Providers and PCPs. The EPO 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 Provider Manuals.

The EPO must require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement must be specified in all Provider Manuals.

Follow-up after Hospitalization for Behavioral Health Services

The EPO 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 days from the date of discharge. The EPO must ensure that Behavioral Health Service Providers contact Members who have missed appointments within 24 hours to reschedule appointments.

Chemical Dependency

The EPO 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.

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 EPO must provide inpatient 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 EPO is not obligated to cover placements as a condition of probation, authorized by the Texas Family Code.

The EPO cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court-ordered Commitment for Members under age 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.

Local Mental Health Authority (LMHA)

The EPO 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.

8.2.1.5.6 Disease Management (DM)

Section 8.2.1.5.6 modified by Versions 1.3 and 1.5

The EPO 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 person-based approach to DM and holistically address the needs of persons with multiple chronic conditions. The EPO must develop and implement DM services that relate to chronic conditions that are prevalent in Members. The EPO must develop a DM Program that address the chronic conditions identified in HHSC's **Uniform Managed Care Manual** and implement the program during the second year of the Contract. HHSC will not identify-individual Members with chronic conditions.

The EPO 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 EPO 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 in the **Uniform Managed Care Manual**. The EPO 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 EPO and who require DM services,

the EPO must evaluate and ensure continuity of care with any previous DM services in accordance with the requirements in the **Uniform Managed Care Manual**.

The DM Program(s) must include:

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

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

The EPO must provide designated staff to implement and maintain DM Programs and assist participating Members in accessing DM services. The EPO must educate Members and Providers about the EPO's DM Programs and activities.

DM Services and Participating Providers

At a minimum, the EPO must:

1 implement a system for Providers to request specific DM interventions;

2. give Providers information, including differences between recommended prevention and treatment and actual care received by Members enrolled in a DM Program, and information concerning such Members' adherence to a plan of care; and

3. For Members enrolled in a DM Program, provide reports on changes in a Member's health status to their PCP.

EPO DM Evaluation

HHSC or its EQRO will evaluate the EPO's DM Program.

8.2.1.5.7 Provider Contract Requirements

The Vendor's contract with health care Providers must comply with the requirements of **HHSC's Uniform Managed Care Manual**.

8.2.1.5.8 Provider Reimbursement

The EPO must:

PRC-1 Pay for benefits provided to all CHIP Members for whom the EPO is paid a premium.

PRC-2 The EPO is required to do back-up withholding from all payments to Providers who fail to give tax identification numbers or who give incorrect numbers.

8.2.1.5.9 Dental Coverage for CHIP Members and CHIP Perinate Newborn Members

Section 8.2.1.5.9 added by Version 1.7

The EPO is not responsible for reimbursing dental providers for preventive and therapeutic dental services obtained by CHIP Members or CHIP Perinate Newborn Members. However, medical and/or hospital charges, such as anesthesia, that are necessary in order for such Members to access standard therapeutic dental services, are Covered Services. The EPO must provide access to facilities and physician services that are necessary to support the dentist who is providing dental services to a CHIP Member or a CHIP Perinate Newborn Member under general anesthesia or intravenous (IV) sedation.

The EPO must inform Network facilities, anesthesiologists, and PCPs what authorization procedures are required, and how Providers are to be reimbursed for the preoperative evaluations by the PCP and/or anesthesiologist and for the facility services. For dental-related medical Emergency Services, the EPO must reimburse Network and Out-of-Network Providers in accordance with federal and state laws, rules, and regulations.

8.2.1.5.10 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Section 8.2.1.5.10 added by Version 1.7

On or after October 1, 2009: The EPO is required to pay the full encounter rates as determined by HHSC to FQHCs and RHCs for dates of services occurring on or after October 1, 2009.

8.2.1.6 Claims Processing Requirements

8.2.1.6.1 EPO Responsibilities

Section 8.2.1.6.1 modified by Versions 1.2 and 1.4

The EPO must process all provider claims and must pay all claims for Medically Necessary Covered Services that are filed within the time frames specified by this Section.

The EPO must administer an effective, accurate, and efficient claims payment process in compliance with state and federal laws, rules and regulations, the Contract, and, except as provided below the **Uniform Managed Care Manual.**

The EPO must maintain a claim retrieval service processing system that can identify date of receipt, action taken on all provider claims or Encounters (i.e., paid, denied, pended, appealed, other), and when any action was taken in real time.

All provider claims that are clean and payable must be paid within 30 days from the date of claim receipt.

The EPO 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.

Effective September 1, 2006, the EPO is subject to remedies, including liquidated damages, if within 30 days of receipt, the EPO does not process and finalize to a paid or denied status 98% of all Clean Claims. The EPO is subject to remedies, including liquidated damages, if within 90 days of receipt, the EPO does not process and finalize to a paid or denied status 99% of all Clean Claims.

The EPO is subject to remedies, including liquidated damages, if the EPO does not pay providers interest at an 18 % annual rate, calculated daily for the full period in which the Clean Claim remain unadjudicated beyond the 30-day claims processing deadline. The EPO may negotiate Provider contract terms that indicate that duplicate claims filed prior to the expiration of 31 days would not be subject to the 18 % interest payment if not processed within 30 days.

The EPO must not pay any claim submitted by a provider excluded or suspended from the Medicare, Medicaid, CHIP programs for Fraud, Abuse, or Waste. The EPO 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.

Claims pended for additional information must be closed (paid or denied) by the 30th day following the date the claim is pended if requested information is not received prior to the expiration of 30 days (see the **Uniform Managed Care Manual**, Chapter 2). The EPO must send Providers written notice for each claim that is denied, including the reason(s) for the denial, the date the EPO received the claim, and the information required from the provider to Adjudicate the claim.

The EPO must process and adjudicate all provider claims for Medically Necessary Covered Services within the time frames specified in the **Uniform Managed Care Manual.**

The EPO 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 EPO/Provider contract. The EPO must make available to Providers claims coding and processing guidelines for the applicable provider type. Providers must receive 90 days notice prior to the EPO's implementation of changes to claims guidelines.

The EPO may deny a claim for failure to file timely if a Provider does not submit claims to the EPO within 95 days of the date of service. If a provider files with the wrong EPO, or with the HHSC Administrative Services Contractor, and produces documentation verifying the initial timely claims filing within 95 days of the date of service, the EPO must process the provider's claim without denying for failure to timely file (see the **Uniform Managed Care Manual**, Chapter 2).

8.2.1.7 Member Services

The EPO must:

Section 8.2.1.7, MSC-1 modified by Version 1.3

MSC-1 Design, print and distribute Member identification cards, provider directories and policies or certificates of coverage detailing benefits and the complaint and appeals process. The materials must be available in English, Spanish, and the languages of other major population groups making up 10 % or more of the enrolled CHIP EPO Program and CHIP Perinatal Program population, as specified by HHSC. English and Spanish text must appear together within the same document rather than as separate documents.

MSC-2 Member materials must be submitted to HHSC for approval prior to use or mailing by the EPO. Within 15 business days HHSC will identify any required changes to the Member Material. If HHSC has not responded to the EPO by the fifteenth day, the EPO may use the submitted material.

MSC-3 All Member Materials must be available in a format accessible to the visually impaired, which may include large print, Braille, and audiotapes.

Section 8.2.1.7, MSC-4 modified by Version 1.3

MSC-4 No later than the fourth business day of the month following the receipt of an enrollment file from the Administrative Services Contractor, the EPO must mail a Member's ID card and evidence of coverage or Member handbook to the CHIP account name for each new Member. When the CHIP account name is on behalf of two or more new Members, only one provider directory and Member handbook must be sent. The EPO is responsible only for those Members for whom valid data is contained in the enrollment file. For the CHIP Perinatal Program, the EPO must issue Provider Directory and Member Handbooks to both CHIP Perinates and CHIP Perinate Newborns. The Provider Directory and Member Handbook for CHIP Perinate Newborns may be the same as that used for the CHIP EPO Program, provided they identify the differences in the Programs.

Section 8.2.1.7, MSC-5 modified by Version 1.3

Section 8.2.1.7, MSC-6 modified by Version 1.3

MSC-5 The EPO must produce for the CHIP EPO Program and CHIP Perinatal Program Members a certificate of coverage that is culturally appropriate and written for understanding at the 6th grade reading level. It must be specifically oriented to the medical needs of children. A methodology for verifying that the materials are geared to the 6th grade reading level is required.

MSC-6 The CHIP EPO Program and CHIP Perinatal Program certificates of coverage must explain the covered benefits and the complaint and appeals process.

Section 8.2.1.7, MSC-7 modified by Version 1.3

MSC-7 The CHIP EPO Program and CHIP Perinatal Program certificates of coverage, in addition, must contain any additional information necessary for a Member to fully access the covered benefits.

MSC-8 If the scope of benefits changes, the EPO must produce a new certificate of coverage within the timeframe specified by HHSC in its notification of change. Notice of the change(s) must also be sent to all current Members within the timeframe specified in HHSC's notification of the change.

MSC-9 The CHIP Administrative Services Contractor must handle all disenrollments. The EPO is not allowed to discuss, induce or accept disenrollment from a CHIP Member except to refer to the CHIP Administrative Services Contractor.

MSC-10 In the event the EPO terminates its contract with a health care provider, the EPO must provide timely written notification, as defined by the Texas Insurance Code and TDI regulations, to affected Members.

Section 8.2.1.7, MSC-11 modified by Version 1.3

MSC-11 **Cost-Sharing Administration** – For the CHIP EPO Program, families that meet the annual cost share limit requirement report it to the CHIP administrative contractor. (Cost-sharing does not apply to the CHIP Perinatal Program.) The administrative contractor notifies the EPO the families cost share limit has been reached. The EPO must then issue a new Member's ID card, which reflects the new copay requirements.

MSC-12 **CHIP-Specific Internet Website –**The EPO 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 plan, its Provider Network, its customer services, and its Complaints

Section 8.2.1.7, MSC-12 Modified by Versions 1.4 and 1.6

and Appeals process. The site's content must be: written in English and Spanish and in other languages specified by HHSC; culturally appropriate; written for understanding at the 6th grade reading level; and be geared to the health needs of children, including those with special needs. The EPO must ensure that Members have access to the most current and accurate information concerning the EPO's Network Provider participation. To comply with this requirement, at least twice per month the EPO 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 EPO must list Home Health Ancillary providers on its website, with an indicator for Pediatric services if provided. The EPO's website must receive prior approval from HHSC. The EPO may develop a CHIP page within its existing website to meet the requirements of this section.

The standards and approach used to develop and operate the CHIP website must recognize that many applicant families or community based organizations will be using computers that are two or more years old with browsers and modems that are several generations behind current standards. To minimize download and "wait times," the CHIP 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 will not be allowed. Tools that take advantage of efficient data access methods and reduce the load on the server or bandwidth will be strongly encouraged.

Section 8.2.1.7, MSC-13 modified by Version 1.3

MSC-13 The EPO must maintain provider directories on the CHIP website with designation of PCPs with open vs. closed panels.

Section 8.2.1.7, MSC-14 Modified by Versions 1.3 and 1.6

MSC-14 The EPO must operate a separate toll-free hotline that Members can call 24 hours a day, seven (7) days a week. The Member hotline must be staffed with personnel who are knowledgeable about CHIP EPO Program and the CHIP Perinatal Program and the covered health care benefits between the hours of 8:00 a.m. to 5:00 p.m., (in the time zone of the Service Area(s) where the EPO provides Covered Services), Monday through Friday, excluding State-approved holidays.

MSC-15 The EPO must ensure that its Member service representatives treat all callers with dignity and respect the callers' need for privacy. At a minimum, the EPO's Member service representatives must be:

- Knowledgeable about the scope of the health care benefits;
- Able to give correct cost-sharing information relating to co-pays or deductibles;
- Able to answer questions pertaining to referrals or the process for receiving authorization for special procedures or services;
- Able to give information about health care 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 of the program;

- Trained regarding cultural competency; and
- Trained regarding the process used to confirm the status of children with special health care needs.

MSC-16 The EPO will be expected to process all incoming correspondence and telephone inquiries in a timely and responsive manner.

MSC-17 Ensure that after hours and on weekends and holidays the line is answered by an automated system with the capability to provide callers with operating hours. All recordings must be in English and in Spanish. Calls received by the automated system must be returned on the next working day.

MSC-18 Ensure that the toll-free line meets the following minimum performance requirements:

Section 8.2.1.7, MSC-18 Modified by Versions 1.4 and 1.6

- 99% of calls are answered by the fourth ring or an automated call pick up system is used.
- No more than one percent of incoming calls receive a busy signal.
- At least 80% of calls must be answered by a live person within 30 seconds.
- Call abandonment rate is 7% or less.
- Average hold time is 2 minutes or less.
- EPO staff is knowledgeable and helpful.
- EPO conducts ongoing call quality assurance.
- Annual traffic studies are completed to assess the need for additional lines.

MSC-19 The EPO must appropriately handle calls from non-English speaking (and particularly Spanish-speaking) callers, as well as calls from individuals who are deaf or hard-of-hearing. To meet these requirements, the EPO may secure the services of other vendors such as the Texas Relay or the AT&T language line.

Section 8.2.1.7, MSC-20, modified by Version 1.2

MSC-20 Submit a quarterly report to HHSC summarizing call center performance for the Member toll-free line, in accordance with the requirements set forth in Attachment B-1 to the EPO Managed Care Contract, §8.2.3.7.1, Task RRC-9.

Section 8.2.1.7, MSC-20.5, added by Version 1.5

MSC-20.5 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.

MSC-21 The EPO must monitor the standards regarding the Member services standards and submit monthly performance reports. Failure to meet the standards will subject the EPO to the remedies, including those specified in **Attachment B-4, Tailored Remedies Matrix**.

MSC-22 **Member Education -** Each EPO must propose Member education activities. Such activities must include:

- Basic education about accessing services and using the plan;
- Innovative strategies for meeting wellness care and immunization standards, as well as health promotion and prevention.

MSC-23 The EPO must develop, implement and maintain a system for tracking and resolving Member Complaints and Appeals regarding its services, processes, procedures, and staff. Within this process, the EPO must respond fully and completely to each appeal and establish a tracking mechanism to document the status and final disposition of each appeal. Member Complaints and Appeals are subject to disposition consistent with any applicable insurance law or Texas Department of Insurance regulations.

Any person, including those dissatisfied with an EPO's resolution of a complaint or appeal, may report an alleged violation to TDI. TDI must investigate a complaint to determine EPO compliance with the law within 60 days after TDI receives the complaint and all the information needed to determine compliance. TDI may extend the 60-day period if additional information is needed, on-site review is necessary, or circumstances beyond TDI's control require the delay.

Section 8.2.1.7, MSC-24 added by Version 1.3

MSC-24 Member Complaints and Appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. HHSC will require the HMO to resolve Member Complaints and Appeals (that are not elevated to TDI) within 30 days from the date the Complaint or Appeal is received. The EPO is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints or Appeals are not resolved within 30 days of receipt of the Complaint or Appeal by the EPO. Please see the **Uniform Managed Care Contract Terms & Conditions** and **Attachment B-4, Tailored Remedies Matrix.** Any person, including those dissatisfied with the EPO's resolution of a Complaint or Appeal, may report an alleged violation to TDI.

8.2.1.8 Early Childhood Intervention (ECI)

Section 8.2.1.8 added by Version 1.5

The EPO must ensure that Network Providers are educated regarding their responsibility under federal laws (e.g., 20 U.S.C. §1435 (a)(5); 34 C.F.R. §303.321(d)) to identify and refer any Member age three (3) or under 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 EPO 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 EPO must contract with qualified ECI Providers to provide ECI services to Members under age three who have been determined eligible for ECI services. The EPO must

permit Members to self refer to local ECI Service Providers without requiring a referral from the Member's PCP. The EPO's policies and procedures, including its Provider Manual, must include written policies and procedures for allowing such self-referral to ECI providers.

The EPO 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 EPO 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 EPO must require compliance with these requirements through Provider contract provisions. The EPO must not withhold authorization for the provision of such medical diagnostic procedures. The EPO must promptly provide to the ECI program, relevant medical records available to the EPO. The interdisciplinary team will determine Medical Necessity for health and Behavioral Health Services as approved by the Member's PCP. The EPO 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 EPO must allow services to be provided by a non-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 EPO cannot modify the plan of care or alter the amount, duration, scope, or service setting required by the Member's IFSP. The EPO 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.

8.2.2 Marketing and Community Outreach

The EPO and its Subcontractors must adhere to the Marketing Policies and Procedures as set forth by HHSC in the Contract and the **Uniform Managed Care Manual**.

8.2.3 Additional Operations Requirements

8.2.3.1 Key Personnel

EPO must designate key personnel. The EPO will supply the State with an updated organization chart and staffing plan identifying each of the staff on a quarterly basis and whenever a key person is replaced. Hiring or replacement of Key Personnel must conform to all Contract requirements.

8.2.3.2 Provider Medical Record Audit and Reports

The EPO is required to conform to commonly accepted medical record standards consistent with federal protocols and have documentation on file at the EPO for review by the State or its designee during an on-site review. The EPO is required to ensure that all entries are legible to individuals other than the author, dated (month, day, and year), and signed by the appropriate person.

8.2.3.3 Quality Assurance

During the term of the Contract, the EPO shall develop ongoing performance improvement projects including the following elements:

- An evaluation of performance using objective quality indicators;
- Implementation of interventions to achieve quality improvement;
- An evaluation of the effectiveness of the interventions;
- Planning and initiation of activities for increasing or sustaining improvement;
- An evaluation of the EPO's compliance with the performance measures listed elsewhere in this RFP

The EPO will provide a written quality improvement plan (QIP) to HHSC for review and approval.

In the quality of services rendered by Providers under contract with the EPO, the EPO must develop and implement policies and procedures to ensure continuous improvement in the quality of services provided under the contract. The EPO must have a quality improvement committee, including pediatricians or other children-specific Providers, and provide to HHSC a written (QIP). The QIP must describe how the EPO will:

- Conduct physician credentialing and recredentialing;
- Provide effective peer review;
- Monitor and evaluate clinical issues;
- Assess and enhance the EPO's plan to address the needs of Children with Special Health Care Needs (CSHCN);
- Promote preventive health activities.

The EPO and HHSC will also 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 EPO improvement. To facilitate this process, the EPO will supply claims data to the EQRO in a format identified elsewhere in this RFP.

8.2.3.4 Utilization

The EPO must develop and implement policies and procedures to:

- Detect over and under utilization.
- Compare Member and Provider utilization with norms for comparable individuals.
- Track utilization control functions.
- Monitor inpatient admissions, emergency room use, ancillary and out-of-area services.
- Refer suspected cases of provider or Member fraud, abuse, or waste to the Office of Inspector General (OIG) for the Texas Health and Human Services System.
- Consult with pediatricians or other children-specific Providers to assess utilization activities.

8.2.3.5 Right to Audit

HHSC notifies EPO in writing ten business days prior to initiating a comprehensive audit (intensive review of files and documents and interviews with key staff) not resulting from a complaint. HHSC does not notify EPO for audits or evaluation activities conducted under the authority of the Office of Inspector General (OIG) for the Texas Health and Humans Services System or the State Auditor's Office. HHSC provides the EPO with written notification at least ten working days prior to any site visit at a EPO's offices (a general inspection and interview with EPO staff) not resulting from a complaint. If an on-site visit or audit is the result of a complaint against the EPO, except for complaints alleging fraud, abuse or waste, HHSC sends the EPO written notice via facsimile at least 24 hours prior to the hour the visit or audit will occur. The EPO must cooperate with the HHSC evaluation or audit process.

8.2.3.6 Fraud and Abuse Compliance Plan

Section 8.2.3.6 Modified by Version 1.6

A EPO is subject to all state and federal laws and regulations relating to Fraud, Abuse and Waste in health care and the CHIP Program. These requirements may change based on the rules to be promulgated in August 2004 related to the creation of special investigation units, as mandated by House Bill 2292 of the 78th Regular Session of the Texas Legislature. The EPO must cooperate and assist HHSC and any state or federal agency with the duty of identifying, investigating, sanctioning or prosecuting suspected Fraud, Abuse or Waste. The EPO must provide originals and/or copies of all records and information requested and 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 Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services (DHHS), Federal Bureau of Investigation, TDI, or other unit of state

government. The EPO must provide all copies of records free of charge.

The EPO must submit a written Fraud and Abuse compliance plan to Office of Inspector General at HHSC for approval each year. The plan must be submitted 60 days prior to the start of the State fiscal year. (See section 9.3.2.3.1 for requirements regarding timeframes for submitting the plan.) If the EPO 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, and (2) the plan will remain in place for the upcoming State Fiscal Year. The notification must be signed and certified by an officer or director of the EPO who is responsible for carrying out the Fraud and Abuse compliance plan. Upon receipt of a written request from the HHSC OIG, the EPO must submit the complete Fraud and Abuse compliance plan.

The EPO is subject to and must meet all requirements in Title 1 Texas Administrative Code (TAC), Part 15, Chapter 370, Subchapter F, Rule 370.501-370.505.

8.2.3.7 Administrative Performance Requirements

The EPO must track and respond to all complaints, as defined by TDI, regarding:

- The physician/patient relationship.
- Quality of medical care.
- The disposition of claims.
- Administration of benefits (for example, disagreements regarding the scope of covered benefits).
- Any other matter.

8.2.3.8 Performance Reporting

The State will require the EPO to provide periodic reports and data for use in monitoring and evaluating the CHIP health care services and the EPO's performance of its responsibilities under this Contract. The required reports are described in this and other sections of this RFP.

The State will require the EPO to provide ad hoc reports and data in addition to regular periodic reports.

Contractor shall provide reports in a format approved by HHSC. Specific Operational and Contract Management Activities reports may include the following, and will not be considered ad hoc/special reports.

8.2.3.8.1 Required Plans and Reports

The EPO must provide the following plan:

- Annual Business Plan – The annual business plan must be delivered to HHSC 45 days prior to the beginning of each fiscal year. The business plan will be an interactive and flexible working document and will be revised, with State approval, as necessary to reflect changing situations throughout the year. The plan will include:

- An outline of all major activities planned for the upcoming year.
- Business improvement objective and outcomes for the upcoming year.
- The methodology for performing activities and meeting objectives.

The EPO must provide and 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 the EPO to establish time frames and formats reasonably acceptable to both parties.
- The EPO'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.

Section 8.2.3.7.1 modified by Version 1.3

The EPO must provide and require all its subcontractors to provide the following reports, in addition to the Financial Reports described in Section 6 of this RFP and those reporting requirements listed elsewhere in the RFP. For the following reports, CHIP Perinatal Program data will be integrated into existing CHIP EPO Program reports. Generally, no separate CHIP Perinatal Program reports are required. Where appropriate, HHSC will designate specific attributes within the CHIP EPO Program reports that the EPO must complete to allow HHSC to extract data particular to the CHIP Perinatal Program.

The **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. The **Uniform Managed Care Manual** will include, but is not limited to, the following reports:

RRC-1 **Claims Data Specifications Report** – HHSC, in collaboration with the EPO and the quality review contractor will develop specifications on the reporting and processing of claims data that meet federal and programmatic requirements.

Section 8.2.3.7.1, RRC-2, modified by Version 1.4

RCC-2 The EPO must submit an **"All Claims Summary Report"**. The report must be submitted quarterly by the last day of the month following the reporting period. The fourth quarter report must also include a cumulative annual report. The reports must be submitted to HHSC in a format specified by HHSC in the **Uniform Managed Care Manual**. The report will provide HHSC with information on how many claims were processed within the required timeframes, by claim type. Claim types include facility and/or professional services for Acute Care, Behavioral Health, and Vision. Within each claim type, claims data must be reported separately on the UB and CMS 1500 claim

forms. The EPO must submit quarterly non-cumulative All Claims Summary Reports by contracted claims processing subcontractor(s).

Section 8.2.3.7.1, RRC-3, modified by Version 1.3

RRC-3 **Provider Network Report** – For the CHIP EPO Program, the EPO must submit to HHSC on a quarterly basis an electronic listing of all Providers participating in the Network.

For the CHIP Perinatal Program, the Perinate Newborns are assigned PCPs, but Perinates are not. For Perinate Newborns, the MCO must submit a quarterly report listing all unduplicated PCPs in the MCO's Provider Network. The report must be submitted to HHSC in the format specified by HHSC, no later than 30 days after the end of the reporting quarter. For Perinates, the MCO must submit a quarterly report listing all unduplicated CHIP Perinatal Providers in the MCO's CHIP Perinatal Provider Network. The report must be submitted to HHSC in the format specified by HHSC, no later than 30 days after the end of the reporting quarter.

Section 8.2.3.7.1, RRC-4, deleted by Version 1.2

RRC-4 **Provider Specialist Report – [deleted as redundant].**

RRC-5 **Provider Network Change Report** - EPO must submit a quarterly report summarizing changes in the EPO's Provider Network. The report must be submitted to the State in the format specified by HHSC 30 days following the end of the reporting period. The report must identify Provider additions and deletions and the impact of the following:

- Geographic access for CHIP enrolled Members
- Cultural and linguistic services
- The ethnic composition of Providers
- The change in the ratio of pediatricians to the number of CHIP enrolled Members under age 19

RRC-6 **Fraudulent Practices Report -** The EPO must report all Fraud Abuse, and Waste enforcement actions or investigations taken against the EPO and/or any of its Subcontractors or Providers by any state or federal agency under Title XVIII or Title XIX of the Social Security Act or any State law or regulation and any basis upon which an action for Fraud or Abuse may be brought by a State or federal agency as soon as such information comes to the EPO's attention. The report must include information concerning the detection and the disposition of any potential fraudulent or abusive practices. These reporting requirements may change based on the rules to be promulgated in August 2004 related to the creation of special investigation units mandated by House Bill 2292 from the 78th Regular Session of the Texas Legislature.

Section 8.2.3.7.1, RRC-7, modified by Version 1.3

RRC-7 **Summary Report of Member Complaints and Appeals** - The EPO must submit quarterly Member Complaints and Appeals reports. The EPO 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 EPO must submit the Complaint and Appeals reports electronically on or before 45 days following the end of the state fiscal quarter, using the TDI format specified in 28 T.A.C. §§21.2501-21.2507.

HHSC may direct the EPO to provide segregated Member Complaints and Appeals reports for the CHIP Perinatal Program on an as-needed basis.

Section 8.2.3.7.1, RRC-8, modified by Version 1.3

RRC-8 **Summary Report of Provider Complaints -** The EPO must submit Provider complaints reports on a quarterly basis. The EPO must also report complaints submitted 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 the 45 days following the end of the state fiscal quarter using the TDI format specified in 28 TAC §§21.2501-21.2507.

HHSC may require, at its sole discretion, that the EPO submit additional copies in a quantity and format to be specified by HHSC directly to TDI.

HHSC may direct the EPO to provide segregated Provider Complaints and Appeals reports for the CHIP Perinatal Program on an as-needed basis.

Section 8.2.3.7.1, RRC-9, modified by Version 1.2

RRC-9 The EPO and any subcontractors providing telephone services must submit, on an SFQ basis, a status report summarizing each performance element for the Member and Provider hotlines and the Behavioral Health Services hotline, in comparison with the performance standards set out in Section 8 of the RFP. The report must summarize the call center performance elements for each hotline and for each of month in the SFQ.

If the EPO is not meeting a hotline performance standard, HHSC may require the EPO to submit monthly hotline performance reports and implement corrective actions until the hotline performance standards are met. If an EPO has a single hotline serving multiple hotline functions, (i.e. Member, Provider, Behavioral Health Services hotlines), HHSC may request on an annual basis that the EPO submit certain hotline response information by hotline function. HHSC may also request this type of hotline information if an EPO is not meeting a hotline performance standard.

RRC-10 The EPO must produce ad hoc reports based on HHSC request so long as the data resides in either the enrollment file or the service utilization file. If the requested information is not currently available or easily modified from existing data, the amendment process set out in the Uniform Managed Care Contract will apply or the EPO and HHSC may mutually agree on an alternative.

Section 8.2.3.7.1, RRC-11, added by Version 1.5

RCC-11 **Audit Reports –** The EPO must comply with the Uniform Managed Care Manual's requirements regarding notification and/or submission of audit reports.

8.2.3.8.2 Records Management

The EPO must ensure that all original business documentation is retained for a period of five (5) years after the expiration of the Contract or until the resolution of all litigation, claim, financial management review or audit pertaining to the Contract, whichever is longer.

8.3 Management Information Systems

The health care services EPO must have a management information system (MIS) with sufficient capacity and capability to administer the CHIP program requirements, including the timely submission of data as required by HHSC. The EPO's MIS personnel must have sufficient expertise and experience to support the automated functions related to CHIP. All MIS subcontractors must complete a confidentiality statement and will be subject to HHSC approval.

The EPO must maintain an MIS that will provide support for all functions related to the flow and use of data between the EPO and its subcontractors, Providers, the CHIP Administrative Services Contractor and the External Quality Review Organization. The system must be flexible and capable of adapting to changes in business practices and policies within 90 days of notification by HHSC. The system must support and facilitate data transmission requirements as stipulated in the contract.

The EPO will develop a Joint Interface Plan as described in Section 9.2.1.1.

The EPO must maintain accounting records for all claim payments, refunds and adjustments of payments to Providers, interest income and any administrative fees paid to subcontractors for services under this contract for a period of four years. Provider payments for services must be reported separately from administrative payments. The EPO must submit periodic reports and data as required by HHSC.

The EPO's MIS must include the following functional capabilities:

- Enrollment (the enrolled population that is eligible for CHIP health care services)
- Provider data
- Claims processing
- Financial
- Utilization/Quality Improvement
- Reporting
- Electronic interfaces with the CHIP Administrative Services Contractor, the CHIP External Quality Review Organization, the Office of Inspector General, the Third Party Liability Program contractor or subcontractor, and any other contractor stipulated in the RFP

Interface and application flowcharts for each functional area must be provided to HHSC 60 days prior to systems readiness testing. NOTE: If MIS services are outsourced, the EPO must provide systems documentation 60 days prior to systems readiness testing and the outsourced system will be a part of the systems readiness review.

Data override capability must be available to authorized EPO staff to correct erroneous data entry or mitigate specific system-wide data problems (i.e., data correction or data adjustments).

All hardware and software components maintained by the EPO, including operating systems, must be year 2000 compliant.

The EPO must comply with any applicable certificate of coverage and data specification and reporting requirements under the federal Health Insurance Portability and Accountability Act (HIPAA).

The EPO must develop detailed procedures for the security and safeguarding of documents and data files, including complete control over the loss, misuse, or dissemination of confidential information to unauthorized personnel. All EPO employees who have access to confidential information must sign a confidentiality statement as a condition of employment. This confidentiality statement will be subject to HHSC approval. The procedures will include at a minimum the following:

- System security features that include the ability to log and report all unauthorized attempts to access the system, and dial-up access protection to permit systems access only from authorized locations.
- Complete confidentiality of all passwords and IDs used by the EPO and HHSC employees.
- Storage of all critical data files, when not in use, in a fireproof vault.
- Additional security requirements as agreed to by HHSC and the EPO.

The EPO must provide acceptable back-up hardware processing facilities for maintaining back-ups for all computer programs, microfiche originals, major files, system and operations, and user documentation (in magnetic and non-magnetic form) in the event of a disaster.

In the event of a failure of the data processing facilities and/or communications networks because of any disaster, mission critical administrative services normally furnished by the EPO must be fully available within five working days following the disaster. The five-day period does not excuse the EPO from meeting the contractual performance criteria.

The EPO must provide HHSC with an updated and detailed back up and disaster recovery plan 60 days prior to the start of operations and on an annual basis. The plan, and any subsequent modifications, are subject to HHSC approval. The EPO must demonstrate disaster recovery back-up facilities' capability to HHSC at least once a year.

8.3.1 Systems development, maintenance and operation

8.3.1.1 General responsibilities

The EPO will develop, maintain, and operate or arrange for the development, maintenance, and operation of an automated information system that will be utilized by the EPO in the performance of the Services under this RFP (the "System") and that performs functions necessary and convenient to the delivery of the Services, including, but not limited to, the following:

- The general management information systems functions described in subsection 8.3.1.2 of this section; and
- The specific system-wide functions described in subsection 8.3.1.3 of this section.

8.3.1.2 General management information system functions

8.3.1.2.1 General data storage and handling requirements

The System will manage, process, and securely store data in accordance with the requirements of the RFP and resulting contract. The system must be flexible and capable of adapting to changes in business practices and policies within 90 days of notification by HHSC.

The System must process, store, manipulate, or manage information relating to EPO's business operations and this RFP for a period of four years, including, but not limited to:

- Accounting and financial information, including, but not limited to:
    - Health care payment information, (e.g., claims payments and refunds); and
    - Administrative financial information (e.g., payments to subcontractors, suppliers, interest income);
- Enrolled Member information specified by HHSC; and
- Utilization data specified by HHSC.

The EPO's system must be capable of receiving and processing the monthly enrollment file from the Administrative Services contractor through secure Internet file transfer or any other secure method stipulated by the Administrative Services contractor and approved by HHSC with the concurrence of the EPO. The EPO's system must also be capable of producing the reports stipulated in this RFP. The EPO must be prepared to demonstrate system readiness, which includes a facility review, at least 30 days prior to implementation.

In addition to any other requirement specified in this section, the System implemented by the EPO must include the following system features or functionality:

- The capability to access, update and edit all data in a manner approved by HHSC and the timely submission of data as required by HHSC.
- The capability to maintain an automated audit trail, including date of change, the reason for the change, whether the change was made by the system or by a person, and the name of the person making the change, if applicable.
- The capability to allow data input, updating, and editing through manual and electronic transmissions.
- Procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure.
- The capability to maintain automated or manual linkages between and among all MIS subsystems and interfaces.
- The capability to relate Member and Provider data with utilization, service, accounting data, and reporting functions and other relationships deemed appropriate by HHSC within time frames specified by or on behalf of HHSC.
- The capability to relate and extract data elements into detail and summary reporting formats;

- The capability to maintain and cross-reference all Member-related information with the most current CHIP Member unique identifying number.
- The EPO must have written process and procedures manuals that document and describe all manual and automated system procedures and processes for all the above functions and features, and the various subsystem components.

The EPO's MIS personnel must have sufficient expertise and experience to support the automated functions related to CHIP.

8.3.1.2.2 Data override capability

The System implemented by the EPO must include data override capability sufficient to allow the EPO staff to manually or electronically correct data errors and, with appropriate permissions and security clearances, to mitigate specific system-wide data problems.

8.3.1.2.3 Data security and confidentiality

The System implemented by the EPO must contain system security features that include:

- The ability to log and report all unauthorized attempts to access the system.
- Dial-up access protection to permit systems access only from authorized locations and/or users.
- A process for ensuring complete confidentiality of all passwords and IDs used by the EPO and HHSC employees.
- The EPO's employees who have access to confidentiality information must sign a confidentiality statement as a condition of employment.
- Storage of all critical data files, when not in use, in a fireproof vault.
- Additional security requirements as agreed to by HHSC and the EPO.

8.3.1.2.4 Back-up

- The EPO will develop, equip, operate, and maintain or contract with a facility that will conduct back-up operations of all critical operational data (including all major data files, microfiche records, computer programs, system and operations, and documentation) received, generated, and maintained by the System in accordance with the representations in the EPO's Proposal or as specified by HHSC.
- In fulfilling the requirements of this section, the EPO will implement a data back-up plan subject to HHSC approval.
- The data back up operations described in this section will be for the purpose of restoring the System or data to fully operational status within timeframes specified by HHSC in cooperation with the EPO and will be conducted at a site other than the central facility established by the EPO for data center operations.

8.3.1.2.5 Disaster recovery

- The EPO must provide acceptable back-up hardware processing facilities for maintaining back-ups for all computer programs, microfiche originals, major files, system and operations, and user documentation (in magnetic and non-magnetic form) in the event of a disaster.
- In the event of a failure of the data processing facilities and/or communications networks because of any disaster, mission critical administrative services normally furnished by the EPO must be fully available within five (5) working days following the disaster. The five-day period does not excuse the EPO from meeting the contractual performance criteria.
- The EPO must provide HHSC with an updated acceptable detailed back up and disaster recovery plan on an annual basis. The initial disaster recovery plan must be submitted at least 60 days prior to the start of operations. (See section 9.3.2.2 of the RFP.) The plan, and any subsequent modifications, are subject to HHSC approval. The EPO must demonstrate the back-up facilities' capability to HHSC at least once a year.
- Failure to comply with the requirements set out in this Section 8.3.1.2.5 may subject the EPO to imposition of liquidated damages under the Contract.

8.3.1.3 System-wide functions

The System utilized by the EPO will have the functionality of and accomplish the requirements of the separate subsystems and tasks identified in this RFP, including the following:

8.3.1.3.1 Enrollment Subsystem

The System implemented by the EPO must be constructed and programmed to secure all functions that require membership data. The System must have the capability to receive, store, and process the enrollment file that is electronically transmitted to the EPO by the CHIP Administrative Services Contractor on a monthly basis. The system must be capable of updating its records and issue new or revised membership ID cards on the basis of the updated CHIP Member enrollment information. The System must search records by a variety of fields (e.g., name, unique identification numbers, date of birth, etc.) for enrollment verification purposes.

The function and/or features of this subsystem must support the following requirements:

- Maintain historical data (files) as required by HHSC.
- Maintain data on enrollment/disenrollments and complaint and appeal activities. This data must include reason or type of disenrollment, and complaint and appeal resolution by incidence.
- Receive, translate, edit and update files in accordance with the CHIP Administrative Contractor's requirements prior to inclusion in the EPO's MIS. Updates received from the CHIP Administrative Contractor must be processed within two working days of receipt.
- Provide error reports and a reconciliation process between new data and data existing in the MIS.

- Verify Member eligibility for medical services rendered, or for other Member inquires.
- Search records by a variety of fields (e.g. name, unique identification numbers, date of birth, SSN, etc.) for eligibility verification.

8.3.1.3.2 Provider Subsystem

- The System implemented by the EPO must include a Provider Subsystem that accepts, processes, stores and retrieves current and historical data on Providers and third-party billing vendors, including, but not limited to, the following data:
    - Services offered or provided.
    - Tax Identification Number(s).
    - Payment methodology.
    - License/credentialing information.
    - Service capacity and facility linkages.
    - If required by HHSC, information concerning excluded Providers.
- The functions and/or features of the Provider Subsystem must achieve the following:
    - Identify Network Providers, specialty (ies) by Board certification/eligibility, admission privileges, facility linkages, emergency arrangements or contact, and other limitations, affiliations, or restrictions.
    - Maintain Provider history files to include audit trails and effective dates of information.
    - Maintain Provider fee schedules/remuneration agreements to permit accurate payment for services based on the financial agreement in effect on the date of service.
    - Support contractor credentialing, re-credentialing, and credential tracking processes; incorporate or link information to provider record.
    - Incorporate or link appropriate billing, client, and other information to the provider record.
    - Flag and identify Providers with restrictive conditions (e.g. limits to capacity, type of patient, other services if approved out of network, age restrictions, exclusion, etc.).
    - Identify Providers excluded from participation by HHSC as ineligible or excluded and update Provider Subsystem and other files to reflect period and reason for exclusion.
    - Support national and state provider number formats (such as UPIN, NPI, CLIA, Medicaid, TPI, etc. as required by HHSC).
    - Track the progress and resolution of provider complaints.

  - Provide geographical mapping of provider base and assessment of its capabilities to meet Member needs.
  - Update provider information (e.g. provider addresses).

8.3.1.3.3 Claims/Services Data Subsystem.

- The System implemented by the EPO must include a Claims/services Data Subsystem that collects, processes, and stores data on all services delivered for which the EPO is financially responsible, primarily for the following purposes:
  - Processing claims and tracking service utilization data.
  - Capturing all medically related services, including medical supplies, (using standard codes as specified by HHSC, e.g. HCPSC, ICD9-CM, CPT) rendered by service Providers to an eligible Member.
  - Approving, preparing for payment, or rejecting or denying claims submitted. This subsystem may integrate manual and automated systems to validate and adjudicate claims.
- Functions and features of this subsystem are:
  - Accommodate multiple input methods - electronic submission, tape, claim document, magnetic media.
  - Support entry and capture of a minimum of two diagnosis codes for each individual service.
  - Edit and audit to ensure allowed services are provided to eligible CHIP enrolled Members by eligible Providers.
  - Interface with the Enrollment Subsystem, Provider Subsystem, and/or other CHIP-related systems specified by HHSC.
  - Edit for utilization and service criteria, medical policy, fee schedules, multiple contract periods and conditions.
  - The ability to submit data to HHSC when requested through electronic transmission using specified formats and meeting specified edits.
  - Support multiple fee schedule benefit packages for all contract periods for individual Providers, groups, services, etc. A claim must be initially adjudicated and all adjustments must use the fee and policy applicable to the date of service.
  - Provide timely, accurate, and complete data for monitoring claims processing performance.
  - Provide claims editing capability for detecting coding errors.
  - Provide timely, accurate, and complete data for reporting service utilization.
  - Maintain and apply prepayment edits to verify accuracy and validity of claims data for proper adjudication.

- Submit reimbursement to non-contracted Providers for emergency services and medically necessary services not available in Network but rendered to Members in a timely and accurate manner.
- Validate approval and denials of precertification, prior authorization, and referral requests during adjudication of claims.
- Maintain and apply edits and audits to verify timely, accurate, and complete data reporting.
- Track and report the exact date a service was performed using HHSC approved date ranges.
- Support all functions and report all required data elements.

8.3.1.3.4 Financial Subsystem

The financial subsystem must provide the necessary data for all accounting functions including cost accounting, inventory, fixed assets, payroll, general ledger, accounts receivable and payable and financial statement presentation. The financial subsystem must provide the EPO's management staff with information that can demonstrate that the EPO is meeting, exceeding, or falling short of fiscal goals. The information must also provide management with the necessary data to spot the early signs of fiscal distress, far enough in advance to allow management to take corrective action where appropriate.

Functions and features of this subsystem are:

- Provide information on the EPO's economic resources, assets and liabilities, and present accurate historical data and projections based on historical performance and current assets and liabilities.
- Produce financial statements in conformity with generally accepted accounting principles and in the format prescribed by HHSC.
- If the EPO chooses to engage in TPR activities, provide information relative to TPR, including identifying potential third-party payers; information specific to the client; claims made against third-party payers; collection amounts and dates; denial, if any, and reasons therefore.
- Track and report savings by category as a result of cost avoidance activities.
- Track payments per Member made to Network Providers compared to utilization of the provider's services.
- Generate Remittance and Status reports.
- Make claim payments to Providers or groups.
- Reduce/Increase accounts payable/receivable based on adjustments to claims or other recoveries.

8.3.1.3.5 Utilization/Quality Improvement Subsystem

The quality management/quality improvement/utilization review subsystem combines

data from other subsystems, and/or external systems, to produce reports for analysis which focus on the review and assessment of quality of care given, detection of over and under utilization, and the development of user defined reporting criteria and standards. This system profiles utilization of Providers and Members and compares them against experience and norms for comparable individuals. This system also supports the quality assessment function. The subsystem tracks utilization control function(s) and monitors inpatient admissions, emergency room use, ancillary, and out-of-area services. It provides provider profiles, occurrence reporting, monitoring and evaluation studies, and Member satisfaction survey compilations. The subsystem may integrate the EPO's manual and automated processes or incorporate other software reporting and/or analysis programs. The subsystem incorporates and summarizes information from Member surveys, provider and Member complaints, and appeal processes. Refer to Section **8.2.3.3** of this RFP for additional information. Functions and features of this subsystem are:

- Supports EPO processes to monitor and identify deviations in patterns of treatment from established standards or norms. Provides feedback information for monitoring progress toward goals, identifying optimal practices, and promoting continuous improvement.
- Supports development of cost and utilization data by provider and service.
- Supports functions of reviewing access, use and coordination of services (i.e. actions of Peer Review and alert/flag for review and/or follow-up; laboratory, x-ray and other ancillary service utilization per visit).
- Stores and reports patient satisfaction data through use of Member surveys.
- Provides fraud and abuse detection, monitoring and reporting.
- Meets minimum reporting/data collection/analysis functions required by this RFP.

8.3.1.3.6 Report Subsystem

- The System implemented by the EPO must include a Reporting Subsystem that:
  - Allows the EPO to develop various reports to support contract management and evaluation and to facilitate HHSC oversight.
  - Produces reports in compliance with the requirements of this RFP.
- The minimum functions and capabilities of the Reporting Subsystem are:
  - Produces standard, HHSC-required reports (whether on a recurring or sporadic basis) and ad hoc reports from data available in all MIS subsystems specified in this RFP within the timeframes requested by HHSC.
  - Has system flexibility to permit the development of reports at irregular periods as needed and according to any combination of data

and variety of formats (including paper or electronic). In regard to the age and income reporting categories, those will be consistent with the enrollment file. This means the age category will track the health premium risk groups and income categories will track the co-payment categories.

- Generates reports of unduplicated counts of Members, Providers, payments and units of service as requested by HHSC.
- Generates claims lag reports, including dates of service, claims receipts, and claims paid or denied.
- Generates alphabetic and numeric Member listings.
- Generates Member eligibility listings by each physician (panel report).
- Generates aged outstanding liability report.
- Reports on third party liability information to HHSC.
- Produces Member ID Cards.
- Produce client/provider mailing lists and labels.

8.3.1.3.7 Data Interface Subsystem

The System implemented by the EPO must include a Data Interface Subsystem that maintains secure electronic interfaces with the following entities:

- The CHIP Administrative Services Contractor.
- The CHIP Quality Monitor Contractor.
- Any other entity specified by HHSC.

The electronic interfaces required for the Data Interface Subsystem must:

- Maintain and update critical data, including, but not limited to:
  - Member enrollment data;
  - Provider data;
  - Enrollment/disenrollment status; and
  - Other relevant data identified by HHSC.
- Comply with frequency, file formatting and other relevant requirements established by the CHIP Administrative Services Contractor in conjunction with HHSC;
- Exchange data for the following functions:
  - Enrollment/disenrollment functions.
  - Confirmation of the status of children with special health care needs.
  - Premiums payable functions.
  - Cost-sharing data.

- Provider capacity and availability functions.
- Quality monitoring functions.
- Information pertaining to Complaints and Appeals.
- The EPO, subcontractor, or health care provider performance measurement.

Section 8.3.1.3.7 modified by Version 1.3

Data will be transferred electronically to the entity designated by HHSC**.** Data interfaces between EPOs and their subcontractors will also exist. Specific data interfaces will include, but are not limited to, the following:

- From the CHIP Administrative Contractor to the EPO Enrollment/Disenrollment Interface
  - Content – This interface will provide the EPO with eligibility dates and identifying information for all new CHIP EPO Program and CHIP Perinatal Program enrolled Members and disenrolled Members, and plan selection information.
  - Frequency – Monthly
- From the CHIP administrative contractor to the EPO and from the EPO to the CHIP administrative contractor
  - Premiums Payable Interface
  - Content – This interface transfers premium and Member information to and from the CHIP administrative contractor and the EPO. It balances the administrative contractor's and EPO's Member and premium information, serving as the basis for payment to the EPO.
  - Frequency – Monthly
- From the EPO to the CHIP administrative contractor – EPO/Provider Capacity Enrollment Interface
  - Content – This interface provides the administrative contractor with updated provider information so that Members can be informed of available Providers within a plan when making plan selections.
  - Frequency –Weekly or Monthly
- From the EPO to the CHIP administrative contractor - Confirmation of the Status of Children with Special Health Care Needs
  - Content – This interface provides the administrative contractor with confirmations of the status of CSHCN.
  - Frequency – Monthly
- From the EPO to the CHIP Quality Monitor - Quality Interface
  - Content – This interface provides the CHIP Quality Monitor with data sets, to be determined by HHSC, to monitor the quality and accessibility of health care services.
  - Frequency – Monthly

- Protocol – To be determined

- From the EPO to the CHIP administrative contractor - Listing of Pregnant CHIP Children
  - Content—This interface provides the administrative contractor with information about CHIP Members who become pregnant during their six continuous months of CHIP eligibility.
  - Frequency – Monthly

8.3.1.3.8 Additions or changes to the requirements set out in this section

The Parties will negotiate in good faith to reach agreement on when requested additions or changes to the requirements in this section will be made by the EPO at no additional charge to HHSC and when requested additions or changes should be handled through the Amendment Process set out in the Uniform Managed Care Contract.

8.3.1.3.9 Encounter Data

Section 8.3.1.3.9 modified by Versions 1.2, 1.5, and 1.7

The EPO 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 EPO must submit Encounter Data transmissions monthly, and include all Encounter Data and Encounter Data adjustments processed by the EPO. Encounter Data quality validation must incorporate assessment standards developed jointly by the EPO and HHSC. The EPO 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 EPO 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.

EPO will submit an Encounter Data each month not later than ten calendar days from the end of the reported month.

For reporting Encounters and fee-for-service claims to HHSC, the EPO 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 EPO requesting an exception. The EPO must also use the provider numbers as directed by HHSC for both Encounter and fee-for-service claims submissions, as applicable.

8.3.1.3.10 Additional EPO Readiness Reviews

Section 8.3.1.3.10 added by Version 1.4

During the Operations Phase, if the EPO makes a change to any operational system or undergoes any major transition, it may be subject to an additional Readiness Review(s). HHSC will determine whether the proposed changes will require a desk review and/or an onsite review. The EPO is responsible for all costs incurred by HHSC or its authorized agent to conduct an onsite Readiness Review.

Refer to **Attachment B-1, Section 7** and **Attachment B-1, Section 8.3.1.3.10** for

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

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	August 19, 2004	Initial version of Attachment B-1, Section 9.
Revision	1.1	September 1, 2006	Contract Amendment did not revise Attachment B-1, Section 9.
Revision	1.2	March 1, 2006	Contract Amendment did not revise Attachment B-1, Section 9.
Revision	1.3	September 1, 2006	Revised version of the Attachment B-1, Section 9 that includes provisions applicable to participating in the CHIP Perinatal Program. Sections 9.1, 9.2, 9.2.1, 9.2.1.1, 9.3.1, 9.3.2.1, 9.3.2.1.3, 9.3.2.1.4, 9.3.2.2, 9.3.2.2.2, 9.3.2.2.4, 9.3.2.3, 9.3.2.3.1, 9.3.2.3.2, 9.3.2.3.5, 9.3.2.4, and 9.4 modified to include the CHIP Perinatal Program.
Revision	1.4	September 1, 2007	Section 9.3.3 is modified to add a cross-reference to Attachment B-1, Section 8.3.1.3.10.
Revision	1.5	September 1, 2008	Contract Amendment did not revise Attachment B-1, Section 9.
Revision	1.6	April 1, 2009	Contract Amendment did not revise Attachment B-1, Section 9.
Revision	1.7	September 1, 2009	Contract Amendment did not revise Attachment B-1, Section 9.

[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.

9 Transition Phase Scope of Work

9.1 Introduction

Section 9.1 modified by Version 1.3

This Section presents the scope of work for the Transition Phase of the Contract resulting from this procurement. Transition is defined as those activities that must take place between the time of Contract award and the Operational Start Date for each Program, as set forth in the EPO Managed Care Contract document.

For the CHIP Perinatal Program, the EPO must meet the Readiness Review requirements established by HHSC not later than 60 days prior to the Operational Start Date. EPO agrees to provide all materials required to complete the Readiness Review by the dates established by HHSC and its contracted Readiness Review vendor.

9.2 System Requirements

Section 9.2 modified by Version 1.3

This Section provides the requirements related to the selected EPO's computer system. It addresses the requirements for HIPAA compliance, and the requirements related to the acceptance of information from other CHIP EPO Program and CHIP Perinatal Program contractors, including the current CHIP Exclusive Provider Organization (EPO) Contractor, the CHIP Administrative Services Contractor, the health care providers and the External Quality Review Organization's Contractor.

9.2.1 System Interfaces

Section 9.2.1 modified by Version 1.3

The selected EPO will be required to establish the telecommunications network required to operate the CHIP EPO Program and CHIP Perinatal Program health care services in the designated counties of the state. The EPO must be able to interface with some or all of the computer systems in the current operations environment, including the Administrative Services Contractor's system and provide reports to HHSC in the format required. Any software or hardware needed to support the maintenance of required data elements by the EPO must be available and tested prior to implementation. This includes required telephone lines for providers and clients, connections to the Administrative Services Contractor and the External Quality Review Organization, the Third Party Liability (TPL) Program contractor or subcontractor, the Office of Inspector General at HHSC, and to the health care providers.

9.2.1.1 Joint Interface Plan

Section 9.2.1 .1 modified by Version 1.3

The EPO must submit a joint interface plan (JIP) in a format specified by HHSC. The JIP will include required information on all contractor interfaces that support the CHIP Information Systems. The submission of the JIP will be in coordination with other CHIP contractors and is due no later than 30 calendar days prior to the start of operations and within ten business days after the end of each state fiscal year or whenever there is a change or modification related to the EPO's files.

A separate JIP is not required for the CHIP Perinatal Program.

9.2.2 EPO Equipment Requirements

The EPO selected as a result of this procurement is responsible for providing hardware, software, and communications links for EPO staff to meet the requirements set forth in this RFP.

9.2.3 Information Transfer

The CHIP contractor who has been providing EPO health care services to the applicable CHIP clients will be responsible for preparing all required documentation updates during the Transition Phase. The State will work with the current CHIP EPO contractor and the selected EPO to develop procedures and protocols to manage the migration of records and documentation from the current CHIP EPO contractor to the selected EPO.

Procedures will also be established to communicate to all affected providers under contract with the current EPO health services contractor any changes necessary to transition to the selected EPO.

9.2.4 HIPAA Compliance

The State of Texas will implement the electronic data interchange (EDI) portion of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), known as HIPAA on October 16, 2003.

The EPO selected as a result of this procurement must ensure that the proposed business solutions, including files or data transferred from the current EPO Contractor, comply with HIPAA EDI requirements. Current enrollment files must be in the 834 HIPAA compliant format on October 16, 2003. Eligibility inquiry must be in the 270/271 format and all claims and remittance transactions in the 837/835 format by October 16, 2003. Testing with the State must follow the State prescribed schedule. It will be the EPO's responsibility to comply with future requirements of HIPAA as routine part of doing business and part of this ensuing contract.

9.3 Project Management Requirements

The State will establish a project management team to closely monitor the timely and acceptable performance of the Transition Phase tasks.

9.3.1 Transition Phase Schedule

Section 9.3.1 modified by Version 1.3

The Transition Phase will begin on the Effective Date of the Contract. The Transition Phase must be completed no later than the agreed upon Operational Start Date for each Service Area. The mutually agreed upon Operations Start Date is a key date and will be subject to damages. If for any reason, the EPO does not fully met the Operational Start Date and a contract amendment delaying this date has not been approved, then the EPO will be liable for costs incurred by the State to continue operations and to complete the transactions effort.

Exhibit 1: Proposed Critical Activities and Key Dates

	EPO Program Rural Service Area	EPO Program Additional Service Area(s)	CHIP Perinatal Program Service Area
EPO(s) Start of Work	June 2004	To be negotiated, but the EPO must start work no later than 90 days prior to the Operational Start Date for the Service Area	September 1, 2006
Transition Begins	June 2004	To be negotiated, but Transition must begin no later than 90 days prior to the Operational Start Date for the Service Area	September 1, 2006
System Testing Begins	June 2004	To be negotiated	October 2006
Operational Readiness Assessment	July 28th – 29th, 2004	To be negotiated	October 2006
Provider Training & Provider Directories/Member Materials mailed	August 16, 2004	No later than 45 days prior to the Operational Start Date	No later than 45 days prior to the Operational Start Date
Start of EPO Operations	September 1, 2004	To be negotiated, but no later than 90 days following HHSC's notice that it is exercising the option to include the Additional Service Area	January 1, 2007

The State will actively monitor transition activities during this phase of the Contract. Monitoring activities will focus on progress made and the State's assessment of the EPO's readiness to begin operations.

Please note that the Operational Readiness Assessment noted in Exhibit 1 refers to the execution of the EPO's Operational Readiness Assessment Plan.

9.3.2 Transition Phase Tasks

In general, the EPO has overall responsibility for the timely and successful completion of each of the Transition Phase tasks. In addition, the EPO is responsible for clearly specifying and requesting information needed from the State and health care providers in a manner that does not delay the schedule or work to be performed.

The following is a list of the Transition Phase tasks:

- Contract Start-Up and Planning.
- System Testing and Transfer of Data

Demonstration and Assessment of Systems Readiness

- Operations Readiness

Demonstration and Assessment of Operational Readiness

9.3.2.1 Contract Start-Up and Planning

HHSC and the EPO will work together during the initial Contract start-up phase to define project management and reporting standards, establish communication protocols between HHSC and the EPO, and establish contacts within the provider community. The EPO will be responsible for developing a written work plan that will be used to monitor progress throughout the Transition Phase. The EPO and HHSC will work together during initial Contract start-up to establish a schedule for key activities, milestones and define expectations for the content and format of Contract Deliverables.

9.3.2.1.1 Key Personnel

The EPO must designate key personnel. The EPO will supply the State with an updated organizational chart and staffing plan identifying each of the staff. Hiring or replacement of Key Personnel must conform to all Contract requirements.

9.3.2.1.2 State Data Center

The 2003 General Appropriations Act (H.B.1, 78th Legislature), Article IX, Section 9.03, requires all State agencies and institutions of higher learning to consider utilizing the State Data Center for testing disaster recovery plans, for disaster recovery services, and/or for data center operations.

EPOs are requested to include in their proposals State Data Center, disaster recovery testing, and data center operations available through the State of Texas Department of Information Resources at: http://www.dir.state.tx.us/wtdroc/index.html.

Note: If the EPO chooses not to include State Data Center in its proposal, the proposal will still be considered. If the proposal is considered best value by the State, a waiver from the legislative provision will be requested by HHSC.

9.3.2.1.3 EPO Responsibilities

For each Program, the EPO must:

Section 9.3.2.1.3, CSC-1 modified by Version 1.3

CSC-1 Finalize the work plan for Transition Phase activities and submit it to the State for approval. For the CHIP Perinatal Program, the EPO must provide HHSC with an updated work plan no later than October 1, 2006.

Section 9.3.2.1.3, CSC-2 modified by Version 1.3

CSC-2 Designate Key Personnel and provide organizational chart and staffing plan. For the CHIP Perinatal Program, the EPO must provide HHSC with an updated organizational chart and staffing plan no later than September 1, 2006.

CSC-3 Work with HHSC to establish communication protocols between the EPO and the State (i.e., Communication Plan and Problem Escalation Procedures).

CSC-4 Work with the State to establish project management and reporting standards.

Section 9.3.2.1.3, CSC-5 modified by Version 1.3

CSC-5 Develop a Risk Management Plan to help avoid risks and mitigate risks. Separate Risk Management Plans are not required for each Program.

CSC-5 Submit weekly written status reports to the State on the progress of tasks against the approved work plan.

9.3.2.1.4 EPO Deliverables

Section 9.3.2.1.4 modified by Version 1.3

- State-approved final work plans.
- Organizational chart and staffing plan for Key Personnel.
- State-approved data and records retention plan. Separate plans are not required for each Program.

- Risk Management Plan. Separate Risk Management Plans are not required for each Program.
- Weekly status reports.

9.3.2.2 System Testing and Transfer of Data

Section 9.3.2.2 modified by Version 1.3

During this task, the EPO will accept into its system any and all necessary data files and information available from the current EPO contractor regarding the provision of health care services, install all software, and establish the telecommunications network required to operate the CHIP EPO Program and CHIP Perinatal Program health care services. As part of the system readiness and data transfer, the EPO must be able to interface with the computer systems in the current environment, including the current CHIP EPO Contractor, the CHIP Administrative Services Contractor, the CHIP/Medicaid External Quality Review Organization and the Health Care Providers voluntarily contracting with the selected EPO.

The EPO will install and test all hardware, software, and telecommunications required to support the EPO and provide test data files for systems and interface testing for all required interfaces. This includes testing of the required telephone lines for providers and Members and any necessary connections to the Administrative Services Contractor. The EPO will demonstrate their system capabilities and adherence to the contracted specifications. The EPO will test data extracts and direct data connections and develop resolution procedures to address problems identified during the test. If the EPO has already demonstrated the ability to produce an EQRO encounter file and 837-encounter file for the CHIP EPO Program it will not be required to produce separate files for the CHIP Perinatal Program.

The EPO will define and test any minor modifications to the EPO system required to support the business functions stated in this RFP.

9.3.2.2.1 System Readiness

The EPO must assure that systems services are not disrupted or interrupted during the implementation and term of the contract. The EPO must coordinate with other contracted systems and vendors to ensure the business and systems continuity for the processing of all EPO health care claims and data as prescribed in the RFP.

The EPO must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities, including a systems update schedule, Joint Interface Plan, Disaster Recovery Plan, Risk Management Plan and Business Continuity Plan to provide ongoing support of the service delivery function as prescribed in the RFP. The EPO will also be responsible for developing and documenting its approach to systems quality assurance.

9.3.2.2.2 Demonstration and Assessment of System Readiness

The State will provide to the EPO a test plan that will outline the activities that need to be performed by the EPO prior to the implementation of the contract. It will be the EPO's responsibility to obtain an Independent Verification and Validation certification for the following items:

- Facility security including all appropriate building inspections and fire and safety approval.
- Facility hardware and software applications are HIPAA compliant and secure.
- The EPO's Facility Management Information System (MIS) has the capacity to administer the CHIP EPO Program and CHIP Perinatal Program State business.

Section 9.3.2.2.2 modified by Version 1.3

Systems and Facility Security

The EPO must provide documentation on systems and facility security and demonstrate that these policies and procedures are adhered to.

Systems Development and Implementation Plan

The EPO will provide a comprehensive systems development and implementation plan and schedule to support the systems development life cycle.

The EPO must have a system adaptable to changes in Business Practices and Policies within the timeframe negotiated between HHSC and the EPO.

The EPO must notify and advise HHSC Information Resource Management staff of major systems changes, rewrites or new systems developed that directly impact the MIS. The notice should be reported to HHSC 90 days prior to implementation. A complete plan must be submitted. This plan should reflect the systems changes and any impacts to the operational business process. The EPO's MIS staff would need to assess the systems changes and operations to assess the output changes. There should be a cost benefit provided. The EPO is required to provide an implementation plan and schedule of proposed system changes at the time of this notification.

HHSC's Information Resource Management (IRM) staff conducts a Systems Readiness test to validate the EPO's ability to meet the systems requirements. This is done through systems demonstration and performance of specific systems and subsystem functions. The System Readiness test may include a desk review and/or an onsite review. The EPO must be prepared to demonstrate system readiness, which includes a facility review, at least 30 days prior to implementation.

The EPO is required to provide a Corrective Action Plan in response to HHSC Systems Readiness Testing Deficiencies no later than ten working days after notification of

deficiencies by HHSC.

The EPO must have hardware, software, network and communications systems with the capability and capacity to handle and operate all MIS subsystems.

Section 8.3 Management Information Systems provides the requirements regarding functional capabilities. Interface and application flowcharts for each functional area must be provided to HHSC 60 days prior to systems readiness testing. If MIS services are outsourced, the EPO must provide systems documentation 60 days prior to the systems readiness testing and the outsourced system will be a part of the systems readiness review.

The EPO must notify HHSC of any changes to the EPO's MIS department dedicated to or supporting this RFP. Any updates to the organizational chart and the description of responsibilities must be provided to HHSC IRM staff at least 30 days prior to the effective date of the change. Official points of contact must be provided to HHSC IRM staff on an on-going basis. An Internet E-mail address must be provided for each point of contact.

9.3.2.2.3 EPO Responsibilities

The EPO must:

- Participate in meetings with the State to define the details of the system readiness assessment and develop the assessment schedule.
- Perform system activities during the system readiness assessment as they would be performed during the Operations Phase of the Contract.
- Execute system readiness test cycles to include all external data interfaces.
- Develop, and submit for State review and approval, at least 60 days prior to the start of operations, the disaster recovery and data security procedures.
- Prepare, and submit to the State for review, a Business Continuity Plan that details the EPO's approach to provide ongoing support of the service delivery function as described in the RFP and to describe the EPO's approach to reestablishing operations in the event of a catastrophe.
- Develop all system documentation.

9.3.2.2.4 EPO Deliverables

- All systems documentation including systems update schedule and facility security documentation.
- Joint Interface Plan.

- Disaster Recovery Plan
- Business Continuity Plan
- Risk Management Plan.
- Corrective Action Plan.

Section 9.3.2.2.4 modified by Version 1.3

Separate plans are not required for the CHIP Perinatal Program.

9.3.2.3 Operations Readiness

The EPO must clearly define and document the policies and procedures that will be followed to support day-to-day business activities, including coordination with other contractors. The EPO will also be responsible for developing and documenting its approach to quality assurance.

Section 9.3.2.3 modified by Version 1.3

During this task, the State reviews the EPO's operating procedures and any updates to documentation to support the addition of the provision of CHIP EPO Program and CHIP Perinatal Program Health Care Services. Based on the information contained in the documents, the State will assess the EPO's understanding of its responsibilities and the EPO's capability to assume the functions required under the Contract.

9.3.2.3.1 EPO Responsibilities

The EPO must:

OPC-1 Provide the State with a plan for toll-free line management.

OPC-2 Develop new, or revise existing, operations procedures and associated documentation to support the EPO's proposed approach to conducting operations activities.

OPC-3 Prepare and submit a Policies and Operating Procedures Manual for the business functions to the State for review and approval. The Operating Procedures must be written in a procedural, step-by-step format, and include instructions for sequential functions that follow the flow of actual activity. Transaction codes or acronyms used in operating procedures must be identified.

OPC-4 Hire and train staff to assume the operations responsibilities in the contracted scope of work.

OPC-5 Prepare a Coordination Plan that documents how the EPO will coordinate its business activities with those activities performed by other contractors. The Plan will include identification of all coordinated activities and protocols for

Section 9.3.2.3.1, OPC-5 modified by Version 1.3

the Operations Phase, a work flow plan that specifically identifies how the interfaces between the CHIP Program and CHIP Perinatal Program providers will function, and work flow diagrams. The EPO will update the information contained in this document throughout the life of the Contract.

OPC-6 Prepare a Quality Management Plan and submit it for State review and approval.

OPC-7 The EPO must submit a written Fraud and Abuse compliance plan to HHSC for approval no later than the scheduled date for initiating readiness reviews. (See section 8.2.3.5 for the requirements of the plan.)

Section 9.3.2.3.1, OPC-7 modified by Version 1.3

For the CHIP Perinatal Program, the EPO must submit acknowledgement that the EPO's approved Fraud and Abuse Compliance Plan also applies to the CHIP Perinatal Program, or submit a revised Fraud and Abuse Compliance Plan for HHSC's approval, with an explanation of changes to be made to incorporate the CHIP Perinatal program into the plan, by September 15, 2006.

OPC-8 The EPO must designate executive and essential personnel to attend mandatory training in Fraud and Abuse detection, prevention and reporting. The training will be conducted by the Office of Investigation and Enforcement, Health and Human Services Commission, and will be provided free of charge. The EPO must schedule and complete training no later than 90 days after the date of initial plan operations.

OPC-9 The EPO must designate an officer or director in its organization with responsibility and authority for carrying out the provisions of the compliance plan.

9.3.2.3.2 EPO Deliverables

Section 9.3.2.3.2 modified by Version 1.3

- Policies and Operating Procedures Manual including plan for toll-free line management.
- Coordination Plan.
- Quality Management Plan.
- Fraud and Abuse Compliance Plan.

Except as provided above, separate plans are not required for the CHIP Perinatal Program.

9.3.2.3.3 Demonstration and Assessment of Operational Readiness

The State will work with the EPO to define the structure of the operational readiness assessment, including the schedule of activities. The EPO will be responsible for

participating in and defining the details of the Operational Readiness Assessment Plan and will be responsible for preparing and submitting its Operational Readiness Assessment Plan to the State for review and approval.

During this task, the EPO will demonstrate readiness to perform all contracted functions and contractual requirements, including manual processes. To support the operational readiness assessment, the EPO will be expected to have all staff support services fully operational during the operational readiness assessment period. The EPO must demonstrate that all system processes and staffed functions are ready to assume responsibilities for operations. The EPO will be responsible for demonstrating data security and fire/disaster prevention and recovery procedures.

The State places great emphasis on operational readiness. The State intends to include providers in the operational readiness assessment. Provider participation could include initiating telephone calls requesting information.

The EPO will prepare an operations contingency plan to address potential and probable issues or problems that could occur during the initial months of operations. Based on the information collected during the previous tasks, the EPO will describe what problems should be anticipated and how the EPO plans to address or resolve these problems (e.g., additional staff, outreach to providers, etc.). The State is interested in a realistic assessment of where potential problems are likely to occur.

9.3.2.3.4 EPO Responsibilities

The EPO must:

ORC-1 Participate in meetings with the State to define the details of the operational readiness assessment and develop the assessment schedule.

ORC-2 Prepare the Operational Readiness Assessment Plan.

ORC-3 Sufficiently staff operational functions for the entire operational readiness assessment period.

ORC-4 Demonstrate phone systems and provide examples of phone reports for State review and approval.

ORC-5 Demonstrate that the staff is trained and communications procedures are in place.

ORC-6 Document the results of the operational readiness assessment and submit to the State for review and approval. The EPO will discuss outstanding problems and how and when the EPO plans to address and resolve the outstanding problems.

9.3.2.3.5 EPO Deliverables

Section 9.3.2.3.5 modified by Version 1.3

- Operational Readiness Assessment Plan.
- Operational Readiness Assessment Results.
- Operations Contingency Plan.

The EPO must update these plans as necessary for the CHIP Perinatal Program.

9.3.2.4 Provider Training and Member Materials

Section 9.3.2.4 modified by Version 1.3

The EPO(s) must conduct provider training sessions prior to implementation according to the schedule approved by HHSC. The EPO(s) must send the appropriate provider directories and Member Materials to CHIP EPO Program and CHIP Perinatal Program Members as directed by HHSC. For the CHIP Perinatal Program, the EPO must develop Provider Directories and Member Materials for both CHIP Perinates and CHIP Perinate Newborns. The Provider Directory and Member Materials for CHIP Perinate Newborns may be the same as those used for the CHIP EPO Program, provided they identify any differences in the Programs.

9.3.3 Post-Transition Support

Section 9.3.3 modified by Version 1.4

During the Post-Transition Support task, the EPO and the State will work together with the provider community to identify and resolve problems identified after the start of operations. The EPO will work in a proactive and timely manner to address issues and problems identified and to communicate to both the State and the provider community the steps the EPO is taking to resolve the problems.

Refer to **Attachment B-1, Section 8.3.1.3.10** for additional information regarding EPO Readiness Reviews during the Operations Phase.

9.3.3.1 State Responsibilities

The State will:

PTS-1 Meet with the EPO to discuss post-transition issues.

9.3.3.2 EPO Responsibilities

The EPO must:

PTC-1 Meet with State staff to discuss post-transition issues.

PTC-2 Participate and work to resolve issues or problems identified by the provider community and the State.

PTC-3 Document problems and their causes encountered during the post-transition period, and provide information regarding steps to correct the problem, including the resources that will be used to correct the problem, the timetable for correcting the problem, and the steps that will be taken to prevent the problem from recurring. The EPO will also document when the problem is resolved. This documentation will be provided to the State on a weekly basis during the first two months of operations, at which time the State will reassess the required frequency of providing this information.

9.3.3.2.1 EPO Deliverables

- Weekly problem reports.

9.4 Quality Management

Section 9.4 modified by Version 1.3

The State is committed to establishing and operating a high quality Children's Health Insurance Program. The Texas CHIP EPO Program and CHIP Perinatal Program is committed to providing the best service possible to the program's stakeholders-the State, providers, and Members. The EPO will commit to support the State to ensure a continuous focus on the delivery of quality systems and services.

The EPO will prepare a plan that documents its quality assurance program. Items that must be addressed in the quality management plan include:

- Description of processes and procedures that will be implemented to ensure the cooperation and coordination of activities and operations with other CHIP EPO Program and CHIP Perinatal Program vendors.
- Description of the processes and procedures that will be implemented to ensure quality and accuracy in the areas identified in Section 8.2.3.2, Quality Assurance of this RFP.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	August 19, 2004	Initial version of Attachment B-2, HHSC CHIP EPO Covered Services.
Revision	1.1	September 1, 2006	Contract Amendment 1 replaced the initial version of Attachment B-2, HHSC CHIP EPO Covered Services with a revised version.
Revision	1.2	March 1, 2006	Contract Amendment 2 did not revise Attachment B-2, HHSC CHIP EPO Covered Services.
Revision	1.3	September 1, 2006	Modified Attachment B-2 as follows: 1. Added benefits for "Inpatient General Acute and Inpatient Rehabilitation Services;" 2. Added benefits for "Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital Clinic (Including Health Center) and Ambulatory Health Care Center;" 3. Modified to correct services related to artificial aids including surgical implants. 4. Reformatted document for clarification 5. Added Attachment B-2.1, CHIP Perinatal Covered Services. This is the initial version of Attachment B-2.1, which lists the CHIP Perinatal Covered Services, exclusions and DME/Supplies.
Revision	1.4	September 1, 2007	Attachment B-2, HHSC CHIP EPO Covered Services, modified to eliminate references to the six (6) month enrollment period, effective 9/1/07.
Revision	1.5	September 1, 2008	Contract Amendment did not revise Attachment B-2, HHSC CHIP EPO Covered Services.
Revision	1.6	April 1, 2009	Contract Amendment did not revise Attachment B-2, HHSC CHIP EPO Covered Services.
Revision	1.7	September 1, 2009	Modified Attachment B-2 as follows: 1. CHIP Covered Services "Inpatient General Acute and Inpatient Rehabilitation Hospital Services" is modified clarify the requirements regarding miscarriage and non-viable pregnancy, as well as orthodontic services for treatment of craniofacial anomalies. 2. CHIP Covered Services "Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center" is modified clarify the requirements regarding miscarriage and non-viable pregnancy, as

			well as orthodontic services for treatment of craniofacial anomalies. 3. CHIP Covered Services "Physician/Physician Extender Professional Services" is modified to clarify the requirements regarding miscarriage and non-viable pregnancy. 4. CHIP Covered Services "Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies" is modified to include additional CHIP covered services to conform to Federal legislation. 5. CHIP Covered Services "Outpatient Mental Health Services" is revised to provide additional clarity as it relates to Qualified Mental Health Providers – Community Services (QMHP-CS). 6. CHIP Exclusions From Covered Services is modified to include additional CHIP covered services to conform to Federal legislation. 7. CHIP DME/Supplies is modified to include additional CHIP covered services to conform to Federal legislation.

[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.

Modified by Version 1.4

Covered CHIP services must meet the CHIP definition of "Medically Necessary Covered Services" as defined in **HHSC EPO Managed Care Contract Terms & Conditions**. There is no lifetime maximum on benefits; however, 12-month period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays apply until a family reaches its specific cost-sharing maximum.

Type of Benefit	Description of Benefit

Inpatient General Acute and Inpatient Rehabilitation Hospital Services
 	
Modified by Versions 1.3 and 1.7
	Medically necessary services include, but are not limited to, the following:
	• Hospital-provided physician or provider services.
	• Semi-private room and board (or private if medically necessary as certified by attending).
	• General nursing care.
	• ICU and services.
	• Patient meals and special diets.
	• Operating, recovery and other treatment rooms.
	• Anesthesia and administration (facility technical component).
	• Surgical dressings, trays, casts, splints.
	• Drugs, medications and biologicals, Blood or blood products not provided free-of-charge to the patient and their administration.
	• X-rays, imaging and other radiological tests (facility technical component).
	• Laboratory and pathology services (facility technical component).
	• Machine diagnostic tests (EEGs, EKGs, etc).
	• Oxygen services and inhalation therapy.
	• Radiation and chemotherapy.
	• Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care.
	• In-network or out-of-network facility for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
	• Hospital, physician and related medical services, such as anesthesia, associated with dental care.
	• Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
	  ◦ dilation and curettage (D&C) procedures;
	  ◦ appropriate provider-administered medications;
	  ◦ ultrasounds, and
	  ◦ histological examination of tissue samples.
	• Surgical implants.
	• Other artificial aids including surgical implants.
	• Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.
	• Orthodontic services for treatment of craniofacial anomalies requiring or resulting from surgical intervention including, but not limited to:
	  ◦ cleft lip or palate;
	  ◦ severe skeletal and/or congenital deviations;
	  ◦ severe facial asymmetry including skeletal and/or congenital origins; and
	  ◦ non-functional full Class II bite relationship and non-functional Class III bite relationship as defined by the American Association of Oral and Maxillofacial Surgeons' classification of occlusion or malocclusion.

Skilled Nursing Facilities (Includes	Medically necessary services include, but are not limited to, the following: • Semi-private room and board. • Regular nursing services.

Type of Benefit	Description of Benefit
Rehabilitation Hospitals) Modified by Version 1.3	• Rehabilitation services. • Medical supplies and use of appliances and equipment furnished by the facility. • 60 days per 12-month period limit.
Tobacco Cessation Programs	• Covered up to $100 for a 12-month period limit for a plan-approved program. • Health Plan defines plan-approved program.
Chiropractic Services	• Medically necessary services do not require physician prescription and are limited to spinal subluxation. • Twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit). Requires authorization for additional visits.

Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center
Modified by Versions 1.3 and 1.7
	Medically necessary services include, but are not limited to, the following services provided in a hospital clinic, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:
	• X-ray, imaging, and radiological tests (technical component).
	• Laboratory and pathology services (technical component).
	• Machine diagnostic tests.
	• Ambulatory surgical facility services.
	• Drugs, medications and biologicals.
	• Casts, splints, dressings..
	• Preventive health services.
	• Physical, occupational and speech therapy.
	• Renal dialysis.
	• Respiratory Services.
	• Radiation and chemotherapy.
	• Blood or blood products not provided free-of-charge to the patient and the administration of these products.
	• Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility.
	• Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
	  ◦ dilation and curettage (D&C) procedures;
	  ◦ appropriate provider-administered medications;
	  ◦ ultrasounds, and
	  ◦ histological examination of tissue samples.
	• Surgical implants.
	• Other artificial aids including surgical implants.
	• Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.
	• Orthodontic services for treatment of craniofacial anomalies requiring or resulting from surgical intervention including, but not limited to:
	  ◦ cleft lip or palate;
	  ◦ severe skeletal and/or congenital deviations;
	  ◦ severe facial asymmetry including skeletal and/or congenital origins; and
	• non-functional full Class II bite relationship and non-functional Class III bite relationship as defined by the American Association of Oral and Maxillofacial Surgeons' classification of occlusion or malocclusion.

<table>
<tr><td>Physician/Physician Extender Professional Services

Modified by Version 1.7</td><td>Medically necessary services include, but are not limited to, the following:

American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations).
Physician office visits, inpatient and outpatient services.
Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation.
Medications, biologicals and materials administered in physician's office.
Allergy testing, serum and injections.
Professional component (in/outpatient) of surgical services, including:
Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care.
Administration of anesthesia by physician (other than surgeon) or CRNA.
Second surgical opinions.
Same-day surgery performed in a hospital without an over-night stay.
Invasive diagnostic procedures such as endoscopic examination.
Hospital-based physician services (including physician-performed technical and interpretative components).
In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to:

dilation and curettage (D&C) procedures;
appropriate provider-administered medications;
ultrasounds, and
histological examination of tissue samples.

Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.
Orthodontic services for treatment of craniofacial anomalies requiring or resulting from surgical intervention including, but not limited to:

cleft lip or palate;
severe skeletal and/or congenital deviations;
severe facial asymmetry including skeletal and/or congenital origins; and
non-functional full Class II bite relationship and non-functional Class III bite relationship as defined by the American Association of Oral and Maxillofacial Surgeons' classification of occlusion or malocclusion.

</td></tr>
<tr><td>Durable Medical Equipment (DME), Prosthetic Devices and
Disposable Medical Supplies

Modified by Version 1.7</td><td>$20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Covered services include DME (equipment which can withstand repeated use, and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury or disability, and is appropriate for use in the home), devices and supplies that are medically necessary and necessary for one or more activities of daily living, and appropriate to assist in the treatment of a medical condition, including, but not limited to:

Orthotic braces and orthotics.
Dental devices
Prosthetic devices such as artificial eyes, limbs and braces.
Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease.
</td></tr>
</table>

	• Hearing aids. • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements.
Home and Community Health Services	Medically necessary services are provided in the home and community and include, but are not limited to: • Home infusion. • Respiratory therapy. • Private Duty Nursing (R.N., L.V.N.). • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). • Home health aide when included as part of a plan of care during a period that skilled visits have been approved. • Speech, physical and occupational therapies. Services are not intended to replace the child's caretaker or to provide relief for the caretaker. Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services. Services are not intended to replace 24-hour inpatient or skilled nursing facility services.
Inpatient Mental Health Services	Medically necessary services include, but are not limited to: • Mental health services furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities. • Inpatient mental health services are limited to 45 days per 12-month period. • Includes inpatient psychiatric services, up to 12-month period limit, ordered 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. Court order serves as binding determination of medical necessity. Any modification of services must be presented to the court with jurisdiction over the matter for determination. • 25 days of the inpatient benefit can be converted to residential treatment, therapeutic foster care or other 24-hour therapeutically planned and structured services or sub-acute outpatient (partial hospitalization or rehabilitative day treatment) mental health services on the basis of financial equivalence against the inpatient per diem cost. • 20 of the inpatient days must be held in reserve for inpatient use only. • Does not require PCP referral. • Neuropsychological and psychological testing.
Outpatient Mental Health Services Modified by Version 1.7	• Medically necessary services include, but are not limited to, mental health services provided on an outpatient basis. • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility. • Includes outpatient psychiatric services, up to 12-month period limit, ordered 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, or placements as a Condition of Probation as authorized by the Texas Family Code. Court order serves as binding determination of medical necessity. Any modification of services must be presented to the court with jurisdiction over the matter for determination. • Up to 60 days per 12-month period limit for rehabilitative day treatment. • 60 outpatient visits per 12-month period limit. • 60 rehabilitative day treatment days can be converted to outpatient visits on the basis of financial equivalence against the day treatment per diem cost. • 60 outpatient visits can be converted to skills training (psycho educational skills development) or rehabilitative day treatment on the basis of financial equivalence against the outpatient visit cost.

	• Inpatient days converted to sub-acute outpatient services are in addition to the outpatient limits and do not count towards these limits. • Does not require PCP referral. • Medication management visits do not count against the outpatient visit limit. • Neuropsychological and psychological testing. • 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(31). 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.
Inpatient Substance Abuse Treatment Services	Medically necessary services include, but are not limited to: • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs. • Medically necessary detoxification/stabilization services, limited to 14 days per 12-month period. • 30 days may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost. • 30 days must be held in reserve for inpatient use only. • Does not require PCP referral. • 24-hour residential rehabilitation programs, or the equivalent, up to ~~30~~ 60 days per 12-month period.
Outpatient Substance Abuse Treatment Services	Medically necessary outpatient substance abuse treatment services include, but are not limited to: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. • Includes aftercare for chemical dependency services that primarily focus on relapse prevention to the member who completed treatment and/or their family members. • Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day. • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training. • Does not require PCP referral. • Outpatient treatment services up to a maximum of: • Intensive outpatient program (up to 12 weeks per 12-month period). • Outpatient services (up to six-months per 12-month period).
Rehabilitation Services Modified by Version 1.3	Medically necessary habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to, the following: • Physical, occupational and speech therapy. • Developmental assessment.

Hospice Care Services	Medically necessary hospice services include, but are not limited to: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death. • Treatment for unrelated conditions is unaffected. • Services apply to the hospice diagnosis. • Up to a maximum of 120 days with a 6-month life expectancy. • Patients electing hospice services waive their rights to treatment related to their terminal illnesses; however, they may cancel this election at anytime.
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Modified by Version 1.3	Health plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Medically necessary covered services include: • Emergency services based on prudent lay person definition of emergency health condition. • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers. • Medical screening examination. • Stabilization services. • Access to DSHS designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services. • Emergency ground, air or water transportation.
Vision Benefit	Medically necessary services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization. • One pair of non-prosthetic eyewear per 12-month period. • The health plan may reasonably limit the cost of the frames/lenses. • Requires authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.
Transplants	Medically necessary services include: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.

Modified by Version 1.7

CHIP EXCLUSIONS FROM COVERED SERVICES

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Personal comfort items including butnot limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment flight clearance, camps, insurance or court, or evaluations required by third parties.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Dental devices solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
- Routine refraction services and glasses/contacts
- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice.
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training and vision therapy.
- Reimbursement for physical therapy, occupational therapy, and speech therapy school-based services are not covered except when ordered by a physician/PCP
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan

Modified by Version 1.7

CHIP DME/SUPPLIES

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing..
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X	.	For covered DME items
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for medically necessary treatment of craniofacial anomalies requiring surgical intervention.
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery
Electrodes	X		Eligible for coverage when used with a covered DME.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: • Identification of a metabolic disorder , dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula: • For members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the parenteral nutrition has been authorized by the Health Plan.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	August 19, 2004	Initial version of Attachment B-2, Covered Services
Revision	1.1	September 1, 2006	Contract Amendment 1 replaced the initial version of Attachment B-2, HHSC CHIP EPO Covered Services with a revised version.
Revision	1.2	March 1, 2006	Contract Amendment 2 did not revise Attachment B-2, CHIP EPO Covered Services.
Revision	1.3	September 1, 2006	Revised Attachment B-2, Covered Services, by adding Attachment B-2.1, CHIP Perinatal Covered Services. This is the initial version of Attachment B-2.1, which lists the CHIP Perinatal Covered Services, exclusions and DME/Supplies.
Revision	1.4	September 1, 2007	Contract Amendment 4 did not revise Attachment B-2.1, CHIP Perinatal Covered Services.
Revision	1.5	September 1, 2008	Contract Amendment did not revise Attachment B-2.1, CHIP Perinatal Covered Services.
Revision	1.6	April 1, 2009	Contract Amendment did not revise Attachment B-2.1, CHIP Perinatal Covered Services.
Revision	1.7	September 1, 2009	Modified Attachment B-2 as follows: 1. CHIP Perinatal Covered Services "Inpatient General Acute and Inpatient Rehabilitation Hospital Services" is modified to clarify the requirements regarding miscarriage and non-viable pregnancy. 2. CHIP Perinatal Covered Services "Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center" is modified to clarify the requirements regarding miscarriage and non-viable pregnancy.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			3. CHIP Perinatal Covered Services “Physician/Physician Extender Professional Services” is modified to clarify the requirements regarding miscarriage and non-viable pregnancy. 4. “Outpatient Mental Health Services” is revised to provide additional clarity as it relates to Qualified Mental Health Providers – Community Services (QMHP-CS). 5. CHIP Perinatal Covered Services “Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services” is modified to clarify the requirements regarding miscarriage and non-viable pregnancy. 6. CHIP Perinatal Program Exclusions From Covered Services For CHIP Perinates is modified to clarify the requirements regarding miscarriage and non-viable pregnancy.

[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.

CHIP Perinatal Program Covered Services

Covered CHIP Perinatal Program services must meet the definition of Medically Necessary Covered Services as defined in this **Contract**. There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays do not apply to CHIP Perinatal Program Members. CHIP Perinatal Program Members are eligible for 12-months continuous coverage following enrollment in the program.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
Inpatient General Acute and Inpatient Rehabilitation Hospital Services Modified by Version 1.7	For CHIP Perinate Newborns in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit for the initial Perinate Newborn admission; however, facility charges are a covered benefit after the initial Perinate Newborn admission. "Initial Perinate Newborn admission" means the hospitalization associated with the birth. For CHIP Perinate Newborns in families with incomes at or below 185% of the Federal Poverty Level, professional service charges are a covered benefit for the initial Perinate Newborn admission and subsequent admissions. "Initial Perinate Newborn admission" means the hospitalization associated with the birth. Medically Necessary Services include, but are not limited to, the following: ▪ Hospital-provided Physician or Provider services. ▪ Semi-private room and board (or private if medically necessary as certified by attending). ▪ General nursing care. ▪ Special duty nursing when medically necessary. ▪ ICU and services. ▪ Patient meals and special diets. ▪ Operating, recovery and other treatment rooms. ▪ Anesthesia and administration (facility technical component). ▪ Surgical dressings, trays, casts, splints. ▪ Drugs, medications and biologicals. ▪ Blood or blood products that are not provided free-of-charge to the patient and their administration. ▪ X-rays, imaging and other radiological tests (facility technical component). ▪ Laboratory and pathology services	For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with incomes between 186% and 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or a non-viable pregnancy. Services include: ▪ Operating, recovery and other treatment rooms ▪ Anesthesia and administration (facility technical component) Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit. Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: • dilation and curettage (D&C) procedures; • appropriate provider-administered medications; • ultrasounds, and histological examination of tissue samples.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	(facility technical component). ▪ Machine diagnostic tests (EEGs, EKGs, etc.) ▪ Oxygen services and inhalation therapy. ▪ Radiation and chemotherapy. ▪ Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care. ▪ In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. ▪ Hospital, physician and related medical services, such as anesthesia, associated with dental care. ▪ Surgical implants. ▪ Other artificial aids including surgical implants. ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.	▪
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Medically Necessary Services include, but are not limited to, the following: ▪ Semi-private room and board. ▪ Regular nursing services. ▪ Rehabilitation services. ▪ Medical supplies and use of appliances and equipment furnished by the facility. ▪ 60 days per 12 month limit	Not a covered benefit.
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Modified by Version 1.7	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: ▪ X-ray, imaging, and radiological tests (technical component) ▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Ambulatory surgical facility services ▪ Drugs, medications and biologicals ▪ Casts, splints, dressings ▪ Preventive health services ▪ Physical, occupational and speech	Services include, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: ▪ X-ray, imaging, and radiological tests (technical component) ▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Drugs, medications and biologicals that are medically necessary prescription and injection drugs. ▪ Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	therapy ▪ Renal dialysis ▪ Respiratory services ▪ Radiation and chemotherapy ▪ Blood or blood products that are not provided free-of-charge to the patient and the administration of these products ▪ Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. ▪ Surgical implants ▪ Other artificial aids including surgical implants ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.	pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: ▪ dilation and curettage (D&C) procedures; ▪ appropriate provider-administered medications; ▪ ultrasounds, and histological examination of tissue samples. (1) Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth. (2) Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation or miscarriage or non-viable pregnancy. (3) Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis. (4) Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinanalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
		care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client. (5) Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit.
Physician/ Physician Extender Professional Services Modified by Version 1.7	Services include, but are not limited to, the following: ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations) ▪ Physician office visits, in-patient and out-patient services ▪ Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation ▪ Medications, biologicals and materials administered in Physician's office ▪ Allergy testing, serum and injections ▪ Professional component (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care - Administration of anesthesia by Physician (other than surgeon) or CRNA - Second surgical opinions - Same-day surgery performed in a Hospital without an over-night stay - Invasive diagnostic procedures such as endoscopic examinations ▪ Hospital-based Physician services (including Physician-performed technical and interpretive components) ▪ In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. ▪ Physician services medically necessary to support a dentist providing dental services to a CHIP member such as	Services include, but are not limited to the following: ▪ Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth ▪ Physician office visits, in-patient and out-patient services ▪ Laboratory, x-rays, imaging and pathology services including technical component and /or professional interpretation ▪ Medically necessary medications, biologicals and materials administered in Physician's office ▪ Professional component (in/outpatient) of surgical services, including: o Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. o Administration of anesthesia by Physician (other than surgeon) or CRNA o Invasive diagnostic procedures directly related to the labor with delivery of the unborn child. o Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) ▪ Hospital-based Physician services (including Physician performed technical and interpretive components) ▪ Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	general anesthesia or intravenous (IV) sedation.	pregnancy, fetal growth retardation, or gestational age confirmation. ▪ Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT. ▪ Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to: ▪ dilation and curettage (D&C) procedures; ▪ appropriate provider-administered medications; ▪ ultrasounds, and histological examination of tissue samples.
Prenatal Care and Pre-Pregnancy Family Services and Supplies	Not a covered benefit.	Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: (1) One visit every four weeks for the first 28 weeks or pregnancy; (2) one visit every two to three weeks from 28 to 36 weeks of pregnancy; and (3) one visit per week from 36 weeks to delivery. More frequent visits are allowed as Medically Necessary. Benefits are limited to: Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: ▪ interim history (problems, marital status, fetal status); ▪ physical examination (weight, blood pressure, fundalheight, fetal position and size, fetal heart rate, extremities)

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
		and ▪ laboratory tests (urinanalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	$20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including: ▪ Orthotic braces and orthotics ▪ Prosthetic devices such as artificial eyes, limbs, and braces ▪ Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease ▪ Hearing aids ▪ Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. (See Attachment A)	Not a covered benefit.
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: ▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.) ▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.).	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	▪ Home health aide when included as part of a plan of care during a period that skilled visits have been approved. ▪ Speech, physical and occupational therapies. ▪ Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker ▪ Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services ▪ Services are not intended to replace 24-hour inpatient or skilled nursing facility services	
Inpatient Mental Health Services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: ▪ Neuropsychological and psychological testing. ▪ Inpatient mental health services are limited to: ▪ 45 days 12-month inpatient limit ▪ Includes inpatient psychiatric services, up to 12-month period limit, ordered 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. Court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination ▪ 25 days of the inpatient benefit can be converted to residential treatment, therapeutic foster care or other 24-hour therapeutically planned and structured services or sub-acute outpatient (partial hospitalization or rehabilitative day treatment) mental health services on the basis of financial equivalence against the inpatient per diem cost ▪ 20 of the inpatient days must be held in reserve for inpatient use only ▪ Does not require PCP referral	Not a covered benefit.
Outpatient Mental	Mental health services, including for	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
Health Services Modified by Version 1.7	serious mental illness, provided on an outpatient basis, including, but not limited to: ▪ Medication management visits do not count against the outpatient visit limit. ▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility ▪ Up to 60 days 12-month period limit for rehabilitative day treatment ▪ 60 outpatient visits 12-month period limit ▪ 60 rehabilitative day treatment days can be converted to outpatient visits on the basis of financial equivalence against the day treatment per diem cost ▪ 60 outpatient visits can be converted to skills training (psycho educational skills development) or rehabilitative day treatment on the basis of financial equivalence against the outpatient visit cost ▪ Includes outpatient psychiatric services, up to 12-month period limit, ordered 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. Court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination ▪ Inpatient days converted to sub-acute outpatient services are in addition to the outpatient limits and do not count towards those limits ▪ 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(31). 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	

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	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 ▪ Does not require PCP referral	
Inpatient Substance Abuse Treatment Services	Services include, but are not limited to: ▪ Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs ▪ Does not require PCP referral ▪ Medically necessary detoxification/stabilization services, limited to 14 days per 12-month period. ▪ 24-hour residential rehabilitation programs, or the equivalent, up to 60 days per 12-month period ▪ 30 days may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost ▪ 30 days must be held in reserve for inpatient use only.	Not a covered benefit.
Outpatient Substance Abuse Treatment Services	▪ Services include, but are not limited to, the following: ▪ Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. ▪ Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day ▪ Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training ▪ Outpatient treatment services up to a maximum of: ▪ Intensive outpatient program (up to 12	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	weeks per 12-month period) ▪ Outpatient services (up to six-months per 12-month period) ▪ Does not require PCP referral	
Rehabilitation Services	Services include, but are not limited to, the following: ▪ Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: ▪ Physical, occupational and speech therapy ▪ Developmental assessment	Not a covered benefit.
Hospice Care Services	Services include, but are not limited to: ▪ Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death ▪ Treatment for unrelated conditions is unaffected ▪ Up to a maximum of 120 days with a 6 month life expectancy ▪ Patients electing hospice services waive their rights to treatment related to their terminal illnesses; however, they may cancel this election at anytime ▪ Services apply to the hospice diagnosis	Not a covered benefit.
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Modified by Version 1.7	HMO cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include, but are not limited to, the following: ▪ Emergency services based on prudent lay person definition of emergency health condition ▪ Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers ▪ Medical screening examination ▪ Stabilization services ▪ Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services ▪ Emergency ground, air and water	HMO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery. Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth. ▪ Emergency services based on prudent lay person definition of emergency health condition ▪ Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. ▪ Stabilization services related to the labor with delivery of the covered unborn child. ▪ Emergency ground, air and water transportation for labor and

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	transportation ▪ Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.	threatened labor is a covered benefit ▪ Emergency ground, air and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit. Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
Transplants	Services include, but are not limited to, the following: ▪ Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.	Not a covered benefit.
Vision Benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include: ▪ One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization ▪ One pair of non-prosthetic eyewear per 12-month period	Not a covered benefit.
Chiropractic Services	▪ Services do not require physician prescription and are limited to spinal subluxation.	Not a covered benefit.
Tobacco Cessation Program	Covered up to $100 for a 12- month period limit for a plan- approved program ▪ Health Plan defines plan-approved program. ▪ May be subject to formulary requirements.	Not a covered benefit.
Case Management and Care Coordination Services	These services include outreach informing, case management, care coordination and community referral.	Covered benefit.
Value-added services	*See Attachment B-3.2*	

CHIP PERINATAL PROGRAM EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATES

Modified by Version 1.7

- For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit for the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a) miscarriage and (b) a non-viable pregnancy, and postpartum care related to the covered unborn child until birth.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies.
- Home and community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the labor with delivery of the covered unborn child.
- Transplant services.
- Tobacco Cessation Programs.
- Chiropractic Services.
- Medical transportation not directly related to labor or threatened labor, miscarriage or non-viable pregnancy, and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor with delivery or post partum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery

- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor with delivery of the covered unborn child.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training, vision therapy, or vision services
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered
- Donor non-medical expenses
- Charges incurred as a donor of an organ

CHIP PERINATAL PROGRAM EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATE NEWBORNS

With the exception of the first bullet, all the following exclusions match those found in the CHIP Program.

- For CHIP Perinate Newborns in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit for the initial Perinate Newborn admission. "Initial Perinate Newborn admission" means the hospitalization associated with the birth.
- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes

- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan

CHIP & CHIP PERINATAL PROGRAM DME/SUPPLIES

Note: DME/SUPPLIES are not a covered benefit for CHIP Perinate Members but are a benefit for CHIP Perinate Newborns.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X	.	For covered DME items
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery
Electrodes	X		Eligible for coverage when used with a covered DME.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula: • For members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	August 19, 2004	Initial version of Attachment B-3, EPO Value Added Services.
Revision	1.1	September 1, 2006	Contract Amendment 1 did not revise Attachment B-3.
Revision	1.2	March 1, 2006	Contract Amendment 2 did not revise Attachment B-3.
Revision	1.3	September 1, 2006	Revised version of Attachment B-3, EPO Value Added Services, that clarifies that Value Added Services apply to both CHIP EPO Program and CHIP Perinatal Program Members.
Revision	1.4	September 1, 2007	Contract Amendment 4 did not revise Attachment B-3.
Revision	1.5	September 1, 2008	Contract Amendment did not revise Attachment B-3.
Revision	1.6	April 1, 2009	Contract Amendment did not revise Attachment B-3.
Revision	1.7	September 1, 2009	Revised Attachment B-3, Value-added Services, to reflect newly negotiated Value-added Services for FY 2010.

[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.

Attachment B-3
Value-added Services

Modified by Versions 1.3 and 1.7

1. Nurse Hotline. The EPO will provide, as a Value-added Service to its CHIP EPO Program and CHIP Perinatal Program Members, an after-hours phone line called NurseWise (SM). NurseWise will be staffed by registered nurses who can answer Members' health questions and get them the help they need, 24 hours a day, 7 days a week.

2. Healthy Rewards Account. Superior will provide pregnant Members a MasterCard® Debit card with a specific dollar amount of credit upon their completion of a specified visit as part of Superior's "Start Smart" prenatal health program. With the card, Members may purchase approved health care goods and services online or at more than 150 retailers that accept MasterCard® Debit cards, such as Wal-Mart, Walgreens, Target, and CVS. Examples of items that may be purchased include over-the-counter drugs such as Tylenol, Motrin, Claritin, and Zyrtec; eyeglasses; and disposable diapers.

   Pregnant Members will receive credit on their Healthy Rewards Account debit card for completing the following visits:

   - Second prenatal visit completed: $30 credit
   - Fifth prenatal visit completed: $30 credit
   - Thirteenth prenatal visit completed: $30 credit
   - One post-partum visit completed: $30 credit

   Purchases must be made from retailers that accept the MasterCard® Debit card. Items eligible for purchase under this benefit are over-the-counter, health related items only, as designated through the Inventory Information Approval System (IIAS), as well as disposable diapers.

   In order for credit to be placed on the Member's debit card, the Member must receive one of the specified prenatal/post-partum examinations, and the Member's provider must file a claim with Superior for the service.

   The issued amount of credit is valid for one year.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	August 19, 2004	Initial version of Attachment B-4, Tailored Remedies Matrix.
Revision	1.1	September 1, 2006	Contract Amendment 1 did not revise Attachment B-4, Tailored Remedies Matrix.
Revision	1.2	March 1, 2006	Contract Amendment 2 revised Attachment B-4, Tailored Remedies Matrix, to include quarterly measurement periods for items 8.2.1.5.3(E) and 8.2.1.7.
Revision	1.3	September 1, 2006	Contract Amendment 3 revised Attachment B-4, Tailored Remedies Matrix, as follows: 8.2.1.7 modified to include a remedy for failure to meet Member complaints or appeals resolution target.
Revision	1.4	September 1, 2007	Contract Amendment 4 revised Attachment B-4, Tailored Remedies Matrix as follows: 1. Section 8.2.1.5.3 modified to revise the call center performance standards; 2. Section 8.2.1.5.5 modified to revise the call abandonment rate; 3. Section 8.2.1.6 modified to clarify that remedies apply to claims by type; 4. Section 8.2.1.6.1 added; and 5. Section 8.2.1.7 modified to revise the call center performance standards.
Revision	1.5	September 1, 2008	Contract Amendment 5 revised Attachment B-4, Tailored Remedies Matrix as follows: 1. Section 8.2.1.5.3 is modified to bring it into alignment with the Uniform Managed Care Contract 2. General Requirement: Failure to Perform an Administrative Service is clarified. 3. General Requirement: Failure to Provide a Covered Service is added.

Revision	1.6	April 1, 2009	Contract Amendment 6 revised Attachment B-4, Tailored Remedies Matrix as follows: 1. Item 6 Provider Call Center Services (8.2.1.5.3) is modified to be consistent with the Uniform Managed Care Contract. 2. Item 12 Behavioral Health Services Hotline (8.2.1.5.5) is modified to be consistent with the Uniform Managed Care Contract. 3. Item 14 Member Services (8.2.1.7) is modified to be consistent with the Uniform Managed Care Contract. 4. Item 27 General Requirement: Failure to Provide a Covered Service modified to clarify calendar day in the final sentence.
Revision	1.7	September 1, 2009	Contract Amendment 7 revised Attachment B-4, Tailored Remedies Matrix as follows: Line 21.5 Contract Attachment B-1 RFP §8.3.1.3.9 Encounter Data is added

[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.

Exclusive Provider Organization Contract

Tailored Remedies Matrix

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[4]	Measurement Assessment[5]	Liquidated Damages[3]
1.	Financial Accounting Requirements 6.5.3.2	The EPO must establish and maintain an accounting system in accordance with generally accepted accounting principles and/or statutory accounting principles and the cost principles contained in the HHSC Uniform Managed Care Manual. The records will be maintained separate and apart from other unrelated corporate accounting records.	Ongoing	Each month of non-compliance	HHSC may assess up to $10,000 for the EPO's failure to meet the requirements in any given month.
2.	Financial Reporting 6.5.5.2	Create and provide financial reports as stated in this section of the RFP, including the requirements of the actuarial opinion, and maintain the process documentation for each report.	Ongoing	Per report.	HHSC may assess up to $1,000.00 per calendar day for each report that is late, incomplete or inaccurate.
3.	Transfer of Data 7.2; Post-Turnover Services – 7.3.1	The EPO must transfer all data regarding the provision of health care services to CHIP eligible clients and EPO operations to HHSC or a new EPO, at the sole discretion of HHSC and as directed by HHSC.	Turnover	Each incident of non-compliance.	HHSC may assess up to $5,000.00 per calendar day for each calendar day past the due date for each incident of where the EPO has failed to provide the data, or the data is inaccurate or incomplete. The transfer of data date will be determined by HHSC.

[1] Service and components are derived from Contract Attachment B-1.
[2] Standard specified in Attachment B-1.
[3] HHSC will have the sole discretion to determine whether the deliverables materially comply with the Contract requirements. HHSC may waive liquidated damages in accordance with Section 12.02(e) of the EPO Managed Care Contract Terms and Conditions.
[4] Period during which service will be evaluated for purposes of application of tailored remedies.
[5] Measure against which a remedy will be applied.

Exclusive Provider Organization Contract

Tailored Remedies Matrix

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[4]	Measurement Assessment[5]	Liquidated Damages[3]
4.	Turnover Services 7.3	Six months prior to the end of the initial contract period or any extension thereof, the EPO must develop and implement a State-approved Turnover Plan covering the possible turnover of the records and information maintained to either the State or a successor EPO. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks.	Turnover	Each calendar day of non-compliance.	HHSC may assess up to $1000.00 per calendar day for each day the Turnover Plan is late, incomplete or inaccurate.
5.	Post-Turnover Services 7.3.1	Turnover Results report documenting the completion and results of each step of the Turnover Plan.	Turnover	Each calendar day of non-compliance.	HHSC may assess up to $250.00 per calendar day for each day that the Turnover Results report is late, incomplete or inaccurate.
6.	Provider Call Center Services 8.2.1.5.3 Section 8.2.1.5.3 modified by Versions 1.4, 1.5, and 1.6	A. The EPO must operate a toll-free Provider telephone hotline for Provider inquiries staffed with personnel from 8 AM – 5 PM, local time for the Service Area(s), Monday through Friday, excluding State approved holidays. B. Performance Standards: 1. Call pickup rate -- At least 99% of calls are answered on or before the fourth ring or an automated call pick up system is used; and	Operations and Turnover	A. Each incident of non-compliance B. Per month, each percentage point below the standard for1 and 2. C. Per month, for each 30 second time increment,	A. Up to $100.00 per hour may be assessed for each hour appropriately staffed toll-free lines are not operational. If the EPO's failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the EPO fails to implement its Disaster Recovery Plan. B. Up to $100.00 may be assessed for each percentage point for each standard that the EPO fails to meet the requirements for a monthly reporting period for the EPO's toll-free Provider Hotline.

Exclusive Provider Organization Contract

Tailored Remedies Matrix

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[4]	Measurement Assessment[5]	Liquidated Damages[3]
		2. Call abandonment rate – 7% or less C. Average hold time is 2 minutes or less.		or portion thereof, by which the average hold time exceeds the maximum acceptable hold time.	C. Up to $100.00 may be assessed for each 30 second time increment, or portion thereof, by which the EPO's average hold time exceeds the maximum acceptable hold time.
7.	Provider Services 8.2.1.5.3 8.2.1.5.3(E) modified by Amendment 2	E. Submit a report to HHSC summarizing call center performance for the provider toll-free line.	Quarterly during Operations and Turnover. Submit the report for the previous SFQ no later than the 15th of each month.	Each incident of non-compliance.	HHSC may assess up to $500.00 per report that is late, incomplete or inaccurate.
8.	HHSC's Uniform Managed Care Manual	The EPO will make its CHIP provider contract available for downloading from its website.	By September 1, 2004	Each calendar day of non-compliance beginning September 1, 2004	HHSC may assess up to $1,000.00 per calendar day for each day of that the standard is not met.
9.	Provider Services	The initial template of each provider directory must be submitted to HHSC for approval no later than 60 days prior to implementation.	At least 60 days prior to the Implementation	Each calendar day of non-compliance beginning 60	HHSC may assess up to $250.00 per calendar day for each day after the due date that the initial Provider Directory template is not received.

Exclusive Provider Organization Contract

Tailored Remedies Matrix

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[4]	Measurement Assessment[5]	Liquidated Damages[3]
	8.2.1.5.3		Start Date	days prior to the Start of Operations	
10.	Provider Services 8.2.1.5.3	Updates to the Provider Directory The provider directories will be updated quarterly, unless there are more than 300 additions and/or deletions to the directory. If the update exceeds 300 additions and/or deletions, a revised directory will be printed.	Monthly during Operations	Each calendar day of non-compliance with the performance standard.	HHSC may assess up to $250.00 per calendar day for failure to provide an accurate and complete update or revised Provider Directory.
11.	Provider Services 8.2.1.5.3	Mail a revised directory to all current Members and new Members. No later than three months post-implementation, the EPO will mail a revised directory to all current Members and deliver revised directories to the State's administrative contract for mail-out to new members that reflects the network as it exists 15-days prior to the mailing date.	Three months post operation start date	Each calendar day after the due date that the directory is not mailed	HHSC may assess up to $250.00 per calendar day for each day past the due date that the EPO fails to mail the complete and accurate revised directory to the current members and/or deliver complete and accurate revised directories to the State's administrative contractor to be mailed to any new members.
12.	Behavioral Health Services Hotline 8.2.1.5.5	A. The EPO must have an emergency and crisis Behavioral Health Services Hotline available 24 hours a day, 7 days a week, toll-free throughout the Service Area(s). B. Crisis hotline staff must include or have	Operations and Turnover	A. Each incident of non-compliance	A. Up to $100.00 per hour may be assessed for each hour appropriately staffed toll-free lines are not operational. If the EPO's failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the EPO fails to implement its Disaster

Exclusive Provider Organization Contract

Tailored Remedies Matrix

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[4]	Measurement Assessment[5]	Liquidated Damages[3]
		access to qualified Behavioral Health Services professionals to assess behavioral health emergencies. C. The EPO must ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for the EPO Program: 1. 99% of calls are answered by the fourth ring or an automated call pick-up system; 2. at least 80% of calls must be answered by toll-free line staff within 30 seconds; 3. the call abandonment rate is 7% or less. D. Average hold time is 2 minutes or less.		B. Each incident of non-compliance C. Per month, each percentage point below the standard for1 and 2; and each 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.	Recovery Plan. B. Up to $100 per incident may be assessed for each occurrence that HHSC identifies through its recurring monitoring processes that toll-free line staff were not knowledgeable of the CHIP program and covered Behavioral Health Care Services. C. Up to $100.00 may be assessed for each percentage point for each standard that the EPO fails to meet the requirements for a monthly reporting period for the EPO's emergency and crisis Behavioral Health Services Hotline. D. Up to $100.00 may be assessed for each 30 second time increment, or portion thereof, by which the EPO's average hold time exceeds the maximum acceptable hold time.
13.	Materials sent to Member 8.2.1.7	No later than the fourth business day following the receipt of the enrollment file from the Administrative Services Contractor, the EPO must mail a member's ID card, and evidence of coverage or Member handbook to the CHIP account name for each new member. When the	• Quarterly (each month measured separately.	Each incident that materials are not mailed to the CHIP account.	HHSC may assess up to $500.00 per incident of the EPO's failure to mail member materials to the CHIP account name for each new member.

Exclusive Provider Organization Contract

Tailored Remedies Matrix

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[4]	Measurement Assessment[5]	Liquidated Damages[3]
		CHIP account name is on behalf of two or more new members, only one provider directory and member handbook must be sent.	• Ongoing for complaints and reports from members.		
14.	Member Services 8.2.1.7 Section 8.2.1.7 modified by Versions 1.4 and 1.6	A. The EPO must operate a separate toll-free hotline that Members can call 24 hours a day, seven (7) days a week. B, 1. Call pickup rate -- At least 99% of calls are answered on or before the fourth ring or an automated call pick up system is used. 2. Call hold rate – 80% of calls must be answered by a live person within 30 seconds. 3. Call abandonment rate is 7% or less. C. Average hold time is 2 minutes or less.	Ongoing during Operations and Turnover	A. Each incident of non-compliance B. Each percentage point below the standard for 1 and 2 and each percentage point above the standard for 3. C. Per month, for each 30 second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time.	A. Up to $100.00 per hour may be assessed for each hour toll-free lines are not available. If the EPO's failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the EPO fails to implement its Disaster Recovery Plan. B. Up to $100.00 may be assessed for each percentage point for each standard that the EPO fails to meet the requirements for a monthly reporting period for the EPO's Member Services Hotline. C. Up to $100.00 may be assessed for each 30 second time increment, or portion thereof, by which the EPO's average hold time exceeds the maximum acceptable hold time.

Exclusive Provider Organization Contract

Tailored Remedies Matrix

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[4]	Measurement Assessment[5]	Liquidated Damages[3]
15.	Member Services 8.2.1.7 Section 8.2.1.7 modified by Amendment 2	Call Center Performance Report -- Submit a report to HHSC summarizing call center performance for the member toll-free line.	Quarterly during Operations and Turnover. Submit the report for the previous SFQ no later than the 15th of each month.	Each incident of non-compliance.	HHSC may assess up to $500.00 per report that is late, inaccurate or incomplete.
16.	Member Services 8.2.1.7 Section 8.2.1.7 modified by Version 1.3	At least 98 percent of Member complaints or appeals must be resolved within 30 days of receipt of the complaint or appeal by the EPO.	Measured quarterly during the operations period.	Per reporting period.	HHSC may assess up to $250 per reporting period if the EPO fails to meet the performance standard.
17.	Required Reports – unless specified otherwise, this standard applies to all plans and reports required by the contract, including those set forth in	The EPO must produce the plans and reports as specified in the contract, including the following: • Annual Business Plan • Claims Data Specifications Report • "All Claims Summary Report" • Provider Network Report	Ongoing. Initial reports are due as agreed by the Parties and ongoing reports for the previous month are due by the 10th business day of the month	Each incident of non-compliance..	HHSC may assess up to $500.00 per calendar day per report for any report that is late, incomplete, or inaccurate.

Exclusive Provider Organization Contract

Tailored Remedies Matrix

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[4]	Measurement Assessment[5]	Liquidated Damages[3]
	Performance Reporting, 8.2.3.7	• Provider Specialist Report • Provider Network Change Report • Fraudulent Practices Report • Summary Report of Provider and Client Complaints • Incidence and disposition of Member • and provider complaints and appeals • Telephone status report • Ad Hoc reports • All other reports as specified in the RFP.	unless stated differently in the RFP.		
18.	System Support Requirements 8.2.1.3	Ensure all hardware and software used to support operations under this RFP complies with all requirements associated with the Health Insurance Portability and Accountability Act (HIPAA), as amended. The EPO must be capable of exchanging CHIP member data with the Administrative Services Contractor and with the External Quality Review Organization, the TPL contractor, and the Office of Inspector General at HHSC.	Prior operations Start Date and Ongoing	Each incident of non- compliance	HHSC may assess up to $1,000.00 per calendar day for each calendar day the system is not HIPAA compliant.

Exclusive Provider Organization Contract

Tailored Remedies Matrix

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[4]	Measurement Assessment[5]	Liquidated Damages[3]
19.	Claims Processing Requirements 8.2.1.6 Section 8.2.1.6 modified by Version 1.4	The EPO must comply with all claims processing requirements set forth in Section 8.2.1.6 and the Uniform Managed Care Manual.	Operations and Turnover	Per quarterly reporting period, per Claim Type and per Program.	HHSC may assess liquidated damages of up to $5,000, per Claim Type and Program, for the first quarter that the EPO's Claims Performance percentages fall below the performance standards HHSC may assess up to $25,000, per Claim Type and Program, per quarter for each additional quarter that the Claims Performance percentages fall below the performance standards.
20.	Claims Processing Requirements 8.2.1.6.1 and UMCM Chapter 2 Section 8.2.1.6.1 added by Version 1.4	The EPO must adjudicate all provider Clean Claims within 30 days of receipt by the EPO. The EPO must pay providers interest at an 18% 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.
21.	Administrative Performance Requirements 8.2.3.6	The EPO must track and respond to all complaints, as defined by TDI, regarding: The physician/patient relationship; Quality of medical care;	Operations and Turnover	Each incident that a complaint is not tracked or responded to according to the TDI regulations	HHSC may assess up to $500.00per incident of the EPO's failure to track and respond to any complaints as defined by TDI.

Exclusive Provider Organization Contract

Tailored Remedies Matrix

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[4]	Measurement Assessment[5]	Liquidated Damages[3]
		The disposition of claims; Administration of benefits; and Any other quality assurance matter.			
21.5	Contract Attachment B-1 RFP §8.3.1.3.9 Encounter Data Section 8.3.1.3.9 is added by Version 1.7	The EPO must submit Encounter Data transmissions and include all Encounter Data and Encounter Data adjustments processed by the EPO on a monthly basis, not later than the 30th day after the last day of the month in which the claim(s) are adjudicated. Additionally, the EPO will be subject to liquidated damages if the Quarterly Encounter Reconciliation Report (which reconciles the year-to-date paid claims reported in the Financial Statistical Report (FSR) to the appropriate paid dollars reported in the Texas Encounter Data (TED) Warehouse) includes more than a 2% variance (i.e., less than a 98% match).	Measured Quarterly during Operations Period	Per incident of non-compliance, per EPO Program	HHSC may assess up to $2,500 per Quarter, per EPO Program if the EPO fails to submit monthly Encounter Data. HHSC may assess up to $5,000 per quarter, per EPO Program for each additional quarter that the EPO fails to submit monthly Encounter Data. Additionally, HHSC may assess up to $2,500 per Quarter, per EPO Program if the MCO falls below the 98% match standard. HHSC may assess up to $5,000 per Quarter, per EPO Program for each additional Quarter that the MCO falls below the 98% match standard.
22.	Joint Interface Plan 9.2.1.1	The EPO must develop a Joint Interface Plan. It is due no later than 30 calendar days after the start of operations and within 10 business days after the end of each fiscal year or whenever there is a change or modification.	Operations and Turnover	Each calendar day of non-compliance.	HHSC may assess up to $1,000.00 per calendar day that the plan in late, incomplete or inaccurate.
23.	Disaster Recovery Plan and Business Continuity Plan 8.3.1.2.5 and 9.3.2.1.2,	The EPO must provide HHSC with an updated and detailed back up and Disaster Recovery Plan on an annual basis. The EPO must demonstrate disaster recovery back-up facilities' capability to HHSC at least once a year. The disaster recovery plan is due 30 calendar days prior to the	Annually, beginning 30 days prior to September 1	Each calendar day of non-compliance.	HHSC may assess up to $1,000.00 per calendar day for each day that the Disaster Plan and Business Continuity Plan are late, incomplete or inaccurate.

Exclusive Provider Organization Contract

Tailored Remedies Matrix

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[4]	Measurement Assessment[5]	Liquidated Damages[3]
	9.3.2.2.1, and 9.3.2.2.4	beginning of each state fiscal year. The EPO must provide HHSC with a Business Continuity Plan. The Plan must detail the EPO's approach to reestablishing operations in the event of a catastrophe. The Plan must be updated and submitted annually. The disaster recovery plan is due 30 calendar days prior to the beginning of each state fiscal year.			
24.	Transition Phase Tasks 9.3.1 and 9.3.2 and General Operations Requirements 8.2	Transition Phase Schedule, Transition Phase Tasks and Operations Start Date The EPO will be responsible for developing a written work plan that will be used to monitor progress throughout the Transition Phase. The EPO and HHSC will work together during initial Contract start-up to establish a schedule for key activities, milestones and define expectations for the content and format of Contract Deliverables. The EPO must begin Operations on the Agreed upon Start Date.	During the Transition period up to and including the Operations Start Date	Each incident that a critical activity or milestone is not completed by the key date as negotiated in the written work plan For the Operations Start Date – each day after the stated start date agreed to by both parties prior to signing the contract.	HHSC may assess up to $5,000 per calendar day for each day that any of the Critical Activities or milestones are not completed by the date negotiated in the written work plan. HHSC may assess up to $5000.00 per calendar day for each day beyond the agreed upon start date.
25.	Demonstration of System	The EPO must be prepared to demonstrate system readiness, which includes a facility	30 days prior to implementation	Each calendar day of non-	HHSC may assess up to $250.00 per calendar day for each day after the due date that the EPO fails to be

Exclusive Provider Organization Contract

Tailored Remedies Matrix

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[4]	Measurement Assessment[5]	Liquidated Damages[3]
	Readiness 9.3.2.2.2	review, at least 30 days prior to implementation.	of Operations	compliance – defined as each calendar day after the due date that the EPO fails to demonstrate system readiness	able to demonstrate system readiness including the facility review.
26.	General Requirement: failure to perform an Administrative Service Failure to perform an Administrative Service is modified by Version 1.5	The EPO fails to timely perform an EPO 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 places a Member at risk of imminent harm, or (2) materially affects HHSC's ability to administer the Program(s).	Ongoing	Each incident of non-compliance.	HHSC may assess up to $5,000.00 per calendar day for each incident of non-compliance.
27.	General Requirement: Failure to Provide a Covered Service Failure to Provide a Covered Service is added by Version 1.5 and modified by Version 1.6	The HMO fails to timely provide an HMO 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 $ 7,500.00 per calendar day for each incident of non-compliance.

Exclusive Provider Organization Contract Tailored Remedies Matrix					
#	Service/ Component[1]	Performance Standard[2]	Measurement		Liquidated Damages[3]
			Period[4]	Assessment[5]	
28.	General Requirement: Failure to comply with Performance Standard not described above.	Failure to meet a performance standard or requirement included in the Contract but not listed above.	Ongoing	Each calendar day of non-compliance.	Up to $250.00 per calendar day for each incident of non-compliance.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	August 19, 2004	Initial version of Attachment B-5.
Revision	1.1	September 1, 2006	Contract Amendment 1 did not revise Attachment B-5.
Revision	1.2	March 1, 2006	Contract Amendment 2 did not revise Attachment B-5.
Revision	1.3	September 1, 2006	Revised Attachment B-5 to include the CHIP Perinatal Program Service Areas.
Revision	1.4	September 1, 2007	Contract Amendment 4 did not revise Attachment B-5.
Revision	1.5	September 1, 2008	Contract Amendment 4 did not revise Attachment B-5.
Revision	1.6	April 1, 2009	Contract Amendment 4 did not revise Attachment B-5.
Revision	1.7	September 1, 2009	Contract Amendment 4 did not revise Attachment B-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.

Modified by Version 1.3

EPO Program and CHIP Perinatal Program Service Area (170 Counties)

Anderson
Andrews
Angelina
Archer
Armstrong
Bailey
Baylor
Bell
Blanco
Borden
Bosque
Bowie
Brazos
Brewster
Briscoe
Brown
Burleson
Callahan
Cameron
Camp
Cass
Castro
Cherokee
Childress
Clay
Cochran
Coke
Coleman
Collingsworth
Colorado
Comanche
Concho
Cooke
Coryell
Cottle
Crane
Crockett
Culberson
Dallam
Dawson
Delta
DeWitt
Dickens
Dimmit
Donley
Eastland
Ector
Edwards
Erath
Falls
Fannin
Fisher
Foard
Franklin
Freestone
Frio
Gaines
Gillespie
Glasscock
Gonzales
Gray
Grayson
Gregg
Grimes
Hall
Hamilton
Hansford
Hardeman
Harrison
Hartley
Haskell
Hemphill
Henderson
Hidalgo
Hill
Hopkins
Houston
Howard
Irion
Jack
Jackson
Jeff Davis
Jones
Kent
Kerr
Kimble
King
Kinney
Knox
La Salle
Lamar
Lampasas
Lavaca
Leon
Limestone
Lipscomb
Llano
Loving
Madison
Marion
Martin
Mason
Maverick
McCulloch
McLennan
McMullen
Menard
Midland
Milam
Mills
Mitchell
Montague
Moore
Morris
Motley
Nacogdoches
Nolan
Ochiltree
Oldham
Palo Pinto
Panola
Parmer
Pecos
Presidio
Rains
Reagan
Real
Red River
Reeves
Roberts
Robertson
Runnels
Rusk
Sabine
San Augustine
San Saba
Schleicher
Scurry
Shackelford
Shelby
Sherman
Smith
Somervell
Starr
Stephens
Sterling
Stonewall
Sutton
Taylor
Terrell
Throckmorton
Titus
Tom Green
Trinity
Upshur
Upton
Uvalde
Val Verde
Van Zandt
Ward
Washington
Wheeler
Wichita
Wilbarger
Willacy
Winkler
Wood
Yoakum
Young
Zavala

Modified by Version 1.3

Additional EPO Program and CHIP Perinatal Program Service Areas that may be added at HHSC's request

CSA 8	CSA 10	CSA 5
(Corpus Area)	**(Laredo Area)**	**(Travis Area)**
Aransas	Duval	Burnet
Bee	Jim Hogg	Caldwell
Brooks	Webb	Fayette
Calhoun	Zapata	Hays
Duval		Lee
Goliad		Travis
Jim Wells		Williamson
Karnes		
Kenedy		
Kleberg		
Live Oak		
Nueces		
Refugio		
San Patricio		
Victoria		