Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: Amendment Three to the Integrated Care Management Contract

Part 1: Parties to the Contract:

This Contract is 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 Evercare of Texas, L.L.C. (Contractor) a corporation organized under the laws of the State of Texas, having its principal place of business at 9700 Bissonet, Suite 2225, Houston, Texas 79902.

HHSC and HMO may be referred to in this Amendment individually as a "Party" and collectively as the "Parties."

Part 2: Effective Date of Amendment Three:	**Part 3: Contract Expiration Date**	**Part 4: Revised Operational Start Date:**
September 1, 2008	August 31, 2010	February 1, 2008

Part 5: Project Managers:

HHSC:	Contractor:
Joe Morganti Associate Director for Health Management Programs 11209 Metric Blvd., Building H Mail Code H-312 Austin, Texas 78758 Phone: 512-491-1425 Fax: 512-491-1972	Beth Mandell Regional Executive Director EverCare Texas Bldg One, Suite 360 1250 Capitol of Tx Highway Austin, Texas 78746 Phone: 512-347-2723 FAX: 512-347-2735

Part 6: Deliver Legal Notices to:

HHSC:	Contractor:
General Counsel 4900 North Lamar Boulevard, 4th Floor Austin, Texas 78751 Fax: 512-424-6586	Beth Mandell Regional Executive Director EverCare Texas Bldg One, Suite 360 1250 Capitol of Tx Highway Austin, Texas 78746 Phone: 512-347-2723

Part 7: Payment

Contract Year One will begin on the Contract Effective Date and end on August 31, 2008. HHSC will begin paying the per-Member per-month (PMPM) Contractor Rate after the Operational Start Date.

For Contract Year One and Year Two, HHSC will pay the Contractor a PMPM amount of **$24.99*** for each ICM Member. The Parties will negotiate the Contractor Rate for subsequent Contract Years in accordance with the requirements of Attachment A, "General Contract Terms & Conditions", Article 10, "Terms & Conditions of Payment." See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for additional information concerning the Contractor Rate and the Payment requirements.

The Contractor Rate for Contract Year One and Year Two consists of the following components:

Component	Contract Reference	Rate
Base Price		**$23.65**
Component Pricing for Administrative Pilots		
Telephonic-based Authentification System	Attachment B-1, RFP §5.2.1.2; Attachment C-1, Proposal §4.7.2.4 and 4.8.2	$.28
Provider Access to Electronic Health Information – Phase One	Attachment B-1, RFP §5.2.1.2; Attachment C-1, Proposal §§4.7.2.5, and 4.8.2, as modified by Attachment C-2	$.22*
Total Price for Administrative Pilots		**$.50**
Component Pricing for Optional Services		
Evercare Partnership Plus	Attachment C-1, Proposal §4.8.3	$.23
Evidence-based Medicine Connect	Attachment C-1, Proposal §4.8.3	$.18
LifeSolutions Behavioral Disease Management	Attachment C-1, Proposal §4.8.3	$.43
Total Price for Optional Services		**$.84**
Total Contractor Rate		**$24.99***

*The various phases of the EHI system are described in Attachment C-1, Proposal §§4.7.2.5, and 4.8.2, and Attachment C-2. Providers will not have access to Phase One of the EHI system (Phase One) on the Operational Start Date. HHSC will not pay the **$.22** component of the total PMPM until Phase One is approved by HHSC and operational. If Phase One becomes operational after the first day of the month, HHSC will pay the Contractor on a pro rata basis for all calendar days that Phase One is operational.

In addition to the Contractor Rate described above, HHSC will pay a one-time development fee of **$250,000.00** for the EHI system. This one-time development fee is intended to reimburse the Contractor for the actual costs associated with the development of all phases of the EHI system. This amount will be payable within 30 calendar days of the Contractor's completion, and HHSC's approval, of all Readiness Review activities for Phase One. The Parties understand and agree that the Contractor will not receive additional reimbursement for the development of Phase Two of the EHI system, or any subsequent phases.

Additional financial incentives and disincentives are addressed in Attachment B-1, RFP Section 6.

Part 8: Contract Attachments:

A: General Contract Terms & Conditions, Version 1.3

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: Amendment Three to the Integrated Care Management Contract

B: Scope of Work/Performance Measures

B-1: HHSC RFP 529-06-0406, Sections 1-6 Version 1.0**
B-2: Contractor Managed Services, Version 1.0 (previously RFP Attachment C)
B-3: ICM Service Area Performance Improvement Goals, Version 1.0
B-4: Deliverables/Liquidated Damages Matrix, Version 1.0 (previously RFP Attachment I)

**The following RFP attachments are incorporated herein by reference: F, H, K4, O, and the Vendor Questions and Answers. The following RFP attachments are not incorporated herein by reference: A, A1, B, C, D, E, G1, G2, I, J1, J2, J3, K1, K2, K3, M, N1, and N2. All remaining references in the Agreement to RFP attachments not incorporated herein by reference are superfluous. Some of the RFP attachments will become part of the Uniform Managed Care Manual, which is incorporated herein by reference as amended or modified.

C: Contractor's Proposal and Related Documents

C-1: Contractor's October 6, 2006 Proposal
C-2: Agreed Modifications to the Proposal, Version 1.0

Part 10: Signatures:

The Parties have executed this Contract in their capacities as stated below with authority to bind their organizations on the dates set forth by their signatures.

Texas Health and Human Services Commission

By: C.E. Bell MD
Charles E. Bell, M.D.
Deputy Executive Commissioner for Health Services

Date: 8/27/08

Contractor

By: John L. Larsen
~~Jeff Maloney~~
~~Chief Operating Officer~~ President

Date: August 5, 2008

Texas Health & Human Services Commission

General Terms & Conditions

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Version 1.0	n/a	February 15, 2007	Initial version of the General Terms & Conditions that includes all modifications negotiated by the Parties.
Revision	Version 1.1	November 16, 2007	Contract Amendment One modified the following provisions of Attachment A: 1. Article 2, "Definitions," modified to add definitions of Farmworker Child (FWC) and Migrant Farmworker. 2. Article 2, "Definitions," modified to change 1915 (c) Community Based Alternatives Waivers to ICM 1915(c) waiver. 3. Article 2. "Definitions," modified to remove the Web link to the CBA Handbook. 4. Section 4.08(c) modified to include cross-references to other readiness review provisions.
Revision	Version 1.2	February 1, 2008	Contract Amendment Two did not revise the Attachment A Genderal Terms & Conditions.
Revision	Version 1.3	September 1, 2008	Contract Amendment Three modified the following provisions of Attachment A: 1. Article 2, "Definitions," modified to add definitions for Discharge and Transfer. 2. Article 2, "Definitions," modified to clarify the definitions for Contractor Managed Services and Utilization Review. 3. Attachment A, Section 5.02 is modified to add clarification that only Medicaid ICM Contractors have a limited right to request that a Member be disenrolled. 4. Attachment A, Section 09.07 is added to require the ICM Contractors to notify HHSC of legal and other proceedings, and related events. 5. Attachment A, Section 11.07 is modified to remove extraneous word.

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions

[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.

[3] Brief description of the changes to the document made in the revision.

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Article 1. Introduction

Section 1.01 ***Purpose.***

The purpose of this Contract is to set forth the terms and conditions for the Contractor's participation as an administrative service organization in the Integrated Care Management Program administered by HHSC. Under the terms of this Contract, Contractor will provide comprehensive administrative and care management services to qualified Program recipients in a managed care delivery system.

Section 1.02 ***Inducements.***

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

(1) Contractor is a utilization review agent that is currently licensed as such in the State of Texas and is fully authorized to conduct business in the ICM Service Areas;

(2) Contractor and its Subcontractors have the skills, qualifications, expertise, financial resources and experience necessary to provide the Services and Deliverables described in this Contract in an efficient, cost-effective manner, with a high degree of quality and responsiveness;

(3) Contractor has thoroughly reviewed, analyzed, and understood the RFP, has timely raised all questions or objections to the RFP;

(4) Contractor 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, Contractor currently has the capability to perform in accordance with the terms and conditions of this Contract;

(5) Contractor also has reviewed and understands the risks associated with the ICM 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 Contractor to perform the Services and provide the Deliverables described in this Contract under the terms and conditions set forth in this Contract.

Section 1.03 ***Construction of the Contract.***

(a) Scope of Introductory Article.

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

(b) References to the "State."

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

(c) Severability.

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

(d) Survival of terms.

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

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

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

(e) Headings.

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

(f) Global drafting conventions.

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

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

(3) Any references to laws 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 1.04 ***No implied authority.***

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

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

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

Section 1.05 ***Legal Authority.***

(a) HHSC is authorized to enter into this Contract under Chapters 531 and 533, Texas Government Code; and Section 2155.144, Texas Government Code. Contractor 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 Program, or in authorization of 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 Program.

Action means:

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

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

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

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

(5) the failure of the Contractor to act within the timeframes set forth in the Contract.

An Adverse Determination is one type of Action.

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

Acute Care Services are the Contractor Managed Services listed under the heading "Acute Care Services" in **Attachment C.** Acute Care Services include Behavioral Health Services in the Tarrant Service Area.

Acute Care Hospital means a Hospital that provides Acute Care Services.

Administrative Services Contractor(s) See HHSC Administrative Services Contractor(s).

Adverse Determination means a determination by the Contractor that the Contractor Managed Services furnished, or proposed to be furnished to a Member, are not Medically Necessary or not Functionally Necessary Services or not appropriate.

Affiliate means any individual or entity owning or holding more than a five percent (5%) interest in the Contractor or in which the Contractor owns or holds more than a five percent (5%) interest; any parent entity; or subsidiary entity of the Contractor, regardless of the organizational structure of the entity.

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

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

Auxiliary Aids and Services includes:

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

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

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

Behavioral Health (BH) Services means ICM Services for the treatment of mental, emotional, or chemical dependency disorders. Behavioral Health Services are Contractor Managed Services in Tarrant Service Area and NorthSTAR Managed Services in Dallas Service Area.

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

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

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

CAHPS means the Consumer Assessment of Healthcare Providers and Systems. 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.

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

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

Children's Hospitals mean Hospitals that offer their services exclusively to children. Services include clinical care, research, and pediatric medical education focused on children**.**

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.

Claims Administrator means the HHSC Administrative Services Contractor that processes and adjudicates all claims for Medicaid services outside the scope of capitated arrangements between health plans and HHSC. As of the Effective Date, ACS State Healthcare, L.L.C. is HHSC's Claims Administrator.

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.

COLA means Cost of Living Adjustment.

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

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

Complex Need means a condition or situation resulting in a need for coordination or access to services beyond what a PCP would normally provide, triggering the Contractor's determination that Service 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 Member information, including HIPAA-defined protected health information;

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

(3) All Privileged Work Product;

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

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

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

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

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

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

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

Contract Year means one complete State Fiscal Year (i.e., September 1 to August 31 of the following calendar year) under the Contract, except that the first Contract Year may include a partial State Fiscal Year plus one full State Fiscal Year.

Contractor (or ICM Contractor) means the successful Bidder that is a party to this Contract and is licensed by TDI as a Utilization Review Agent in accordance with Chapter 4201 of the Texas Insurance Code.

Contractor Managed Services means the Medicaid Acute Care Services and Long Term Services and Supports listed in **Attachment C**. The Contractor is responsible for utilization review of these services pursuant to the Contract and for Service Coordination of all ICM Services.

Modified by Version 1.3

Corrective Action Plan means the detailed written plan that may be required by HHSC to correct or resolve a deficiency or event causing the assessment of a remedy or damage against the Contractor. The term also refers to a plan developed by the Contractor and an ICM Program Provider to

improve the Provider's deficient performance under the ICM Program.

Court-Ordered Commitment means a commitment of a 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.

Credentialing means the process of collecting, assessing, and validating qualifications and other relevant information pertaining to a Provider to determine eligibility to deliver Contractor Managed 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.

Day means a calendar day unless specified otherwise.

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

Day Activity and Health Services (DAHS) means health social and related support services provided during the day to functionally impaired adults by facilities licensed by DADS under Chapter 103, Texas Human Resource Code.

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

DARS means the Texas Department of Assistive and Rehabilitative Services or its successor agency.

DFPS means the Texas Department of Family and Protective Services or its successor agency.

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

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

Disability means a physical, cognitive, behavioral or sensory 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.

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

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

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

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.

Definition Added by Version 1.3

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.

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

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

EDI means electronic data interchange.

Effective Date means the effective date of this Contract, as specified in the **ICM Contract Document**.

Effective Date of Enrollment means the first day for which a Medicaid recipient is enrolled in the ICM Program.

Eligibles means individuals residing in the ICM Service Areas who are required to participate in the ICM Program or who are eligible to voluntarily enroll in the ICM 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 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) serious jeopardy to the health of a pregnant woman or her unborn child.

Enrollment Broker means the HHSC Administrative Services Contractor that assists Medicaid clients enrolling in Medicaid managed care and in selecting managed care options. As of the Effective Date, Accenture LLP is HHSC's Enrollment Broker.

Enrollment Report/Enrollment File means the list of Eligibles that are enrolled as ICM 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.

Excluded Population means the following categories of individuals who are excluded from participation in the ICM Program:

(1) Persons in institutional settings, including a resident of a nursing facility; an Intermediate Care Facility for the Mentally Retarded (ICF-MR), or an Institution of Mental Disease (IMD) or state Hospital.

(2) Persons enrolled in a Medicaid waiver program other than the Community-Based Alternatives (CBA) program.

(3) Individuals not eligible for full Medicaid benefits.

(4) Individuals who are diagnosed with End Stage Renal Disease (ESRD) and who do not qualify for Medicare ESRD coverage (except those in CBA).

Expedited Appeal means an appeal to the Contractor in which the decision is required quickly based on the Member's health status, and the amount of time necessary to participate in a standard appeal could jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

Expiration Date means the expiration date of this Contract, as specified in the **ICM Contract Document**.

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

Fair Hearing means the process adopted and implemented by HHSC in 25 T.A.C. Chapter 1, in compliance with federal regulations and state rules relating to Medicaid Fair Hearings.

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

FPL means the Federal Poverty Level.

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

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

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

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

FSR (or Contractor FSR) means the Financial Statistical Report for the ICM Contractor.

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

General Hospital means an establishment that:

(1) offers services, facilities, and beds for use for more than 24 hours for two or more unrelated individuals requiring diagnosis, treatment, or care for illness, injury, deformity, abnormality, or pregnancy; and

(2) regularly maintains, at a minimum, clinical laboratory services, diagnostic X-ray services, treatment facilities including surgery or obstetrical care or both, and other definitive medical or surgical treatment of similar extent.

General Hospitals include Acute Care Hospitals and Children's Hospitals. See Title 25, Texas Administrative Code, Chapter 133.

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

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

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

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

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

HHSC Administrative Services Contractor (or ASC) means an entity performing Medicaid managed care administrative services functions, including enrollment or claims payment functions, under contract with HHSC.

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

Home and Community Support Services Agency (or HCSSA) means an entity licensed by DADS under Chapter 142, Texas Health and Safety Code to provide home health, hospice, or personal assistance services to individuals in their own homes or independent living environments as prescribed by a physician or individualized service plan.

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.

Intermediate Care Facility for the Mentally Retarded (or ICF-MR) means a facility licensed under Chapter 252, Texas Health and Safety Code.

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

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

ICM Non-Managed Services means Medicaid Services available in the ICM Service Area other than:

(1) Contractor Managed Services; and

(2) NorthSTAR Services for Members in the Dallas Service Area.

ICM Program or Program means the Integrated Care Management Program in the Dallas and Tarrant Service Areas to manage and coordinate Acute Care Services and Long Term Services and Supports for eligible SSI recipients and other eligible Medicaid recipients. The ICM Program includes all ICM Services for Members.

ICM Provider (or Provider) means an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, who has executed a Medicaid Provider Contract with HHSC or DADS and a Provider Agreement with the Contractor to provide Contractor Managed Services to Members residing in the ICM Service Area.

ICM Provider Agreement means the agreement to which a Provider and the Contractor are parties and which must be executed before a Provider may provide Contractor Managed Services to ICM Members. The Provider Agreement details Contractor requirements the Provider must meet in order to participate in the Network and provide Contractor Managed Services to ICM Members.

ICM Services means all Contractor Managed Services listed in **Attachment C** plus:

(1) ICM Non-Managed Services and

(2) for Members in the Dallas Service Area, North STAR Services.

ICM Service Area means all the counties in the Dallas Service Area (Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall counties) and the Tarrant Service Area (Denton, Hood, Johnson, Parker, Tarrant and Wise counties) See **Attachment B** for a map of all counties in the ICM Service Area.

ICM 1915(c) Waivers means the HHSC 1915(c) waiver program that provides home and community-based services to ICM Members as cost-effective alternatives to institutional care in nursing homes. See Community Care for Aged and Disabled Handbook for a detailed list of CBA Waiver services.

Definition modified by Version 1.1.

Joint Interface Plan (or 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 Contractor's interfaces required to conduct business under this Contract. The JIP must address the coordination with each of the Contractor'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 Contractor Personnel means the critical management and technical positions identified by the Contractor in accordance **Article 4** of this Contract.

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 (or 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.

Long Term Services and Supports (LTSS) means services provided to Members in their home or other community based settings necessary to provide assistance with activities of daily living to allow the Member to remain in the most integrated setting possible. These LTSS services include services provided to all SSI recipients under the state plan as well as those services available only to persons who qualify for 1915 (c) CBA Waiver services. These Contractor Managed Services are listed in **Attachment C** under the header "Long Term Services and Supports."

Major Population Group means any population, which represents at least 10% of the Medicaid population in any of the counties in the ICM Service Area.

Mandatory Enrollee (or Mandatory Member) means a Medicaid eligible who must enroll in the ICM Program. Mandatory Enrollees must reside in any part of the Service Area and fall within one of the following categories:

(1) SSI eligibles over age 20;

(2) Individuals over age 20 who are Medicaid-eligible because they are in a Social Security Exclusion Program (these Members will still need to meet financial eligibility for 1915(c) Waiver services;

(3) MAO eligibles who qualify for 1915(c) Waiver services.

Material Subcontractor (or Major Subcontractor) means any entity that contracts with the Contractor to perform all or some ICM Contractor Services, where the value of the subcontracted ICM Contractor Service(s) exceeds $100,000, or is reasonably expected to exceed $100,000, per State Fiscal Year.

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-only (Non-Medicare) means an ICM Member who is not dually-eligible for Medicare.

Medical Assistance Only (or MAO) means a person who qualifies financially for Medicaid but does not receive Supplemental Security Income payments.

Medicaid Provider Contract means the contract between an Acute Care provider and the Claims Administrator or between a Long Term Services and Supports provider and DADS. A Medicaid Provider Contract is necessary for an ICM Provider to submit a claim and receive payment for ICM Services.

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

Medically Necessary means:
Acute Care Services, other than Behavioral Health Services, that are:

(1) 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;

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

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

(4) consistent with the diagnoses of the conditions;

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

(6) are not experimental or investigative; and
(7) are not primarily for the convenience of the Member or Provider.

Behavioral Health Services that are:

(1) 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;

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

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

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

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

(6) are not experimental or investigative; and

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

Medicare means the federal health insurance program administered by the Centers for Medicare

and Medicaid Services (CMS) for people age 65 and over and some people with disabilities under age 65 authorized under Title XVIII of the Social Security Act.

Member (or ICM Member) means a person who is entitled to benefits under Title XIX of the Social Security Act and Medicaid, is in a mandatory or voluntary Medicaid eligibility category included in the ICM Program, and is enrolled in the ICM Program.

Member Materials means all written materials produced or authorized by the Contractor and distributed to Members containing information concerning the ICM Program. Member Materials include, but are not limited to, Member ID cards, Member handbooks, and Provider directories.

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

Member Services means the administrative functions performed by the Contractor for the purpose of informing Members about the ICM Program and ICM Services.

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

Definition added by Version 1.1.

Migrant Farmworker means a migratory agricultural worker, generally defined as an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last twenty-four months, and who establishes for the purposes of such employment a temporary abode.

MIS means Management Information System.

Minimum Data Set for Home Care (or MDS) means the required data obtained from the Resident Assessment Instrument for Home Care (RAI-HC) that include health, social support and service use information on persons receiving long term care services outside of an institutional setting.

Nursing Facility (or Nursing Home) means a facility licensed by and approved by the State of Texas in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) long-term care program.

Nursing Facility Level of Care means the determination that the level of care required to adequately serve a Member is at or above the level of care provided by a nursing facility. In the ICM Program, Nursing Facility Level of Care services are provided in the home or in community-based settings including assisted living facilities as a cost-effective, less restrictive alternative to institutional care in a nursing facility.

OB/GYN means obstetrician-gynecologist.

Open Panel means Providers who are accepting new patients for the ICM Program.

Operational Start Date means the first day on which the Contractor is responsible for authorizing and coordinating Contractor Managed Services to ICM Program Members under the Contract. The Operational Start Date applicable to this Contract is included in the **ICM Contract Document**.

Operations Phase means the period of time when Contractor is responsible for authorizing and coordinating the Contractor Managed Services and all related Contract functions for the ICM Service Area. The Operations Phase begins on the Operational Start Date.

Parties mean HHSC and the Contractor, collectively.

Party means either HHSC or the Contractor, individually.

Payment (or Contractor Payment) means the aggregate amount paid by HHSC to the Contractor on a monthly basis in accordance with the Contractor Rate.

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

Definition modified by Version 1.0.

Primary Care Physician or Primary Care Provider (or PCP) means a physician or provider who has agreed with the Contractor to provide a Medical Home to Medicaid-only Members and who is responsible for providing initial and primary care to Members, maintaining the continuity of Member care, and initiating referrals for specialized care.

Promoting Independence means the initiative undertaken by HHSC in response to the U.S. Supreme Court ruling in *Olmstead v. Zimring.* The Promoting Independence Initiative and Plan may be found at http://www.hhs.state.tx.us/news/circulars/C-002.shtml.

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

Provider Network (or Network) means all ICM Providers.

Psychiatric Hospital means a Hospital that provides inpatient mental health services to individuals with mental illness or with a substance use disorder except that, at all times, a majority of the individuals admitted are individuals with a mental illness. Such services include psychiatric assessment and diagnostic services, physician services, professional nursing services, and monitoring for patient safety provided in a restricted environment. See Title 25, Texas Administrative Code, Chapter 134

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

Public Information means information that:

(1) Is collected, assembled, or maintained under a law or ordinance or in connection with the

transaction of official business by a governmental body or for a governmental body; and

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

Qualified and Disabled Working Individual (or QDWI) means an individual whose only Medicaid benefit is payment of the Medicare Part A premium. The Omnibus Budget Reconciliation Act of 1989 requires the state to pay the Medicare Part A premiums for certain disabled and working individuals who are enrolled in Medicare Part A, who are not otherwise eligible for Medicaid, who have countable income of no more than 200% of the Federal poverty level, and whose countable resources do not exceed twice the resource limit of the SSI program.

Qualified Medicare Beneficiary (or QMB) means a Medicare beneficiary whose only Medicaid benefits are payment of Medicare premiums, deductibles, and coinsurance for individuals who are entitled to Medicare Part A, whose income does not exceed 100% of the federal poverty level, and whose resources do not exceed twice the resource limit of the SSI program.

Quality Improvement (or Quality Assurance) means a system to continuously measure, analyze, and improve a) Provider delivery of Contractor Managed Services and b) Contractor processes and systems that support the administration of the ICM Program.

Rate (or Contractor Rate) means the per-Member per-month amount paid by HHSC to the Contractor for each ICM Member.

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 the Contractor and the examination conducted by HHSC, or its agents, of Contractor'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 Contractor exceeding payments made by HHSC under the Contract.

Risk Management Plan means describing methods for managing risks that emanate from the product, processes, resources, and constraints.

Routine Care means preventive and Medically Necessary Contractor Managed Services that are non-emergent or non-urgent.

Rural Health Clinic 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, including Deliverables, specified in this Contract, the RFP, the Contractor's Proposal, and any agreed modifications to these documents.

SDX means State Data Exchange.

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

Service Coordinator means the person with primary responsibility for providing Service Coordination to ICM Members and meeting the qualifications for this position as described in the Contract.

Service Coordination means a specialized, Member-centered care management service that meets the requirements of the Contract and that includes but is not limited to:

(1) identification and monitoring of needs, including physical health, mental health and long term support needs,

(2) development and monitoring of a Service Plan that addresses identified needs;

(3) providing authorizations and referrals for timely and coordinated access to needed ICM Services;

(4) attention to addressing unique needs of Members;

(5) coordination of Contractor Managed Services with other medical and social services that are not Contractor Managed Services, as necessary and appropriate.

Service Plan (SP) means an individualized plan developed with and for Members. The SP includes, but is not limited to, the following:

(1) the Member's history;

(2) a summary of the Member's current medical and social needs and concerns;

(3) the Member's short and long term needs and goals, with action plans which include steps the Member and Service Coordinator will take and services needed to address each goal;

(4) units and frequency of each service; and

(5) a description of service providers.

The Service Plan should incorporate the Individual Family Service Plan (IFSP) for members in the Early Childhood Intervention (ECI) Program. The Service Plan should reflect needed non-ICM Services and resources, such as food stamps, housing or other community resources to be accessed.

Services (or Contractor Services) means the tasks, functions, and responsibilities assigned and delegated to the Contractor under this Contract.

Significant Traditional Provider (or STP) means PCPs, Long Term Services and Supports providers identified by HHSC as having provided a significant level of care to Fee-for-Service Medicaid beneficiaries in Dallas and Tarrant Service Areas. Disproportionate Share Hospitals (DSH) are also STPs.

Software means all operating system and applications software used by the Contractor 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 Hospital or Psychiatric Hospital. It is an establishment that:

(1) offers services, facilities, and beds for use for more than 24 hours for two or more unrelated individuals who are regularly admitted, treated, and discharged and who require services more intensive than room, board, personal services, and general nursing care;

(2) has clinical laboratory facilities, diagnostic X-ray facilities, treatment facilities, or other definitive medical treatment;

(3) has a medical staff in regular attendance; and

(4) maintains records of the clinical work performed for each patient.

See Title 25, Texas Administrative Code, Chapter 133.

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

Specified Low-Income Medicare Beneficiary (or SLMB) means a Medicare beneficiary whose only Medicaid benefit is payment of the Medicare Part B premium. The Omnibus Budget Reconciliation Act of 1990 requires the state to pay the Medicare Part B premiums for individuals who are enrolled in Medicare Part A, whose income is more than 100% of the federal poverty level (FPL) but less than 120% of the FPL, and whose resources do not exceed twice the resource limit of the SSI program.

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.

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

Subcontract means contract between the Contractor and a third party that performs a function that the Contractor is required to perform under its Contract with HHSC.

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

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

Supplemental Security Income (or SSI) means the federal cash assistance program of direct financial payments to the aged, blind, and disabled administered by the SSA under Title XVI of the Social Security Act. All persons who are certified as eligible for SSI in Texas are eligible for Medicaid. Local SSA claims representatives make SSI eligibility determinations. The transactions are forwarded to the SSA in Baltimore, which then notifies the states through the SDX.

Supplemental Security Income (SSI) Beneficiary means a person that receives supplemental security income cash assistance as cited in 42 U.S.C.A. § 1320 a-6 and as described in the definition of Supplemental Security Income.

Systems Quality Assurance Plan means describing the processes, techniques, and tools that will be used for assuring that the Contractor meets its commitments to plans, standards, and processes, and that it demonstrates that the products meet the agreed-to requirements.

T.A.C. means Texas Administrative Code.

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

TDI means the Texas Department of Insurance.

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

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

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

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

Definition Added by Version 1.3

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 Contractor is required to perform between the Contract Effective Date and the Operational Start Date for a Service Area.

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

Turnover Plan means the written plan developed by Contractor, approved by HHSC, to be employed during the Turnover Phase.

Uniform Managed Care Manual means the manual published by or on behalf of HHSC that contains policies and procedures required of the ICM Contractor.

URAC (or 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 that does not place the Member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment.

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

Modified by Version 1.3

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

Waste means practices that are not cost-efficient.

Article 3. General Terms & Conditions

Section 3.01 *Contract elements.*

(a) Contract documentation.

The Contract between the Parties will consist of the **ICM Contract Document** and all attachments and amendments.

(b) Order of documents.

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

(1) The final executed **ICM Contract Document,** and all amendments thereto;

(2) **Attachment A** – "General Terms and Conditions," and all amendments thereto;

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

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

(5) **Attachment C** – "Contractor's Proposal and Related Documents," and all attachments thereto.

Section 3.02 *Term of the Contract.*

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

Section 3.03 *Funding.*

This Contract is expressly conditioned on the availability of state and federal appropriated funds. Contractor 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 Contractor to resolve any Contractor claims for payment that represent accepted ICM Services or Deliverables that are pending at the time funds become unavailable. HHSC shall make best efforts to provide reasonable written advance notice to Contractor 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 Contractor on request.

Section 3.05 *No waiver of sovereign immunity.*

The Parties expressly agree that no provision of this Contract is in any way intended to constitute a waiver by HHSC or the State of Texas of any

immunities from suit or from liability that HHSC or the State of Texas may have by operation of law.

Section 3.06 ***Force majeure.***

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

Section 3.07 ***Publicity.***

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

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

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

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

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

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

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

(3) Member Materials (the Contractor 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 Contractor.

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

(b) Assignment by HHSC.

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

(c) Assumption.

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

Section 3.09 ***Cooperation with other vendors and prospective vendors.***

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

Section 3.10 ***Renegotiation and reprocurement rights.***

(a) Renegotiation of Contract terms.

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

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

Notwithstanding anything in the Contract to the contrary, whether or not HHSC has accepted or rejected Contractor's ICM Services and/or Deliverables provided during any period of the

Contract, HHSC may at any time issue requests for proposals or offers to other potential contractors for performance of any portion of the Scope of Work covered by the Contract or Scope of Work similar or comparable to the Scope of Work performed by Contractor under the Contract.

(c) Termination rights upon reprocurement.

If HHSC elects to procure the ICM Services or Deliverables or any portion of the ICM 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.***

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

Section 3.12 ***Attorneys' fees.***

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

Contractor is required in performing the Contract to purchase products and materials produced in the State of Texas when they are available at a price and time comparable to products and materials produced outside the State.

Section 3.14 ***Time of the essence.***

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

Section 3.15 ***Notice.***

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

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

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

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

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

(c) All notices must be sent to the Project Manager identified in the **ICM Contract Document**. In addition, legal notices must be sent to the Legal Contact identified in the **ICM Contract Document**.

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

Article 4. Contract Administration & Management

Section 4.01 ***Qualifications, retention and replacement of Contractor employees.***

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

(a) Designation of Key Personnel.

Contractor must designate key management and technical personnel who will be assigned to the Contract. For the purposes of this requirement, Key Personnel are the following:

(1) those with management responsibility or principal technical responsibility for Management Information Systems;

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

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

(b) Support and Replacement of Key Personnel.

The Contractor 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 Contractor 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 Contractor must maintain the overall level of expertise, experience, and skill reflected in the Key Contractor Personnel job descriptions and qualifications included in the Contractor's proposal.

(c) Notification of replacement of Key Personnel.

Contractor 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 Contractor in writing. Upon receipt of HHSC's notice, HHSC and Contractor will attempt to resolve HHSC's concerns on a mutually agreeable basis.

Section 4.03 ***Executive Director.***

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

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

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

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

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

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

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

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

Section 4.04 ***Medical Director.***

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

(b) The Medical Director, or his or her 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 Contractor 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 Contractor 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 Contractor personnel and Subcontractors.***

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

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

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

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

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

(f) Contractor 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 Contractor pursuant to this Contract or any judgment rendered against the Contractor. HHSC's liability to the Contractor's employees, agents and Subcontractors, if any, will be governed by the Texas Tort Claims Act, as amended or modified (TEX. CIV. PRACT. & REM. CODE §101.001et seq.).

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

Section 4.06 ***Cooperation with HHSC and others.***

(a) Cooperation with other contractors.

Contractor agrees to reasonably cooperate with and work with the other contractors in the ICM Program, 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 Contractor and to use its best efforts to ensure that other HHSC contractors reasonably cooperate with the Contractor.

(b) Cooperation with state and federal administrative agencies.

Contractor must ensure that Contractor 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 ICM Program including, but not limited to the following purposes:

(1) The investigation and prosecution of fraud, abuse, and waste in the ICM Program;

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

(3) Testimony in judicial or quasi-judicial proceedings relating to the ICM 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 Contractor personnel.***

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

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

Section 4.08 ***Subcontractors.***

(a) Contractor 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 Contractor's employees, and for purposes of this

Contract such work will be deemed work performed by Contractor. 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) Contractor 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) notify HHSC in writing 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.

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

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

(2) an existing Material Subcontractor provides services in a new service area;

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

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

(6) a Readiness Review is requested by HHSC.

Section 4.08 modified by Version 1.1.

Refer to **Attachment B-1, Sections 5.1.9 and 5.2.18.2** for additional information regarding Contractor Readiness Reviews during the Contract Period.

(d) Contractor must not disclose Confidential Information of HHSC, the HHS Agencies, 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 Contractor under this Contract.

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

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

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

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

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

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

Section 4.10 ***Contractor Agreements with Third Parties.***

(a) If the Contractor intends to report compensation paid to a third party (including without limitation an Affiliate) as an Allowable Expense under this Contract, and the compensation paid to the third party exceeds $100,000, or is reasonably anticipated

to exceed $100,000, in a State Fiscal Year, then the Contractor's agreement with the third party must be in writing. The agreement must provide HHSC the right to examine the agreement and all records relating to the agreement.

(b) All agreements whereby Contractor receives rebates, recoupments, discounts, payments, or other consideration from a third party (including without limitation Affiliates) pursuant to or related to the execution of this Contract, must be in writing and must provide HHSC the right to examine the agreement and all records relating to such consideration.

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

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

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

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

(g) This section shall not apply to agreements with utility or mail service providers.

Article 5. Member Eligibility & Enrollment

Section 5.01 *Eligibility Determination.*

The State or its designee will determine whether potential enrollees are eligible to become Members of the ICM Program.

Section 5.02 *Member Enrollment & Disenrollment in the ICM Program.*

Section 5.02 modified by Version s 1.0 & 1.3

(a) The HHSC Administrative Services Contractor will enroll and disenroll eligible individuals in the Program. The Contractor is not allowed to induce or accept disenrollment from a Member. The Contractor must refer the Members or potential members to the HHSC Administrative Services Contractor for ICM Program eligibility determinations.

(b) HHSC makes no guarantees or representations to the Contractor regarding the number of eligible Members who will ultimately be enrolled into the ICM Program or the length of time any such Members will remain enrolled in the ICM Program.

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

(d) Members will be enrolled in the ICM Program, and the Contractor must begin to coordinate Contractor Managed Services on the Effective Date of Enrollment.

(e) The Contractor must assign each Member a PCP within one Business Day after the Contractor's receipt of the enrollment file from the HHSC Administrative Services Contractor. The Member can change the PCP designation at any time.

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

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

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

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

(4) ICM Contractor must take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors. (g) HHSC must notify the Member of HHSC's decision to disenroll the Member if all reasonable measures have failed to remedy the problem.

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

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

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

Section 5.03 ***Span of Coverage.***

(a) General

(1) The Contractor must provide ICM Services to all Members without regard to the Member's previous coverage, health status, confinement in a health care facility, or any other factor.

(b) Excluded Populations

Excluded Populations are not included in the ICM Program. Members who become part of an Excluded Population while enrolled in the ICM Program will be disenrolled on the Effective Date of Disenrollment.

(c) Verification of Member Eligibility.

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

Article 6. Service Levels & Performance Measurement

Section 6.01 ***Performance measurement.***

Satisfactory performance of this Contract will be measured by:

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

(b) Delivery of the ICM Services and Deliverables;

(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 Contractor and HHSC and as modified from time to time by written agreement during the term of this Contract.

Article 7. Governing Law

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 Contractor 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 ***Contractor responsibility for compliance with laws.***

Section 7.02 modified by Version 1.0.

(a) Contractor must comply, to the satisfaction of HHSC, with all provisions set forth in this Contract, all applicable provisions of law that govern the performance of the Scope of Work including, but not limited to:

(1) Titles XIX of the Social Security Act;

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

(3) 45 C.F.R. Parts 74 and 92;

(4) 48 C.F.R. Part 31, or OMB Circular A-122, as applicable;

(5) 1 T.A.C. Part 15, Chapters 391 and 392;

(6) consent decree, *Frew, et al. v. Hawkins, et al.*, U.S. District Court, Eastern District of Texas, Paris Division, Civil Action No. 3:93-CA-065WWJ;

(7) partial settlement agreements, *Alberto N., et al. v. Hawkins, et al.*, U.S. District Court, Eastern District of Texas, Tyler Division, Case No. 6:99CV459;

(8) all State and Federal tax laws, State and Federal employment laws, State and Federal regulatory requirements, and licensing provision;

(9) all administrative rules governing the ICM Program that are adopted by HHSC and/or DADS in the Texas Administrative Code.

(b) The Parties acknowledge that the laws that affect the performance of the Scope of Work may change from time to time or be added, judicially interpreted, or amended by competent authority. Contractor acknowledges that the Contractor Programs will be subject to continuous change during the term of the Contract and, except as provided in Section 8.02, Contractor 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 Contractor was selected, in part, because of its expertise, experience, and knowledge concerning applicable aws that affect the performance of the Scope of Work. In keeping with HHSC's reliance on this knowledge and expertise, Contractor is responsible for identifying the impact of changes in applicable laws that affect the performance of the Scope of Work or the State's use of the ICM Services

and Deliverables. Contractor 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 ICM Services and Deliverables.

(c) HHSC will notify Contractor of any changes in applicable law that HHSC becomes aware of in the ordinary course of its business.

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

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

(f) Contractor warrants that the ICM Services and Deliverables will comply with all applicable laws. Contractor will indemnify HHSC from and against any losses, liability, claims, damages, penalties, costs, fees, or expenses arising from or in connection with Contractor's failure to comply with or violation of any such law.

Section 7.03 ***TDI status.***

Section 7.03 modified by Version 1.0.

Contractor, or a Material Subcontractor performing Utilization Review functions on behalf of the Contractor, must be licensed by TDI as a utilization review agent (URA) in compliance with Chapter 4201 of the Texas Insurance Code.

Section 7.04 ***Immigration Reform and Control Act of 1986.***

Contractor 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 1.0.

(a) CONTRACTOR 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) HHSC's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

CONTRACTOR 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) CONTRACTOR 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. CONTRACTOR 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. CONTRACTOR 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) CONTRACTOR 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, CONTRACTOR will provide HHSC with copies of all of the CONTRACTOR'S civil rights policies and procedures.

(e) CONTRACTOR 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.***

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

(a) Pro-Children Act of 1994.

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

(b) National Environmental Policy Act of 1969.

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

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

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

(d) State Clean Air Implementation Plan.

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

(e) Safe Drinking Water Act of 1974.

Contractor 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.***

Contractor shall comply with applicable provisions of HIPAA. This includes, but is not limited to, the requirement that the Contractor's MIS system comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA. Contractor 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 laws 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 Contractor will specify those modifications to the Scope of Work, the Contract pricing terms, or other Contract terms and conditions.

(b) Contractor must respond to HHSC's proposed modification within the timeframe specified by HHSC, generally within thirty (30) days of receipt. Upon receipt of Contractor's response to the proposed modifications, HHSC may enter into negotiations with Contractor 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 Contractor of its intent not to extend the Contract beyond the Contract Term then in effect.

Section 8.05 ***Modification of Uniform Managed Care Manual.***

(a) HHSC will provide Contractor with at least thirty (30) days advance written notice before implementing a substantive and material change in the Uniform Managed Care Manual (a change that materially and substantively alters the Contractor's ability to fulfill its obligations under the Contract). The Uniform Managed Care Manual, and all modifications

thereto made during the Contract Term, are incorporated by reference into this Contract. HHSC will provide Contractor 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 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 Contractor's response deadline, and such changes will be incorporated into the Uniform Managed Care Manual. If the Contractor has raised an objection to a material and substantive change to the Uniform Managed Care Manual and submitted a notice of termination in accordance with **Section 12.04(d),** HHSC will not enforce the policy change during the period of time between the receipt of the notice and the date of Contract termination.

Section 8.06 ***CMS approval of Contracts.***

The implementation of amendments, modifications, and changes to the Contract is subject to the approval of the Centers for Medicare and Medicaid Services ("CMS.")

Section 8.07 ***Required compliance with amendment and modification procedures.***

No different or additional services, work, or products will be authorized or performed except as authorized by this Article. No waiver of any term, covenant, or condition of this Contract will be valid unless executed in compliance with this Article. Contractor 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.***

Contractor agrees to maintain, and require its Subcontractors to maintain, supporting financial information and documents that are adequate to ensure that payment is made, and financial incentives and disincentives are calculated, in accordance with the terms of the Contract. Such information and documents will be maintained and retained by Contractor 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, Contractor 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) Contractor 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) HHSC, DADS or their designees;

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

Section 9.03 ***General Access to Accounting Records***

(a) The Contractor must provide authorized representatives of the Texas and federal government

full access to all financial and accounting records related to performance of the Contract.

(b)The Contractor must:

(1) Cooperate with the state and federal governments in their evaluation, inspection, audit and/or review of accounting records and any necessary supporting information.

(2) Permit authorized representatives of the state and federal governments' full access, during normal business hours, to the accounting records that the state and federal government determine are relevant to the Contract. Such access is guaranteed at all times during the performance and retention period of the Contract, and will include both announced and unannounced inspections, on-site audits, and the review, analysis, and reproduction of reports produced by the Contractor.

(3) Make copies of any accounting records or supporting documentation relevant to the Contractor available to HHSC or its agents within ten (10) Business Days of receiving a written request from HHSC for specified records or information. If such documentation is not made available as requested, the Contractor agrees to reimburse HHSC for all costs, including, but not limited to transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, and reproduction functions a the locations(s) of such accounting records.

(4) Pay any and all additional costs incurred by the state and federal government that are the result of the Contractor's failure to provide the requested accounting records or financial information within ten (10) Business Days of receiving a written request from the state or federal government.

Section 9.04 ***Audits of ICM Services, Deliverables and inspections.***

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

(2) Contractor Software and equipment.

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

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

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

(d) If, as a result of an audit or review of payments made to the Contractor, HHSC discovers a payment error or overcharge, HHSC will notify the Contractor of such error or overcharge. HHSC will be entitled to recover such funds as an offset to future payments to the Contractor, or to collect such funds directly from the Contractor. Contractor 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 Contractor have resulted in errors in payments to the Contractor or errors in the calculation of financial incentives or disincentives, the Contractor will indemnify HHSC for any losses resulting from such errors, including the cost of audit.

Section 9.05 ***SAO Audit***

The Contractor 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 Contractor 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 Contractor will ensure that this clause concerning the authority to audit funds received indirectly by Subcontractors through Contractor and the requirement to cooperate is included in any Subcontract it awards, and in any third party agreements described in **Section 4.10 (a-b)**.

Section 9.06 ***Response/compliance with audit or inspection findings.***

(a) Contractor must take action to ensure its or a Subcontractor's compliance with or correction of any finding of noncompliance with any law, audit requirement, or generally accepted accounting principle relating to the ICM Services and Deliverables or any other deficiency contained in any audit, review, or inspection conducted under this Article. This action will include Contractor'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) Contractor must bear the expense of compliance with any finding of noncompliance under this Section that is:

(1) Required by law, or other audit requirement relating to Contractor's business;

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

(3) Necessary due to Contractor's noncompliance with any law or audit requirement imposed on Contractor.

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

Section 9.07 Added by Version 1.3.

Section 9.07 Notification of Legal and Other Proceedings, and Related Events.

The ICM Contractor 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 Payment.***

(a) HHSC will calculate the fixed monthly Payments by multiplying the number of Members enrolled on the first day of the month by the Rate. In consideration of the monthly Payment(s), the Contractor agrees to provide ICM Services and Deliverables described in this Contract.

(b) Contractor will be required to provide timely finanancial and statistical information necessary: (1) in the Rate development process; and (2) for the assessment of performance incentives or disincentives. Information provided by Contractor must conform to all HHSC requirements. Non compliant information will not be considered during the development of Rates or the assessment of performance incentives.

(c) Financial and statiscal information must be provided to HHSC: (1) within thirty (30) days of receipt of the letter from HHSC requesting the information or data; and (2) not later than March 31st of each year.

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

Section 10.02 ***Time and Manner of Payment.***

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

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

(c) HHSC may adjust the monthly Payment to the Contractor: in the case of an overpayment to the Contractor; for any amounts due and unpaid; or money damages are assessed in accordance with **Article 12** ("Remedies and Disputes").

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

(1) equitably adjust Payments and reduce scope of service requirements as appropriate in accordance with **Article 8** ("Amendments & Modifications"), or

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

Section 10.03 ***Modification of Rates.***

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

Section 10.04 modified by Version 1.0.

Section 10.04 ***Negotiation of Rates.***

No later than April 1st each year following the Operational Start Date, the parties will begin negotiating the Rate for the next Contract Year. Such negotiations must conclude no later than July 1st. The negotiations will include a review of the Contractor FSR; historical enrollment and claims experience information; any changes to ICM Services and covered populations; and any other relevant information.

Section 10.05 ***Adjustments to Payments.***

(a) Recoupment.

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

(1) the Member is enrolled into the Contractor in error, and the Contractor coordinated no Contractor Managed Services for the Member during the month for which the payment was made;

(2) the Member moves outside the United States, and the Contractor has not coordinated

Contractor Managed Services for the Member during the month for which the payment was made;

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

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

(b) Appeal of recoupment.

The Contractor may appeal the recoupment or adjustment of payments in the above circumstances using the HHSC dispute resolution process set forth in **Section 12.12**, ("Dispute Resolution").

Section 10.06 ***Restriction on assignment of fees.***

During the term of the Contract, Contractor may not, directly or indirectly, assign to any third party any beneficial or legal interest of the Contractor 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 10.07 ***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 Contractor's performance of this Contract. Contractor 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 Contractor or any taxes levied on employee wages.

Section 10.08 ***Liability for employment-related charges and benefits.***

Contractor will perform work under this Contract as an independent contractor and not as agent or representative of HHSC. Contractor 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 10.09 ***No additional consideration.***

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

(c) Contractor 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 10.10 ***Federal Disallowance***

Section 10.10 added by Version 1.0.

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

Article 11. Disclosure & Confidentiality of Information

Section 11.01 ***Confidentiality.***

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

(b) Contractor is responsible for understanding the degree to which information obtained through performance of this Contract is confidential under law.

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

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

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

Section 11.03 ***Member Records***

(a) Contractor must comply with the requirements of law, including the HIPAA requirements set forth in **Section 7.07** ("HIPAA"), 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 Contractor, to another entity, as consistent with laws and applicable releases.

(c) The term "Member Record" for this Section means the administrative, enrollment, case management and other such records maintained by Contractor.

Section 11.04 ***Requests for public information.***

(a) HHSC agrees that it will promptly notify Contractor 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 Contractor's confidential information, including without limitation, information or data to which Contractor has a proprietary or commercial interest. HHSC will deliver a copy of the request for public information to Contractor.

(b) With respect to any information that is the subject of a request for disclosure, Contractor 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. Contractor 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 Contractor that the Contractor believes to be confidential information. Contractor 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) Contractor acknowledges that HHSC asserts that privileged work product may be prepared in

anticipation of litigation and that Contractor is performing the ICM 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 Contractor of any privileged work product to which Contractor has or may have access. After the Contractor is notified or otherwise becomes aware that such documents, data, database, or communications are privileged work product, only Contractor personnel, for whom such access is necessary for the purposes of providing the ICM Services, may have access to privileged work product.

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

(1) Immediately notify HHSC; and

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

(d) If Contractor 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 law, have the right and duty to:

(1) represent Contractor in such resistance;

(2) to retain counsel to represent Contractor; or

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

(e) If a court of competent jurisdiction orders Contractor 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, Contractor 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 Contractor as confidential or proprietary;

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

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

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

Section 11.07 ***Legal action.***

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

Section 11.07 Modified by Version 1.3.

Article 12. Remedies & Disputes

Section 12.01 ***Understanding and expectations.***

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

Section 12.02 ***Tailored remedies.***

(a) Understanding of the Parties.

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

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

(1) HHSC will notify Contractor in writing of specific areas of Contractor 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 ICM Services.

(2) Contractor 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, Contractor's plan to address or cure the deficiency, and the date and time by which the deficiency will be cured; or

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

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

(c) Corrective Action Plan.

(1) At its option, HHSC may require Contractor 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) Contractor'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 Contractor in writing of HHSC's final disposition of HHSC's concerns. If HHSC accepts Contractor'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 Contractor's proposed Corrective Action Plan; or

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

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

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

(A) Excuse Contractor's prior substandard performance;

(B) Relieve Contractor 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.

(d) Administrative remedies.

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

(A) Assess liquidated damages in accordance with **Attachment B-4, "Deliverables/Liquidated Damages Matrix"**;

(B) Conduct accelerated monitoring of the Contractor. 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 Contractor;

(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 Contractor;

(I) Require forfeiture of all or part of the Contractor'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 Contractor that:

(A) Violates a material provision of the Contract;

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

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

(3) HHSC will provide notice to Contractor 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 Contractor to file a written response in accordance with this Section.

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

(e) Damages.

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

(3) If Contractor fails to perform any of the ICM 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 Contractor; or

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

(f) Equitable Remedies

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

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

(g) Suspension of Contract

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

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

(B) HHSC has reason to believe that Contractor 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 Contractor knew, or should have known of, Fraud, Abuse, Waste, malfeasance, or nonfeasance by any party concerning the Contract, and the Contractor 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 ICM Program.

(2) HHSC will notify Contractor in writing of its intention to suspend the Contract in whole or in part. Such notice will:

(A) Be delivered in writing to Contractor;

(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 Contractor or describe actions that Contractor may take to

avoid the contemplated suspension of the Contract.

Section 12.03 ***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:

(a) Termination in the best interest of HHSC.

HHSC may terminate the Contract without cause at any time when, in its sole discretion, HHSC determines that termination is in the best interests of the State of Texas. HHSC will provide reasonable advance written notice of the termination, as it deems appropriate under the circumstances. The termination will be effective on the date specified in HHSC's notice of termination.

(b) Termination for cause.

HHSC reserves the right to terminate this Contract, in whole or in part, upon the following conditions:

(1) *Assignment for the benefit of creditors, appointment of receiver, or inability to pay debts*.

HHSC may terminate this Contract at any time if Contractor:

(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 Contractor or of all or any part of its property.

(2) *Failure to adhere to laws.*

HHSC may terminate this Contract if a court of competent jurisdiction finds Contractor failed to adhere to any laws or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of Contractor's duties under this Contract. HHSC will provide at least thirty (30) days advance written notice of such termination.

(3) Breach *of confidentiality*.

HHSC may terminate this Contract at any time if Contractor breaches confidentiality laws with respect to the ICM Services and Deliverables provided under this Contract.

(4) *Failure to maintain adequate personnel or resources.*

HHSC may terminate this Contract if, after providing notice and an opportunity to correct, HHSC determines that Contractor has failed to supply personnel or resources and such failure results in Contractor'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 Contractor's exhaustion of all legal remedies that Contractor, 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) Contractor 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 Contractor's behalf.

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

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

(2) Such failure constitutes cause, as described in this 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 applicable laws.

(6) *Termination for non-appropriation of funds*.

Notwithstanding any other provision of this Contract, if funds for the continued fulfillment of this Contract by HHSC are at any time not forthcoming or are insufficient, through failure of any entity to appropriate funds or otherwise, then HHSC will have the right to terminate this Contract at no additional cost and with no penalty whatsoever by giving prior written notice documenting the lack of funding. HHSC will provide at least thirty (30) days advance written notice of such termination. HHSC will use reasonable efforts to ensure appropriated funds are available.

(7) *Judgment and execution.*

(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 Contractor and Contractor 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 Contractor, 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 Contractor:

(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 a Contract for the composition, extension, or readjustment of substantially all of its obligations.

(B) Contractor 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 Contractor 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 Contractor'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 Contractor'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 Contractor has materially breached the Contract. HHSC will provide at least thirty (30) days advance written notice of such termination.

Section 12.04 ***Termination by Contractor.***

(a) Failure to pay.

Contractor may terminate this Contract if HHSC fails to pay the Contractor undisputed charges when due as required under this Contract. Retaining payment, recoupment, sanctions, or penalties that are allowed under this Contract or that result from the Contractor's failure to perform or the Contractor'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 Contractor may submit a notice of intent to terminate for failure to pay in accordance with the requirements of **Subsection 12.04(d)**. If HHSC pays all undisputed amounts then due within thirty (30)-days after receiving the notice of intent to terminate, the Contractor cannot proceed with termination of the Contract under this Article.

(b) Change to Uniform Managed Care Manual.

Contractor may terminate this agreement if the Parties are unable to resolve a dispute concerning a material and substantive change to the Uniform Managed Care Manual (a change that materially and substantively alters the Contractor's ability to fulfill its obligations under the Contract). Contractor must submit a notice of intent to terminate due to a material and substantive change in the Uniform Managed Care Manual no later than thirty (30) days after the effective date of the policy change. HHSC will not enforce the policy change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(c) Change to Capitation Rate.

If HHSC proposes a modification to the Capitation Rate that is unacceptable to the Contractor, the Contractor may terminate the Contract. Contractor must submit a written notice of intent to terminate due to a change in the Capitation Rate no later than thirty (30) days after HHSC's notice of the proposed change. HHSC will not enforce the rate change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(d) Notice of intent to terminate.

In order to terminate the Contract pursuant to this Section, Contractor must give HHSC written notice of intent to terminate. The termination date will be calculated as the last day of the month following ninety (90) days from the date the notice of intent to terminate is received by HHSC.

Section 12.05 ***Termination by mutual agreement.***

This Contract may be terminated by mutual written agreement of the Parties.

Section 12.06 ***Effective date of termination.***

Except as otherwise provided in this Contract, termination will be effective as of the date specified in the notice of termination.

Section 12.07 ***Extension of termination effective date.***

The Parties may extend the effective date of termination one or more times by mutual written agreement.

Section 12.08 ***Payment and other provisions at Contract termination.***

(a) In the event of termination pursuant to this Article, HHSC will pay the Capitation Payment for ICM Services and Deliverables rendered through the effective date of termination. All pertinent provisions of the Contract will form the basis of settlement.

(b) Contractor must provide HHSC all reasonable access to records, facilities, and documentation as is required to efficiently and expeditiously close out the ICM Services and Deliverables provided under this Contract.

(c) Contractor 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**. Contractor must negotiate such proposed modifications in good faith.

Section 12.10 ***Turnover assistance.***

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

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

Section 12.13 ***Dispute resolution.***

(a) General agreement of the Parties.

The Parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the Parties employ all reasonable and informal means to resolve any dispute under this Contract. The Parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

(b) Duty to negotiate in good faith.

Any dispute that in the judgment of any Party to this Contract may materially or substantially affect the performance of any Party will be reduced to writing and delivered to the other Party. The Parties must then negotiate in good faith and use every reasonable effort to resolve such dispute and the Parties shall not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible. The resolution of any dispute disposed of by Contract between the Parties shall be reduced to writing and delivered to all Parties within ten (10) Business Days.

(c) Claims for breach of Contract.

(1) *General requirement.* Contractor'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 Contractor'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, Contractor must submit written notice to HHSC that specifically states that Contractor 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 Contractor'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 Contractor'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 Contractor'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) *Contractor'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 Contractor 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 & Modifications").

Section 12.14 ***Liability of Contractor.***

(a) Contractor bears all risk of loss or damage to HHSC or the State due to:

(1) Defects in ICM Services or Deliverables;

(2) Unfitness or obsolescence of ICM Services or Deliverables; or

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

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

(c) Contractor 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.

Article 13. Assurances & Certifications

Section 13.01 ***Proposal certifications.***

Contractor acknowledges its continuing obligation to comply with the requirements of the following certifications contained in its Proposal, and will immediately notify HHSC of any changes in circumstances affecting these certifications:

(1) Federal lobbying;

(2) Debarment and suspension;

(3) Child support; and

(4) Nondisclosure statement.

Section 13.02 ***Conflicts of interest.***

(a) Representation.

Contractor agrees to comply with applicable laws regarding conflicts of interest in the performance of its duties under this Contract. Contractor warrants that it has no interest and will not acquire any direct or indirect interest that would conflict in any manner or degree with its performance under this Contract.

(b) General duty regarding conflicts of interest.

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

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

(b) Warranty.

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

(c) Continuing duty to disclose.

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

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

(d) Remedy.

If HHSC determines that an organizational conflict of interest exists, HHSC may, at its discretion, terminate the Contract pursuant to **Subsection 12.03(b)(9).** If HHSC determines that Contractor was aware of an organizational conflict of interest before the award of this Contract and did not disclose the conflict to the contracting officer, such nondisclosure will be considered a material breach of the Contract. Furthermore, such breach may be submitted to the Office of the Attorney General, Texas Ethics Commission, or appropriate State or Federal law enforcement officials for further action.

(e) Flow down obligation.

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

Section 13.04 ***HHSC personnel recruitment prohibition.***

Contractor 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 Contractor for this Contract.

Unless authorized in writing by HHSC, Contractor 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.***

Contractor 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, Contractor agrees that any payments due to Contractor under the Contract will be first applied toward any debt and/or back taxes Contractor owes State of Texas. Contractor further agrees that payments will be so applied until such debts and back taxes are paid in full.

Section 13.07 ***Outstanding debts and judgments.***

Contractor certifies that it is not presently indebted to the State of Texas, and that Contractor is not subject to an outstanding judgment in a suit by State of Texas against Contractor for collection of the balance. For purposes of this Section, 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 Contractor'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 Contractor and no additional approval, authorization or consent of any governmental or regulatory agency is required to be obtained in order for Contractor to enter into this

Contract and perform its obligations under this Contract.

(b) Contractor has obtained all licenses, certifications, permits, and authorizations necessary to perform the ICM Services under this Contract and currently is in good standing with all regulatory agencies that regulate any or all aspects of Contractor's performance of this Contract. Contractor will maintain all required certifications, licenses, permits, and authorizations during the term of this Contract.

Section 14.02 ***Ability to perform.***

Contractor 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 ***Workmanship and performance.***

(a) All ICM 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 ICM Services and Deliverables must meet or exceed the required levels of performance specified in or pursuant to this Contract.

(c) Contractor will perform the ICM 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 14.04 ***Warranty of deliverables.***

Contractor 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 Contractor and HHSC. Contractor will promptly repair or replace any such Deliverables not in compliance with this warranty at no charge to HHSC.

Section 14.05 ***Compliance with Contract.***

Contractor 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 14.06 ***Technology Access***

(a) Contractor 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, Contractor represents and warrants to HHSC that this technology is capable, either by virtue of features included within the technology or because it is readily adaptable by use with other technology, of:

(1) Providing equivalent access for effective use by both visual and non-visual means;

(2) Presenting information, including prompts used for interactive communications, in formats intended for non-visual use; and

(3) Being integrated into networks for obtaining, retrieving, and disseminating information used by individuals who are not blind or visually impaired.

(b) For purposes of this Section, the phrase "equivalent access" means a substantially similar ability to communicate with or make use of the technology, either directly by features incorporated within the technology or by other reasonable means such as assistive devices or services that would constitute reasonable accommodations under the Americans with Disabilities Act or similar 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 Contractor 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) Contractor warrants that all Deliverables provided by Contractor 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) Contractor 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 Contractor in writing of the claim, provide Contractor a copy of all information received by HHSC with respect to the claim, and cooperate with Contractor in defending or settling the claim. HHSC will not unreasonably withhold, delay or condition approval of counsel selected by the Contractor.

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

Section 15.02 ***Exceptions.***

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

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

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

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

Section 15.03 ***Ownership and Licenses***

(a) Definitions.

For purposes of this Section 15.03, the following terms have the meanings set forth below:

(1) "**Custom Software**" means any software developed by the Contractor: for HHSC or another HHS Agency; in connection with the Contract; and with funds received from HHSC. The term does not include Contractor Proprietary Software or Third Party Software.

(2) "**Contractor Proprietary Software**" means software: (i) developed by the Contractor prior to the Effective Date of the Contract, or (ii) software developed by the Contractor after the Effective Date of the Contract that is not developed: for HHSC or another HHS Agency; 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 or another HHS Agency. Third Party Software includes without limitation: commercial off-the-shelf software; operating system software; and application software, tools, and utilities.

(b) Deliverables.

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

(c) Ownership rights.

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

(d) License Rights

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

Contractor in the performance of the ICM 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 ICM Services performed as a result of the Contract.

(e) Proprietary Notices

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

(f) State and Federal Governments

In accordance with 45 C.F.R. §95.617, all appropriate State and Federal agencies will have a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, translate, or otherwise use, and to authorize others to use for Federal Government purposes all materials, the Custom Software and modifications thereof, and associated documentation designed, developed, or installed with federal financial participation under the Contract, including but not limited to those materials covered by copyright, all software source and object code, instructions, files, and documentation.

Article 16. Liability

Section 16.01 ***Property damage.***

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

(c) Contractor 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 Contractor any special defect or unsafe condition encountered while on HHSC premises. Contractor 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 Contractor, its carriers or HHSC prior to being accepted by HHSC, Contractor 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 Contractor'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 Contractor UNDER THE CONTRACT WILL NOT EXCEED THE TOTAL CHARGES TO BE PAID BY HHSC TO Contractor UNDER THE CONTRACT.

Contractor's remedies are governed by the provisions in **Article 12** ("Remedies & Disputes").

Article 17. Insurance & Bonding

Section 17.01 modified by Version 1.0.

Section 17.01 ***Insurance Coverage.***

(a) Required Coverage

(1) *Statutory and General Coverage*.

Contractor will maintain, at Contractor's own expense, during the Term of the Contract and until final acceptance of all ICM Services and Deliverables, the following insurance coverage. Contractor will provide HHSC with proof of the following insurance coverage on or before the Contract Effective Date:

(A) Standard Worker's Compensation Insurance coverage;

(B) Automobile Liability;

(C) Comprehensive Liability Insurance including Bodily Injury coverage of $100,000.00 per each occurrence and Property Damage Coverage of $25,000.00 per each occurrence; and

(D) General Liability Insurance of at least $1,000,000.00 per occurrence and $5,000,000.00 in the aggregate.

If Contractor's current Comprehensive General Liability insurance coverage does not meet the above stated requirements, Contractor will obtain

excess liability insurance to compensate for the difference in the coverage amounts.

(3) Contractor is responsible for any and all deductibles stated in the policies. Insurance will be maintained at all times during the performance of the Contract. Insurance coverage must be issued by insurance companies authorized by applicable law to conduct business in the State of Texas. With the exception of Standard Workers Compensation Insurance, insurance coverage must name HHSC as an additional insured.

(4) The policies will have an extended reporting period of two years. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, the Contract Effective Date.

(b) Proof of Insurance Coverage

(1) Contractor will furnish the HHSC Project Manager original Certificates of Insurance evidencing the required coverage to be in force on the date of award, and renewal certificates of insurance, or such similar evidence, if the coverages have an expiration or renewal date occurring during the term of the Contract. Contractor will submit original evidence of insurance prior to the Effective Date of the Contract. The failure of HHSC to obtain such evidence from Contractor before permitting Contractor to commence work will not be deemed to be a waiver by HHSC and Contractor will remain under continuing obligation to maintain and provide proof of the insurance coverage.

(2) The insurance specified above will be carried until all services required to be performed under the terms of the Contract are satisfactorily completed. Failure to carry or keep such insurance in force will constitute a violation of the Contract.

(3) The insurance will provide for thirty (30) calendar days prior written notice to be given to HHSC in the event coverage is substantially changed, canceled, or non-renewed. Contractor must submit a new coverage binder to HHSC to ensure no break in coverage.

(4) The Parties expressly understand and agree that any insurance coverages and limits furnished by Contractor will in no way expand or limit Contractor's liabilities and responsibilities specified within the Contract or by applicable law.

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

(6) If Contractor desire additional coverage, higher limits of liability or other modifications for its own protection, Contractor will be responsible for the acquisition and cost of such additional protection.

Section 17.02 ***Surety Bond.***

Beginning on the Operational Start Date of the Contract, and each Contract Year thereafter, the Contractor must obtain a surety bond. Contractor must obtain and maintain the surety bond in the form prescribed by HHSC, naming HHSC as obligee. The surety bond must be issued in the amount of $3,000,000.00. All surety bonds must be issued by a surety licensed by TDI, and specify cash payment as the sole remedy. Contractor must deliver the initial surety bond to HHSC prior to the Operational Start Date of the Contract, and each renewal surety bond prior to the first day of the Contract Year.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Version 1.0	n/a	February 15, 2007	Initial version of Attachment B-1, RFP Sections 1-3. Includes all modifications negotiated by the Parties.
Revision	Version 1.1	November 16, 2007	Entire document modified to change wording from CBA waiver to 1915(c) waiver. Section 1.3.4 modified to clarify the age requirements for mandatory participation in the ICM Program.
Revision	Version 1.2	February 1, 2007	Contract Amendment Two did not revise Attachment B-1, RFP Section 1-3.
Revision	Version 1.3	September 1, 2008	Contract Amendment Three did not revise Attachment B-1, RFP Section 1-3.

[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.

Texas Health & Human Services Commission

Albert Hawkins, Executive Commissioner

Request for Proposals

for

Integrated Care Management Contractor

RFP No. 529-06-0406

Date of Final Release: August 14, 2006

Texas Health & Human Services Commission

RFP No. 529-06-0406
Date of Final Release: August 14, 2006

Notice of Intent to Propose

HHSC requests that Bidders who intend to submit a Proposal submit this form; however, Bidders are not required to submit this form.

Name of Bidder: _____

_____

Contact Person: _____ Title: _____

Mailing Address: _____

_____

_____

_____

Telephone: _____ Fax: _____

E-mail Address: _____

Please return no later than September 7, 2006 to:
Dana Nichols, Project Manager
Texas Health and Human Services Commission
11209 Metric Blvd, Bldg H
Austin, Texas 78758
Fax: (512) 491-1972

1 GENERAL INFORMATION

1.1 Mission Statement

To improve the management and coordination of services to certain Medicaid Aged, Blind and Disabled (ABD) populations, the Texas Legislature passed House Bill 1771 (79th Legislature, Regular Session, 2005)[1]. This bill requires the Health and Human Services Commission (HHSC) to develop and implement a non-capitated, enhanced primary care case management system of Medicaid managed care referred to as the integrated care management (ICM) model.

The purpose of this procurement is to contract with a single qualified Contractor to assist HHSC in the implementation of an Integrated Care Management Program (ICM Program) to manage and coordinate Acute Care Services and Long Term Services and Supports (LTSS) for the eligible Supplemental Security Income (SSI), SSI-related and Medical Assistance Only (MAO) Medicaid population. **Attachment A** to the **ICM Contract Document** includes the General Terms and Conditions for the ICM Contract.[2]

The ICM Contractor will assist HHSC, the Texas Department of Aging and Disability Services (DADS), and other state vendors in implementing the ICM Program.

Section 1.2 modified by RFP Addendum No. 1.

1.2 Mission Objectives

HHSC's objective for this ICM Contractor procurement is to procure a package of administrative and service management functions from a single qualified entity to assist HHSC in the successful implementation of a non-capitated model of Medicaid managed care for the ICM Program eligible population.

To execute the ICM Contractor Contract, an entity must be licensed by the Texas Department of Insurance as a Utilization Review Agent.

The ICM Contractor will serve the entire ICM Service Area, which includes all counties in the Dallas Service Area and all counties in the Tarrant Service Area. A map of the ICM Service Area is provided in **RFP Attachment B**.

[1] House Bill 1771 is now codified in Texas Government Code Chapter 533, Subchapter D.
[2] The definitions for terms that are capitalized in the document are found in **Attachment A** to the **ICM Contract Document, General Terms and Conditions**. These terms may also be defined within the text of the document.

HHSC seeks to contract with an entity to perform ICM Contractor functions that will enable the ICM Program to meet the legislative objectives for the ICM Program. The objectives of the ICM Program as described in HB 1771 are to:

- integrate the spectrum of Acute Care and Long Term Services and Supports;
- improve health and social outcomes;
- improve access to care; and
- constrain health care costs.

HHSC's primary objective for this procurement is to identify a qualified Bidder to effectively perform the following ICM Program components identified in HB 1771 in the ICM Service Area:

1. assign Medicaid-only Members to a Medical Home;
2. conduct Utilization Management to ensure appropriate access to and utilization of Medicaid services;
3. assess health risks and functional needs;
4. inform the Medical Home and other Providers about recipients' service utilization and associated costs;
5. reduce inappropriate emergency room utilization through mechanisms that include but are not limited to availability of after-hours primary care for Medicaid-only Members;
6. implement a robust system of Service Coordination for assessing, planning, coordinating and monitoring recipients with complex, chronic or high-cost health care or social support needs, including attendant care and other services needed to remain in the community;
7. provide comprehensive, community-based education to recipients about effective use of the ICM Program, while ensuring meaningful access to services for persons with sensory or mental disabilities and persons with limited English proficiency; and
8. prevent or delay institutionalization of Members through effective utilization of home and community-based support services.

In addition, HHSC's objectives include procuring services from a qualified Bidder to support the ICM Program implementation in the ICM Service Area, including but not limited to:

1. provide Member services to ICM Members;
2. provide Provider services to Medicaid Providers serving ICM Members;
3. support HHSC and DADS in establishing and managing the ICM Provider Network; and
4. comply with applicable Federal and state Medicaid managed care regulations,.

1.3 Background

1.3.1 Overview of the Health and Human Services Commission

The Texas Legislature created HHSC in 1991 to oversee and coordinate the planning and delivery of health and human services programs in Texas. HHSC was established pursuant to Chapter 531, Texas Government Code and is responsible for oversight of Texas health and human services agencies (HHS Agencies). The chief executive officer of the Commission is Albert Hawkins, Executive Commissioner of Health and Human Services.

The HHS Agencies are as follows:

- DADS provides an array of aging and disability services that include mental retardation services, State school models, community care services, nursing facility and long-term care regulatory services, and aging services and programs.
- The Department of State Health Services (DSHS) provides public health and behavioral health services programs, including oversight of the NorthSTAR program.
- The Department of Assistive and Rehabilitative Services (DARS) provides programs and support for people with disabilities and families of children with developmental delays, including rehabilitation services and Social Security Administration (SSA) disability determination services.
- The Department of Family and Protective Services (DFPS) investigates reports of abuse, neglect and exploitation of elderly people and people with disabilities who reside in the community and if appropriate, provides or arranges for protective services, including referral to other programs, respite care, guardianship, transportation, counseling and emergency assistance with food, shelter, and medical care.

HHSC coordinates administrative functions for the HHS Agencies, determines eligibility for health and human services programs, and administers the Texas Medicaid Program. The Contractor that is awarded a Contract will work with HHSC, DADS, other HHSC Agencies and their contractors to coordinate the delivery of services for ICM Members.

1.3.2 ICM Advisory Committee

HHSC established the ICM Advisory Committee (Committee) in accordance with the directives set forth in House Bill 1771. The purpose of the Committee is to assist HHSC in the development and implementation of the ICM model to serve the eligible ABD populations in the Dallas and Tarrant Service Areas. The Committee solicited comments from consumers, providers and other interested stakeholders. The ICM Advisory Committee made recommendations to HHSC in January 2006. The direction provided by the Committee assisted HHSC in developing this RFP.

1.3.3 ICM Program Overview

The ICM Program will provide Acute Care and Long Term Services and Supports to eligible SSI, SSI-related and MAO Medicaid clients in the Dallas Service Area and the Tarrant Service Area (See **RFP Attachment B** for a map of the ICM Service Area).

Participation in the ICM Program will be mandatory for most Medicaid clients eligible for the ICM Program and voluntary for children under age 21. Medicare-eligible ICM Eligibles will be required to participate in the ICM Program unless they meet the criteria for exclusion, such as residing in an institutional setting. See **RFP Section 1.3.4** for more information on the ICM Eligible Population.

HHSC will pay ICM Network Providers on a Fee-for-Service basis according to the Medicaid fee schedule for the ICM Program.

Section 1.3.3.1 modified by RFP Addendum No. 2.

1.3.3.1 ICM Services

ICM Members will remain eligible for the full set of Medicaid benefits to which they are currently entitled. ICM Members that are not covered by Medicare will receive unlimited Medically Necessary prescriptions and have access to an annual adult well check. The Medicaid Fee-for-Service 30-day spell of illness limitation on hospitalization will remain in effect for the ICM Program

ICM Members in the Dallas Service Area will continue to receive Behavioral Health (BH) services through the NorthSTAR program.

SSI and SSI-related ICM Members who meet medical necessity criteria for the 1915(c) Community Based Alternative Waiver (CBA Waiver) in the ICM Service Area will receive Medically Necessary CBA Waiver services without waiting on an interest list. The Contractor is responsible for achieving cost savings necessary to fund these additional services, which HHSC estimates to be delivered to 628 clients at an all funds (state and federal funds) cost of $6.8 million per year. DADS will continue to maintain an interest list for MAO applicants for CBA Waiver services. Eligible MAO individuals will receive Medically Necessary CBA Waiver services when a slot is available, at which time they will be enrolled into the ICM Program.

1.3.3.2 Contractor Scope of Work

The Contractor will assist HHSC in implementing the ICM Program, which will include the components indicated in HB 1771. The ICM Contractor will be responsible for the Scope of Services as described in **Section 5** of this RFP. In general, the Contractor will authorize, conduct Utilization Review of and provide Service Coordination for Medically Necessary and Functionally Necessary Contractor Managed Services.

The Contractor will coordinate, make referrals to and provide information about Medicaid services that are not included in **Attachment B-2** to the **ICM Contract Document (Contractor Managed Services)**. The Contractor will provide Disease Management services for Medicaid-only ICM Members. In addition, the Contractor will perform the Nursing Facility Risk Assessment for Member and MAO recipient entry into the CBA Waiver. The Contractor will be involved in implementation of the state's Promoting Independence Initiative.

The Contractor will execute Provider Agreements with providers of Acute Care Services and Long Term Services and Supports. The Contractor will be responsible for authorizing and coordinating Contractor Managed Services and HHSC will pay such providers on a Fee-for-Service basis (see **RFP Section 1.3.3.3**, below).

The Contractor will provide non-Medicare Members a Medical Home. The Contractor will assign non-Medicare Members to Primary Care Providers (PCPs) in the ICM Provider Network, allow Members the ability to change their PCP, and educate Members on the PCP assignment and selection process and Members' ability to change PCPs. The Contractor will provide ICM Member panel reports to PCP Providers.

The Contractor will coordinate with NorthSTAR but will not execute Provider Agreements with or manage Providers who provide BH Services to ICM Members in the Dallas Service Area. The Contractor will be responsible for executing Provider Agreements with and managing Providers who provide BH Services for ICM Members in the Tarrant Service Area.

1.3.3.3 Coordination with HHSC, DADS, and HHSC Vendors

The Contractor will be responsible for coordinating with HHSC and DADS, the Claims Administrator, the Enrollment Broker and related information systems and other state vendors as required to implement the ICM Program.

For purposes of making Provider payments for Medicaid services to ICM Members, HHSC and DADS will continue to hold Medicaid provider contracts with the ICM Network Providers of Acute Care Services and Long Term Services and Supports, respectively. Providers will submit claims to the HHSC Claims Administrator, and HHSC will pay claims based on a Fee-for-Service basis. In addition to holding HHSC or DADS Medicaid provider contracts, Providers must also hold Network Provider contracts with the ICM Contractor to participate in the ICM Program.

1.3.4 ICM Eligible Population

The following groups of mandatory and voluntary Medicaid eligibles (referred to herein as "the ICM Eligible Population") will be required or permitted to participate in the ICM Program in the Dallas and Tarrant Service Areas. Within these broad eligible groups, there are certain types of Medicaid eligibles that are specifically excluded from participation in the ICM Program. These excluded Medicaid eligibles in the Dallas and Tarrant Service Areas will remain in Medicaid Fee-for-Service.

In general, ICM Program participation is mandatory for SSI and SSI-related adults and voluntary for SSI children under 21. Individuals on SSI who are dually eligible for Medicaid and Medicare are eligible for the ICM Program.

Section 1.3.4 modified by Version 1.1

Mandatory Participation
Medicaid Eligibles in the following categories who reside in any part of an ICM Service Area must enroll with the ICM Program: [3]

1. Supplement Security Income (SSI) eligibles age 21 and older;
2. Individuals age 21 and older who are Medicaid-eligible because they are in a Social Security Exclusion Program. These individuals are mandatory participants in the ICM Program but will have to meet financial eligibility criteria for the 1915 (c) waiver eligibility;
3. MAO eligibles that qualify for 1915 (c) waiver services.

Voluntary Participation
Children (under age 21) who are SSI-eligible or who are Medicaid-eligible because they are in a Social Security Exclusion Program may choose whether or not to enroll in the ICM Program.

Excluded Participation
The following groups of Medicaid eligibles are excluded from participation in the ICM Program.

[3] Primary Acute Care and pharmacy services for Dual Eligibles are covered through Medicare. Participation in the ICM Program will not affect the Dual Eligible Members' rights to receive their Medicare services in any way they choose.

1. Persons in institutional settings, including a resident of:
   a. a nursing facility;
   b. an Intermediate Care Facility for the Mentally Retarded (ICF-MR), or
   c. an Institution of Mental Disease (IMD) or state hospital.

2. Persons enrolled in a 1915 (c) Medicaid waiver program other than the CBA Waiver program, including the following waiver programs:
   a. Community Living Assistance and Support Services;
   b. Medically Dependent Children's Waiver;
   c. Home and Community Services Waiver;
   d. Deaf Blind Multiple Disability Waiver;
   e. Consolidated Waiver Program, and
   f. Texas Home Living Waiver.

3. Individuals not eligible for full Medicaid benefits, such as
   a. individuals that are in the Community Attendant Services program;
   b. Qualified Medicare Beneficiaries (QMB);
   c. Specified Low-income Medicare Beneficiaries (SLMB);
   d. Qualified Disabled and Working Individuals (QDWI), and
   e. undocumented aliens.

4. Individuals under age 21 in state foster care or the foster care youth transitional Medicaid program.

The following table contains an estimate of the ICM enrollment for each Service Area.

ESTIMATED MEDICAID AGED, BLIND AND DISABLED ENROLLMENT (April 2004)			
Service Area	**Aged, Blind & Disabled (Mandatory) Age 21 and over**	**Blind and Disabled (Voluntary) Under age 21**	**Total Estimated Eligibles**
Dallas Service Area	42,403	9,984	52,387
Tarrant Service Area	22,632	5,489	28,121
TOTAL	**65,035**	**15,473**	**80,508**

1.4 External Factors

Respondents should be aware that external factors may affect the project, including budgetary and resource constraints. Any Contract resulting from this procurement is subject to the availability of state and federal funds. As of the issuance of this RFP, HHSC anticipates that budgeted funds are available to reasonably fulfill the requirements of this RFP. If, however, funds become unavailable, HHSC reserves the right to withdraw this RFP or terminate the resulting Contract without penalty.

1.5 Legal and Regulatory Constraints

1.5.3 Delegation of Authority

Bidders should be aware that State and Federal law generally limit HHSC's ability to delegate certain decisions to a contractor. Specifically, HHSC may not delegate certain functions to a contractor, including but not limited to policy-making authority and final decision-making authority regarding acceptance of contracted services.

1.5.4 Conflicts of Interest

Bidders may not have any personal or business interest that would present an actual, potential or apparent conflict of interest with the performance of the Contract, and the Bidder awarded the Contract will not reasonably create an appearance of impropriety. Furthermore, HHSC is obliged by State and Federal law to ensure a level playing field in the award of contracts. HHSC will implement an aggressive policy concerning actual or potential conflicts of interest that will ensure fair and open competition for HHSC contracts. For purposes of this RFP, a conflict of interest is any set of facts or circumstances that, in HHSC's determination:

- compromises, appears to compromise, or that may reasonably compromise the fairness, independence, or objectivity of a consultant or public servant, and/or
- creates an unfair competitive advantage because of access to strategic, non-public information relating to Services and/or Deliverables obtained pursuant to this RFP.

Bidders must supply with their proposals a list of potential conflicts or a statement acknowledging that no conflict currently exists with respect to the performance of services solicited under this RFP. If the Bidder identifies potential conflicts, it must include the procedures and safeguards it will implement to ensure that no actual conflicts of interest will arise. The Bidder awarded a Contract will be under a continuing duty to notify HHSC of any potential conflicts of interest that develop during the course of the Contract. HHSC reserves the right to evaluate any conflict and reject any Proposal due to conflicts, or to terminate the Contract due to a conflict of interest.

HHSC does not consider holding an existing HHSC Medicaid HMO contract to be a conflict of interest for purposes of bidding on the ICM Contractor RFP.

1.5.5 Former Employees of a State Agency

Bidders must comply with State and Federal laws and regulations relating to the hiring of former State employees (see e.g., Texas Government Code §572.054 and 45 C.F.R. §74.43). Such "revolving door" provisions generally restrict former agency heads from communicating with or appearing before the agency on certain matters for two years after leaving the agency. The revolving door provisions also restrict certain former employees from representing clients on matters that the employee participated in during State service or matters that were within the employee's official responsibility. As a result of such laws and regulations and as required in **RFP Section 4.6**, a Bidder must certify that it has complied with all applicable State and Federal laws and regulations relating to the hiring of former State employees. Furthermore, the Bidder must disclose any relevant past employment of its employees and agents, or Material Subcontractors' employees and agents, by HHSC or another Texas health and human service agency, including a description of:

- the nature of the previous employment with HHSC or the other HHS agency;
- the date the employment terminated, and
- the annual rate of compensation for the employment at the time of termination.

1.5.6 Interpretive Conventions

Whenever the terms “shall,” “must,” or “is required” are used in this RFP in conjunction with a specification or performance requirement, the specification or requirement is mandatory. A Bidder’s failure to address or meet any mandatory requirement in its Proposal may be cause for rejection of the Proposal. Whenever the terms “can,” “may,” or “should” are used in this RFP in conjunction with a specification or performance requirement, the specification or performance requirement is a desirable, but not mandatory, requirement. Accordingly, a respondent’s failure to address or provide any items so referred to will not be the cause for rejection of the Proposal, but will likely result in a less favorable evaluation.

1.5.7 Agreement to Accept and Abide by the RFP and RFP Process

A Bidder that submits a Proposal in response to this RFP agrees, on its own behalf and on behalf of any parent or subordinate organization and all proposed Subcontractors, to the following:

1. It accepts without reservation or limitation as lawful and binding the Proposal submission requirements and rules and the procurement procedures, processes, and specifications identified in this RFP, including any RFP addenda and all appendices to this RFP.
2. It accepts without reservation or limitation as lawful and binding the State’s use of the evaluation methodology and evaluation process as described in **Section 7** of this RFP.
3. It accepts without reservation or limitation as lawful and binding the State’s sole, unrestricted right to reject any or all Proposals submitted in response to this RFP.
4. It accepts without reservation or limitation as lawful and binding the substantive, professional, legal, procedural, and technical propriety of the scope of work in the RFP.
5. If awarded a Contract as the result of this RFP, it accepts without reservation or limitation the contractual language set forth in the Contract, including the **General Terms and Conditions** (**Attachment A** to the **ICM Contract Document**). A Bidder may raise objections to certain contractual language in the RFP, including the **General Terms and Conditions,** if the objections are clearly stated in the Bidder’s Transmittal Letter as described in **RFP Section 4.6.** A Bidder may not object to contractual language that is required by Federal or State laws or regulations. HHSC will more favorably evaluate a Bidder that raises few or no objections to the contractual terms and conditions. HHSC reserves the right to consider a Proposal as non-responsive if the Bidder objects to contractual language required by Federal or State laws or regulations.

1.5.8 Texas Public Information Act

A Proposal submitted to HHSC in response to this RFP is subject to public disclosure under the Texas Public Information Act (the Act), Texas Government Code, Chapter 552, unless the Proposal, or any part of the Proposal, can be shown to fall within one or more of the exceptions to required public disclosure listed in the Act. If a respondent believes that parts of a Proposal are excepted from required

public disclosure under the Act, the respondent must specify those parts and the exception(s) that it believes apply, with specific detailed reasons. HHSC will process any request for information comprising all or part of the respondent's Proposal in accordance with the procedures prescribed by the Act. A respondent should consult the Attorney General's website (www.oag.state.tx.us) for information concerning the application of the Act's provisions to proposals and potential proprietary information.

1.6 HHSC Point of Contact

The sole point of contact for inquiries concerning this RFP is:

Dana Nichols, Project Manager
Texas Health and Human Services Commission
11209 Metric Blvd, Bldg H
Austin, Texas 78758
(512) 491-1129
Fax (512) 491-1972
Dana.Nichols@hhsc.state.tx.us

The physical address for overnight, commercial and hand deliveries is:

Texas Health and Human Services Commission
c/o Dana Nichols, Project Manager
11209 Metric Blvd, Bldg H
Austin, Texas 78758
(512) 491-1129

All communications relating to this RFP must be directed to HHSC contact person named above. All other communications between a respondent and HHSC staff concerning this RFP are prohibited. In no instance is a respondent to discuss cost information contained in a Proposal with the HHSC point of contact or any other staff prior to Proposal evaluation. Failure to comply with this section may result in HHSC's disqualification of the Proposal.

Section 1.7 modified by Version 1.0.

1.7 Project Timeline

The anticipated schedule for this procurement is as follows. HHSC reserves the right to revise this schedule. Revisions, if any, will be posted on the ICM Contractor RFP webpage found at http://www.hhsc.state.tx.us/Contract/529060406/rfp_home.html

Procurement Schedule	
Draft RFP Release Date	May 18, 2006
Comments to the Draft RFP Due	June 18, 2006
Final RFP Release Date	August 14, 2006
Bidder Conference	August 21, 2006

Bidder Questions Due	September 18, 2006
HHSC Responses to Bidder Questions Posted	September 27, 2006
Notice of Intent to Propose Due	September 7, 2006
Proposals Due	October 6, 2006
Deadline for Withdrawal of Proposals	October 6, 2006
Tentative Award Announcement	January 26, 2007
Anticipated Contract Signing	February 9, 2007
Anticipated ICM Operational Start Date	July 1, 2007

1.8 Communications Regarding This Procurement

HHSC will post all official communications regarding this procurement on its website, including the notice of tentative award. In addition, HHSC reserves the right to amend this RFP at any time prior to the Proposal submission deadline. Any changes, amendments, or clarifications will be made in the form of responses to Bidder questions, amendments, or addendum issued by HHSC. Bidders should check HHSC's website frequently for notice of matters affecting the procurement.

1.9 RFP Cancellation/Non-Award

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

1.10 Right to Reject Proposals or Portions of Proposals

HHSC may, in its discretion, reject any and all proposals, or portions of proposals, submitted in response to this RFP.

1.11 Bidder Protest Procedures

Texas Administrative Code, Title 1, Chapter 392, Subchapter C outlines HHSC's bidder protest procedures. A Bidder may protest HHSC's tentative award of a Contract. Such protest must be in writing and signed by the protestant or the protestant's authorized representative.

The protest must state the protestant's name and the specific award that is being protested, the legal and factual basis for the protest with specific supporting information and when applicable, how the protestant alleges the award or tentative award violated HHSC's rules, state or federal laws, or regulations governing the procurement. The protest must state an explanation of the facts in disagreement and the subsequent action the protestant is requesting.

The protest must be submitted to the HHSC's official point of contact no later than seven (7) calendar days following the announcement of the tentative award of the Contract on HHSC's website. The

protest must be delivered by hand, certified mail return receipt requested, facsimile or other verifiable delivery service and be limited to matters relating to the protestant's qualifications, the suitability of the goods or services offered by the protestant, or alleged irregularities in the procurement process. Failure to comply with the foregoing timeframe will result in HHSC's dismissal of the protest.

The HHSC division that conducted the procurement will review the protest and the Division Director will make an initial recommendation to the Executive Commissioner. The Executive Commissioner will review the protest and Division Director's recommendations, and then issue a final determination regarding the protest. HHSC will provide the protestant with a written copy of the final determination within thirty days of receiving the protest, or as soon thereafter as practicable. The Executive Commissioner's final determination will be HHSC's final action on the protest, and the protestant will have no further administrative recourse.

2 PROCUREMENT STRATEGY AND APPROACH

2.1 Best Value Procurement

Section 2155.144, Texas Government Code, obligates HHSC to purchase goods and services on the basis of best value. HHSC rules define "best value" as the optimum combination of economy and quality that is the result of fair, efficient, and practical procurement decision-making and that achieves health and human services procurement objectives (see 1 TAC §391.31). HHSC will evaluate proposals using the best value criteria set forth in **Section 7** of this RFP and will contract with one Contractor.

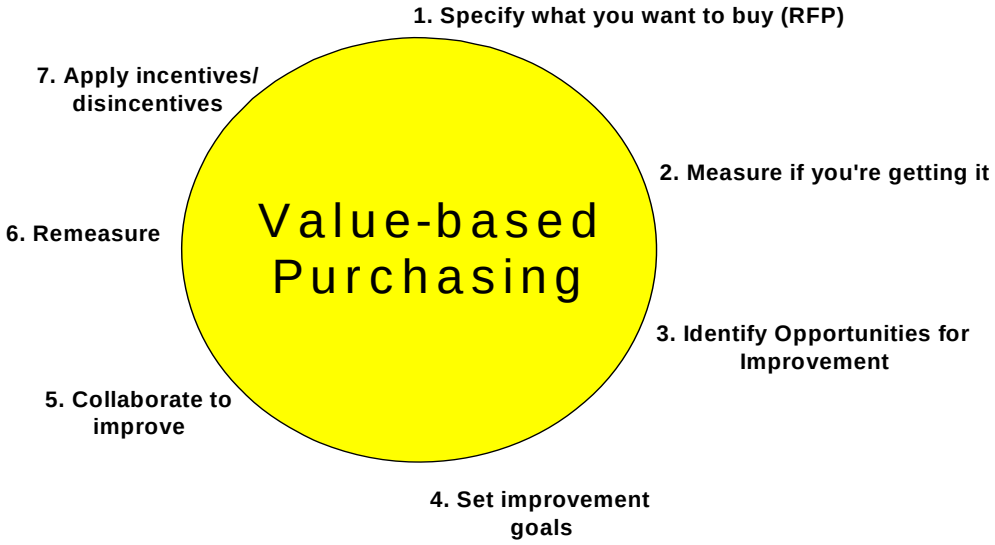
2.2 Basic Philosophy: Contracting for Results

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

2.3 Value-Based Purchasing (VBP)

As part of this RFP, HHSC seeks to improve the State's procurement and management of its managed care models by using a strategy known as "value-based purchasing" (VBP). This approach was first developed by large corporate purchasers of health insurance, but has now been used by public sector purchasers for several years. VBP requires a fundamental shift from traditional state management of Medicaid Fee-for-Service models, which historically focused on simple claims payment and processing. The new approach emphasizes a more strategic, focused approach to specifying data-based performance requirements, and to identifying clear consequences for performance that exceeds or falls below contract standards.

Contractors are held accountable not only for standard performance requirements, but also for performance improvements identified and achieved through a collaborative, incentivized business relationship with HHSC. VBP also enables a strategic, clearly defined, improved and streamlined analytical approach to contract management. The VBP circle below depicts the ongoing, seven-step cycle that begins with the procurement of services and continues throughout the term of the Contract.



The objectives of HHSC's VBP initiative for the ICM Contract are as follows:

1. specify desired Contractor services and outcomes;
2. prioritize attention to those aspects of Contractor performance that are most important to HHSC and to the ICM Members;
3. create data-based measurement and accountability on key performance dimensions;
4. recognize and reward the Contractor's excellence and improvement, and apply disincentives when there is poor performance;
5. develop a streamlined Contract management structure with associated practices and policies, and
6. create a collaborate relationship between HHSC and the ICM Contractor regarding performance improvement.

HHSC recognizes the importance of applying a variety of financial and non-financial incentives and disincentives in response to demonstrated Contractor performance. It is HHSC's objective to recognize and reward both excellence in Contractor performance, and improvement in performance, within existing State and federal financial constraints. It is likely that this approach will be modified over time based on several variables, including accumulated experience by HHSC and the Contractor, changes in the status of State finances, and changes in Contractor performance levels. **RFP Section 6** describes the incentive and disincentive approach in additional detail. HHSC anticipates that incentives and disincentives will be linked to some of the measures in the Performance Indicator Dashboard, as found in the **Uniform Managed Care Manual.**

2.4 Eligible Bidders

To be eligible for selection as the ICM Contractor, a Bidder must be licensed by the Texas Department of Insurance (TDI) as a Utilization Review Agent (URA).
A Bidder that has submitted an application to TDI for a URA license prior to the deadline for submitting a Proposal in response to this ICM Contractor RFP is eligible to respond to this RFP provided a certificate of authority from TDI to operate as a URA is obtained and submitted to HHSC prior to Contract execution. Failure to submit this documentation to HHSC on or before Contract execution will result in the cancellation of the award.

2.5 Contract Development

Attachment A of the RFP includes the draft Contract. The Contract includes a listing of all documents that will become part of the Agreement between HHSC and the Contractor. HHSC's **General Terms and Conditions** will apply to the Contract awarded as a result of this procurement. HHSC reserves the right to negotiate additional terms and conditions.

2.6 Contract Term

The Contract will be effective on the date signed by both Parties and will expire on August 31, 2010 (the "Initial Contract Period"), unless terminated earlier or extended. The Parties may renew the Contract for an additional period or periods, but the total Contract Term may not extend beyond August 31, 2013. All reserved Contract extensions beyond the Initial Contract Period will be subject to good faith negotiation between the Parties.

2.7 Contract Price/Type

HHSC will award a single Contract under this procurement for the ICM Contractor.

Bidders must propose to serve all counties in the Dallas Service Area (Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall Counties) and all counties in the Tarrant Service Area (Denton, Hood, Johnson, Parker, Tarrant and Wise Counties).

HHSC will pay the Contractor a monthly administrative payment based on a per-Member per month Rate as described in **Section 6** of this RFP. **Section 5** of this RFP describes the Scope of Work. A portion of the Contractor's Payment will be at-risk based on the Contractor's performance related to HHSC goals for a) effective management of the appropriate utilization of Acute Care hospital inpatient services and Nursing Facility services, and b) delivery of other Contractor Services relative to HHSC standards.

2.8 Definition of Terms

Capitalized terms shall have the meaning described in the **General Terms and Conditions** (**Attachment A** to the **ICM Contract Document**), unless the context clearly indicates otherwise.

2.9 Authorization

The Texas Legislature has designated HHSC as the single State agency to administer the Medicaid and managed care models in the State of Texas. HHSC has authority to contract with a Contractor to carry out the duties and functions of the ICM Program under Title XIX of the Social Security Act, §12.011 and §12.021, Texas Health and Safety Code, and Chapter 533, Texas Government Code. Contracts awarded under this RFP are subject to all necessary Federal and State approvals, including, but not limited to, Centers for Medicare and Medicaid Services (CMS) approval.

3 GENERAL INSTRUCTIONS AND REQUIREMENTS

3.1 Procurement Documents

This entire RFP, including Appendices and Attachments, may be downloaded through the HHSC website at: (***http://www.hhsc.state.tx.us/about_hhsc/BusOpp/BO_home.html***).

3.2 Notice of Intent to Propose

HHSC requests that Bidders submit a Notice of Intent to Propose to the HHSC Point of Contact identified in **RFP Section 1.6** no later than September 7, 2006. This is not a mandatory requirement.

3.3 Bidder Conference

HHSC will hold a Bidder conference on August 23, 2006. Attendance at the conference is strongly recommended, but is not required.

Bidders may e-mail questions for the conference to the HHSC Point of Contact (see **RFP Section 1.6**) no later than five (5) days before the conference. HHSC will also provide Bidders the opportunity to submit written questions at the conference. All questions submitted by email or at the conference must reference the appropriate RFP page and section number. Although HHSC may provide tentative responses to questions at the conference, responses are not official until they are posted on the HHSC website. HHSC reserves the right to amend answers prior to the Proposal submission deadline.

3.4 Bidder Questions and Comments

All questions and comments regarding this RFP must be submitted electronically to the e-mail address contained in **RFP Section 1.6** (HHSC Point of Contact). All questions must reference the appropriate RFP page and section number. In order to receive a response, Bidder questions and comments must be received no later than the deadline set forth in **RFP Section 1.7** (Project Timeline). Inquiries received after the due date may be reviewed by HHSC but will not receive a response. Any clarifications, addenda, or amendments, whether made as a result of a potential Bidder's written question or otherwise, will be posted on the HHSC website.

A Bidder must inquire in writing as to any ambiguity, conflict, discrepancy, exclusionary specification, omission or other error in this RFP prior to submitting a Proposal. If a Bidder fails to notify HHSC of any error, ambiguity, conflict, discrepancy, exclusionary specification or omission, the Bidder shall submit a Proposal at its own risk and, if awarded the Contract, shall have waived any claim that the RFP and Contract were ambiguous and shall not contest HHSC's interpretation. If no error or ambiguity is reported by the deadline for submitting written questions, the Bidder shall not be entitled to additional compensation, relief or time, by reason of the error or its later correction.

HHSC will post answers on its website to all written questions received by the deadline for submitting written questions. HHSC reserves the right to amend answers prior to the Proposal submission deadline.

3.5 Modification or Withdrawal of Proposal

Proposals may be withdrawn from consideration at any time prior to the Proposal submission deadline. A written request for withdrawal must be made to the HHSC Point of Contact (**RFP Section 1.6**).

A Bidder has the right to amend its Proposal at any time and to any degree by written amendment to the HHSC Point of Contact prior to the Proposal submission deadline. HHSC reserves the right to request an amendment to any part of the Proposal during negotiations.

HHSC reserves the right to waive minor informalities in a Proposal and award a Contract that is in the best interests of the State of Texas. A minor informality may include, but is not limited to, a minor irregularity or error such as a clerical error in the production of copies of the Proposal. When HHSC determines that a Proposal contains a minor informality, HHSC shall notify the Bidder of the irregularity or error and shall provide the Bidder the opportunity to correct.

3.6 News Releases

A Bidder may not issue press releases or provide any information for public consumption regarding its participation in this procurement without specific, prior written approval of HHSC.

3.7 Incomplete Proposals

HHSC will reject without further consideration a Proposal that does not include a complete, comprehensive, and total solution as requested by this RFP.

3.8 State Use of Bidder Ideas

All products produced by a Bidder as a result of this RFP or a resulting Contract, including without limitation, plans, designs, software and other deliverables, will become the sole property of HHSC. HHSC reserves the right to use any and all ideas presented in any Proposal unless the Bidder presents a legal case citing ownership of the Bidder's intellectual property. A Bidder may not object to the use of ideas that are not the Bidder's proprietary information and so designated in the Proposal that:

- were known to the State before submission of the Proposal;
- were in the public domain through no fault of the State; or
- became properly known to the State after submission of the Proposal through other sources or through acceptance of the Proposal.

3.9 Property of HHSC

All products produced by a Bidder as a result of this RFP or a resulting Contract, including without limitation, plans, designs, software and other deliverables, will become the sole property of HHSC.

3.10 Additional Information

By submitting a Proposal, the Bidder grants HHSC the right to obtain information from any lawful source regarding:

1. the past business history, practices, conduct and ability of a Bidder to supply goods, services and requirements; and
2. the past business history, practices, conduct and ability of the Bidder's directors, officers and employees. By submitting a Proposal, the Bidder generally releases from liability and waives all claims against any party providing information about the Bidder at HHSC's request. HHSC may take such information into consideration in evaluating proposals.

3.11 Multiple Responses

A Bidder may submit only one Proposal. If a Bidder submits more than one Proposal, all proposals from that Bidder may be rejected. This requirement does not limit a subcontractor's ability to collaborate with more than one Bidder.

3.12 Inducements

HHSC submits this RFP setting forth certain information regarding the objectives of the ICM Contractor Contract and HHSC's desire to mitigate risk throughout the life of the Contract by use of expert Bidder services. Therefore, HHSC will consider all representations contained in a Proposal, oral or written presentations, correspondence, discussions, and negotiations as representations of the Bidder's expertise. HHSC accepts these representations as inducements to contract.

3.13 Costs Incurred

Bidders understand that issuance of this RFP in no way constitutes a commitment by HHSC to award a Contract or to pay any costs incurred by a Bidder in the preparation of a response to this RFP. HHSC is not liable for any costs incurred by a Bidder prior to issuance of or entering into a formal Agreement, Contract, or purchase order. Costs of developing Proposals, preparing for or participating in oral presentations and site visits, or any other similar expenses incurred by a Bidder are entirely the responsibility of the Bidder, and will not be reimbursed in any manner by the State of Texas.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Version 1.0	n/a	February 15, 2007	Initial version of Attachment B-1, RFP Section 4. Includes all modifications negotiated by the Parties.
Revision	Version 1.1	November 16, 2007	Contract Amendment One did not revise Attachment B-1, RFP Section 4.
Revision	Version 1.2	February 1, 2008	Contract Amendment Two did not revise Attachment B-1, RFP Section 4.
Revision	Version 1.3	September 1, 2008	Contract Amendment Three did not revise Attachment B-1, RFP Section 4.

[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.

4 SUBMISSION REQUIREMENTS

4.1. Instructions for Submitting Proposals

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

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

If a Bidder believes that parts of a Proposal are excepted from required public disclosure under the Public Information Act, the Bidder must specify those parts and the exception(s) that it believes apply, with specific detailed reasons. See **RFP Section 1.5.6** for more information.

4.2. Number of Copies

Submit one original and 20 copies of the Proposal. The original must be signed in ink by an authorized representative of the Bidder and clearly labeled "Original" on the outside of the binder. In addition to the hard-bound original and copies, submit one electronic copy of the Proposal on a PC-formatted floppy disk, zip disk, or compact disk compatible with Microsoft Office 2000. Any disparities between the contents of the hard-bound original proposal and the electronic proposal will be interpreted in favor of HHSC.

Section 4.2 modified by RFP Addendum No. 3.

Bidders must submit requested attachments using Microsoft Office 2000 or Adobe Acrobat (.pdf) files. A Bidder must not include unrequested materials or pamphlets in the Proposal.

HHSC will not accept Proposals by facsimile or e-mail.

4.3. Submission

Submit all copies of the Proposal to the HHSC Point of Contact specified in **RFP Section 1.6** no later than 2:00 p.m. Central Time on the Proposal due date specified in **RFP Section 1.7**.

Section 4.3 modified by RFP Addendum No. 1.

4.4. Additional Requirements

All Proposals must be:

- Clearly legible;
- Sequentially page-numbered;
- Organized in the sequence outlined in RFP Section 4.6, 4.7 and 4.8 of the RFP;
- Bound in a notebook or cover clearly marked with the Bidder's name, the RFP number and the RFP submission date;
- The Price Proposal must be placed in a separate, sealed package, clearly marked with the Bidder's name, the RFP number and the RFP submission date.
- Responsive to the requirements of this RFP;
- Typed, single-spaced on 8½" x 11" paper, and
- In Arial or Times New Roman font, size 11 for normal text, no less than size 10 for tables, graphs and appendices.

Proposals must include the Bidder's name at the top of each page.

4.5. Format and Content

The Proposal must consist of three parts:

Part 1 – Business Proposal.
Part 2 – Programmatic Proposal.
Part 3 – Price Proposal.

4.6. Business Proposal Submission Instructions

Part 1, Business Proposal, must include:

Section 1 – Transmittal Letter.
Section 2 – Corporate Background and Experience.
Section 3 – Material Subcontractors.
Section 4 – Historically Underutilized Business (HUB) Participation.
Section 5 -- Certifications and Other Required Forms.

Section 4.6 modified by RFP Addendum No. 1.

Section 1 -- Transmittal Letter

Bidders must include a transmittal letter printed on official company letterhead. The letter must be signed in ink by an individual authorized to legally bind the Bidder.

The transmittal letter must include:

1. Disclosure of all pending, resolved, or completed litigation, mediation, arbitration, or other alternate dispute resolution procedure involving the Bidder (including subcontractors, subsidiaries, or affiliates) within the past 24 months.
2. Disclosure of all affiliations or ownership relationships (at least 5%) with HHSC's Claims Administrator or Enrollment Broker.
3. A description of any personal or business interest that may present an actual, potential or apparent conflict of interest with the performance of the contract (see

RFP Section 1.5.2), and an explanation of how the Bidder can assure HHSC that these relationships will not create a conflict of interest.

4. A description of the past employment by HHSC or another Texas State agency in accordance with the requirements of **RFP Section 1.5.3**.
5. A complete list of all exceptions, reservations and limitations to the terms and conditions of the RFP, including HHSC's **General Terms and Conditions (Attachment A** to the **ICM Contract Document)**.

Section 2 -- Corporate Information, Background and Experience

This section should include the following information about the Bidder's corporate background and experience.

1. Contact Information.

a. Bidder's full organization, company or corporate name.
b. Headquarter address.
c. Type of ownership (e.g., partnership, corporation).
d. If Bidder is a subsidiary or affiliate, the name of parent organization.
e. State where the Bidder is incorporated or otherwise organized to do business.
f. Federal taxpayer identification.
g. Name and title of the person who will sign the Contract.
h. Name and title of the person responsible for responding to questions regarding the Proposal, with telephone number, facsimile number and email address.

2. Corporate Background and Experience.

Provide the following information on all current publicly-funded managed care and utilization review agent contracts, or contracts for services comparable to ICM Contractor Services described in **Section 5**. If the Bidder does not have such contracts currently, it shall include information on privately-funded managed care or utilization review agent contracts or privately-funded contracts for services comparable to ICM Contractor Services described in **Section 5.**

a. Client name and address.
b. Name, telephone, and e-mail address of the person HHSC could contact as a reference that can speak to the Bidder's performance.
c. Contract size: average monthly covered or served lives and annual revenues.
d. Whether payments under the contract were capitated or non-capitated, and whether and to what degree any non-capitated payments were fully or partially at risk.
e. Contract start date and duration.
f. Whether work was performed as a prime contractor or subcontractor.
g. A general and brief description of the scope of services provided by the Bidder, including the covered or served population and services (e.g., Medicaid HMO, state-funded program utilization review, etc.).
h. Briefly describe any regulatory action, sanctions, and/or fines imposed by any federal or Texas regulatory entity or a regulatory entity in another state within the

last 3 years, including a description of any letters of deficiencies, corrective actions, findings of non-compliance, and/or sanctions. Please indicate which of these actions or fines, if any, were related to Medicaid programs. HHSC may, at its option, contact these clients or regulatory agencies and any other individual or organization whether or not identified by the Bidder.

i. Indicate whether the Bidder has had a contract terminated or not renewed for nonperformance or poor performance within the past five years. In such instance, the Bidder must describe the issues, the parties involved, and provide the address and telephone number of the principal terminating party. The Bidder must also describe any corrective action taken by the Bidder to prevent any future occurrence of the problem leading to the termination.

3. **Financial Requirements**
   Submit documents to demonstrate the Bidder's financial solvency and its willingness to comply with HHSC's **General Terms and Conditions (Attachment A** to the **ICM Contract Document)**:

   a. Submit the following most recent annual reports and annual and quarterly financial statements including:
      - Balance sheet.
      - Statement of income and expenses.
      - Statement of changes in financial position.
      - Cash flows.
      - Capital expenditures.
   b. If the Bidder is either substantially or wholly owned by another corporation or entity, submit the most recent detailed financial report of the corporation or entity. The Bidder must also include a statement that the entity or entities will unconditionally guarantee performance by the Bidder of each and every obligation, warranty, covenant, term and condition of the contract. If HHSC determines that an entity does not have sufficient financial resources to guarantee the Bidder's performance, HHSC may require the Bidder to obtain another acceptable financial instrument or resource from such entity, or to obtain an acceptable guarantee from another entity with sufficient financial resources to guarantee performance.
   c. Submit a statement that, if selected as a Contractor, the Bidder agrees to secure and maintain throughout the life of the Contract, bonds in accordance with the **General Terms and Conditions**.

Section 3 – Material Subcontractors

If the Bidder proposes to use a Material Subcontractor, the Bidder must identify such subcontractor(s) and provide the information required in this section. HHSC reserves the right to disqualify a Proposal that does not include the following information concerning Material Subcontractors.

Bidders must submit the following for each proposed Material Subcontractor, if any:

1. A signed letter of commitment from each Material Subcontractor that states the Material Subcontractor's willingness to enter into a Subcontractor agreement with the Bidder and a statement of work for activities to be subcontracted. Letters of Commitment must be provided on the Material Subcontractor's official company letterhead and signed by an official with the authority to bind the company for the subcontracted work. The Letter of Commitment must state, if applicable, the company's certified HUB status.
2. All information required for Bidders in Section 2, Corporate Information, Background and Experience, above.

Section 4 -- Historically Underutilized Business (HUB) Participation

HHSC employs HUB "Best Practices" reporting procedures for client services contracts. A client service contract is a contract for the purchase, lease, or exchange of goods or services for the direct benefit of HHSC's program clients or recipients. To allow bidders to demonstrate a good faith effort to include HUB subcontracts in client services contracts, HHSC has developed a set of Best Practices guidelines. These guidelines are used:

1. To implement HUB subcontracting practices for HHSC client service contracts anticipated to be valued at $100,000 or more with probable subcontracting opportunities.
2. To allow the State Auditor's Office to review those practices.

HHSC developed the Best Practices reporting procedures to ensure equal access for all bidders, to provide HUB providers an increased knowledge about and opportunity for state business, and to ensure improved accountability of both State agencies and prime contractors for good faith HUB procurement practices. In addition, the Best Practices reporting procedures help ensure that HUBs, when applicable, are included in client services contracts by contracting directly with HHSC or indirectly through subcontracting opportunities.

The bidder's adherence to HHSC's Best Practices guidelines, as well as the bidder's HHSC-approved Client Services HUB Subcontracting Plan, will enable HHSC will track, monitor and report on the utilization of HUBs.

Because the anticipated value of the contract exceeds $100,000, and HHSC has determined that subcontracting opportunities are probable, the Best Practices guidelines apply to this contract. **Bidders therefore must submit the HUB Status Determination (C-HSD) Form** included as **RFP Attachment O. Failure to submit this form will result in disqualification of the bidder's proposal.**

The selected bidder must attend a post award meeting with HHSC's HUB Office to discuss the development and submission of the bidder's Client Services HUB Subcontracting Plan, which will include the bidder's plan for inclusion and proposed good faith efforts to notify HUB vendors of potential subcontracting opportunities.

In addition, the selected bidder will provide monthly reports to HHSC's HUB Office detailing the level of HUB and/or minority/woman-owned business participation for compliance. These

reports will be in the format described in the HHSC-approved Client Services HUB Subcontracting Plan.

Section 5 – Certifications and Other Required Forms

Bidders must submit the following completed forms:

1. Child Support Certification.
2. Debarment, Suspension, Ineligibility and Voluntary Exclusion for Covered Contracts.
3. Federal Lobbying Certification.
4. Nondisclosure Statement.
5. Certification Letter.

The required forms are located on HHSC's website, under the Business Opportunities link. HHSC will not evaluate Proposals that do not contain completed copies of the required forms. HHSC encourages Bidders to carefully review all of these forms and submit questions concerning their completion prior to the deadline for submitting questions relating to this RFP (see **RFP Section 1.7**).

4.7. Programmatic Proposal Submission Instructions

Bidders should respond to each submission requirement in **RFP Section 4.7** to demonstrate how the Bidder will meet the Scope of Work requirements in **RFP Section 5**. Responses must include the headings and numbering used in **RFP Section 4.7** and provide requested information in the order it appears in **RFP Section 4.7**.

The Bidder must adhere to page limits where specified. Page limits are listed in parentheses at the end of the title of the section to which the page limit applies. A three-page limit, for example, means that the response should not be in excess of three one-sided pages that meet the size, font and margin requirements specified above. If the Bidder chooses to repeat the RFP question in its Proposal, the question text will be included in the page limit. HHSC reserves the right not to review information provided in excess of the page limits. Bidders need not feel compelled to submit unnecessary text in order to reach the page limits. Attachments required by the RFP, such as organizational charts or certain policies and procedures, are not counted in calculating the Bidder's page limits.

Bidders shall not submit information or attachments not explicitly requested in the RFP. Elaborate artwork, expensive paper and bindings, and expensive visual or other presentation aids are neither necessary nor desired.

In addition to the information requested in each submission requirement below, the Bidder must:

1. Indicate if the Bidder plans to provide the service or perform the function through a **Material Subcontractor**. If so, the Bidder shall detail the services and/or function to be subcontracted, and how the Bidder and the Material Subcontractor will coordinate such service or function. The Bidder should describe any prior working relationships with the Material Subcontractor. In responding to questions for which the Bidder includes information

about a Material Subcontractor, up to one page may be used to describe each Material Subcontractor arrangement. This page is outside of the page limit instructions for the specific submission requirement.

2. Summarize, when applicable to the question, the extent to which the Bidder has experience providing the service or performing the function that is the subject of the question. Bidders should indicate if their experience is in Texas or with another state's Medicaid program. Bidders should also describe the extent to which their experience includes elderly and disabled populations and persons eligible for Medicare. Information related to experience must be provided within the specified page limits.

4.7.1. **Executive Summary** (2 pages)

Summarize the Bidder's Programmatic proposal, indicating the Bidder's unique qualifications for meeting HHSC's Mission Objectives for this procurement.

4.7.2. Administration and Contract Management

Section 4.7.2.1 modified by RFP Addendum No. 2.

4.7.2.1. **Organizational Overview** (1 page description for each organizational chart, excluding organizational chart itself)

1. Submit an organizational chart (Chart A), showing the corporate structure and lines of responsibility and authority in the administration of the Bidder's business as the proposed ICM Contractor.
2. Submit an organizational chart (Chart B) showing the Texas organizational structure, including staffing and functions performed within the ICM Service Area. If Chart A represents the entire organizational structure, label the submission as Charts A and B.
3. If the Bidder is proposing to use a Material Subcontractor(s), the Bidder shall include an organizational chart demonstrating how the Material Subcontractor(s) will be managed within the Bidder's Texas organizational structure, including the primary individuals at the Bidder's organization and at each Material Subcontractor organization responsible for overseeing such Material Subcontract. This information may be included in Chart B, or in a separate organizational chart(s).
4. Submit a brief narrative explaining the organizational charts submitted, and highlighting the key functional responsibilities and reporting relationships of each organizational unit relating to the Bidder's proposed management of the ICM Program, including its management of any proposed Material Subcontractors.
5. Indicate whether the Bidder, or a Material Subcontractor of the Bidder, is currently certified by the Texas Department of Insurance (TDI) as a utilization review agent (URA). If the Bidder, or a Material Subcontractor retained for purposes of Utilization Review, is not currently certified by TDI as a URA, the Bidder must document that it or the Material Subcontractor has applied to TDI for such certification authority prior to the submission of a Proposal for this RFP. The Bidder shall indicate the date it or the Material Subcontractor applied for such certification and the status of the application to obtain TDI certification in this section of the submission to HHSC.

4.7.2.2. **Key Contractor Personnel** (1 page per Key Contractor Personnel, excluding resumes)

For each of the Key Contractor Personnel listed below, submit (a) a job description and qualifications; (b) a resume of the individual expected to hold such position, if such person has already been identified by the Bidder, and (c) indicate the portion of each person's time the Bidder anticipates will be dedicated to the ICM Program.

1. Executive Director
2. Medical Director
3. Management Information Systems Manager

The job descriptions and qualifications should be in compliance with **Section 5** of the RFP and with HHSC's **General Terms and Conditions (Attachment A** to the **ICM Contract Document**). All Contractor Personnel are required to have appropriate qualifications for the proposed job functions.

4.7.2.3. **Coordination with Other HHS Agencies and Vendors** (8 pages)

Requirements for coordination with other HHS agencies and vendors are described in **RFP Section 5.2.1.1**. and in **RFP Section 5.2.18** (MIS Requirements).

1. Describe the Bidder's process for complying with the requirements in **RFP Sections 5.2.1.1** and **5.2.18** to coordinate with HHSC, the Claims Administrator and the Enrollment Broker.

2. Describe the Bidder's process for complying with the requirements in **RFP Sections 5.2.1.1** and **5.2.18** to coordinate with DADS.

3. Describe the Bidder's process for complying with the requirements in **RFP Sections 5.2.1.1** and **5.2.18** to coordinate with NorthSTAR.

4. Briefly describe the Bidder's relevant experience coordinating managed care program development and implementation with multiple state agencies, managed behavioral health vendors, and administrative service contractors.

4.7.2.4. **Home and Community Support Service Verification System** (1 page)

Contractor requirements to design and implement a service verification pilot for home and community support services are described in **RFP Section 5.2.1.2**.

1. Describe how the Bidder proposes to pilot incorporation of telephone and/or web-based verification into provision of home and community support services, such as personal assistance services. The description must include:
    a. a proposed timeline for pilot development prior to the Operational Start Date, and;

b. how the Bidder will coordinate with HHSC, DADS and applicable Administrative Services Contractors and information systems.

4.7.2.5. Electronic Health Information (2 pages)

Contractor requirements to design and implement an electronic health information pilot are described in **RFP Section 5.2.1.2**.

1. Describe the Bidder's proposed pilot approach to utilize electronic health information (EHI) capabilities to assist Network Providers and to reduce duplication and improve efficiency of the provision of ICM Services. The description must include:
    a. a proposed timeline for pilot development prior to the Operational Start Date, and
    b. how the Bidder will coordinate with HHSC, DADS and applicable Administrative Services Contractors and information systems.

4.7.3. ICM Provider Network Development

Provider Network requirements are described in **RFP Section 5.2.4.**

4.7.3.1. Provider Network Development (1 page)

Briefly describe the Bidder's relevant experience developing and managing the following types of Provider Networks for Medicaid programs:

1. Acute Care Providers (excluding BH providers)
2. LTSS Providers
3. Behavioral Health (BH) Providers

4.7.3.2. Acute Care Providers (1 page excluding Provider lists)

Section 4.7.3.2 modified by RFP Addendum No. 2.

ICM Provider Network requirements are described in **RFP Section 5.2.4**. Significant Traditional Provider (STP) requirements are described in **RFP Section 5.2.4.1**. PCP requirements are described in **RFP Section 5.2.4.4**. Bidders should review all three sets of requirements when developing the response to this section.

Only Acute Care providers with which the Bidder has signed an ICM Provider Agreement, Letter of Intent (LOI) or Letter of Agreement (LOA) may be included in the ICM Provider listing. The ICM Provider Agreement, LOI, or LOA between the Bidder and the proposed ICM Provider must include the information described in **RFP Attachment M**, Model Provider LOI/LOA.

Submit a complete listing of proposed Network Providers for each of the following Acute Care provider types that would be responsible for providing Contractor Managed Services. Such listing must indicate for each provider type, the name, address, and Texas Payee Identification Number (TPIN), if applicable, of the Providers with signed Provider Agreements, LOIs or LOAs, using the Excel file format provided in **RFP Attachment N**. As indicated in the Excel file format, the listing shall include separate lists of each provider type in the order listed below.

1. Acute Care Facilities.

    a. Acute Care Hospitals, providing inpatient and outpatient services
    b. Hospitals providing Level 1 trauma care
    c. Hospitals providing Level 2 trauma care
    d. Transplant centers
    e. CMS designated children's hospitals
    f. Psychiatric hospitals serving the Tarrant Service Area
    g. Other facilities or clinics providing outpatient mental health services
    h. Hospitals serving the Tarrant Service Area providing substance abuse services
    i. Other facilities or clinics providing outpatient substance abuse services

2. Identify the types of Providers the Bidder allows to be PCPs and, for the Tarrant Service Area, what types of Providers the Bidder allows to be outpatient Behavioral Health Service Providers. The Bidder should exclude from the PCP listing any specialists that may serve as PCPs only for specific individuals but are not willing to serve as PCPs for any Member who might select them as a PCP.

3. Identify the facilities in the Bidder's proposed ICM provider Network that are Texas institutions that provide graduate medical education. Only providers with which the Bidder has signed an ICM Provider Agreement, LOI, or LOA may be included in the Bidder's response.

4.7.3.3. **Long Term Services and Supports Providers** (1 page excluding Provider lists)

LTSS are described in **Attachment B-2** to the **ICM Contract Document**, Contractor Managed Services. Long Term Services and Supports requirements are described in **RFP Section 5.2.4.2**. STP requirements are described in **RFP Section 5.2.4.1**. The Bidder should review both sets of requirements when developing the response to this section.

Only LTSS providers with which the Bidder has signed an ICM Provider Agreement, LOI or LOA may be included in the LTSS Provider listing. The ICM Provider Agreement, LOI, or LOA between the Bidder and the proposed ICM Provider must include the information described in **RFP Attachment M**, Model Provider LOI/LOA.

Submit a complete listing of proposed Network Providers for each of the following LTSS Provider types that would be responsible for providing Contractor Managed Services. Such listing must indicate for each provider type the name, address and TPIN, if applicable, of the Providers with signed Provider Agreements, LOIs or LOAs, using the Excel file format provided in **RFP Attachment N**. As indicated in the Excel file format, the listing shall include separate lists of each provider type in the order listed below.

1. Primary Home Care
2. Day Activity and Health Services
3. adult foster care

4. assisted living services
5. emergency response services
6. home delivered meals
7. in-home skilled nursing care
8. personal assistance services
9. occupational therapy
10. physical therapy
11. speech therapy and/or language pathology services
12. fiscal intermediaries for Consumer Directed Services

4.7.3.4. **Significant Traditional Providers** (No page limit. Bidders should only submit STP tables, not text.)

STP requirements are described in **RFP Section 5.2.4.1**. HHSC-designated ICM Significant Traditional Providers (STPs) and the total number of STPs in the ICM Service Area by STP type are listed in **RFP Attachment L**. STPs include PCPs, Disproportionate Share Hospitals (DSHs) and Long Term Services and Supports Providers. LTSS Providers provide the LTSS listed in **RFP Attachment C** and include the types of providers listed in **RFP Section 4.7.3.3** above.

Complete the following chart for each STP provider type. The Bidder should insert the total number of STP PCPs and the total number of STP DSH hospitals in order to calculate the percentage of STPs in the ICM Service Area that are within the Bidder's proposed Network.

	PCPs	DSHs	LTSS Providers
Bidder's Proposed Network			
Total STPs in the Service Area			
Bidder's STP Network as a % of all STPs in the Service Area			

4.7.3.5. **Provider Agreements** (No page limit on templates)

Provider Agreements requirements are described in **RFP Section 5.2.4.3**. Contractor requirements specific to PCPs are included in **RFP Section 5.2.4.4**.

1. Provide a sample template(s) of the Bidder's Letter of Agreement (LOA) and if applicable, the Bidder's Letter of Intent (LOI) used to develop the proposed ICM Provider Network.
2. Provide a sample template of the Bidder's proposed ICM Provider Agreement for:

    a. PCPs.
    b. Hospitals.
    c. LTSS Providers.

The LOI/LOA must, at a minimum, include the mandatory components specified in the prototype LOI/LOA included as **RFP Attachment M**.

Bidders do not need to submit signed Provider Agreements, LOIs, or LOAs with the Proposal, but HHSC may request to review these documents during the evaluation of the Proposal and may call Providers to verify that they have executed such Agreements, LOIs or LOAs.

Providers included in the ICM Provider Network must be licensed in the State of Texas to provide the contracted Contractor Managed Services and must have or be willing to enter into a contract with HHSC or DADS, as applicable, in order to submit claims for the ICM Services provided to ICM Members. As described in **RFP Section 5.2.4.6**, Providers must be credentialed by the Contractor prior to serving Members.

4.7.3.6. Credentialing and Re-credentialing (6 pages)

Provider Credentialing and recredentialing requirements are described in **RFP Section 5.2.4.6**. LTSS Provider licensure requirements are described in **RFP Section 5.2.4.2**

1. Describe, by Provider type, the Bidder's minimum credentialing and/or licensure requirements and procedures for Acute Care Providers, Behavioral Health Providers serving ICM Members residing in the Tarrant Service Area and Long Term Services and Supports Providers.

2. Demonstrate how the Bidder will ensure that the minimum credentialing requirements are met by any such Provider prior to the Provider rendering Contractor Managed Services. The Bidder should not attach relevant policies and procedures.

3. Describe the re-credentialing process for Acute Care Providers, Behavioral Health Providers serving ICM Members residing in the Tarrant Service Area, and Long Term Services and Supports Providers and how the Bidder will capture and assess the following information:

    a. Member Complaints and Appeals.
    b. results from quality reviews and Provider quality profiling.
    c. Utilization Management information.
    d. information from licensing and accreditation agencies.

4.7.3.7. Coordination of Behavioral Health Care (6 pages)

Coordination of Behavioral Health Care requirements are described in **RFP Section 5.2.5**.

1. Describe the Bidder's approach to coordinating Behavioral Health Service delivery with primary care services delivered by a Member's PCP and vice versa. The description should include how the Bidder will ensure that Members know they may self-refer for Behavioral Health Services. Indicate any difference in approach between the Dallas and Tarrant Services Areas.

2. Describe how the Bidder will assist in coordination between the PCP and the Behavioral Health Provider when a Member self-refers for Behavioral Health Services. Indicate any difference in approach between the Dallas and Tarrant Services Areas.

3. Describe the process by which the Bidder will work to ensure the delivery of outpatient Behavioral Health Services to Members residing in the Tarrant Service Area within seven (7) days of inpatient discharge for Behavioral Health Services.

4.7.4. Access To Care

Access to care requirements are described in RFP Section **5.2.6**.

4.7.4.1. **Travel Distances** (No page limit. Bidder should only submit applicable tables)

Travel distance requirements are described in **RFP Section 5.2.6.2**.

1. Submit tables created using GeoAccess, or a comparable software program, to demonstrate the geographic adequacy of the Bidder's proposed ICM Provider Network for Contractor Managed Services compared to the applicable Mandatory Eligible Population. The Bidder shall refer to **RFP Attachment K,** the ICM Databook for information on the distribution of ICM Members to prepare the tables for this submission requirement.

   The Bidder shall generate GeoAccess or comparable tables to display the following information on the proposed ICM Provider Network, using the assumptions listed at the end of this section.

   a. Adults with access to PCPs.

      i. Percentage and number of adult Members with access to one open panel PCP within 30 miles, and the average number of miles within which adults have such access.
      ii. Percentage and number of adult Members with access to two open panel PCPs within 30 miles, and the average number of miles within which adults have such access.

   b. Access to General Hospitals.

      i. Percentage and number of Members with access to a General Hospital within 30 miles.

   c. Access to cardiologists.

      i. Percentage and number of adult Members with access to one open panel cardiologist within 75 miles, and the average number of miles within which adults have such access.
      ii. Percentage and number of adult Members with access to two open panel cardiologists within 75 miles, and the average number of miles within which adults have such access.

   d. Access to outpatient Behavioral Health Services Provider in Tarrant Service Area.

i. Percentage and number of Members in the Tarrant Service Area with access to one open panel outpatient Behavioral Health Service Provider within 75 miles, and the average number of miles within which Members have such access.

Each table should indicate the zip code, the city or town associated with the zip code, the percentage and number of eligible Members residing within the zip code, and the percentage and number of eligible Members residing within a zip code who have access to ICM Provider addresses within the HHSC-specified travel distance standard. Each table should be sorted in descending order based on zip code-eligible Member population. In addition, each table should report the aggregate percentage of eligible Members residing within the ICM Service Area who have access within the HHSC-specified travel standard.

Providers without an executed Provider Agreement, or signed LOI/LOAs, for the provision of Contractor Managed Services to ICM Members may not be included in the proposed ICM Provider Network for purposes of responding to this RFP submission requirement.

2. The Bidder shall insert the following table, and insert an "X" in each of row of the Checklist column to verify that it used each of the following assumptions in generating the above-defined tables.

Checklist	Assumption
	Travel distance is from the Members' addresses (as specified in **RFP Attachment K**) to the Provider office or facility.
	Adult PCPs do not include pediatricians or OB/GYNs (unless the OB/GYN has assumed all PCP responsibilities).
	Advance practice nurses and certified nurse midwives are not included as PCPs.
	PCPs are not included as Outpatient Behavioral Health providers.
	"Open panel" and "Open Practice" Providers are defined as those who are currently accepting new patients.
	Only Open panel/Open Practice Providers are included in the tables.
	Only Providers with signed Provider Agreements, LOI, or LOAs are included in these Network assessments.

4.7.4.2. **Monitoring Access to Care** (4 pages)

Monitoring access to care requirements are described In **RFP Section 5.2.6.3**.

1. Identify the process by which the Bidder shall measure and regularly verify:

   a. The Bidder's compliance with travel distance access standards in **RFP Section 5.2.6.2**.
   b. Provider compliance regarding appointment access standards in **RFP Section 5.2.6.1**.
   c. PCP compliance with after-hours coverage standards in **RFP Section 5.2.4.4**.

2. Describe the steps the Bidder proposes to take when it identifies:

   a. a deficiency in its compliance with state travel distance access standards.

b. a Provider that was not meeting Bidder or state appointment access standards.
c. a PCP that was not in compliance with Bidder or state after-hours coverage requirements.

4.7.4.3 Provider Network Capacity (2 pages)

1. Briefly describe how deficiencies will be addressed when the ICM Provider Network is unable to provide a Member with appropriate access to Contractor Managed Services due to lack of a qualified, in-network Provider within the travel distance of the Member's residence specified in **RFP Section 5.2.6.2**. The description should include how the Bidder will address deficiencies in the Network related to:

    a. The lack of a PCP with an open panel within the required travel distance of the Member's residence.
    b. The lack of an outpatient BH provider serving Members in Tarrant Service Area.
    c. The lack of a cardiologist within the required travel distance of the Member's residence.

4.7.5. Service Coordination (10 pages)

Service Coordination requirements are described in **RFP Section 5.2.7**.

1. Briefly describe the Bidder's experience providing service coordination for Medicaid managed care programs for SSI and dual eligible members including service coordination for LTSS.

2. Summarize the Bidder's approach to Service Coordination, including:

    a. The criteria the Bidder will use to assign Service Coordinators to Members.
    b. The role of the Member/representative in assessment and service planning.
    c. How the Service Coordinator will work as a team with the Member's PCP or Medicare provider and coordinate with and support the Member's other service providers to develop and implement the Service Plan. The description should include how the Service Coordinator will interact with providers of ICM Services, government-funded services not covered under the ICM Program, community resources, and the informal network of family and other non-paid caregivers and supports.
    d. The process for authorizing services in the Service Plan, including the role of the Service Coordinator in authorizing Contractor Managed Services.
    e. How Service Coordination will ensure Members receive services in the most integrated setting possible.
    f. How Service Coordination will differ according to the Member's Medicare eligibility status.
    g. How Service Coordination will differ according to the Member's NorthSTAR eligibility status.

4.7.5.1. Service Coordination Staffing (10 pages, excluding job descriptions)

Service Coordination staffing requirements are described in **RFP Section 5.2.7.2**.

1. Describe the Bidder staffing plan to ensure that Service Coordinators will collectively have the range of skills, experience and expertise required to meet the diverse needs of Members.

2. Describe the Bidder's qualifications for the ICM Service Coordinator position, including education and experience. If the Contractor proposes to use multiple job descriptions for the Service Coordinator position, such as a separate job description for a clinical Service Coordinator compared to a Service Coordinator with a social work degree, the Contractor should provide multiple job descriptions for such Service Coordinator position as applicable.

3. Describe how the Bidder proposes to assign Service Coordinators to ICM Members and what criteria will be considered, such as Member service needs and Service Coordinator qualifications.

4. Describe the process a Member could initiate to request a change in his/her Service Coordinator.

5. Describe the Bidder's proposed Service Coordination caseload per Service Coordinator or per Service Coordination unit, as applicable to the Bidder's proposed Service Coordination approach, including the methodology for developing the caseload. Specify how different types of ICM Members, such as dual eligibles and Members with medical case management needs, are accounted for in the proposed caseload.

6. Describe the Bidder's experience, or provide a recognized source on caseload standards relevant to the ICM eligible population, that demonstrates that a Service Coordinator with a full caseload will be able to meet all Service Coordination requirements.

7. Describe how the Bidder will monitor caseloads to assess the appropriateness of caseload standards, and what actions it will take should standards be exceeded.

8. Describe the Bidder's proposed training program for Service Coordinators, including both initial and ongoing training.

9. Describe how and when Members can contact a Service Coordinator and how the Bidder will ensure that Service Coordinators are accessible to Members.

10. Describe how the Bidder will monitor and assess quality of Service Coordination to ensure exceptional performance of individual Service Coordinators as well as the effectiveness of the overall Service Coordination provided by the Bidder.

Section 4.7.5.2 modified by RFP Addendum No. 2.

4.7.5.2. **Assessment, Service Planning and Service Plan Implementation** (12 pages excluding assessment tool list)

Assessment, service planning and Service Plan implementation requirements are described in **RFP Section 5.2.7.**

1. Describe the process the Bidder will use to identify Members requiring Service Coordination.

2. Describe the process the Bidder will use to assess new Members' needs, including how the Bidder will assess a Member's risk for nursing facility placement.

3. If the Bidder proposes to use assessment tools, in addition to the HHSC-required functional assessment tools, provide a list indicating the name of any additional assessment tool the Bidder will use and what each tool is used to assess.

4. Describe the process the Bidder will use to develop the Service Plan. Include:

    a. How functional assessment information will be used.
    b. The role of the Member/representative.
    c. How Service Plan development and implementation will ensure the Member makes an informed choice about services, settings and providers.
    d. How Service Plan development and implementation will assist the Member in developing measurable goals and identifying services that will best meet those goals.
    e. How Service Plan development and implementation will assess informal supports and look for ways to support unpaid caregivers and integrate them into service planning.
    f. How Service Plan development and implementation will address coordination between primary care and behavioral health providers, including any differences between the Dallas and Tarrant Service Areas.

5. Describe the criteria for Members to participate in Consumer-Directed Services (CDS) and the training the Bidder will provide to those who meet the criteria for CDS and wish to participate.

6. Describe how the Bidder will perform assessment, service planning and Service Plan implementation for individuals transitioning out of a nursing facility and into the ICM Program via the Promoting Independence initiative.

7. Describe how the Bidder will initially and periodically assess Member need for services in a timely and appropriate manner.

4.7.5.3. Monitoring and Reassessment of the Service Plan (4 pages)

Monitoring and reassessment of the Service Plan requirements are described in **RFP Sections 5.2.7.4 and 5.2.7.9**.

1. Describe the process for regular monitoring of Service Plans to ensure the effectiveness and appropriateness of the Service Plan.

2. Describe the triggers for review of Service Plans between regularly scheduled monitoring.

3. Describe the process for revising the Service Plan, including:

    a. The role of the Member.
    b. How the Service Coordinator will evaluate goals and outcomes to date.

4.7.6. Disease Management (5 pages)

Disease Management (DM) requirements are described in **RFP Section 5.2.8**.

1. Describe the Bidder's proposed DM program, including:

    a. the disease(s) or conditions for which the Bidder proposes to provide Disease Management;
    b. how the Bidder will identify Members in need of the Disease Management program;
    c. the proposed DM outreach and enrollment approach;
    d. the DM components for Members with different risk levels;
    e. how the Bidder would provide DM to Members with multiple chronic conditions (e.g., congestive heart failure, diabetes and multiple sclerosis), and
    f. how the Bidder would integrate and coordinate the DM and Service Coordination functions for ICM Members.

2. Identify, if applicable, any measurable results in terms of clinical outcomes and program savings that have resulted from the Bidder's past or existing Disease Management initiatives. Briefly describe the DM program and population as well as the methodology used to identify such outcomes and savings.

4.7.7. Provider Services

4.7.7.1. Provider Training (4 pages)

Provider training requirements are described in **RFP Section 5.2.11.1**.

1. Briefly describe the Bidder's experience providing comparable provider training for Medicaid programs.

2. Provide a brief description of the proposed ICM Provider training program. The description should include:

    a. The types of training programs to be offered, including the modality of training.
    b. The frequency of Provider training.
    c. What topics will be covered.
    d. Which Providers will be invited to attend.
    e. How the Bidder proposes to maximize Provider participation.
    f. How Provider training programs will be evaluated.

4.7.7.2. Provider Hotline (4 pages excluding hotline reports)

Provider hotline requirements are described in RFP Section **5.2.11.2**.

1. Briefly describe the Bidder's experience providing comparable provider hotlines for Medicaid programs.

2. Describe the proposed Provider hotline function. Such description shall include:

    a. Normal hours of operation of the hotline.
    b. Staffing for the hotline.
    c. Training for the hotline staff on ICM Services and ICM Program requirements.
    d. The routing of calls among hotline staff to ensure timely and appropriate response to provider inquiries.
    e. After-hours procedures and available services.

4.7.8. Member Services

4.7.8.1. **Member Services Staffing** (5 pages)

Member Services staffing requirements are described in **RFP Section 5.2.13.1.**

1. Briefly describe the Bidder's experience providing member services for comparable Medicaid programs.

2. Explain the functions of the Member Services staff, including brief job descriptions and qualifications.

3. Describe the curriculum for training to be provided to Member Services representatives, including when the training is conducted and how the training addresses:

    a. ICM Services, including Contractor Managed Services and those not managed by the Contractor;
    b. HHSC ICM Program requirements, including Member Complaint and Appeal processes;
    c. ICM Service Coordination;
    d. dual eligibles;
    e. the Contractor's role in Promoting Independence;
    f. Cultural Competency, and
    g. providing assistance to Members with limited English proficiency.

4. Describe the Bidder's proposed monitoring approach to ensure the effectiveness of the Member Services training.

4.7.8.2. **Member Hotline** (3 pages excluding hotline reports)

Member hotline requirements are described in **RFP Section 5.2.13.8**.

1. Briefly describe the Bidder's experience providing comparable Member hotlines for Medicaid programs.

2. Describe the proposed Member hotline function, including:

a. Normal hours of operation.
b. Number of Member hotline staff expressed in full-time employees (FTEs) per 1000 Members, 8:00 a.m. to 5:00 p.m., local time in the ICM Service Area, Monday through Friday, excluding state-approved holidays.
c. Routing of calls among hotline staff to ensure timely and accurate response to Member inquiries.
d. Responsibilities of hotline staff, if any, in addition to responding to ICM Member hotline calls, (e.g., responding to non-ICM calls and/or ICM Provider hotline calls).
e. After-hours procedures and available services, including those provided to non-English speaking Members in Major Population Groups.
f. The number and percentage of FTE Member hotline staff who are bilingual in English and Spanish.
g. The number and percentage of FTE Member hotline staff who are fluent in any additional language, by language spoken.

4.7.8.3. **Member Education** (6 pages)

Member education requirements are described in RFP Section **5.2.13.2-7, 5.2.13.9 and 5.2.13.10.**

1. Describe the proposed approach to providing new Member orientation and education, including:

a. When new Members receive orientation and education.
b. The methods and staff used for providing orientation and education.
c. The topics covered.
d. How the Bidder's approach ensures informed Member choice of service options and ability to access needed services, including Consumer-Directed Services.
e. How the Bidder's approach covers Medicaid Estate Recovery for Members who desire or qualify for 1915(c) CBA Waiver Services.
f. How the Bidder's approach educates Members about advance directives.
g. How the Bidder proposes to evaluate new Member orientation and education.

2. The proposed approach to providing ongoing Member education, including:

a. how the Bidder will select general Member education topics.
b. the process for providing the general Member education.
c. how the Bidder will identify and educate Members who may need additional assistance to understand the ICM Program or follow procedures for accessing care.
d. How the Bidder proposes to evaluate ongoing Member education.

4.7.8.4. **Member Service Scenarios** (5 pages)

Describe the procedures a Member Services representative will follow to deal with the following situations:

1. A Member has received a bill for payment of ICM Services from an ICM Provider.
2. A Member is having difficulty scheduling an appointment for preventive care with her PCP.
3. A Member's Personal Attendant has not shown up as scheduled.
4. A Member is not receiving the Long Term Services and Supports she believes she needs.
5. A Member's daughter calls seeking information about a nursing facility for her mother.
6. A nursing facility resident's family calls expressing interest in moving the resident from the facility to a home or community-based living arrangement.

4.7.8.5. **Member Complaint and Appeal Processes** (5 pages excluding flow chart)

Member Complaint and Appeal Process requirements are described in **RFP Section 5.2.14**. A Bidder should not submit detailed Complaint and Appeal policies and procedures as an attachment to the Proposal.

1. Briefly describe the Bidder's experience developing and operating complaint and appeals processes for Medicaid programs, including such experience with processes for SSI and dual eligible members.

2. Provide a flowchart that depicts the Bidder's proposed Member Complaint and Appeal processes, from the receipt of a request through each phase of the review to notification of disposition, including providing notice of access to Fair Hearings.

3. Describe the process the Bidder will put in place for the review of Member Complaints and Appeals, including which staff would be involved.

4.7.9. Quality Improvement

Quality improvement (QI) requirements are described in **RFP Section 5.2.15**.

Section 4.7.9.1 modified by RFP Addendum No. 2.

4.7.9.1. **Clinical Initiatives and Guidelines** (5 pages)

Clinical practice guidelines requirements are described in **RFP Section 5.2.15.6**.

1. Describe two clinical initiatives that the Bidder proposes to pursue in the first Contract Year. Document why each topic warrants quality improvement investment and describe the Bidder's measurable goals for the initiative.

2. Describe one non-clinical initiative relating to Long Term Services and Supports the Bidder proposes to pursue in the first Contract Year. Indicate why the topic warrants quality improvement investment and describe the Bidder's measurable goals for the initiative.

3. Describe two clinical guidelines that are relevant to the ICM population and to which the Bidder believes Providers currently do not adhere at a satisfactory level.

4. Describe what steps the Bidder will take to increase compliance with the clinical guidelines noted in its response to number three.

5. Provide a general description of the Bidder's process for developing and updating clinical guidelines and for disseminating them to participating Providers.

4.7.9.2. **Provider Profiling and Network Management** (6 pages excluding sample profile reports)

Provider profiling and Network management requirements are described in **RFP Sections 5.2.15.7** and **5.2.15.8**.

For each of the following numbered instructions, the Bidder should provide a response for each category of Providers: PCPs, other Acute Care Providers (e.g., high volume specialists, hospitals) and Long Term Services and Supports Providers (Home and Community Support Services Agencies, Adult Day Health Facilities and Personal Attendant Services Providers only).

1. Submit sample quality profile reports currently used or proposed for use by the Bidder (identify whether the submitted sample report is currently used or proposed for use).

2. Describe the Bidder's practice of profiling the quality of care delivered by Providers, including the methodology for determining which and how many Providers will be profiled.

3. Describe the rationale for selecting the performance measures presented in the sample profile reports.

4. Describe the proposed frequency with which the Bidder will distribute such reports to Providers, and identify which Providers will receive such profile reports.

5. Describe how the Bidder would actively work with Providers to ensure accountability and improvement in the quality of care provided by the Providers based on the profile report data and any other relevant information obtained by the Contractor. The description should include:

    a. The explicit steps the Bidder would take with each profiled Provider following the production of each profile report, including a description of how the Bidder will motivate and facilitate improvement in the performance of each profiled Provider.
    b. The process and timeline the Bidder proposes for periodically assessing Provider progress on its implementation of strategies to attain improvement goals.
    c. How the Bidder will share best practice methods or programs with Providers.
    d. How the Bidder will take action with Providers who demonstrate continued unacceptable performance or performance that does not improve over time.
    e. The steps the Bidder would take with a Provider that specifically was not meeting state-mandated appointment, after-hours or home care service initiation standards.
    f. Measurable results the Bidder has achieved through past provider profiling-informed performance improvement activities, if applicable.

4.7.10. Utilization Management (8 pages)

Utilization Management (UM) requirements are described in **RFP Section 5.2.16**.

A Bidder's response to this submission requirement should address UM for all Contractor Managed Services provided under the ICM Program, including Long Term Services and Supports, and also Behavioral Health Services provided to ICM Members residing in the Tarrant Service Area.

1. Briefly describe the Bidder's experience developing and operating UM processes for Medicaid managed care programs, including UM processes for SSI and dual eligible members, as well as UM experience with LTSS.

2. Describe the UM guidelines the Bidder plans to employ, including how the guidelines comply with the standards in **RFP Section 5.2.16**.

3. If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed, and when they were last comprehensively reviewed and revised.

4. Describe how the UM guidelines will generally be applied to authorize or retrospectively review Contractor Managed Services. The Bidder should note the types of Contractor Managed Services for which it expects to require Prior Authorization.

5. Describe how the Bidder intends to utilize UM to attain the reductions in inpatient hospital use prescribed by this RFP, while ensuring that Members are provided with access to Medically Necessary inpatient services, and that inappropriate discharges to Nursing Facilities and the community do not occur.

6. If the Bidder currently has or is seeking NCQA certification, URAC accreditation, or comparable certification or accreditation for any product(s) for a scope of activities that includes utilization management, indicate certification/accreditation term effective date(s) and briefly describe the product(s), including the location, population served, and services provided.

7. If the Bidder has previously obtained or sought NCQA accreditation or URAC certification and such certification/accreditation, was ever terminated or denied, indicate when such certification/accreditation was terminated or denied and briefly describe the circumstances, including the product(s), location, population served, and services provided.

4.7.11. Management Information System (10 pages excluding system diagrams and process flow charts)

Management Information System requirements are described in **RFP Section 5.2.18**.

1. Briefly describe the Management Information System (MIS) the Bidder will implement, including how the MIS will comply with HIPAA. At a minimum, the description should:

    a. Describe hardware and system architecture specifications.
    b. Describe data and process flows for all key business processes in **RFP Section 5.2.18**.
    c. Attest to the availability of the data elements required to produce the reports required by **RFP Section 5.2.20**.

2. Describe the Bidder's experience in providing management information systems and functions for Medicaid managed care programs (including Medicaid HMO, Prepaid health plan, Disease Management, PCCM and administrative services arrangements) and for creating MIS interfaces with State agencies and related vendors such as claims administration vendors and enrollment brokers.

4.7.12. Transition Plan (4 pages)

Transition Plan Requirements are described in **RFP Section 5.1**.

1. Briefly describe the Bidder's Transition Plan, including the schedule and major activities related to the System Readiness Review and the Operational Readiness Review, such as:

    a. Securing office space and equipment.
    b. Development of internal policies and procedures to reflect all HHSC requirements, including policies and procedures for coordinating with state agencies and for assisting with the Promoting Independence initiative.
    c. Recruitment, hiring and training of staff.
    d. Internal system testing.
    e. Adoption and submission to HHSC of optional functional assessment instruments the Contractor will use, if any, (as described in **RFP Section 5.2.7.7**).
    f. Other requirements described in **RFP Section 5.1**.

4.8. Price Proposal Submission Instructions

This section documents how the Bidder should prepare its Proposal for submission to HHSC.

The Price Proposal must be placed in a separate, sealed package, clearly marked with the Bidder's name, the RFP number and the RFP submission date.

4.8.1. Base Price Proposal (1 page plus completed Price Proposal Template)

The Bidder shall submit a Price Proposal for ICM Contractor Services on a per-member per-month (PMPM) basis. The ICM Contractor Services PMPM must represent the Bidder's proposed price for performing the Contractor work requirements in **RFP Section 5** of this RFP.

For purposes of preparing its Price Proposal, the Bidder should assume that it will serve the following numbers of Members. While the Members are listed by Service Area and by age category the Price Proposal should include one overall PMPM Rate. Experience in other Service Areas suggests that in general about one-half of the estimated ICM Members will also be Medicare Members (dual eligibles).

ESTIMATED MEDICAID AGED, BLIND AND DISABLED ENROLLMENT (April 2004)			
Service Area	**Aged, Blind & Disabled (Mandatory) Age 21 and over**	**Blind and Disabled (Voluntary) Under age 21**	**Total Estimated Eligibles**
Dallas Service Area	42,403	9,984	52,387
Tarrant Service Area	22,632	5,489	28,121
TOTAL	**65,035**	**15,473**	**80,508**

1. State the Bidder's proposed PMPM Rate for the first Contract Year. The Bidder must propose one PMPM Rate for the combined Dallas and Tarrant Service Areas. The Bidder must **not** propose separate PMPM Rates for different population groups, e.g., dual eligibles vs. Medicaid-only.
2. Provide supporting budget detail to demonstrate how the Bidder arrived at the proposed PMPM Rate using the Price Proposal Template provided in **RFP Attachment E**.
3. Provide accompanying narrative to describe the key business assumptions that went into the development of the Price Proposal.

4.8.2. Component Pricing for Administrative Pilots (1 page, not including section of Price Proposal Template)

The Bidder shall submit component prices for each of the two Contractor Services to be piloted, as described in **RFP Section 5.2.1.2**.

1. Using the format in **RFP Attachment E**, propose one PMPM rate for each of the two administrative pilots, assuming the pilots will be implemented no later than the Operational Start Date. The Bidder must present two separate items for each pilot:
    a. the price of services associated with the pilot development up to the Operational Start Date, and
    b. the price of services for the first 12 months the pilot is operational.
2. Provide supporting budget detail to demonstrate how the Bidder arrived at the proposed PMPM Rate.
3. Provide accompanying narrative to describe the key business assumptions that went into the development of the component pricing for the administrative pilots.

The Bidder must not include costs in the pilot components of the Price Proposal if the costs have already been allocated in the Base PMPM of the Bidder's Price Proposal. For example, Bidder personnel costs related to the Executive Director and Medical Director, and other personnel and MIS functionality that will be required regardless of the pilot, must be excluded from the pilot components of the Price Proposal.

4.8.3. Optional Cost-Saving Strategies (1 page for each proposed strategy, not including revised Price Proposal Template)

Bidders may propose to provide additional Contractor Managed Services that would result in ICM Program cost-savings. If a Bidder proposes a cost-saving strategy, the Bidder must show the effect of such strategies on the Price Proposal and Contractor Scope of Work.

Bidders who choose to propose optional cost-saving strategies must provide:

1. a brief narrative description of each proposed strategy, including how the Bidder would implement the strategy and the anticipated effect on the utilization of ICM Services and HHSC costs;
2. the additional PMPM fee that the Bidder would propose to add to the Price Proposal associated with implementing the particular cost-saving strategy; and
3. a revised Price Proposal Template (**RFP Attachment E**) indicating changes to the Bidder's proposed price and assumptions associated with implementing the cost-saving strategy.

4.8.4 Primary Care, Case Management and Care Cooridination Incentive Strategies (1 page for each proposed strategy, not including revised Price Proposal Template)

HHSC estimates that additional funds will be available in the ICM program because Primary Care Providers in the Dallas and Tarrant Service Areas will not automatically be eligible for the Primary Care Case Management fee, which is currently $2.93 Per Member Per Month. Bidders are encouraged to propose innovative suggestions for the use of these funds that result in increased case management and care coordination for ICM Members and overall ICM Program cost-savings. If the Bidder proposes a strategy that involves direct payments to Providers, HHSC will be responsible for those payments and the strategy would not effect the Bidder's Price Proposal. If a Bidder proposes a strategy not involving direct Provider payments, the Bidder must show the effect of such strategies on the Price Proposal and Contractor Scope of Work.

Bidders who choose to propose innovative strategies must provide:

1. a brief narrative description of each proposed strategy, including how the Bidder would implement the strategy and the anticipated effect on the utilization of ICM Services and HHSC costs;
2. the additional PMPM fee that the Bidder would propose to add to the Price Proposal associated with implementing the particular cost-saving strategy (if any); and
3. a revised Price Proposal Template (**RFP Attachment E**) indicating changes to the Bidder's proposed price and assumptions associated with implementing the strategy.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Version 1.0	n/a	February 15, 2007	Initial version of Attachment B-1, RFP Section 5. Includes all modifications negotiated by the Parties.
Revision	Version 1.1	November 16, 2007	Contract Amendment 1 revised Attachment B-1, RFP Section 5 as follows: 1. Section 5.1.9 added to require the Contractor to pay for additional readiness reviews. 2. Section 5.2.2.3 modified to change wording from 1915(c) Community-based Alternatives (CBA) Waiver Services to ICM 1915 (c) waiver services. 3. Section 5.2.2.4 modified to clarify the requirements regarding consumer directed services. 4. Section 5.2.2.4.1 modified to clarify the Service Responsibility Option requirements. 5. Section 5.2.4.2 revised to correct typographical errors in “Service Licensure and Certification Requirements” table. 6. Section 5.2.6.2 modified to include common medical specialties for child members, and to add access requirements for eye Health Care Services. 7. Section 5.2.6.6 added to include *Frew v. Hawkins* requirements regarding enhancement of care for FWC. 8. Section 5.2.7.5 modified to include additional transition requirements. 9. Section 5.2.7.7 modified to replace specific form number to state approved form 10. Section 5.2.7.8 modified to revise the MDS-HC requirements. 11. Section 5.2.7.9 modified to revise the timeline for Service Plan reassessment. 12. Section 5.2.7.10 is added regarding Service Coordinator training for emergency prescription standards and DME processes. 13. Section 5.2.13.7 modified to clarify website requirements for the Provider Directory. 14. Section 5.2.13.8 modified to include *Frew v. Hawkins* requirements regarding assistance

			obtaining emergency supplies of prescriptions and durable medical equipment. 15. Section 5.2.14.4 amended to include additional fair hearings requirements. 16. Section 5.2.14.5 modified to include additional notice requirements, in compliance with the settlement agreement in the *Alberto N*. litigation. 17. Section 5.2.13.9 modified to correct typographical errors and include *Frew v. Hawkins* requirements regarding assistance obtaining emergency supplies of prescriptions. 18. Section 5.2.14.4 amended to include additional fair hearings requirements. 19. Section 5.2.14.5 amended to include additional information regarding Action and Disposition of Appeals 20. Section 5.2.17.2 modified to include *Frew v. Hawkins* requirements regarding durable medical equipment providers. 21. Section 5.2.18.2 modified to add cross-references to sections of the contract addressing Readiness Reviews. 22. Section 5.2.19 amended to include recent requirements of Section 1902(a)(68) of the Social Security Act. 23. Section 5.2.20 modified to clarify that HHSC will post all Financial Statistical Reports on its website; to comply with *Frew v. Hawkins* by adding two new reports: Medical Check-ups Report and FWC Report; and to add a requirement for a provider termination report. 24. Section 5.2.20 modified to delete the word Administrative to conform to the UMCM Cost Principals Language.
Revision	Version 1.2	February 1, 2008	Contract Amendment Two revised Attachment B-1, RFP Section 5 as follows: 1. Section 5.2.1.4 Service Coordinator modified to clarify the requirements of the Service Coordinator.
Revision	Version 1.3	September 1, 2008	Contract Amendment Three revised Attachment B-1, RFP Section 5 as follows: 1. Section 5.2.4.4 is modified to remove the "Pediatric and Family" qualifier from Advanced Practice Nurses. 2. Section 5.2.6.4 is modified to add a cross reference to Section 5.2.8 for specific requirements for Members transferring to

			and from the ICM Contractor's DM Program 3. Section 5.2.7.8 is modified to reflect current Waiver requirements and the conversion from the TILE to the RUG assessment instrument. 4. Section 5.2.8 is modified to require the ICM Contractor to coordinate continuity of care for Members in Disease Management who change plans. 5. Section 5.2.11.2 is modified to require the ICM Contractors to pay all reasonable costs for HHSC to conduct onsite monitoring of the ICM Contractor's Provider Hotline functions. 6. Section 5.2.13.8 is modified to require the ICM Contractors to pay all reasonable costs for HHSC to conduct onsite monitoring of the ICM Contractor's Member Hotline functions. 7. Section 5.2.14.2 is modified to align contract references to TDI's recodification. 8. Section 5.2.17.2.1 is added to require the ICM Contractor to educate THSteps providers on the availability of the Oral Evaluation and Fluoride Varnish (OEVS) Medicaid benefit. 9. Section 5.2.20 is modified to require the ICM Contractors to submit copies of all internal and external audit reports.

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions

[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.

[3] Brief description of the changes to the document made in the revision.

5. SCOPE OF WORK REQUIREMENTS

This Section is designed to provide potential Bidders with sufficient information to understand the ICM Contractor's responsibilities. This Section describes Scope of Work requirements for the Transition Phase (**RFP Section 5.1**), the Operations Phase (**RFP Section 5.2**), and the Turnover Phase (**RFP Section 5.3**).

5.1 Transition Phase Requirements

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. Prior to executing the Contract, the Bidder selected for the ICM Contract award must provide HHSC with a copy of its applicable Utilization Review Agent license from TDI.

The Transition Phase includes a Readiness Review of the Contractor that involves system and operational Readiness Review components. The Readiness Review must be completed successfully completed, as determined by HHSC, no later than 60 days prior to the Operational Start Date. If the Contractor fails to satisfy all HHSC requirements set forth in this Section, or as otherwise required pursuant to this RFP, HHSC may, at its discretion, postpone the Operational Start Date of the Contract.

If for any reason, the Contractor does not fully meet the Readiness Review requirements prior to the Operational Start Date, and HHSC has not approved a delay in the Operational Start Date or approved a delay in the Contractor's compliance with the applicable Readiness Review requirement(s), then HHSC may impose remedies, including liquidated damages.

The Contractor agrees to provide all materials required to complete the Readiness Review by the dates established by HHSC as described in **RFP Sections 5.1.6 and 5.1.7**.

5.1.1 Transition Phase Schedule and Tasks

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

5.1.2 Contract Start-Up and Planning

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

- define project management and reporting standards;
- establish communication protocols between HHSC and the Contractor;
- establish contacts with DADS and Administrative Service Contractors;
- establish communication protocols and contacts with NorthSTAR;
- establish a schedule for key activities and milestones; and
- clarify expectations for the content and format of Contract Deliverables.

The Contractor will be responsible for developing a written work plan, referred to as the Transition Plan, which will be used to monitor progress throughout the Transition Phase. A summary work plan for the transition is required to be submitted with a Bidder's Proposal. An updated Transition Plan will be due to HHSC after the Contract is awarded and not later than the date the Contract is executed. The Transition Plan shall comply with the deadlines established in this Section.

5.1.3 Administration and Key Contractor Personnel

No later than the Effective Date of the Contract, the Contractor must designate and identify Key Contractor Personnel that meet the requirements of this RFP. The Contractor will supply HHSC with resumes of each Key Contractor Personnel as well as organizational information that has changed relative to the Contractor's Proposal, such as updated job descriptions and updated organizational charts, if applicable. If the Contractor is using a Material Subcontractor(s), the Contractor must also provide the organizational chart for such Material Subcontractor(s).

5.1.4 Financial Readiness Review

In order to complete a Financial Readiness Review, HHSC will require that Contractors update information submitted in their Proposals related to the Bidder's identification and information, Material Subcontractor information, organizational overview, and other relevant information in the Business Proposal.

5.1.5 System Readiness Review

The Contractor must have hardware, software, network and communications systems with the capability and capacity to handle and operate all MIS systems and subsystems identified in **RFP Section 5.2.18** of this RFP. For example, the Contractor's MIS system must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

During this Readiness Review task, the Contractor will accept into its system all necessary data files and information available from HHSC, DADS, the Administrative Services Contractors or related contractors. The Contractor will install and test all hardware, software, and telecommunications required to support the Contract. The

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

The Contractor will produce data extracts and receive all electronic data transfers and transmissions. If any errors or deficiencies are evident, the Contractor will develop resolution procedures to address problems identified. The Contractor will provide HHSC, or a designated vendor, with test data files for systems and interface testing for all external interfaces. This includes testing of the required telephone lines for Providers and Members and any necessary connections to HHSC, DADS, Administrative Service Contractors or MIS systems. The HHSC Administrative Services Contractor will provide enrollment test files to the Contractor. The Contractor will demonstrate its system capabilities and adherence to Contract specifications during Readiness Review.

The Contractor must assure that systems services are not disrupted or interrupted during the implementation and term of the Contract. The Contractor must coordinate with HHSC, DADS, and other contractors to ensure the business and systems continuity for the processing of all health care claims and data as prescribed in the RFP. The Contractor must submit to HHSC, descriptions of interfaces, and of data and process flow for each key business process described in **RFP Section 5.2.18.3, System-wide Functions**.

The Contractor must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. The Contractor must develop, and submit for State review and approval, the following plans, no later than March 6, 2007: Joint Interface Plan, Disaster Recovery Plan, Business Continuity Plan, Risk Management Plan, and Systems Quality Assurance Plan.

The Contractor must provide documentation on systems and facility security and provide evidence or demonstrate that it is compliant with HIPAA.

The Contractor shall provide HHSC with a summary of all recent external audit reports, including findings and corrective actions, relating to the Contractor's proposed systems, including any SAS70 audits that have been conducted in the past three years. The Contractor shall promptly make additional information on the detail of such system audits available to HHSC upon request.

HHSC will provide to the Contractor a test plan that will outline the activities that need to be performed by the Contractor prior to the Operational Start Date of the Contract. The Contractor must be prepared to assure and demonstrate system readiness. The Contractor must execute system readiness test cycles to include all external data interfaces, including those with Material Subcontractors.

HHSC, or its agents, may independently test whether the Contractor's MIS has the capacity to administer the ICM Contractor business. This Readiness Review of a Contractor's MIS may include a desk review and/or an onsite review.

Section 5.1.6 modified by Version 1.0.

5.1.6 Operations Readiness Review

The Contractor must clearly define and document the policies and procedures that will be followed to support day-to-day business activities related to the provision of ICM Contractor Services, including coordination with HHSC, DADS, Administrative Services Contractors, and with NorthSTAR in the Dallas Service Area. The Contractor will be responsible for developing and documenting its approach to Quality Assurance.

At a minimum, the Contractor shall:

1. Develop new, or revise existing, operations procedures and associated documentation to support the Contractor's proposed approach to conducting operations activities in compliance with the contracted Scope of Work.
2. Submit to HHSC no later than March 6, 2007, a listing of all contracted and credentialed Providers in a format approved by HHSC and a description of additional contracting and Credentialing activities to be completed before the Operational Start Date.
3. Complete hiring of Contractor Service Coordination staff no later than 60 calendar days prior to the Operational Start Date.
4. Complete training of Service Coordination staff no later than 45 calendar days before the Operational Start Date;
5. Prepare and implement a Member Services staff training curriculum and a Provider training curriculum, both of which shall be completed no later than 45 days prior to the Operational Start Date.
6. Develop and submit a coordination plan to HHSC no later than March 6, 2007 that documents how the Contractor will coordinate its business activities with those activities performed by HHSC, DADS, and related contractors, including NorthSTAR, and the Contractor's Material Subcontractors, if any. The coordination plan will include identification of coordinated activities and protocols for the Transition Phase.
7. Develop and submit to HHSC no later than March 6, 2007, the draft Member Handbook, draft Provider Manual, draft Provider Directory, and draft Member identification card for HHSC's review and approval. The materials must at a minimum meet the requirements specified by **RFP Section 5.2.13.2** and include the critical elements to be defined by HHSC in the **Uniform Managed Care Manual**. Final versions of the Provider Directory must be submitted no later than April 1, 2007.
8. Develop and submit to HHSC no later than March 6, 2007, the Contractor's proposed Member Complaint and Appeals processes that meet the minimum requirements in **RFP Section 5.2.14**.
9. Demonstrate toll-free telephone systems and reporting capabilities for the Member Services hotline and the Provider Services hotline.

10. Submit documentation that demonstrates that the Contractor has secured the required bonds in accordance with the **General Terms and Conditions** (see **Attachment A** to the **ICM Contract Document)**.
11. Submit a written Fraud and Abuse Compliance Plan to HHSC for approval no later than 30 days after the Contract Effective Date. See **RFP Section 5.2.19, Fraud and Abuse,** for the requirements of the plan, which includes requirements for special investigation units. As part of the Fraud and Abuse Compliance Plan, the Contractor shall:
    a. 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 Inspector General, Health and Human Services Commission, and will be provided free of charge. The Contractor must schedule and complete training no later than 90 days after the Operational Start Date.
    b. designate an officer or director in its organization with responsibility and authority for carrying out the provisions of the Fraud and Abuse Compliance Plan.

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

5.1.7 Assurance of System and Operational Readiness

In addition to successfully providing the Deliverables according to the timeframe described in **RFP Section 5.1**, the Contractor must assure HHSC that all processes, MIS systems, and staffed functions are ready and able to successfully assume responsibilities for operations prior to the Operational Start Date. In particular, the Contractor must assure that Key Contractor Personnel, Member Services staff, Provider Services staff, Service Coordination staff and MIS staff are hired and trained, MIS systems and interfaces are in place and functioning properly, communications procedures are in place, Provider Manuals have been distributed, and that Provider training sessions have occurred according to the schedule approved by HHSC.

Based in part on the Contractor's assurances of systems readiness, information contained in the Proposal, additional documentation submitted by the Contractor, and any review conducted by HHSC or its agents, HHSC will assess the Contractor's understanding of its responsibilities and the Contractor's capability to assume the MIS functions required under the Contract

5.1.8 Readiness Review Deficiencies

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

5.1.9 Additional Readiness Reviews

Section 5.1.9 added by Version 1.1.

During the Operations Phase, If the Contractor changes 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 Contractor is responsible for all costs incurred by HHSC or its authorized agent to conduct an onsite Readiness Review.

Refer to **Attachment B-1, Section 5.2.18.2** for additional information regarding HMO Readiness Reviews. Refer to **Attachment A, Section 4.08(c)** for information regarding Readiness Reviews of the Contractor's Material Subcontractors.

5.2 Operations Phase

This Section presents the scope of work for the Operations Phase of the Contract resulting from this procurement. The Operations Phase is defined as those activities that must take place between the Operational Start Date and the termination of the Contract. The Operational Start Date is the first day in which Medicaid Members in the Dallas and Tarrant Service Areas eligible for the ICM Program will be effectively enrolled in the ICM Program. The Contract will terminate on August 31, 2010, unless terminated earlier or extended.

5.2.1 Administration and Contract Management

HHSC will select one Contractor to assist in the implementation of the ICM Program in the ICM Service Area. At a minimum, the Contractor must be licensed by the Texas Department of Insurance (TDI) as a Utilization Review Agent (URA).

The Contractor must comply, to the satisfaction of HHSC, with (1) all provisions set forth in this Contract, and (2) all applicable provisions of state and federal laws, rules, regulations, and waivers.

5.2.1.1 Coordination with HHSC, DADS, and Other Agencies and Contractors

The ICM Contractor will assist HHSC and the Texas Department of Aging and Disability Services (DADS) and other state health and human services agencies and contractors in

implementing the ICM Program. Provider payments for ICM Members will be processed by HHSC's Claims Administrator. At the time of issuance of the RFP, ACS State Healthcare, L.L.C. is HHSC's Claims Administrator. For purposes of Provider payment, HHSC and DADS will continue to hold the Medicaid FFS provider contracts for Acute Care and Long Term Services and Supports providers, respectively.

The Contractor must create and maintain the necessary system and manual interfaces with HHSC, DADS, NorthSTAR (for Dallas Service Area ICM Members), the Claims Administrator, and other HHSC Administrative Service Contractors with responsibility for the ICM Program, including but not limited to the Management Information Systems requirements in **RFP Section 5.18**. The Contractor's system and interfaces must be designed and operated to ensure a smooth transition for Members and Medicaid Providers in the Dallas and Tarrant Service Areas. HHSC will implement MIS enhancements for the ICM Program interfaces as described in **RFP Section 5.2.18.1**

The Contractor must submit reports to HHSC as described in the **Uniform Managed Care Manual** and **RFP Section 5.2.20**, including Provider profile and other quality and Provider Network reports.

5.2.1.2 Administrative Services to be Piloted

The Contractor must propose mechanisms to incorporate a web-based and/or telephonic-based home and community support services verification system that has the capacity to authenticate and verify in real time that each scheduled visit occurs and the precise time and duration of the visit. Available technology to collect additional information such as tasks performed by the worker during the visit and actual mileage should also be considered by the Contractor. HHSC is interested in the Contractor piloting this type of verification system for certain Long Term Services and Supports, including Personal Assistance Services and Primary Home Care services, and potentially, in-home skilled nursing care, respite care, and LTSS provided through Consumer-Directed Services.

The Contractor must also propose electronic health information (EHI) capabilities to assist Network Providers to participate in Service Coordination activities for ICM Members and to reduce duplication and improve the efficiency of the provision of ICM Services. The Contractor should develop and propose an EHI approach to share Member-specific data relating to medical records in a HIPAA-compliant format with ICM Providers. Such EHI information may include the Service Plan, applicable prior authorizations, and other data related to Service Coordination, Disease Management, and Utilization Management (UM). The ICM Contractor must work collaboratively with HHSC and DADS to implement these EHI services, either directly or through a subcontractor arrangement.

HHSC may, at its option, include one or more piloted services in the ICM Program and expects that the piloted services will be functioning by the Operational Start Date.

5.2.1.3 Integration of Contractor Services

The Contractor must have an integrated and consistent approach for providing Contractor Services, including but not limited to Utilization Review, Service Coordination, and Disease Management. The Contractor must ensure that its staff has the appropriate clinical and social work qualifications and experience to perform their duties effectively.

The Contractor shall have mechanisms to ensure consistent policies and procedures across all aspects of clinical and non-clinical care management, including personnel and operations relating to UR, Service Coordination and Disease Management, whether directly managed, delegated to another site operated by the Contractor, or delegated to an external vendor. These mechanisms, policies, and procedures shall be designed to achieve HHSC's and the Contractor's medical management and Service Coordination goals, including appropriate utilization of ICM Services and quality of care.

5.2.1.4 Service Coordinator

The Contractor must employ as Service Coordinators persons experienced in meeting the needs of individuals who are elderly, have disabilities, and/or have Chronic or Complex Conditions. A Service Coordinator must have an undergraduate and/or graduate degree in social work or a related field, be a Registered Nurse, Licensed Vocational Nurse, Advanced Nurse Practitioner, or Physician Assistant. Years of professional experience working with people who are elderly, have disabilities and/or have Chronic and Complex Conditions may substitute for years toward an undergraduate and/or graduate degree on a year-for-year basis. All ICM Service Coordinators must be trained regarding the requirements of and able to accurately respond to questions concerning the ICM Program.

Section 5.2.1.4 modified by Version 1.2

The Contractor must empower its Service Coordinators to authorize the provision and delivery of Contractor Managed Services, including Long Term Services and Supports.

The Contractor must have written policies and procedures and staffing for ensuring that ICM Members with medical case management needs have a Service Coordinator with appropriate clinical expertise, or that the Service Coordinator has sufficient support from Service Coordination team members with such clinical expertise.

5.2.1.5 Performance Evaluation

The Contractor must identify and propose to HHSC, in writing, no later than August 1st of each Contract Year, annual Improvement Goals for the next Contract Year as well as measures and time frames for demonstrating that such goals are being met. HHSC shall indicate to the Contractor the number of Improvement Goals to be proposed each year. In no case should the Improvement Goals number greater than four. Improvement Goals must be identified on the basis of opportunities for improvement in the Contractor's ability to meet all Contract requirements and standards, and Contractor priorities identified by HHSC, including performance issues identified by HHSC through

its ongoing performance evaluation activities. The Contractor must negotiate such Improvement Goals, measures to assess goal achievement, and time frames with HHSC. HHSC and the Contractor must finalize and incorporate into the Contract, Improvement Goals, measures and time frames. If HHSC and the Contractor cannot agree on the Improvement Goals, measures, or time frames, HHSC will set the goals, measures, or time frames.

The Contractor must participate in semi-annual Contract status meetings with HHSC for the primary purpose of reviewing progress toward the achievement of annual Improvement Goals and Contract requirements, including, but not limited to, the timeliness and accuracy of submissions related to the reporting requirements set forth in **RFP Section 5.2.20**.

For the purpose of such meetings, the Contractor must provide to the HHSC, no later than 14 business days prior to each Contract Status Meeting, one electronic copy of a written update, detailing and documenting the Contractor's progress toward meeting the annual Improvement Goals and any other Contract requirements for which the Contractor has been identified by HHSC or the Contractor as non-compliant.

At any time during the Contract Period, the Contractor must meet with HHSC, should HHSC determine that the Contractor is not in compliance with the Contract, including the annual Improvement Goals. HHSC will provide the Contractor with advance notice of such meeting.

HHSC will track Contractor performance on Improvement Goals. It will also track Contractor performance on other key facets of Contractor performance through the use of a Performance Indicator Dashboard (see the **Uniform Managed Care Manual**). HHSC will compile the Performance Indicator Dashboard based on Contractor submissions, data from the EQRO, and other data available to HHSC. HHSC will share the Performance Indicator Dashboard with the Contractor on a quarterly basis.

5.2.2 ICM Services

ICM Members are eligible for the full range of traditional Medicaid Fee-for-Service (FFS) benefits. The set of services available to ICM Members is referred to as ICM Services. ICM Services are defined by the Medicaid State Plan Amendment and by relevant Medicaid waivers, such as any applicable 1915(b) or 1915(c) waivers for eligible Medicaid recipients.

ICM Members who are not dually eligible for Medicare are provided with two enhanced benefits compared to the traditional, Fee-for-Service Medicaid coverage: 1) waiver of the three-prescription-per-month limit; and 2) inclusion of an annual adult well check for Members 21 years of age and older. The customary Texas Medicaid Fee-for-Service 30-day spell-of-illness limitation on hospitalization applies to ICM Members.

ICM Members who meet the Nursing Facility Level of Care are eligible for 1915(c) CBA Waiver Services.

ICM Members who reside in the Dallas Service Area will continue to receive their Behavioral Health Services from NorthSTAR. ICM Members who reside in the Tarrant Service Area will receive their Behavioral Health Services through the ICM Provider Network.

Prescription drugs for ICM Members will continue to be provided through the HHSC Vendor Drug Program.

ICM Services are subject to change due to changes in federal and state law, changes in Medicaid policy, and changes in medical practice, clinical protocols, or technology.

5.2.2.1 Contractor Managed Services

ICM Services include both Contractor Managed Services and ICM Non-Managed Services. Contractor Managed Services are listed in **Attachment B-2** to the **ICM Contract Document** and include Acute Care Services and Long Term Services and Supports. The Contractor is responsible for authorizing, arranging, and coordinating Contractor Managed Services in accordance with the requirements of the Contract.

HHSC and DADS will continue to hold Medicaid provider contracts with the ICM Providers of Acute Care Services and Long Term Services and Supports, respectively. In addition to holding HHSC or DADS Medicaid provider contracts, Providers must also hold Network Provider contracts with the ICM Contractor to participate in the ICM Program.

5.2.2.2 Long Term Services and Supports

The Contractor must ensure that ICM Members needing Long Term Services and Supports (LTSS) are identified and referred to services in a timely manner. LTSS may be necessary as preventative services to avoid more expensive hospitalizations, emergency room visits, or institutionalization. LTSS should also be made available to Members to assure maintenance of the highest level of functioning possible in the most integrated setting. A Member's need for LTSS to assist with the activities of daily living must be considered as important as needs related to a medical condition. The Contractor must authorize Medically Necessary and Functionally Necessary Services to ICM Members eligible to receive LTSS.

5.2.2.3 ICM 1915(c) Waiver Services

Section 5.2.2.3 modified by Version 1.1.

ICM 1915(c) waiver services are included in LTSS in **Attachment B-2** to the **ICM Contract Document.** ICM 1915 (c) waiver services include adult foster care, assisted living, and a variety of other ICM 1915 (c) waiver services that are often provided by Home and Community Support Services Agencies (HCSSA). Certain ICM 1915 (c)

waiver services may also be provided via a Consumer-Directed Service option as described in **RFP Section 5.2.2.4**

For ICM Members who meet the eligibility requirements, the Contractor must authorize and coordinate Medically Necessary and Functionally Necessary ICM 1915(c) waiver services. The ICM 1915(c) waiver services program provides Long Term Services and Supports to Medicaid Eligibles who are elderly, and to adults with disabilities, as a cost-effective alternative to living in a Nursing Facility. These Members must be age 21 or older and be a Medicaid recipient or be otherwise financially eligible for ICM 1915(c) waiver services. To be eligible for ICM 1915(c) waiver services, a Member must meet income and resource requirements for Medicaid Nursing Facility Level of Care, and receive a determination on the Medical Necessity of the Nursing Facility Level of Care.

5.2.2.4 Consumer-Directed Services

Section 5.2.2.4 modified by Versions 1.0 and 1.1.

Consumer-Directed Services is an option in which the Member is the employer of record and recruits, hires, trains, supervises and fires, if necessary, the provider. CDS is an LTSS option for the following services: Primary Home Care (PCH); Personal Assistance Services (PAS); In-Home and Out-of-Home Respite; Nursing Services; Physical Therapy; Occupational Therapy; and Speech, Hearing and Language Therapy. Members who select the CDS option must work with a Consumer Directed Services Agency, whose role is to provide Financial Management Services. Financial Management Services include approving and monitoring budgets, managing payroll, preparing and filing tax forms and reports, and paying allowable expenses.

Information about implementation of CDS in the Fee-for-Service Medicaid program is available at http://www.dads.state.tx.us/providers/CDS/index.cfm. The Contractor is required to use the same policies and procedures for CDS unless the Contractor has received approval from HHSC to deviate from such policies and procedures.

The Contractor should make arrangements to ensure that the Financial Management Services Agencies (CDS Agencies) that are available to Medicaid FFS Members are also available to ICM Members, as long as such Financial Management Services Agencies (FMS Agency) comply with the CDS policies and procedures.

The Contractor must educate Members and their families about the option to use CDS and must identify Members and their families who wish to and can coordinate their own care. The Contractor will provide the Member, and family if applicable, with information on CDS:

1. at initial assessment if the Member meets criteria for PHC or PAS;
2. at annual or other reassessment if the Member meets criteria for PHC or PAS
3. at any time when an ICM Member so requests CDS information; and
4. in the Member Handbook.

The Contractor must provide training on CDS to Members and families when the Member meets criteria for PHC or PAS and the Member/family expresses an interest in CDS. The training must include the services for which CDS is available, how to direct and coordinate these services effectively, the role of the Financial Management Services Agency, how the Contractor will monitor the Member's use of CDS and the Member's right to return to traditional service delivery at any time. If the Member chooses CDS, the Contractor must provide training to the Member and/or representative on how to select, hire and train an attendant; how to work with an FMS Agency; and how to request assistance from the Contractor.

5.2.2.4.1 Other LTSS Service Delivery Options

Section 5.2.2.4.1 added by Version 1.0, modified by Version 1.1.

The Service Responsibility Option (SRO) is another option for consumer direction for Primary Home Care (PHC) and Personal Assistance Services (PAS). SRO gives consumers control over selecting, training and supervising personal care attendants but the provider agency, the employer of record, keeps the fiscal functions and the responsibility for providing substitute attendants and administrative personnel functions.

Under the traditional provider delivery option (also referred to as the "agency model"), the LTSS provider assumes the responsibilities for delivering services.

The Contractor is responsible for informing Members of all options for LTSS service delivery, including CDS, SRO, and the agency model, and helping Members to select the appropriate model.

5.2.2.5 ICM Non-Managed Services

Texas Medicaid programs and services that have been excluded from Contractor Managed Services are defined as ICM Non-Managed Services. The Contractor is not responsible for authorizing ICM Non-Managed Services.

ICM Members are eligible to receive ICM Non-Managed Services from any applicable Texas Medicaid provider. For more information on these Medicaid programs and services, refer to relevant chapters in the HHSC Provider Procedures Manual and Texas Medicaid Bulletin. ICM Non-Managed Services include, but are not limited to:

1. THSteps dental (including orthodontia);
2. Early Childhood Intervention program;
3. MHMR targeted case management;
4. MHMR mental health rehabilitation;
5. Department of State Health Services (DSHS) case management for children and pregnant women;
6. Texas school health and related services (SHARS);
7. Texas Commission for the Blind case management;
8. Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation);

9. Vendor Drug Program (out-of-office drugs);
10. Texas Department of Transportation medical transportation;
11. hospice services (all Members except 1915(c) CBA waiver clients are disenrolled from the ICM Program upon enrollment into hospice);
12. audiology services and hearing aids for children (under age 21) through PACT (Program for Amplification for Children of Texas).
13. LTSS services available through DADS.

5.2.2.6 Contractor Responsibilities Related to ICM Non-Managed Services

The Contractor is responsible for educating Members and Providers about ICM Non-Managed Services. The Contractor is also responsible for coordinating the Contractor Managed Services with the ICM Non-Managed Services, and making appropriate referrals of Members for these services.

The Contractor must implement a systematic process to coordinate ICM Non-Managed Services, and enlist the involvement of community organizations that may not be providing Contractor Managed Services but are otherwise important to the health and well-being of Members.

The Contractor also must make a best effort to establish relationships with State and local programs and community organizations in order to make referrals for ICM Members who need community services. The Contractor must coordinate with DADS for Long Term Services and Supports that are not Contractor Managed Services.

5.2.3 Advance Directives

Federal and state law require the Contractor and providers to maintain written policies and procedures for informing all adult Members 18 years of age and older about their rights to refuse, withhold or withdraw medical treatment and mental health treatment through advance directives (see Social Security Act §1902(a)(57)). The Contractor's policies and procedures must include written notification to Members and comply with provisions contained in 42 C.F.R. §434.28 and 42 C.F.R. § 489, Subpart I, relating to advance directives for all Hospitals, critical access Hospitals, skilled nursing facilities, home health agencies, providers of home health care, providers of personal care services and hospices.

The Contractor cannot require a Member to execute or issue an advance directive as a condition of receiving an authorization for Contractor Managed Services. The Contractor cannot discriminate against a Member based on whether or not the Member has executed or issued an advance directive.

The Contractor's policies and procedures must require the Contractor and subcontractors to comply with the requirements of state and federal law relating to

advance directives. The Contractor must provide education and training to employees and Members on issues concerning advance directives.

All materials provided to Members regarding advance directives must be written at a 7th - 8th grade reading comprehension level, except where a provision is required by state or federal law and the provision cannot be reduced or modified to a 7th - 8th grade reading level because it is a reference to the law or is required to be included "as written" in the state or federal law.

The Contractor must notify Members of any changes in state or federal laws relating to advance directives within 90 days from the effective date of the change, unless the law or regulation contains a specific time requirement for notification.

5.2.4 Provider Network

The Contractor must enter into written contracts with properly credentialed Providers as described in this Section. The Provider Agreements must comply with the **Uniform Managed Care Manual's** requirements.

The Contractor must maintain a Provider Network sufficient to provide all Members with access to the full range of Contractor Managed Services required under the Contract. The Contractor must ensure its Providers and subcontractors meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the Contract.

Prior to providing Contractor Managed Services all providers proposed for the Contractor's Provider Network must enter into Provider contracts with HHSC for Acute Care Services and DADS for LTSS, as applicable. Without Medicaid Fee-for-Service provider contracts, Network Providers cannot obtain reimbursement for ICM Services through the HHSC Claims Administrator.

The Provider Network must be responsive to the linguistic, cultural, and other unique needs of any minority, elderly, or disabled individuals, or other special population in the ICM Service Area, including the capacity to communicate with Members in languages other than English, when necessary, as well as with those who are deaf or hearing impaired.

HHSC encourages the Contractor to establish a Network with wide range of Provider types and to make best efforts to contract with existing HHSC and DADS Medicaid providers. The Contractor must seek to obtain the participation in its Provider Network of qualified providers currently serving the Medicaid Members in the ICM Service Area, including but not limited to Significant Traditional Providers (STPs).

All Providers: All Providers must be licensed in the State of Texas to provide the applicable Contractor Managed Services and not be under sanction or exclusion from

the Medicaid program. All Acute Care Providers must be enrolled as Medicaid providers and have a Texas Provider Identification Number (TPIN). Effective May 23, 2007, Acute Care Providers must also have a National Provider Identification (NPI) number (see 45 C.F.R. Part 162, Subpart D.) All Long Term Services and Supports Providers must be enrolled as Medicaid providers and have a DADS provider identification number.

Inpatient hospital and medical services: The Contractor must ensure that Acute Care Hospitals and specialty Hospitals are available and accessible 24 hours per day, seven days per week, within the Contractor's Network.

Children's Hospitals/Hospitals with specialized pediatric services: The Contractor must ensure Member access to Hospitals designated as Children's Hospitals by Medicare and Hospitals with specialized pediatric services, such as teaching Hospitals and Hospitals with designated children's wings, so that these services are available and accessible 24 hours per day, seven days per week, to provide Contractor Managed Services to Members throughout the ICM Service Area. The Provider Directory must clearly distinguish between Hospitals designated as Children's Hospitals and Hospitals that have designated children's units.

Trauma: The Contractor must ensure Member access to Texas Department of State Health Services (TDSHS) designated Level I and Level II trauma centers within the State or Hospitals meeting the equivalent level of trauma care in the ICM Service Area, or in close proximity to the ICM Service Area.

Transplant centers: The Contractor must ensure Member access to HHSC-designated transplant centers or centers meeting equivalent levels of care.

Hemophilia centers: The Contractor must ensure Member access to hemophilia centers supported by the Centers for Disease Control and Prevention (CDC). A list of these hemophilia centers can be found at http://www.cdc.gov/ncbddd/hbd/htc_list.htm.

Physician services: The Contractor must ensure that Primary Care Providers are available and accessible 24 hours per day, seven days per week, within the Provider Network. The Contractor must contract with a sufficient number of participating physicians and specialists within the ICM Service Area to comply with the access requirements throughout **Section 5.2.6** and meet the needs of Members for all Contractor Managed Services.

The Contractor must ensure that an adequate number of participating specialty physicians have admitting privileges at one or more participating Hospitals in the Contractor's Provider Network to ensure necessary admissions are made. The Contractor shall require that all physicians who admit to Hospitals maintain Hospital access for their patients through appropriate call coverage.

Laboratory services: The Contractor must ensure that Network reference laboratory services are of sufficient size and scope to meet the non-emergency and emergency

needs of the enrolled population and the access requirements in **RFP Section 5.2.6**. Reference laboratory specimen procurement services must facilitate the provision of clinical diagnostic services for physicians, Providers and Members through the use of convenient reference satellite labs in the ICM Service Area, strategically located specimen collection areas in the ICM Service Area, and the use of a courier system under the management of the reference lab. THSteps requires that laboratory specimens obtained as part of a THSteps medical checkup visit must be sent to the TDSHS Laboratory.

Diagnostic imaging: The Contractor must ensure that diagnostic imaging services are available and accessible to all Members in the ICM Service Area in accordance with the access standards in **RFP Section 5.2.6**. The Contractor must work to ensure that diagnostic imaging procedures that require the injection or ingestion of radiopaque chemicals are performed only under the direction of physicians qualified to perform those procedures.

Home health services: The Contractor must have a contract(s) with a home health Provider so that all Members living within the ICM Service Area will have access to at least one such Provider for home health Contractor Managed Services.

FQHCs and RHCs: The Contractor must make reasonable efforts to include Federally Qualified Health Centers and Rural Health Clinics (freestanding and Hospital-based) in its Provider Network.

5.2.4.1 Medicaid Significant Traditional Providers

In the first three (3) years of the ICM Program, the Contractor must seek participation in its Network from all Medicaid Significant Traditional Providers (STPs) defined by HHSC in the ICM Service Area. Medicaid STPs are defined as PCPs and LTSS providers that, when listed by provider type by county in descending order by unduplicated number of clients, historically have served the top 80% of unduplicated clients. Hospitals in the ICM Service Area receiving Disproportionate Share Hospital (DSH) funds are also considered STPs.

The Contractor must give STPs the opportunity to participate in its Network for at least three (3) years commencing on the Operational Start Date of the ICM Program in the ICM Service Area. However, the STP provider must meet the standard credentialing requirements of the Contractor, provided that lack of board certification or accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) is not the sole grounds for exclusion from the Provider Network.

5.2.4.2 Long Term Services and Supports

Section 5.2.4.2 modified by Versions 1.0 and 1.1.

The Contractor must ensure that Providers of LTSS are licensed and certified to deliver the service they are to provide, as applicable to the LTSS services. The Contractor shall enter into written contracts with Providers of LTSS, which, at a minimum, must meet all

of the following state licensure and certification requirements for providing the Contractor Managed Services in **Attachment B-2** to the **ICM Contract Document**. The following table summarizes LTSS licensure and certification requirements. There are no licensure or certification requirements for: transition assistance services, minor home modifications, adaptive aids and medical equipment, and medical supplies.

Service	Service Licensure and Certification Requirements
Primary Home Care	The provider must be licensed by DADS Regulatory Services as a home and community support services agency (HCSSA) under the Personal Assistance Services category of licensure.
Day Activity and Health Services (DAHS)	The Provider must be licensed by DADS, as an adult day care facility.
1915(c) Waiver Personal Assistance Services	The provider must be licensed by DADS Regulatory Services as a home and community support services agency (HCSSA) under the Licensed Home Health category of licensure.
Adaptive Aids and Medical Supplies	Adaptive aids and medical supplies are provided through a HCSSA.
Adult Foster Care	A provider serving three or fewer individuals must be certified using guidelines in 40 T.A.C. Part 1, Chapter 48, Subchapter K, Minimum Standards for Adult Foster Care. A provider serving four individuals must be licensed by DADS Regulatory Services as a Type C assisted living facility. A Type C assisted living facility must meet the requirements in 40 T.A.C. Chapter 48, Subchapter K.
Assisted Living	The provider must be licensed by DADS Regulatory Services a Type A or Type B (large or small) assisted living facility, and meet the setting requirements in 40 T.A.C. Part 1, Chapter 46, §46.13, Setting Requirements.
Consumer Directed Services Financial Management Services	The provider must meet the requirements in 40 T.A.C. Part 1, Chapter 41, Consumer Directed Services Option.
Dental Services	The provider must be licensed as a dentist by the Texas State Board of Dental Examiners. Dental services are provided through a HCSSA.
Emergency Response Service Provider	The provider must be licensed by the Texas Board of Private Investigators and Private Security Agencies as an alarm company unless specifically exempt from such licensure.
Home-Delivered Meals	The provider must meet requirements in 40 T.A.C. Part 1, Chapter 55, Contracting to Provide Home-Delivered Meals.

In-Home Respite	The provider must be licensed by DADS Regulatory Services as a home and community support services agency (HCSSA) under the Licensed Home Health category of licensure.
Minor Home Modifications	Minor Home Modifications are coordinated by a HCSSA.
Occupational Therapy	The provider must be licensed as an occupational therapist by the Texas Board of Occupational Therapy Examiners. Occupational therapy services are provided through a HCSSA.
Out-of-Home Respite – Adult Foster Care	A provider serving three or fewer individuals must be certified using guidelines in 40 T.A.C. Part 1, Chapter 48, Subchapter K, Minimum Standards for Adult Foster Care. A provider serving four individuals must be licensed by DADS Regulatory Services as a Type C assisted living facility. A Type C assisted living facility must meet the requirements in 40 T.A.C. Chapter 48, Subchapter K.
Out-of-Home Respite – Assisted Living	The provider must be licensed by DADS Regulatory Services a Type A or Type B (large or small) assisted living facility.
Out-of-Home Respite – Nursing Facility	The provider must be licensed by DADS Regulatory Services as a nursing facility.
Physical Therapy	The provider must be licensed as a physical therapist by the Texas Board of Physical Therapy Examiners. Physical therapy services are provided through a HCSSA.
Service Responsibility Option	The provider must be licensed by DADS Regulatory Services as a home and community support services agency (HCSSA) under the Personal Assistance Services category of licensure.
Skilled Nursing Services	The provider must be licensed as a registered nurse (RN) or licensed vocational nurse (LVN) by the Texas Board of Nurse Examiners. The level of licensure (RN or LVN) must be appropriate for the type of skilled nursing provided. Skilled nursing services are provided through a HCSSA.
Speech Therapy	The provider must be licensed as a speech therapist by the Department of State Health Services. Speech therapy services are provided through a HCSSA.
Transition Assistance Services	The provider must meet the requirements in 40 T.A.C. Part 1, Chapter 62, Contracting to Provide Transition Assistance Services.

5.2.4.3 Provider Agreement Requirements

The Contractor is prohibited from requiring a provider or provider group to enter into an exclusive contracting arrangement with the Contractor as a condition for participation in its Provider Network.

The Contractor's Agreement with Providers must be in writing, must be in compliance with applicable federal and state laws and regulations, and must include minimum requirements specified in the **General Terms and Conditions (Attachment A** to the **ICM Contract Document)** and the **Uniform Managed Care Manual**.

The Contractor must submit model Provider Agreements to HHSC for review during Readiness Review. HHSC retains the right to reject or require changes to any model Provider contract that does not comply with the Contract.

5.2.4.4 Primary Care Providers

Section 5.2.4.4 modified by Version 1.3

The Contractor's PCP Network may include Providers from any of the following practice areas: General Practice; Family Practice; Internal Medicine; Pediatrics; Obstetrics/Gynecology (OB/GYN); Certified Nurse Midwives (CNM), Advanced Practice Nurses (APNs) and Physician Assistants (PAs) practicing under the supervision of a physician; 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.

The PCP may be a specialist physician who agrees to provide PCP services to the Member. The specialty physician must agree to perform all PCP duties required in the Contract and PCP duties must be within the scope of the specialist's license. Any interested person may initiate the request through the Contractor for a specialist to serve as a PCP. The Contractor shall handle such requests in accordance with 28 T.A.C. Part 1, Chapter 11, Subchapter J.

PCPs must either have admitting privileges at a Hospital that is part of the Contractor's Provider Network or make referral arrangements with a Provider who has admitting privileges to a Network Hospital.

The Contractor must require, through contract provisions, that PCPs are accessible to Members 24 hours a day, 7 days a week. The Contractor is encouraged to include in its Network sites that offer primary care services during evening and weekend hours. The following are acceptable and unacceptable telephone arrangements for contacting PCPs after their normal business hours.

Acceptable after-hours coverage:

1. The office telephone is answered after-hours by an answering service, which meets language requirements of the Major Population Groups and which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes;
2. The office telephone is answered after normal business hours by a recording, in the language of each of the Major Population Groups served, directing the patient to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable; and
3. The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

Unacceptable after-hours coverage:

1. The office telephone is only answered during office hours;
2. The office telephone is answered after hours by a recording that tells patients to leave a message;
3. The office telephone is answered after hours by a recording that directs patients to go to an emergency room for any services needed; and
4. Returning after-hours calls outside of 30 minutes.

The Contractor must require PCPs, through contract provisions or Provider Manual, to provide children under the age of 21 with preventive services in accordance with the THSteps periodicity schedule published in the THSteps Manual for Medicaid Members. The Contractor must require PCPs, through contract provisions or Provider Manual, to provide adults with preventive services in accordance with the U.S. Preventive Services Task Force requirements. The Contractor must make best efforts to ensure that PCPs follow these periodicity requirements for children and adult Members. Best efforts must include, but not be limited to, Provider education, Provider profiling, monitoring, and feedback activities.

The Contractor must require PCPs, through contract provisions or Provider Manual, to assess the medical needs of Members for referral to specialty care providers and provide referrals as needed. PCPs must coordinate Members' care with specialty care providers after referral. The Contractor must make best efforts to ensure that PCPs assess Member needs for referrals and make such referrals. Best efforts must include, but not be limited to, Provider education activities and review of Provider referral patterns.

5.2.4.5 PCP Notification of ICM Members

The Contractor must furnish each PCP with a current list of enrolled Members enrolled or assigned to that Provider each month. The Contractor may offer and provide such enrollment information in alternative formats, such as through access to a secure Internet site, when such format is acceptable to the PCP.

5.2.4.6 Provider Credentialing and Re-credentialing

The Contractor must review, approve and periodically recertify the credentials of all participating physician Providers and all other licensed Providers who participate in the Contractor's Provider Network. The Contractor may subcontract with another entity to which it delegates such Credentialing activities if such delegated Credentialing is maintained in accordance with the National Committee for Quality Assurance (NCQA) delegated credentialing requirements and any comparable requirements defined by HHSC.

At a minimum, the scope and structure of a Contractor's Credentialing and re-credentialing processes must be consistent with recognized Contractor industry standards such as those provided by NCQA and relevant state and federal regulations including 28 T.A.C. §11.1902, relating to credentialing of providers in Contractors. The initial Credentialing process, including application, verification of information, and a site visit (if applicable), must be completed before the effective date of the initial contract with the physician or Provider. The re-credentialing process must occur at least every three years. The re-credentialing process must take into consideration Provider performance data including, but not be limited to, Member Complaints and Appeals, quality of care, and Utilization Management.

5.2.4.7 Board Certification Status

The Contractor must maintain a policy with respect to Board Certification for PCPs and specialty physicians that encourages participation of board-certified PCPs and specialty physicians in the Provider Network. The Contractor must make information on the percentage of Board-certified PCPs in the Provider Network and the percentage of Board-certified specialty physicians, by specialty, available to HHSC upon request.

5.2.4.8 Termination of Provider Contracts

Section 5.2.4.8 modified by Version 1.0.

Unless prohibited or limited by applicable law, at least 15 days prior to the effective date of the Contractor's termination of contract of any participating Provider the Contractor must notify the HHSC Administrative Services Contractor, DADS, and affected current Members in writing. Affected Members include all Members in a PCP's panel and all Members who have been receiving ongoing care from the terminated Provider, where ongoing care is defined as two or more visits for home-based or office-based care in the past 12 months.

5.2.5 Behavioral Health Service and Network Requirements

ICM Members in the Dallas Service Area will be continued to be enrolled in NorthSTAR and will receive the applicable BH Services from NorthSTAR. ICM Members in the Tarrant Service Area will not be enrolled in NorthSTAR.

Contractor Managed Services for ICM Members include all mental health and substance abuse services in **Attachment B-2** to the **ICM Contract Document**. Services that are provided by NorthSTAR to Members in the Dallas Service Area are excluded from Contractor Managed Services.

5.2.5.1 Coordination between the BH Provider and the PCP

The Contractor 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 Contractor must provide training to network PCPs on how to screen for and identify behavioral health disorders, the Contractor's referral process for Behavioral Health Services and clinical coordination requirements for such services. The Contractor 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 training must clearly indicate the different policies and procedures for the Dallas Service Area (where Members will be enrolled with NorthSTAR for BH Services) and the Tarrant Service Area (where NorthSTAR does not operate).

The Contractor shall develop and disseminate policies regarding clinical coordination between Behavioral Health Service Providers and PCPs. The Contractor must require that Behavioral Health Service Providers refer Members in the Tarrant Service Area 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 Service 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 Contractor 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.

5.2.5.2 Follow-up after Hospitalization for Behavioral Health Services

The Contractor must require, through Provider contract provisions, that all Members in the Tarrant Service Area receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. The Contractor must ensure that Behavioral Health Service Providers contact Members in the Tarrant Service Area who have missed appointments within 24 hours to reschedule appointments.

5.2.5.3 Chemical Dependency

The Contractor must comply with 28 T.A.C. §3.8001 *et seq*., regarding Utilization Review for Chemical Dependency Treatment for Members in Tarrant Service Area. Chemical Dependency Treatment must conform to the standards set forth in 28 T.A.C. Part 1, Chapter 3, Subchapter HH.

5.2.5.4 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 Contractor must arrange and coordinate inpatient psychiatric services to Members in the Tarrant Service Area 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 Contractor cannot prior authorize court-ordered services or deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court-ordered Commitment for Members under age 21 in Tarrant Service Area.

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.

5.2.5.5 Local Mental Health Authority (LMHA) in Tarrant Service Area

The Contractor 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 in the Tarrant Service Area committed by a court of law to the state psychiatric facility.

Assessment to determine eligibility for rehabilitative and targeted DSHS case management services is a function of the LMHA. Contractor Managed Services must be arranged for Members in the Tarrant Service Area with severe and persistent mental illness (SPMI) and severe emotional disturbance (SED), when Medically Necessary, whether or not they are also receiving targeted case management or rehabilitation services through the LMHA.

The Contractor must enter into written agreements with all LMHAs in the Tarrant Service Area that describe the process(es) that the Contractor and LMHAs will use to coordinate services for Members with SPMI or SED. The agreements will:

1. Describe criteria, protocols, procedures and instrumentation for referral of Members from and to the Contractor and the LMHA;
2. Describe processes and procedures for referring Members with SPMI or SED to the LMHA for assessment and determination of eligibility for rehabilitation or targeted case management services;
3. Describe how the LMHA and the Contractor will coordinate providing Behavioral Health Services to Members with SPMI or SED;
4. Establish clinical consultation procedures between the Contractor and LMHA including consultation to effect referrals and on-going consultation regarding the Member's progress;
5. Establish procedures to authorize release and exchange of clinical treatment records;
6. Establish procedures for coordination of assessment, intake/triage, Utilization Review/Utilization Management and care for persons with SPMI or SED;
7. Establish procedures for coordination of inpatient psychiatric services (including Court-ordered Commitment of Members under 21) in state psychiatric facilities within the LMHA's catchment area;
8. Establish procedures for coordination of emergency and urgent services to Members;
9. Establish procedures for coordination of care and transition of care for new Members who are receiving treatment through the LMHA; and
10. Establish that when Members are receiving Behavioral Health Services from the LMHA that the Contractor is using the same UM guidelines as those prescribed for use by LMHAs by DSHS. These guidelines are published at: http://www.mhmr.state.tx.us/centraloffice/behavioralhealthservices/RDMClinGuide.html.

The Contractor must offer licensed practitioners of the healing arts (defined in 25 T.A.C., Part 2, Chapter 419, Subchapter L), who are part of the Member's treatment team for rehabilitation services, the opportunity to participate in the Contractor's Network. The practitioner must meet the Contractor's credentialing requirements, and comply with all the terms and conditions of the Contractor's standard Provider contract.

Contractors must allow Members in the Tarrant Service Area receiving rehabilitation services to choose the licensed practitioners of the healing arts who are currently a part of the Member's treatment team for rehabilitation services to provide Contractor Managed Services. Nothing in this section diminishes the potential for the Local Mental Health Authority to seek best value for rehabilitative services by providing these services under arrangement, where possible, as specified is 25 T.A.C. §419.455.

5.2.6 Access to Care

Section 5.2.6 modified by Version 1.0.

All Contractor Managed Services must be available to Members on a timely basis in accordance with medically appropriate guidelines, and consistent with generally accepted practice parameters and the requirements in this Contract.

The Contractor must require, and make best efforts to ensure, that PCPs are accessible to Members 24 hours a day, 7 days a week and that its Network Primary Care Providers (PCPs) have after-hours telephone availability consistent with, **RFP Section 5.2.4.4.**

The Contractor must ensure that its Network includes a sufficient number of Providers who are able to service medically fragile and/or high acuity Members.

The Contractor must provide that if Medically Necessary or Functionally Necessary Contractor Managed Services are not available through Network Providers, the Contractor must, upon the request of a Network 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. The non-Network provider must be a Texas Medicaid provider.

5.2.6.1 Waiting Times for Appointments

Through its Provider Network composition and management, the Contractor must ensure that appointments for the following types of Contractor Managed Services are provided within the time frames specified below. In all cases below, “day” is defined as a calendar day.

1. Emergency Services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities;
2. Urgent care, including urgent specialty care, must be provided within 24 hours of request;
3. Routine primary care must be provided within 14 days of request;
4. Initial outpatient behavioral health visits must be provided within 14 days of request;
5. Routine specialty care referrals must be provided within 30 days of request;
6. Pre-natal care must be provided within 14 days of request, except for high-risk pregnancies or new Members in the third trimester, for whom an appointment must be offered within five days, or immediately, if an emergency exists;
7. Preventive health services for adults must be offered to a Member within 90 days of request; and
8. Preventive health services for children, including well-child check-ups should be offered to Members in accordance with the American Academy of Pediatrics (AAP) periodicity schedule and the THSteps Program modifications to the AAP periodicity schedule. For newly enrolled Members under age 21, overdue or

upcoming well-child check-ups, including THSteps medical check-ups, should be offered as soon as practicable, but in no case later than 60 days after enrollment.

Section 5.2.6.2 modified by RFP Addendum 2 and Versions 1.0 and 1.1

5.2.6.2 Access to Network Providers

The Contractor's Network shall include PCPs in sufficient numbers, and with sufficient capacity, to provide timely access to regular and preventive pediatric care and THSteps services to all child Members in accordance with the waiting times for appointments in **RFP Section 5.2.6.1.**

PCP Access: At a minimum, the Contractor must ensure that all Members have access to an age-appropriate PCP in the Provider Network with an Open Panel within 30 miles of the Member's residence. For the purposes of assessing compliance with this requirement, an internist who provides primary care to adults only is not considered an age-appropriate PCP choice for a Member under age 21, and a pediatrician is not considered an age-appropriate choice for a Member age 21 and over.

OB/GYN Access: At a minimum, the Contractor must ensure that all female Members have access to an OB/GYN in the Provider Network within 75 miles of the Member's residence. (If the OB/GYN is acting as the Member's PCP, the Contractor must follow the access requirements for the PCP.) The Contractor must allow female Members to select an OB/GYN within its Provider Network. A female Member who selects an OB/GYN must be allowed direct access to the OB/GYN's health care services without a referral from the Member's PCP or a prior authorization. A pregnant Member with 12 weeks or less remaining before the expected delivery date must be allowed to remain under the Member's current OB/GYN care though the Member's post-partum checkup, even if the OB/GYN provider is, or becomes, out-of-Network.

Outpatient Behavioral Health Service Provider Access: At a minimum, the Contractor must ensure that all Members in the Tarrant Service Area have access to an outpatient Behavioral Health Service Provider in the Network within 75 miles of the Member's residence. Outpatient Behavioral Health Service Providers must include masters degree and doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient Hospital departments. A Qualified Mental Health Provider (QMHP), as defined and credentialed by the Texas Department of State Health Services standards (T.A.C. Title 25, Part I, Chapter 412), is an acceptable outpatient Behavioral Health Services Provider as long as the QMHP is working under the authority of an MHMR entity and is supervised by a licensed mental health professional or physician.

Other Specialist Physician Access: At a minimum, the Contractor must ensure that all Members have access to a Network specialist physician within 75 miles of the Member's residence for common medical specialties. For adult Members, common medical specialties shall include general surgery, cardiology, orthopedics, urology, and ophthalmology. For child Members, common medical specialties shall include orthopedics and otolaryngology. In addition, all Members must be allowed to: 1) select

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.

Hospital Access: The Contractor must ensure that all Members have access to an Acute Care Hospital in the Provider Network within 30 miles of the Member's residence.

All other Contractor Managed Services, except for services provided in the Member's residence: At a minimum, the Contractor must ensure that all Members have access to at least one Network Provider for each of the remaining Contractor Managed Services within 75 miles of the Member's residence. This access requirement includes, but is not limited to, specialists, specialty Hospitals, diagnostic and therapeutic services, and single or limited service health care physicians or providers.

The Contractor is not precluded from making arrangements with physicians or providers outside the Contractor's Service Area for Members to receive a higher level of skill or specialty than the level available within the Service Area, including but not limited to, treatment of cancer, burns, and cardiac diseases.

HHSC may consider exceptions to the above access-related requirements when a Contractor has established, through utilization data provided to HHSC, that a normal pattern for securing health care services within an area does not meet these standards, or when an Contractor is providing care of a higher skill level or specialty than the level which is available within the Service Area such as, but not limited to, treatment of cancer, burns, and cardiac diseases.

5.2.6.3 Monitoring Access

Section 5.2.6.3 modified by Version 1.0.

The Contractor is required to systematically and regularly verify that Contractor Managed Services furnished by Network Providers are available and accessible to Members in compliance with the standards described in **RFP Sections 5.2.6**, and for Contractor Managed Services furnished by PCPs, the after hours standards described in **RFP Section 5.2.4.4**.

The Contractor must enforce access and other Network standards required by the Contract and take appropriate action with Providers whose performance is determined by the Contractor to be out of compliance. Such action, shall include but not be limited to the Contractor sharing Provider-specific performance information with HHSC, and may include terminating referrals to such a Provider or terminating a Provider Agreement. In addition, if DADS puts a Provider on client hold, then the Contractor must suspend referrals to that Provider until further notice from DADS.

Section 5.2.6.4 modified by Version 1.3.

5.2.6.4 Continuity of Care and Out of Network Providers

The Contractor must ensure that the care of newly enrolled Members is not disrupted or interrupted. The Contractor must take special care to provide continuity in the care of newly enrolled Members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if Medically Necessary or Functionally Necessary Contractor Managed Services are disrupted or interrupted. See Section 5.2.8 Disease Management for specific requirements for new Members transferring to the ICM Contractor's DM Program.

The Contractor must allow pregnant Members with 12 weeks or less remaining before the expected delivery date to remain under the care of the Member's current OB/GYN through the Member's postpartum check-up, even if the provider is out-of-Network. If a Member wants to change her OB/GYN to one who is in the Network, she must be allowed to do so if the Provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

The Contractor must authorize a Member's existing out-of-Network providers for Medically Necessary or Functionally Necessary Contractor Managed Services until the Member's records, clinical information and care can be transferred to a Network Provider.

This Article does not extend the obligation of the Contractor to authorize the Member's existing out-of-Network providers for on-going care for:

1. More than 90 days after a Member enrolls in the ICM Program, or
2. For more than nine (9) months in the case of a Member who, at the time of enrollment in the Contractor, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled in the ICM Program.

The Contractor's obligation to authorize the Member's existing out-of-Network provider for Medically Necessary Contractor Managed Services provided to a pregnant Member with 12 weeks or less remaining before the expected delivery date extends through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six weeks of delivery.

The Contractor must ensure that each Member has access to a second opinion regarding the use of any Medically Necessary Contractor Managed Service. A Member must be allowed access to a second opinion from a Network Provider or out-of-Network provider if a Network Provider is not available in accordance with 42 C.F.R. §438.206(b)(3).

5.2.6.5 Family Planning - Specific Requirements

The Contractor must require, through Provider Agreement provisions, that Members requesting contraceptive services or family planning services are also provided counseling and education about the family planning and family planning services available to Members. The Contractor must develop outreach programs to increase community support for family planning and encourage Members to use available family planning services.

The Contractor must ensure that Members have the right to choose any Medicaid participating family planning provider, whether the provider chosen by the Member is in or outside the Provider Network. The Contractor must provide Members access to information about available providers of family planning services and the Member's right to choose any Medicaid family planning provider. The Contractor must provide access to confidential family planning services.

The Contractor must ensure that Members receive, at minimum, the full scope of services available under the Texas Medicaid program for family planning services. Contraceptive methods must be accompanied by verbal and written instructions on their correct use. The Contractor must establish mechanisms to ensure all medically approved methods of contraception are made available to the Member.

The Contractor must develop, implement, monitor, and maintain standards, policies and procedures for providing information regarding family planning to Providers and Members, specifically regarding State and federal laws governing Member confidentiality (including minors). Providers and family planning agencies cannot require parental consent for minors to receive family planning services. The Contractor must require, through contractual provisions, that subcontractors have mechanisms in place to ensure Member's (including minor's) confidentiality for family planning services.

5.2.6.6 Children of Migrant Farmworkers (FWC)

Section 5.2.6.6 added by Version 1.1.

The Contractor must cooperate and coordinate with the State, outreach programs, and THSteps regional program staff and agents to ensure prompt delivery of services, in accordance with the timeframes in this Contract, to FWC Members and other migrant populations who may transition into and out of the ICM Program more rapidly and/or unpredictably than the general population.

The Contractor must arrange for the provision of accelerated services to FWC Members. For purposes of this section, "accelerated services" are services that are provided to a child of a Migrant Farmworker prior to their leaving Texas to work in other states. Accelerated services include the provision of preventive Health Care Services that will be due during the time the FWC Member is out of Texas. The need for accelerated services must be determined on a case-by-case and according to the FWC Member's age, periodicity schedule and health care needs.

The Contractor must develop a plan annually for the process it will use to identify FWC and for the methods that will be used to provide accelerated services, and submit an annual certification that the Contractor will comply with the plan. The plan for FY2008 must be submitted for HHSC approval no later than December 1, 2007 and implemented by February 1, 2008. The plan must include at a minimum:

- identification of community and statewide groups that work with FWC Member within the ICM Service Area;
- participation of the community groups in assisting with the identification of FWC Members;
- appropriate aggressive efforts to reach each identified FWC to provide timely medical checkups and follow up care if needed;
- methods to maintain accurate, current lists of all identified FWC Members;
- methods that the HMO and its Subcontractors will implement to maintain the confidentiality of information about the identity of FWC; and
- methods to arrange for the provision of accelerated services to FWC.

5.2.7 Service Coordination

The Contractor must provide a Service Coordinator to all ICM Members who request it. The Contractor must also furnish Service Coordination to an ICM Member when initial or periodic assessment of the Member's health and support needs indicates Service Coordination is necessary.

The Contractor must work with each ICM Member's PCP to obtain overall clinical direction for the Service Plan, as appropriate to the Member's needs. This requirement applies whether or not the PCP is a Medicaid provider, as some ICM Members dually eligible for Medicare may have a PCP who is not a Medicaid provider. For dual eligible Members who do not have a PCP, the Contract must work with the Member's primary Medicare provider to obtain overall clinical direction for the Service Plan. The PCP or designated Medicare provider, in conjunction with a Service Coordinator, serves as a central point of integration and coordination of Contractor Managed Services for Members with medical needs.

The Service Coordinator must work as a team with the PCP or Medicare provider, as appropriate, and coordinate all Contractor Managed Services with ICM Non-Managed Services and other services the Member receives. In order to integrate the Member's Acute Care and primary care, and stay abreast of the Member's needs and condition,

the Service Coordinator must also actively involve, and coordinate with, the Member's primary and specialty care Providers, including Behavioral Health Service Providers, LTSS Providers, and providers of ICM Non-Managed Services.

The Contractor must empower its Service Coordinators to authorize Long Term Services and Supports.

The Service Coordinator must work with the Member/representative, the PCP and other Providers (including Medicare providers as applicable) to:

1. develop, implement and monitor a seamless package of care in which primary care, Acute Care, and Long Term Service and Supports needs are met through a single Service Plan;
2. coordinate each Member's Service Plan with the Member's family and informal support systems;
3. facilitate Member access to treatment by a multidisciplinary team when the Member's PCP determines that such treatment is Medically Necessary, or to avoid otherwise separate and fragmented evaluations and Service Plans;
4. ensure the Service Plan is understandable to the Member, or, when applicable, the Member's legal guardian, and
5. identify and train certain Members or their families to coordinate their own care, to the extent of the Member's or the family's capability.

5.2.7.1 Confidentiality

All Service Plan information that is transferred between the Contractor, the Member, the PCP, other service providers, community organizations, family members and guardians, including but not limited to service authorizations, referrals, medical/treatment records and the Service Plan itself, shall be transmitted in a manner that protects and ensures the confidentiality of the information. The Contractor shall have policies and systematized procedures to ensure compliance with this Contract requirement and with HIPAA requirements, as indicated in **RFP Section 5.18**.

5.2.7.2. Service Coordination Staffing

The Contractor may provide Service Coordination to a Member through an individual Service Coordinator or through a Service Coordination team.

The Contractor must monitor Service Coordinator workload and performance to ensure that Service Coordinators perform all required Service Coordination functions for ICM Members in a timely and effective manner. Should the Contractor detect that staffing is inadequate to provide Service Coordination as required by HHSC, it shall promptly adjust its staffing and caseload levels accordingly.

The Contractor, through Service Coordination, shall be responsible for organizing and

authorizing a seamless package of Medically Necessary and Functionally Necessary Contractor Managed Services for each Member.

The Contractor, through Service Coordination, shall also be responsible for coordinating preventive, primary, and Acute Care Services with Long Term Services and Supports as well as with services provided by other payers (including Medicare) into an integrated, understandable, rational Service Plan. Each Member's Service Plan must also be coordinated with the Member's family and community support systems.

5.2.7.3. Referral to Community Organizations

As part of Service Coordination, the Contractor must provide information about and referral to community organizations that may not be providing ICM Services, but are otherwise important to the health and well being of Members. These organizations include, but are not limited to:

- State/federal agencies (e.g., those agencies with jurisdiction over aging, public health, substance abuse, mental health/retardation, rehabilitation, developmental disabilities, income support, nutritional assistance, family support agencies, etc.);
- social service agencies (e.g., Area Agencies on Aging, Local Mental Health and Mental Retardation Authorities, residential support agencies, independent living centers, supported employment agencies, etc.);
- city and county agencies (e.g., welfare departments, housing programs, etc.);
- civic and religious organizations; and
- consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning, etc.).

5.2.7.4. Discharge Planning

As part of Service Coordination, the Contractor must have a protocol for quickly assessing the needs of ICM Members discharged from a Hospital or other care or treatment facility in order to facilitate appropriate and timely discharge with the resources necessary to prevent readmission. The Contractor must ensure that social workers and discharge planners in Hospitals are knowledgeable about the mandatory requirement that ICM Members receive Acute Care and Long Term Services and Supports under the ICM Program.

The Contractor's Service Coordinator must work with the Member's PCP, the Hospital discharge planner(s), the attending physician, the Member and the Member's family to assess and plan for the Member's discharge. When a Member being discharged is at risk for Nursing Facility placement, the Contractor must ensure that the Member's discharge plan includes arrangements for receiving community-based care whenever possible. The Contractor must ensure that the Member, the Member's family, and the Member's PCP are all well informed of all LTSS service options available to meet the Member's needs in the community.

Section 5.2.7.5 modified by Version 1.1.

5.2.7.5. Transition Plan for New ICM Members

The Contractor must provide a transition plan for Members enrolled in the ICM Program. For Members enrolled within 30 days after the Operational Start Date, the Contractor shall develop a transition plan within 90 days of enrollment. For Members enrolled 90 days after the Operational Start Date, the Contractor shall develop a transition plan within 30 days of the enrollment date. The transition plan must remain in place until the Contractor contacts the Member and coordinates modifications to the Member's current service plan. The Contractor must ensure that the existing services continue and that there are no breaks in services.

Thirty days prior to the Operational Start Date, HHSC will provide the Contractor with detailed service plans, names of current providers and other relevant information for mandatory ICM-eligible individuals already receiving Long Term Services and Supports.

HHSC will also provide comparable service plan information on ICM-eligible individuals who have voluntarily elected to enroll in the ICM Program prior to the Operational Start Date.

After the Operational Start Date, if an ICM-eligible individual is already receiving Long Term Services and Supports prior to ICM enrollment, HHSC will provide the Contractor with detailed service plans, names of current providers and other relevant information at the time of the individual's ICM enrollment notification.

HHSC and DADS will work with the Contractor to determine the service plan information that will be made available to the Contractor.

The transition plan will remain in place until the Contractor contacts the Member and conducts an assessment to determine the appropriateness of the Member's current treatment and Long Term Services and Supports plan. The Contractor must ensure that the existing services continue and that there are no breaks in services by authorizing current providers for Medically Necessary Contractor Managed Services that are delivered in accordance with the Member's existing treatment/Long Term Services and Supports plan until the transition plan is developed.

The transition planning process must include, but is not limited to, the following:

1. review of existing DADS Long Term Services and Supports plans;
2. preparation of a transition plan that ensures continuous care under the Member's existing service plan during the transfer into the ICM Program while the Contractor conducts an appropriate assessment and development of a new plan, if needed;
3. if durable medical equipment or supplies had been ordered prior to enrollment, but have not been received by the time of enrollment, coordination and follow-through to ensure that the Member receives the necessary supportive equipment and supplies without undue delay; and

4. authorization of current services until the Contractor has completed the assessment and Service Plan and issued new authorizations.

The Contractor must ensure that the Member is involved in the assessment process and fully informed about options, is included in the development of the Service Plan, and understands the Service Plan when completed.

Section 5.2.7.6 modified by RFP Addendum 2.

5.2.7.6. Initial Member Contact and Service Plan

All ICM Members are considered to be Members with Special Health Care Needs. The HHSC Administrative Services Contractor will provide the Contractor with information on Members with Special Health Care Needs that have been pre-screened by the Administrative Services Contactor. The Contractor shall consider this information when scheduling and conducting initial contacts and, as necessary, Functional Assessments with ICM Members.

The Contractor must make initial contact with an ICM Member within 30 days of the Member's enrollment into the ICM Program. If the Contractor determines during the initial contact that a Functional Assessment is necessary, the Contractor must notify HHSC of the need for a Functional Assessment as described in **RFP Section 5.2.7.4**. The Contractor must complete the Functional Assessment within 30 days of identifying the need for a Functional Assessment. The Contractor must expedite performance of the Functional Assessment if the Member's condition warrants it due to the Member's risk of needing institutional care.

The Contractor must work with the Member, family and/or guardian to develop a Service Plan, to include Contractor Managed Services, ICM Non-Managed Services, other needed services and family and community resources. The Service Plan must be completed within 30 days of the initial contact with an ICM Member. The Contractor must expedite the development and implementation of a Service Plan if the Member's condition warrants it due to the Member's risk of needing institutional care.

The ICM Member must be involved in developing the Service Plan. The Service Coordinator must help the Member to set goals to address medical, social and other support needs identified during the initial assessment, educate the Member about all options, and then develop an action plan for each goal. The action plan shall include services (e.g., units, frequency, etc), and the roles of the Member, Service Coordinator, relevant providers, family, and informal caregivers in achieving each goal. The Service Plan must reflect the most integrated care setting possible and desired by the Member.

Prior to finalization, the ICM Member must sign the plan to indicate understanding of the Service Plan. If the Member does not agree with the Service Plan, the Member may file an Appeal.

The Contractor must obtain written Member permission to discuss and share the Service Plan with the PCP and other Providers, as needed. Once the Member gives permission

to share the Service Plan with Providers, the Service Coordinator must contact the PCP to confirm the PCP's agreement. No PCP-initiated changes may be made to the Service Plan without consulting the Member and obtaining the Member's signature on the revised Service Plan.

Once the Service Plan has been finalized, the Service Coordinator shall send a copy to the Member, the PCP and any other appropriate Provider, family member, or community resource (as appropriate) identified within the Service Plan. The Contractor must have a systematic process for generating or receiving referrals and sharing confidential medical, treatment, and planning information across providers.

The Service Coordinator must authorize Long Term Services and Supports and provide specialty referrals specified within the Service Plan in an expeditious manner, and to coordinate with family members and/or guardians, providers of other services and community resources, as reflected in the Service Plan.

5.2.7.7 Functional Assessment Instruments

The Contractor must use Functional Assessment instruments to identify Members with significant health problems, Members requiring immediate care or services, and Members who need, or are at risk of needing, Long Term Services and Supports. The Contractor or a subcontractor may complete assessment instruments, but the Contractor remains responsible for the data recorded.

The Contractor must use the state approved form as amended or modified, to assess a Member's need for Functionally Necessary Personal Assistance Services or Day Activity and Health Services (DAHS). The Contractor may adapt the form to reflect the Contractor's name or distribution instructions, but the elements must be the same and instructions for completion must be followed without amendment.

Section 5.2.7.7 modified by Version 1.1.

The Contractor must use the state approved form, as amended or modified, to assess Members and to supply current medical information for Medical Necessity determinations for 1915(c) CBA Waiver program recipients to determine if they meet the Nursing Facility Level of Care.

Additional functional assessment instruments, if any, used by the Contractor must be approved by HHSC.

Section 5.2.7.8 modified by Version 1.1 and 1.3

5.2.7.8. Minimum Data Set for Home Care

ICM Contractors must use the DADS Form 2060, as amended or modified, to assess a Member's need for Functionally Necessary Personal Attendant Services. ICM Contractors may adapt the form to reflect the ICM Contractor's name or distribution instructions, but the elements must be the same and instructions for completion must be followed without amendment. The DADS Form 2060 must be completed if a need for or

a change in Personal Attendant Services is warranted at the initial contact, at the annual reassessment, and anytime a Member requests the services or requests a change in services. The DADS Form 2060 must also be completed at any time the ICM Contractor determines the Member requires the services or requires a change in the Personal Attendant Services that are authorized.

ICM Contractors must use the Texas Medicaid Children's Comprehensive Assessment Form (CCAF Form) on the LTC online portal in lieu of the DADS Form 2060 for children under the age of 21 when assessing the Member's need for Functional Necessary Personal Attendant Services. ICM Contractors may adapt the CCAF Form to reflect the ICM Contractor's name or distribution instructions, but the elements must be the same and instructions for completion must be followed without amendment. Reassessments using the CCAF Form must be completed every six months and as requested by the Member's parent or other legal guardian. The CCAF Form must also be completed at any time the ICM Contractor determines the Member may require a change in the number of authorized Personal Attendant Service hours.

For Members and applicants seeking or needing the 1915(c) Nursing Facility Waiver services, the ICM Contractors must use the Community Medical Necessity and Level of Care Assessment instrument, as amended or modified, to assess Members and to supply current medical information for Medical Necessity determinations. The ICM Contractor must also complete the Individual Service Plan (ISP), Form 3671, for each Member receiving 1915(c) Nursing Facility Waiver Services. The ISP is established for a one-year period. After the initial ISP is established, the ISP must be completed on an annual basis and the end date or expiration date does not change. Both of these forms (Community Medical Necessity and Level of Care Assessment instrument and Form 3671) must be completed annually at reassessment. The ICM Contractor is responsible for tracking the end dates of the ISP to ensure all Member reassessment activities have been completed and posted on the LTC online portal no earlier than 90 days and no later than the expiration date of the ISP. Note that the Community Medical Necessity and Level of Care Assessment instrument cannot be submitted earlier than 90 days prior to the expiration date of the ISP.

5.2.7.9. Monitoring and Reassessment of Service Plan

Section 5.2.7.9 Modified by Version 1.1.

No sooner than 90 days prior to the end date of the Service Plan and no later than 30 days prior to the end date of the Service Plan, the Contractor must monitor and re-evaluate the appropriateness of the Service Plan. The Contractor must also re-evaluate the appropriateness of the Service Plan whenever the Member's condition changes significantly or upon request of the Member.

The Service Plan reassessment process must mirror the initial assessment and service planning process, to include working with the Member and relevant providers to evaluate goals and outcomes, and revising the Service Plan, as needed, in consultation with the Member. The Member must sign the revised Service Plan to indicate Member understanding. The contractor must submit the reassessment packet to the DADS ICM

Support unit for review and approval in accordance with the schedule outlined in Appendix VIII of the Case Manager Community Based Alternatives Handbook. This handbook can be accessed on-line at http://www.dads.state.tx.us/handbooks/appendix/17.htm.

5.2.7.10 Service Coordinator Training

Section 5.2.7.10 added by Version 1.1.

The Contractor should train all Service Coordinators about: a) emergency prescription standards and what steps to take to immediately address ICM Members' problems when pharmacies do not provide a 72-hour supply of emergency medicines; and b) DME processes for obtaining services and how to address common problems. Service Coordinators will attempt to respond immediately to problems concerning emergency medicines by means at their disposal, including explaining the rules to ICM Members so that they understand their rights and, if need be, by offering to contact the pharmacy that is refusing to fill the prescription to explain the 72-hour supply policy and DME processes.

5.2.8 Disease Management

The Contractor must provide, or arrange to have provided to non-Dual Eligible Members, comprehensive Disease Management (DM) 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 Contractor must develop and implement DM services that relate to chronic conditions that are prevalent in ICM Program Members. HHSC will not identify the Members with chronic conditions. The Contractor 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 Contractor must develop and maintain screening and evaluation procedures for the early detection, prevention, treatment, or referral of participants at risk for or diagnosed with chronic conditions identified by HHSC. The Contractor 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 Contractor Managed Services.

For all new Members not previously enrolled in the ICM Contractor and who require DM services, the ICM Contractor 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 Contractor must maintain a system to track and monitor all DM participants for clinical, utilization, and cost measures.

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

Section 5.2.8 modified by Version 1.3.

At a minimum, the Contractor 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 the DM Program, and information concerning such Members' adherence to any DM chronic illness self-management terms of the Service Plan; and
3. For Members enrolled in a DM Program, provide reports on changes in a Member's health status to their PCP.

5.2.9 Promoting Independence Initiative

Section 5.2.9 modified by Version 1.1.

The Contractor must participate in the Promoting Independence Initiative (PII) for individuals in Nursing Facilities. The Promoting Independence Initiative is rooted in a commitment that aged and disabled individuals have a choice of the most integrated setting to receive Long Term Services and Supports. PII is Texas' response to the U.S. Supreme Court ruling in Olmstead v. Zimring that requires states to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services, when:

- the state's treatment professionals determine that such placement is appropriate;
- the affected persons do not oppose such treatment; and
- the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state-supported disability services.

The PII was started with then Governor Bush's Executive Order 99-2. The Initiative was codified by Senate Bill 367 (77th Legislature Regular Session, 2001) and reinforced by Governor Rick Perry's Executive Order RP-13. One of the many policy initiatives to arise from PII is "money follows the person" (MFP). MFP began as a rider to the DADS

appropriation (Senate Bill 1, 77th Legislature Regular Session, 2001). The 79th Legislature codified the MFP policy through House Bill 1867 (Regular Session, 2005).

MFP allows a current Nursing Facility resident who is Medicaid eligible to transfer into a 1915(c) waiver program without having to go on to an interest list. The most common waiver program for Nursing Facility residents is the Community Based Alternatives program. The individual must continue to reside in the Nursing Facility until there is a written eligibility determination received from a DADS community care worker that indicates a resident is approved for specific community care services and the effective date of such approval.

An ICM Member that enters a Nursing Facility will remain an ICM Member for a total of four months. Once a Member has resided in a Nursing Facility for a total of four months, the Member will be disenrolled from the ICM Program.

The Contractor will not be responsible for contracting with Nursing Facilities. The Contractor will be responsible for providing certain Contractor Managed Services for Nursing Facility residents that are ICM Members.

A Service Coordinator must complete an assessment of the Member within 30 days of Nursing Facility entry and develop a plan to transition the Member back into the community as appropriate. If at this initial review a return to the community is possible, the Service Coordinator will work with the Member and/or family to develop and implement a transition plan to return the Member to the community.

If the initial review does not support a return to the community, the Service Coordinator will conduct a second assessment of the Member 90 days after the initial assessment to determine any changes in the Member's condition or circumstances that would allow a return to the community. If the assessment concludes that a return to the community is supported, the Service Coordinator will work with the Member and family to develop and implement a transition plan to return the Member to the community.

The Contractor must maintain the documentation of the assessments completed and make them available for state review at any time.

It is possible that the Contractor will be unaware of the Member's entry into a Nursing Facility. It is the responsibility of the Nursing Facility to review the Member's Medicaid card upon entry into the facility and notify the Contractor. The Nursing Facility is also required to notify HHSC of the entry of a new resident. Should the Nursing Facility fail to take these actions, there could be a significant delay between entry into the Nursing Facility and notification to the Contractor or HHSC. In these delayed notice situations, the Contractor shall make best efforts to complete the initial assessment of the Member within 30 days of the Nursing Facility entry or as soon as possible thereafter.

The Contractor must designate a point of contact to receive referrals for non-Medicaid Nursing Facility residents who may potentially be able to return to the community.

Section 5.2.10 modified by Version 1.0.

5.2.10 1915(c) CBA Waiver Service Eligibility for ICM Members

The Contractor must notify HHSC when it initiates 1915(c) CBA Waiver eligibility testing on an ICM Member. The Contractor must initiate 1915(c) CBA Waiver eligibility testing upon request from a Member, the Member's family, or a Provider, or upon identification of a need by a Provider. The Contractor must apply risk criteria, complete the Form 3652 for Medical Necessity determination, complete the assessment documentation, and prepare a 1915(c) CBA Waiver Individual Service Plan (ISP) for each Member requesting 1915(c) CBA Waiver services, and for Members the Contractor has identified as needing 1915(c) CBA Waiver services. In addition, the Contractor must provide each Member who is an applicant for 1915(c) CBA Waiver services with a copy of the Medicaid Estate Recovery Program (MERP) form. The Contractor must provide copies of completed MERP forms to HHSC or its designee in a timely manner. If an applicant for 1915(c) CBA Waiver services refuses to sign the MERP form, then the Contractor must document that the form was conveyed to the applicant but the applicant refused to sign, and timely provide HHSC or its designee with such documentation.

The Contractor must provide HHSC or its designee the results of the 1915(c) CBA Waiver assessment activities within 30 days of initiating the assessment process.

HHSC will notify the Member and the Contractor of the eligibility determination, which will be based on the information provided by the Contractor. If the ICM Member is eligible for 1915(c) Waiver services, HHSC will notify the Member of the effective date of eligibility. If the Member is not eligible for 1915(c) Waiver services, HHSC will provide the Member information on the right to Appeal the Adverse Determination. Regardless of the 1915(c) Waiver eligibility determination, HHSC will send a copy of the Member notice to the Contractor.

Prior to the end date of the annual ISP, the Contractor must initiate an annual reassessment to determine and validate continued eligibility for 1915(c) Waiver services for each Member receiving such services. The Contractor will be expected to complete the same activities for the annual reassessment as required for the initial eligibility determination, except that the Contractor does not need to obtain a physician's signature on the Form 3652 for the annual reassessment. Existing 1915(c) Waiver clients may not be denied 1915(c) Waiver services solely on the basis that the proposed cost of the ISP will exceed the cost of care if the Member were in a Nursing Facility.

5.2.11 Provider Services

5.2.11.1 Provider Manual, Materials and Training

The Contractor must prepare and issue an ICM Provider Manual to all ICM Providers. For newly contracted Providers, the Contractor must issue copies of the Provider Manual within five (5) working days of including the Provider into the ICM Network. The Provider Manual must contain information about the ICM Program(s), the ICM eligible populations, and the roles of HHSC, DADS and HHSC's Claims Administrator in the ICM Program.

HHSC or its designee must approve the Provider Manual, and any substantive revisions to the Provider Manual, prior to publication and distribution to Providers. The Provider Manual must contain critical elements defined by HHSC. HHSC's initial review of the Provider Manual is part of the Operational Readiness Review.

The Contractor must provide training to all Providers and their staff regarding the ICM Program, Contractor Managed Services, and special needs of ICM Members. The Contractor must provide initial training to new Providers as well as ongoing training. Provider training must include information about the ICM Program, Contractor Managed Services, Service Coordination, and the Contractor's policies and procedures, including those related to prior approval, Utilization Review, and referrals. The Contractor must place special emphasis on Long Term Services and Supports and Contractor requirements, policies, and procedures that vary from Medicaid Fee-for-Service and commercial coverage rules.

The Contractor must make available any Provider materials to HHSC upon request.

The Contractor must maintain and make available upon request enrollment or attendance rosters dated and signed by each attendee or other written evidence of training of each Provider and their staff.

5.2.11.2 Provider Hotline

Section 5.2.11.2 modified by Version 1.3.

The Contractor must operate a toll-free telephone line for Provider inquiries from 8 a.m. to 5 p.m. local time for the ICM Service Area, Monday through Friday, except for State-approved holidays. The Provider hotline must be staffed with personnel who are knowledgeable about Contractor Managed Services, the ICM Program, and ICM Non-Managed Services.

The Contractor must ensure that after regular business hours the line is answered by an automated system with the capability to provide callers with operating hours information and instructions on how to verify enrollment for an ICM Member with an Urgent Condition or an Emergency Medical Condition. The Contractor must have a process in place to handle after-hours inquiries from Providers seeking to verify enrollment for an ICM Member with an Urgent Condition or an Emergency Medical Condition, provided, however, that the Contractor and ICM Providers must not require such verification prior to the delivery of Emergency Services.

The Contractor must ensure that the ICM Provider Hotline meets the following minimum performance requirements:

1. 99% of calls are answered by the fourth ring or an automated call pick-up system is used;
2. no more than one percent of incoming calls receive a busy signal;
3. the average hold time is 2 minutes or less; and
4. the call abandonment rate is 7% or less.

The Contractor must conduct ongoing call quality assurance to ensure these standards are met. The Contractor must monitor its performance regarding ICM Provider Hotline standards and submit performance reports summarizing call center performance for the Hotline as indicated in **RFP Section 5.2.20**.

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

5.2.12 Provider Complaints and Appeals

The Contractor must develop, implement, and maintain a system for tracking all ICM Provider Complaints and Appeals and either referring or resolving such Complaints and Appeals as applicable.

The Contractor must develop, implement, and maintain a system for resolving all Provider Complaints and Appeals related to the Contractor's Services for the ICM Program, including but not limited to an Action taken by the Contractor. The Contractor must respond fully and completely to each such Provider Complaint and Appeal and establish a tracking mechanism to document the status and final disposition of each Provider Complaint and Appeal.

The Contractor must contract with physicians who are not Network Providers to resolve disputes related to medical necessity that remain unresolved subsequent to a Provider appeal. The determination of the physician resolving the dispute must be binding on the Contractor and the Provider. The physician resolving the dispute must hold the same specialty or a related specialty as the appealing Provider. HHSC reserves the right to amend this process to include an independent review process established by HHSC for final determination on these disputes.

5.2.12.1 Complaint or Appeal of Provider Claims

The Contractor must develop, implement, and maintain a system for tracking and assisting HHSC and/or DADS to resolve all ICM Provider Complaints and Appeals related to claims payment. Provider Complaints and Appeals related to claims payment should be referred to HHSC's Claims Administrator unless the Complaint or Appeal is related to an Action by the Contractor.

5.2.13 Member Services

The Contractor must maintain a Member Services Department to assist Members and Members' family members or guardians in obtaining ICM Services for Members.

5.2.13.1 Member Services Staffing

The Contractor must maintain employment standards and requirements (e.g., education, training, and experience) for Member Services Department staff and provide a sufficient number of staff for the Member Services Department to meet the requirements of this Section, including Member Hotline response times, and Linguistic Access capabilities. The Contractor must provide training to Member Services staff.

5.2.13.2 Member Materials

Section 5.2.13.2 modified by RFP Addendum 2

The Contractor must design, print and distribute Member identification (ID) cards, an ICM Provider Directory, and a Member Handbook. No later than the fifth business day of the month following the receipt of an Enrollment File from the HHSC Administrative Services Contractor, the Contractor must mail a Member's ID card, Provider Directory, and Member Handbook to each new Member. The Contractor is responsible for mailing materials only to those Members for whom valid address data are contained in the Enrollment File.

Member materials must be at or below a 6th grade reading level as measured by the appropriate score on the Flesch reading ease test. Member materials must be available in English, Spanish, and the languages of other Major Population Groups making up 10% or more of the managed care eligible population in the ICM Service Area, as specified by HHSC. HHSC will provide the Contractor with reasonable notice when the enrolled population reaches 10% within the ICM Service Area. All Member materials must be available in a format accessible to the visually impaired, which may include large print, Braille, and audiotapes.

The Contractor must submit Member materials to HHSC for approval prior to use or mailing. HHSC will identify any required changes to the Member materials within 15 business days. If HHSC has not responded to the Contractor by the fifteenth day, the Contractor may proceed to use the submitted materials. HHSC reserves the right to require discontinuation of any Member materials that violate the **HHSC General Terms and Conditions**, including but not limited to "Marketing Policies and Procedures" as described in the Uniform Managed Care Manual.

5.2.13.3 Member Rights and Responsibilities

The Contractor must maintain written policies and procedures for informing Members of their rights and responsibilities, and must notify their Members of their right to request a copy of these rights and responsibilities. The Member Handbook must include notification of Member rights and responsibilities.

5.2.13.4 Member Identification (ID) Card

All Member ID cards must, at a minimum, include the following information:

1. the Member's name;
2. the Member's Medicaid number;
3. the effective date of the PCP assignment;
4. the PCP's name, address (optional for all products), and telephone number;
5. the name of the Contractor;
6. the 24-hour, seven (7) day a week toll-free Member Services telephone number operated by the Contractor; and
7. any other critical elements identified by HHSC.

The Contractor must reissue the Member ID card if a Member reports a lost card, there is a Member name change, if the Member requests a new PCP, or for any other reason that results in a change to the information disclosed on the ID card.

5.2.13.5 Member Handbook

HHSC must approve the Member Handbook, and any substantive revisions, prior to publication and distribution. The Contractor must develop and submit to HHSC the draft Member Handbook for approval during the Readiness Review and must submit a final Member Handbook incorporating changes required by HHSC prior to the Operational Start Date.

The Member Handbook must, at a minimum, meet the Member materials requirements specified by **RFP Section 5.2.13.2** above and must include critical elements identified by HHSC in the **Uniform Managed Care Manual**. The Contractor must produce a revised Member Handbook, or an insert informing Members of changes to Contractor Managed Services upon HHSC notification of changes to Medicaid services. In addition to modifying the Member materials for new Members, the Contractor must notify all existing Members of the Contractor Managed Services change.

5.2.13.6 Provider Directory

The Provider Directory, and any substantive revisions, must be approved by HHSC prior to publication and distribution. The Contractor is responsible for submitting draft Provider Directory updates to HHSC for prior review and approval if changes other than PCP information or clerical corrections are incorporated into the Provider Directory.

As described in **RFP Section 5.1**, during the Readiness Review, the Contractor must develop and submit to HHSC the draft Provider Directory template for approval and must submit a final Provider Directory incorporating changes required by HHSC prior to the Operational Start Date. Such draft and final Provider Directories must be submitted according to the deadlines established in **RFP Section 5.1**.

The Provider Directory must, at a minimum, meet the Member Materials requirements specified by **RFP Section 5.2.13.2** above and must include critical elements in the **Uniform Managed Care Manual**. The Provider Directory must include only Network

Providers credentialed by the Contractor in accordance with **RFP Section 5.2.4.6.** The Provider Directory must include only Providers that have an active Medicaid Fee-for-Service provider contract with HHSC or DADS, as applicable.

The Contractor must update the Provider Directory on a quarterly basis. The Contractor must make such Provider Directory update available to existing Members on request, and must provide such update to HHSC at the beginning of each state fiscal quarter.

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

5.2.13.7 Internet Website

RFP §5.2.13.7 modified by RFP Addendum No. 1 and Version 1.1.

The Contractor 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 Contractor's ICM Program, its Member Services, and its Complaints and Appeals process. The Contractor may develop a page within its existing website to meet the requirements of this section.

The website's Contractor ICM Program content must be:

1. written in Major Population Group languages (which, at the date of issuance of the RFP, include only English and Spanish);
2. accessible to individuals with disabilities;
3. culturally appropriate;
4. written for understanding at the 6th grade reading level; and
5. be geared to the health needs of the ICM Program population.

The Contractor must maintain a Provider Directory for the ICM Program on its website with designation of open versus closed panels. The Contractor must list Home Health Ancillary providers on their websites, with an indicator for Pediatric services if provided.

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

5.2.13.8 Member Hotline

RFP §5.2.13.8 modified by Version1.1 and Version 1.3.

The Contractor must operate a toll-free hotline that Members can call 24 hours a day, seven (7) days a week. The Member Hotline must be staffed with personnel who are knowledgeable about the ICM Program and Contractor Managed Services, between the

hours of 8:00 a.m. to 5:00 p.m. local time for the ICM Service Area, Monday through Friday, excluding state-approved holidays.

The Contractor must ensure that after hours, on weekends, and on holidays the Member Services Hotline is, at a minimum, answered by an automated system with the capability to provide callers with operating hours and instructions on what to do in cases of emergency. Any recording must be in English and in Spanish, and the language of any Major Population Group. A voice mailbox must be available after hours for callers to leave messages. The Contractor's Member Services representatives must return Member calls received by the automated system on the next Business Day.

If the Member Hotline does not have a voice-activated menu system, the Contractor must have a menu system that will accommodate Members who cannot access the system through other physical means, such as pushing a button.

The Contractor must ensure that its Member Service representatives treat all callers with dignity and respect the callers' need for privacy. At a minimum, the Contractor's Member Service representatives must be:

1. knowledgeable about Contractor Managed Services;
2. able to answer non-technical questions pertaining to the role of the PCP and Service Coordinator;
3. able to answer non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services;
4. able to give information about Providers throughout the ICM Service Area;
5. knowledgeable about Fraud, Abuse, and Waste and the requirements to report any conduct that, if substantiated, may constitute Fraud, Abuse, or Waste in the ICM Program;
6. trained regarding Cultural Competency;
7. able to answer non-clinical questions pertaining to accessing ICM Non-Managed Services; and
8. trained regarding: a) emergency prescription standards and what steps to take to immediately address problems when pharmacies do not provide a 72-hour supply of emergency medicines; and b) DME processes for obtaining services and how to address common problems.

Hotline services must meet Cultural Competency requirements and must appropriately handle calls from non-English speaking callers (from Major Population Groups), as well as calls from individuals who are deaf or hard-of-hearing. To meet these requirements, the Contractor must employ bilingual Member Services representatives or must secure the services of other contractors as necessary.

The Contractor must process all incoming Member correspondence and telephone inquiries in a timely and responsive manner. The Contractor cannot impose maximum call duration limits and must allow calls to be of sufficient length to ensure adequate

information is provided to the Member. The Contractor must ensure that the ICM Member Hotline meets the following minimum performance requirements:

1. 99% of calls are answered by the fourth ring or an automated call pick-up system;
2. no more than one percent (1%) of incoming calls receive a busy signal;
3. at least 80% of calls must be answered by toll-free line staff within 30 seconds;
4. the call abandonment rate is 7% or less; and
5. the average hold time is 2 minutes or less.

The Contractor must conduct ongoing quality assurance to ensure these standards are met. The Contractor must monitor its performance regarding HHSC Member Hotline standards and submit performance reports summarizing call center performance for the Member Hotline as indicated in **RFP Section 5.2.20**

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

5.2.13.9 Member Education

RFP §5.2.13.9 modified by Version 1.1.

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

1. how the ICM Model operates, including the role of the PCP;
2. Contractor Managed Services;
3. the value of screening and preventive care, and
4. how to obtain services, including:

    - Emergency Services;
    - accessing specialty care, including self-referral for behavioral health care;
    - accessing Long Term Services and Supports;
    - accessing Consumer-Directed Services;

5. Service Coordination;
6. Advance directives;
7. Disease Management programs;
8. For Members interested in or applying for LTSS, educating Members about the Medicaid Estate Recovery Program (MERP) using materials reviewed and approved by HHSC; and

9. Obtaining 72 hour supplies of emergency prescriptions from pharmacies enrolled with HHSC as Medicaid providers.

The Contractor must also provide a range of health promotion and wellness information and activities for Members in formats that meet the needs of all Members. The Contractor must propose, implement and assess innovative Member education strategies for health promotion and prevention. The Contractor must conduct wellness promotion programs to improve the health status of its Members. The Contractor must work with Providers to integrate health education, wellness and prevention training into the care of each Member.

The Contractor also must provide condition and disease-specific information and educational materials to Members, including information on its Service Coordination and Disease Management programs**.** Condition- and disease-specific information must be oriented to various groups within the ICM-eligible population, such as the elderly, persons with disabilities and non-English speaking Members.

5.2.13.10 Member Education and Self-referral for Behavioral Health Services

The Contractor must maintain a Member education process to help Members know where and how to obtain Behavioral Health (BH) Services in the Dallas and Tarrant Service Areas, including the role of NorthSTAR in the Dallas Service Area.

The Contractor must permit Members in the Tarrant Service Area to self refer to any Network Behavioral Health Services Provider. The Contractors' policies and procedures, including its Provider Manual, must include written policies and procedures for allowing such self-referral to BH services.

The Contractor must permit Members in the Tarrant Service Area to participate in the selection of the appropriate behavioral health individual Provider(s) who will serve them and must provide the Member with information on accessible in-network Providers with relevant experience.

5.2.13.11 Cultural Competency Plan

RFP §5.2.13.11 modified by RFP Addendum No. 1.

The Contractor must have a comprehensive written Cultural Competency plan describing how the Contractor will ensure culturally competent services and provide Linguistic Access and Disability-related Access. The Cultural Competency plan must describe how the individuals and systems within the Contractor will effectively provide services to people of all cultures, races, ethnic backgrounds and religions, including persons with limited English Proficiency, as well as those with disabilities in a manner that recognizes, values, affirms and respects the worth of the individuals and protects and preserves the dignity of each. The Contractor must submit the Cultural Competency plan to HHSC for Readiness Review. Modifications and amendments to the plan must

be submitted to HHSC no later than 30 days prior to implementation. The plan must also be made available to the ICM Providers.

5.2.13.12 Marketing Activities and Prohibited Practices

The Contractor must not engage in prohibited marketing practices, including but not limited to Federal Medicaid managed care prohibitions for marketing. The Contractor must adhere to the ICM Marketing Policies and Procedures, including for the voluntary ICM eligible population, as set forth by HHSC in the **RFP Uniform Managed Care Manual**.

RFP §5.2.14 modified by RFP Addendum No. 3.

5.2.14 Member Complaint and Appeal Process

The Contractor must develop, implement, and maintain a Member Complaint and Appeal system that complies with the requirements in applicable federal and state laws and regulations, including 42 C.F.R. §431.200 and the provisions of 1 T.A.C. Chapter 357 relating to Medicaid managed care organizations.

The Complaint and Appeal system must include a Complaint process, an Appeal process, and access to HHSC's Fair Hearing System. The procedures must be the same for all Members and must be reviewed and approved in writing by HHSC or its designee. Modifications and amendments to the Member Complaint and Appeal system must be submitted for HHSC's approval at least 30 days prior to the implementation.

The Contractor must notify the HHSC Civil Rights Office (CRO) of a Member's or Provider's Complaint, Appeal, or allegation involving civil rights issues within 10 calendar days of receipt of such Complaint, Appeal, or allegation. The Contractor must provide reasonable assistance, as deemed necessary by the CRO, in the CRO's investigation of such matters. When the Contractor resolves a Complaint, Appeal, or allegation involving a civil rights issue, the Contractor must notify CRO within 10 calendar days of such resolution.

5.2.14.1 Member Complaint Process

The Contractor must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting and resolving Complaints by Members or their authorized representatives. For purposes of this **RFP Section 5.2.14**, an "authorized representative" is any person or entity acting on behalf of the Member and with the Member's written consent. A Provider may be an authorized representative.

The Contractor must resolve Complaints within 30 days from the date the Complaint is received. The Contractor is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints are not resolved within 30 days of receipt of the

Complaint by the Contractor. Please see the HHSC **General Terms & Conditions** and **Attachment B-4** to the **ICM Contract Document, Deliverables/Liquidated Damages Matrix.** The Complaint procedure must be the same for all Members under the Contract. The Member or Member's authorized representative may file a Complaint either orally or in writing. The Contractor must also inform Members how to file a Complaint directly with HHSC, once the Member has exhausted the Contractor's complaint process.

The Contractor must designate an officer of the Contractor who has primary responsibility for ensuring that Complaints are resolved in compliance with written policy and within the required timeframe. For purposes of **RFP Section 5.2.14**, an "officer" of the Contractor means a president, vice president, secretary, treasurer, or chairperson of the board for a corporation, the sole proprietor, the managing general partner of a partnership, or a person having similar executive authority in the organization.

The Contractor must have a routine process to detect patterns of Complaints. Management, supervisory, and Quality Improvement staff must be involved in developing policy and procedure improvements to address the Complaints.

The Contractor's Complaint procedures must be provided to Members in writing and through oral interpretive services. A written description of the Contractor's Complaint procedures must be available in prevalent non-English languages for Major Population Groups identified by HHSC, at no more than a 6th grade reading level.

The Contractor must include a written description of the Complaint process in the Member Handbook. The Contractor must maintain and publish in the Member Handbook, at least one local and one toll-free telephone number with TeleTypewriter/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capabilities for making Complaints.

The Contractor is prohibited from discriminating or taking punitive action against a Member or his or her representative for making a Complaint.

The Contractor will cooperate with the HHSC's Administrative Services Contractor and HHSC or its designee to resolve all Member Complaints. Such cooperation may include, but is not limited to, providing information or assistance to internal Complaint committees.

The Contractor must provide designated Member Advocates to assist Members in understanding and using the Contractor's Complaint system as described in **RFP Section 5.2.14.1**. The Contractor's Member Advocates must assist Members in writing or filing a Complaint and monitoring the Complaint through the Contractor's Complaint process until the issue is resolved.

Section 5.2.14.2 modified by Version 1.3

5.2.14.2 Standard Member Appeal Process

The Contractor must develop, implement and maintain an Appeal procedure that complies with state and federal laws and regulations, including 42 C.F.R.§ 431.200. An Appeal is a disagreement with a Contractor Action as defined in HHSC's **General Terms and Conditions**. The Appeal procedure must be the same for all Members. When a Member or his or her authorized representative expresses orally or in writing any dissatisfaction or disagreement with an Action, the Contractor must regard the expression of dissatisfaction as a request to Appeal an Action.

A Member must file a request for an Appeal with the Contractor within 30 days from receipt of the notice of the Action. The Contractor is subject to remedies, including liquidated damages, if at least 98 percent of Member Appeals are not resolved within 30 days of receipt of the Appeal by the Contractor. Please see the HHSC **General Terms & Conditions** and **Attachment B-4** to the **ICM Contract Document, Deliverables/Liquidated Damages Matrix.** To ensure continuation of currently authorized services, however, the Member must file the Appeal on or before the later of 10 days following the Contractor's mailing of the notice of the Action, or the intended effective date of the proposed Action. The Contractor must designate an officer who has primary responsibility for ensuring that Appeals are resolved in compliance with written policy and within the 30-day time limit.

The provisions of Texas Insurance Code, Title 14, Chapter 4201 relating to a Member's right to Appeal an Adverse Determination made by a Utilization Review Agent do not apply to a Medicaid recipient. Chapter 4201 is pre-empted by federal Fair Hearings requirements.

The Contractor must have policies and procedures in place outlining the Medical Director's role in an Appeal of an Action. The Medical Director must have a significant role in monitoring, investigating and hearing Appeals. The Contractor's policies and procedures must require that individuals who make decisions on Appeals are not involved in any previous level of review or decision-making, and are health care professionals who have the appropriate clinical expertise in treating the Member's condition or disease.

The Contractor must provide designated Member Advocates, as described in **RFP Section 5.2.14.9**, to assist Members in understanding and using the Appeal process. The Contractor's Member Advocates must assist Members in writing or filing an Appeal and monitoring the Appeal through the Contractor's Appeal process until the issue is resolved.

The Contractor must have a routine process to detect patterns of Appeals. Management, supervisory, and Quality Improvement staff must be involved in developing policy and procedure improvements to address the Appeals.

The Contractor's Appeal procedures must be provided to Members in writing and through oral interpretive services. A written description of the Appeal procedures must be available in prevalent non-English languages identified by HHSC, at no more than a 6th grade reading level. The Contractor must include a written description of the Appeals process in the Member Handbook. The Contractor must maintain and publish in the Member Handbook at least one local and one toll-free telephone number with TTY/TDD and interpreter capabilities for requesting an Appeal of an Action.

The Contractor's process must require that every oral Appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless the Member or his or her representative requests an expedited resolution. All Appeals must be recorded in a written record and logged with the following details:

1) date notice is sent;
2) effective date of the Action;
3) date the Member or his or her representative requested the Appeal;
4) date the Appeal was followed up in writing;
5) identification of the individual filing;
6) nature of the Appeal; and
7) disposition of the Appeal, and notice of disposition to Member.

The Contractor must send a letter to the Member within five (5) business days acknowledging receipt of the Appeal request. Except for the resolution of an Expedited Appeal, the Contractor must complete the entire standard Appeal process within 30 calendar days after receipt of the initial written or oral request for Appeal. The timeframe for a standard Appeal may be extended up to 14 calendar days if the Member or his or her representative requests an extension; or the Contractor shows that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, the Contractor must give the Member written notice of the reason for delay if the Member had not requested the delay. The Contractor must designate an officer who has primary responsibility for ensuring that Appeals are resolved within these timeframes and in accordance with the Contractor's written policies.

During the Appeal process, the Contractor must provide the Member a reasonable opportunity to present evidence and any allegations of fact or law in person as well as in writing. The Contractor must inform the Member of the time available for providing this information and that, in the case of an expedited resolution, limited time will be available.

The Contractor must provide the Member and his or her representative opportunity, before and during the Appeal process, to examine the Member's case file, including medical records and any other documents considered during the Appeal process. The Contractor must include, as parties to the Appeal, the Member and his or her representative or the legal representative of a deceased Member's estate.

In accordance with 42 C.F.R.§ 438.420, the Contractor must continue to authorize the Member's benefits currently being received by the Member, including the benefit that is the subject of the Appeal, if all of the following criteria are met:

1. The Member or his or her representative files the Appeal timely as defined in this Contract:
2. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
3. The services were ordered by an authorized provider;
4. The original period covered by the original authorization has not expired; and
5. The Member requests an extension of the benefits.

If, at the Member's request, the Contractor continues to authorize or reinstates authorization of the Member's benefits while the Appeal is pending, the benefits authorization must be continued until one of the following occurs:

1. The Member withdraws the Appeal;
2. Ten (10) days pass after the Contractor mails the notice resolving the Appeal against the Member, unless the Member, within the 10-day timeframe, has requested a Fair Hearing with continuation of benefits until a Fair Hearing decision can be reached; or
3. A state Fair Hearing officer issues a hearing decision adverse to the Member or the time period or service limits of a previously authorized service has been met.

If the Contractor or State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Contractor must authorize the disputed services promptly and as expeditiously as the Member's health condition requires.

The Contractor is prohibited from discriminating or taking punitive action against a Member or his or her representative for making an Appeal.

5.2.14.3 Expedited Contractor Appeals

The Contractor must establish and maintain an expedited review process for Appeals, when the Contractor determines (for a request from a Member) or the Provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life or health. The Contractor must follow all Appeal requirements for standard Member Appeals, except where differences are specifically noted. The Contractor must accept oral or written requests for Expedited Appeals.

Members must exhaust the Contractor's Expedited Appeal process before making a request for an expedited Fair Hearing. After the Contractor receives the request for an Expedited Appeal, it must hear an approved request for a Member to have an Expedited Appeal and notify the Member of the outcome of the Expedited Appeal within 3 business

days, except that the Contractor must complete investigation and resolution of an Appeal relating to an ongoing emergency or denial of continued hospitalization: (1) in accordance with the medical or dental immediacy of the case; and (2) not later than one (1) business day after receiving the Member's request for Expedited Appeal.

Except for an Appeal relating to an ongoing emergency or denial of continued hospitalization, the timeframe for notifying the Member of the outcome of the Expedited Appeal may be extended up to 14 calendar days if the Member requests an extension or the Contractor shows (to the satisfaction of HHSC, upon HHSC's request) that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, the Contractor must give the Member written notice of the reason for delay if the Member had not requested the delay.

If the decision is adverse to the Member, the Contractor must follow the procedures relating to the notice in **RFP Section 5.2.14.5**. The Contractor is responsible for notifying the Member of his or her right to access an expedited Fair Hearing from HHSC. The Contractor will be responsible for providing documentation to the State and the Member, indicating how the decision was made, prior to HHSC's expedited Fair Hearing.

The Contractor is prohibited from discriminating or taking punitive action against a Member or his or her representative for requesting an Expedited Appeal. The Contractor must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a Member's request.

If the Contractor denies a request for expedited resolution of an Appeal, it must:

(1) Transfer the Appeal to the timeframe for standard resolution, and
(2) Make a reasonable effort to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

RFP §5.2.14.4 modified by Version 1.1.

5.2.14.4 Access to Fair Hearing

The Contractor must inform Members that they have the right to access the Fair Hearing process at any time during the Appeal system provided by the Contractor. In the case of an expedited Fair Hearing process, the Contractor must inform the Member that he or she must first exhaust the Contractor's internal Expedited Appeal process prior to filing an Expedited Fair Hearing. The Contractor must notify Members that they may be represented by an authorized representative in the Fair Hearing process.

If a Member requests a Fair Hearing, the Contractor will assist the Member in the completion of the request for Fair Hearing, and will submit the form electronically to the appropriate Fair Hearings office, within eight calendar days of the Member's request.

Upon notification that the Fair Hearing is set, the Contractor will prepare an evidence packet for submission to the HHSC Fair Hearings staff and send a copy of the packet to the Member, in accordance with HHSC Fair Hearings requirements.

5.2.14.5 Notices of Action and Disposition of Appeals

RFP §5.2.14.5 modified by RFP Addendum No. 3 and Version 1.1.

The Contractor must notify the Member, in accordance with 1 T.A.C. Chapter 357, whenever the Contractor takes an Action. The notice must, at a minimum, include any information required by 1 T.A.C. Chapter 357 that relates to a managed care organization's notice of Action and any information required by 42 C.F.R. §438.404 as directed by HHSC, including but not limited to:

1. the dates, types and amount of service requested;
2. the Action the Contractor has taken or intends to take;
3. the reasons for the Action (If the Action taken is based upon a determination that the requested service is not medically necessary, the Contractor must provide an explanation of the medical basis for the decision, application of policy or accepted standards of medical practice to the individual's medical circumstances);
4. the Member's right to access the Contractor's Appeal process.
5. the procedures by which the Member may Appeal the Contractor's Action;
6. the circumstances under which expedited resolution is available and how to request it;
7. the circumstances under which a Member may continue to receive benefits pending resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services;
8. the date the Action will be taken;
9. a reference to the Contractor policies and procedures supporting the Contractor's Action;
10. an address where written requests may be sent and a toll-free number that the Member can call to request the assistance of a Member representative, file an Appeal, or request a Fair Hearing;
11. an explanation that Members may represent themselves, or be represented by a provider, a friend, a relative, legal counsel or another spokesperson;
12. a statement that if the Member wants a Fair Hearing on the Action, the Member must make the request for a Fair Hearing within 90 days of the date on the notice or the right to request a hearing is waived;
13. a statement explaining that the Contractor must make its decision within 30 days from the date the Appeal is received by the Contractor, or 3 business days in the case of an Expedited Appeal;
14. a statement explaining that the hearing officer must make a final decision within 90 days from the date a Fair Hearing is requested; and
15. a statement explaining that a Member who believes that he or she was subjected to illegal discrimination can file a complaint with one or more of the following:

    HHSC Civil Rights Office, 701 West 51st Street, MC W206, Austin, Texas 78751, Phone: (888) 338-6332, TDD: (877) 432-7232.

U.S. Department of Health and Human Services, Office of Civil Rights, 1301 Young Street #1169, Dallas, Texas 75202.

5.2.14.6 Timeframe for Notice of Action

The Contractor must mail a notice of Action within the following timeframes:

1. for termination, suspension, or reduction of previously authorized Contractor Managed Services, within the timeframes specified in 42 C.F.R.§§ 431.211, 431.213, and 431.214;
2. for standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R.§ 438.210(d)(1);
3. if the Contractor extends the timeframe in accordance with 42 C.F.R. §438.210(d)(1), it must:
    a. give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file an Appeal if he or she disagrees with that decision; and
    b. issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires;
4. for service authorization decisions not reached within the timeframes specified in 42 C.F.R.§ 438.210(d) (which constitutes a denial and is thus an adverse Action), on the date that the timeframes expire; and
5. for expedited service authorization decisions, within the timeframes specified in 42 C.F.R. 438.210(d).

5.2.14.7 Notice of Disposition of Appeal

The Contractor must provide written notice of disposition of all Appeals including Expedited Appeals. The written resolution notice must include the results and date of the Appeal resolution. For decisions not wholly in the Member's favor, the notice must contain:

1. the right to request a Fair Hearing;
2. how to request a Fair Hearing;
3. the circumstances under which the Member may continue to receive benefits pending a Fair Hearing;
4. how to request the continuation of benefits;
5. if the Contractor's Action is upheld in a Fair Hearing, the Member may be liable for the cost of any services furnished to the Member while the Appeal is pending; and
6. any other information required by 1 T.A.C. Chapter 357 that relates to a managed care organization's notice of disposition of an Appeal.

5.2.14.8 Timeframe for Notice of Resolution of Appeals

The Contractor must provide written notice of resolution of Appeals, including Expedited Appeals, as expeditiously as the Member's health condition requires, but the notice must not exceed the timelines as provided in this section for Standard or Expedited Appeals. For expedited resolution of Appeals, the Contractor must make reasonable efforts to give the Member prompt oral notice of resolution of the Appeal, and follow up with a written notice within the timeframes set forth in this section for Expedited Appeals. If the Contractor denies a request for expedited resolution of an Appeal, the Contractor must transfer the Appeal to the timeframe for standard resolution as provided in this section, and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two calendar days with a written notice.

5.2.14.9 Member Advocates

The Contractor must provide Member Advocates to assist Members. Member Advocates must be physically located within the ICM Service Area unless an exception is approved by HHSC. Member Advocates must inform Members of the following:

- their rights and responsibilities, including Fair Hearings as described in **RFP Section 5.2.14.4**,
- the Complaint process,
- the Appeal process,
- Contractor Managed Services available to them, including preventive services, and
- ICM Non-Managed Services available to them.

Member Advocates must assist Members in writing Complaints and are responsible for monitoring the Complaint through the Contractor's Complaint process.

Informed by the input of Members, Member Advocates are responsible for making recommendations to the Contractor regarding any changes needed to improve the Contractor's provision of Services.

5.2.15 Quality Improvement

The Contractor must arrange for the delivery of quality services and supports with the primary goal of improving the health status of Members. Where the Member's condition is not amenable to improvement, the Contractor must arrange for service and support delivery that will maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status.

The Contractor must have a Quality Improvement (QI) Program for: a) measuring the Contractor's performance of its contractual responsibilities, b) identifying opportunities for improving performance, c) developing and implementing action steps to improve

performance, and d) measuring whether the targeted improvements have been achieved.

Should the Contractor identify opportunities for improvement affecting the well being of Members and/or the integrity of the ICM or Medicaid program, and that fall under the responsibility of HHSC, its authorized agents, DADS or another state agency, the Contractor shall inform HHSC. Such action shall *minimally* include sharing Provider performance data with HHSC, and its authorized agents, related to Credentialing and re-credentialing, including, but not limited to, Member Complaints and Appeals, quality of care observations, and Utilization Review patterns.

5.2.15.1 Quality Improvement (QI) Program

The Contractor must have on file with HHSC an approved plan describing its QI Program, including how the Contractor will accomplish the activities required by this section. The Contractor must submit a QI Program annual summary in a format and timeframe specified by HHSC or its designee.

The Contractor must keep Network Providers informed about the QI Program and related activities. The Contractor must include in Provider contracts a requirement securing cooperation with the QI Program.

The Contractor must approach all clinical and non-clinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement (CQI)/Total Quality Management (TQM) and must:

1. Evaluate Provider and Contractor performance using objective quality indicators;
2. Foster data-driven decision-making;
3. Recognize that opportunities for improvement are unlimited;
4. Solicit Member and Provider input on performance and QI activities;
5. Support continuous ongoing measurement of clinical and non-clinical effectiveness and Member satisfaction;
6. Support programmatic improvements of clinical and non-clinical processes based on findings from on-going measurements; and
7. Support re-measurement of effectiveness and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

5.2.15.2 QI Program Structure

The Contractor must maintain a well-defined QI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. The Contractor must designate a senior executive responsible for the QI Program and the Medical Director must have substantial involvement in QI Program activities. At a minimum, the Contractor must ensure that the QI Program structure:

1. Is organization-wide, with clear lines of accountability within the organization;
2. Includes a set of functions, roles, and responsibilities for the oversight of QI activities that are clearly defined and assigned to appropriate individuals, including physicians, other clinicians, and non-clinicians;
3. Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and
4. Evaluates the effectiveness of clinical and non-clinical initiatives.

5.2.15.3 Quality Indicators

The Contractor must engage in the collection of quality indicator data. Quality indicators are defined to include statistical measures of clinical and non-clinical quality of Contractor Managed Services, and their impact on the health status and well being of Members. The Contractor must use such quality indicator data in the development, assessment, and modification of its QI Program.

5.2.15.4 QI Program Subcontracting

If the Contractor subcontracts any of the essential functions or reporting requirements contained within the QI Program to another entity, the Contractor must maintain a file of the subcontractors and annually assess their performance. The file must be available for review by HHSC or its designee upon request.

5.2.15.5 Behavioral Health Integration into QI Program

The Contractor must integrate behavioral health into its QI Program and include a systematic and on-going process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members in the Tarrant Service Area. The Contractor must collect, data, and monitor and evaluate the data for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.

5.2.15.6 Clinical Practice Guidelines

The Contractor must adopt not less than two evidence-based clinical practice guidelines. Such practice guidelines must be based on valid and reliable clinical evidence, consider the needs of the Contractor's Members, be adopted in consultation with health care professionals, and be reviewed and updated periodically, as appropriate. The Contractor must develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QI Program. The Contractor must inform the Claims Administrator of any pending clinical practice guidelines that could have implications for claim adjudication processes.

The Contractor may coordinate the development of clinical practice guidelines with HHSC and other HHSC managed care contractors to avoid providers in the ICM Service Area receiving conflicting practice guidelines from different contractors.

The Contractor must disseminate the practice guidelines to all affected Providers and, upon request, to Members and potential Members.

The Contractor must take steps to encourage adoption of the guidelines, and to measure compliance with the guidelines. The Contractor's decisions regarding Utilization Management, Member education, and other areas included in the practice guidelines must be consistent with the Contractor's clinical practice guidelines.

5.2.15.7 Provider Profiling

The Contractor must conduct PCP and other Provider, including LTSS Provider, profiling activities at least annually. As part of its QI Program, the Contractor must describe the methodology it uses to identify which and how many Providers to profile and to identify measures to use for profiling such Providers.

Provider profiling activities must include, but not be limited to:

1. Developing PCP and Provider-specific reports that include a multi-dimensional assessment of a PCP or Provider's performance using clinical, administrative, and Member satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;
2. Establishing PCP, Provider, group, ICM Service Area or regional Benchmarks for areas profiled, where applicable; and
3. Providing feedback to individual PCPs and Providers regarding the results of their performance and the overall performance of the Provider Network.

5.2.15.8 Network Management

The Contractor must:

1. Use the results of its Provider profiling activities to identify areas of improvement for individual PCPs and Providers, and/or groups of Providers;
2. Establish Provider-specific QI goals for priority areas in which a Provider or Providers do not meet established Contractor standards or QI goals;
3. At least annually, measure and report to HHSC on the Provider Network and individual Providers' progress, or lack of progress, toward such QI goals.

5.2.15.9 Collaboration with the EQRO

The Contractor will collaborate with HHSC's external quality review organization (EQRO) to develop studies, surveys, or other analytical approaches that will be carried out by the

EQRO. The purpose of the studies, surveys, or other analytical approaches is to assess the quality of care and service provided to Members and to identify opportunities for Contractor improvement. The Contractor must work collaboratively with HHSC and the EQRO to annually measure selected HEDIS measures that require chart reviews.

5.2.16 Utilization Management

The Contractor must have a written Utilization Management (UM) program description, which includes, at a minimum:

1. procedures to evaluate the need for Medically Necessary Contractor Managed Services;
2. the clinical review criteria used, the information sources, the process used to review and approve the provision of Contractor Managed Services;
3. the method for periodically reviewing and amending the UM clinical and non-clinical review criteria; and
4. the staff position functionally responsible for the day-to-day management of the UM function.

The Contractor must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate in making UM determinations.

The Contractor must issue Utilization Review determinations, including adverse determinations, according to the following timelines:

- within three (3) business days after receipt of the request for authorization of services;
- within one (1) business day for concurrent hospitalization decisions; and
- within one (1) hour for post-stabilization or life-threatening conditions, except that for Emergency Medical Conditions and Emergency Behavioral Health Conditions, the Contractor must not require prior authorization.

The Contractor's UM Program must include written policies and procedures to ensure:

1. consistent application of review criteria that are compatible with Members' needs and situations;
2. determinations to deny or limit services are made by physicians under the direction of the Medical Director;
3. appropriate personnel are available to respond to Utilization Review inquiries 8:00 a.m. to 5:00 p.m., Monday through Friday, with after-hours coverage consisting at a minimum of a telephone system capable of accepting Utilization Review inquiries. The Contractor must respond to calls within one business day;
4. confidentiality of clinical information; and

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

The Contractor must have qualified medical professionals supervise preauthorization and concurrent review decisions.

The Contractor UM Program must also include polices and procedures to:

1. routinely assess the effectiveness and the efficiency of the UM Program;
2. evaluate the appropriate use of medical technologies, including medical procedures, drugs and devices;
3. target areas of suspected inappropriate service utilization;
4. detect over- and under-utilization;
5. routinely generate Provider profiles regarding utilization patterns and compliance with Utilization Review criteria and policies;
6. compare Member and Provider utilization with norms for comparable individuals;
7. routinely monitor inpatient admissions, emergency room use, ancillary, and out-of-area services; and
8. refer suspected cases of provider or Member Fraud, Abuse, or Waste to the Office of Inspector General (OIG).

5.2.17 Medicaid Requirements for Certain Services

5.2.17.1 Emergency Services

Contractor policy and procedures for Emergency Services must comply with all applicable state and federal laws, rules, and regulations including 42 C.F.R. §438.114. Contractor policies and procedures must be consistent with the prudent layperson definition of an Emergency Medical Condition required under the Contract and 42 C.F.R. §438.114.

The Contractor cannot require prior authorization for an Emergency Medical Condition, an Emergency Behavioral Health Condition, or labor and delivery. The Contractor cannot limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. The Contractor cannot refuse to authorize Emergency Services based on the emergency room provider, Hospital, or fiscal agent not notifying the Member's PCP or the Contractor of the Member's screening and treatment within 10 calendar days of presentation for Emergency Services. The Contractor must accept the emergency physician or provider's determination of when the Member is sufficiently stabilized for transfer or discharge.

The Contractor cannot refuse to authorize the professional, facility, and ancillary services that are Medically Necessary to perform the medical screening examination and stabilization of a Member presenting as an Emergency Medical Condition or an Emergency Behavioral Health Condition to the Hospital emergency department, 24 hours a day, 7 days a week, rendered by providers either within or outside the ICM Service Area.

A medical screening examination needed to diagnose an Emergency Medical Condition must be provided in a Hospital-based emergency department that meets the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 C.F.R. §§489.20, 489.24 and 438.114(b)&(c)). The Contractor cannot refuse to authorize the emergency medical screening examination, as required by 42 U.S.C. §1395dd. The Contractor cannot refuse to authorize the physician's services or the Hospital's Emergency Services, including the emergency room and its ancillary services.

When the medical screening examination determines that an Emergency Medical Condition exists, the Contractor cannot refuse to authorize Emergency Services performed to stabilize the Member. The Contractor cannot refuse to authorize the physician's or Hospital's emergency stabilization services, including the emergency room and its ancillary services.

The Contractor cannot refuse to authorize Post-Stabilization Care Services in the amount, duration, and scope necessary to comply with 42 C.F.R. §438.114(b)&(e) and 42 C.F.R. §422.113(c)(iii). Post-stabilization care services obtained within or outside the Network that are not pre-approved by a Provider or other Contractor representative, but administered to maintain, improve, or resolve the Member's stabilized condition are automatically deemed authorized if:

1. the Contractor does not respond to a request for pre-approval within 1 hour;
2. the Contractor cannot be contacted; or
3. the Contractor representative and the treating physician cannot reach an agreement concerning the Member's care and a Network physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a Network physician and the treating physician may continue with care of the patient until a Network physician is reached.

Section 5.2.17.2 modified by Version 1.1 and 1.3.

5.2.17.2 Texas Health Steps (EPSDT)

The Contractor must arrange for THSteps services for all eligible Members except when a Member knowingly and voluntarily declines or refuses services after receiving sufficient information to make an informed decision.

The Contractor must ensure that Members are provided information and educational materials about the services available through the THSteps Program, and how and when they may obtain the services. The Contractor must provide outreach to Members to ensure they are effectively informed about available THSteps services.

Each month, the Contractor must retrieve from the HHSC Administrative Services Contractor Bulletin Board System a list of Members who are due and overdue for THSteps services. Using these lists, the Contractor will contact such Members or their family members or guardians, and urge them to obtain the services as soon as possible. The Contractor outreach staff must coordinate with DSHS THSteps outreach staff to

ensure that Members have access to the Medical Transportation Program, and that any coordination with other agencies is maintained.

The Contractor will encourage Medicaid-enrolled pharmacies to also become Medicaid-enrolled durable medical equipment (DME) providers.

5.2.17.2.1 Oral Evaluation and Fluoride Varnish

The ICM Contractor must educate Providers on the availability of the Oral Evaluation and Fluoride Varnish (OEVS) Medicaid benefit that can be rendered and billed by certified THSteps providers when performed on the same day as the THSteps medical check up. The Provider education must include information about how to assist a Member with referral to a dentist to establish a dental home.

5.2.17.3 Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV)

The Contractor is responsible for implementing procedures to ensure that Members have prompt access to appropriate services for STDs, including HIV. The Contractor must allow Members access to STD services and HIV diagnosis services without prior authorization or referral by a PCP.

The Contractor must comply with Texas Family Code Section 32.003, relating to consent to treatment by a child. The Contractor must make education available to Providers and Members on the prevention, detection and effective treatment of STDs, including HIV.

The Contractor must coordinate with the HHSC regional health authority to ensure that Members with confirmed cases of syphilis, chancroid, gonorrhea, chlamydia and HIV receive risk reduction and partner elicitation/notification counseling.

5.2.17.4 Early Childhood Intervention (ECI)

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

The Contractor 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 ICM Non-Managed Services required by the Member's IFSP.

Cooperation with the ECI program includes authorizing medical diagnostic procedures 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 Contractor must not withhold authorization for the provision of such medical diagnostic procedures.

The Contractor cannot modify the plan of care or alter the amount, duration, scope, or service setting required by the Member's IFSP. The Contractor 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.

5.2.17.5 Tuberculosis (TB)

The Contractor must provide Members and Providers with education on the prevention, detection and effective treatment of tuberculosis (TB). The Contractor must establish mechanisms to ensure all procedures required to screen at-risk Members and to form the basis for a diagnosis and proper prophylaxis and management of TB are available to all Members, except services referenced in **RFP Section 5.2.2.5** as ICM Non-Managed Services.

The Contractor must develop policies and procedures to refer Members who may be, or are at risk for, exposure to TB for TB screening. An at-risk Member means a person who is susceptible to TB because of the association with certain risk factors, behaviors, drug resistance, or environmental conditions. The Contractor must coordinate with the local TB control program. The Contractor must cooperate with the local TB control program in enforcing the control measures and quarantine procedures contained in Chapter 81 of the Texas Health and Safety Code.

The Contractor must have a mechanism for coordinating a post-discharge plan for follow-up Direct Observation Therapy (DOT) with the local TB program. The Contractor must coordinate with the DSHS South Texas Hospital and Texas Center for Infectious Disease for voluntary and court-ordered admission, discharge plans, treatment objectives and projected length of stay for Members with multi-drug resistant TB.

5.2.18 Management Information System (MIS) Requirements

The Contractor must maintain a Management Information System (MIS) that supports all functions of the Contractor's processes and procedures for the flow and use of data. The Contractor must have hardware, software, and a network and communications system with the capability and capacity to handle and operate all MIS subsystems for the following operational and administrative areas:

1. Enrollment Subsystem;
2. Provider Subsystem;

3. Care Management (including Utilization Review, Disease Management and Service Coordination functions) Subsystem;
4. Reporting Subsystem; and
5. Interface Subsystem.

The MIS must enable the Contractor to meet the Contract requirements, including all applicable state and federal laws, rules, and regulations. The MIS must have the capacity and capability to capture and utilize various data elements required for Contractor administration.

The Contractor must have a system that can be adapted to changes in Business Practices/Policies within the timeframes negotiated by the Parties. The Contractor is expected to cover the cost of such systems modifications over the life of the Contract.

5.2.18.1 MIS Enhancements for ICM Program Interfaces

HHSC will implement a web-based real-time prior authorization application so that the Contractor may enter prior authorization information directly into a system that will be matched to in-coming claims for claim payment purposes. This functionality will be created for both the service authorization system used by HHSC for Acute Care and for the service authorization system used by DADS for Long Term Services and Supports.

HHSC will provide the Contractor access to existing on-line look up capability for eligibility, claim status information and new functionality for claim history data for ICM Members.

HHSC will provide the Contractor with ICM Member claim data on a weekly basis in the following fashion:

- pharmacy data through HHSC's pharmacy claims and rebate administration contractor, and
- all other Acute Care and Long Term Services and Supports data through HHSC's Claims Administrator.

HHSC will create a Systems Work Group for the ICM Program. The Contractor will be invited to regular Work Group meetings, including during the Transition Phase and Operations Phase.

5.2.18.2 Changes in Contractor Systems or MIS Operations

The Contractor must provide HHSC prior written notice of major systems changes, generally within 90 days, and implementations, including any changes relating to Material Subcontractors, in accordance with the requirements of this Contract and the HHSC **General Terms and Conditions.**

The Contractor must provide HHSC any updates to the Contractor's organizational chart relating to MIS and the description of MIS responsibilities at least 30 days prior to the effective date of the change. The Contractor must provide HHSC official points of contact for MIS issues on an on-going basis.

HHSC, or its agent, may conduct a Systems Readiness Review to validate the Contractor's ability to meet the MIS requirements as described in **RFP Section 5.1** of the RFP. The System Readiness Review will include a desk review and/or an onsite review.

If for any reason, the Contractor does not fully meet the MIS requirements, then the Contractor must, upon request by HHSC, either correct such deficiency or submit to HHSC a Corrective Action Plan and Risk Mitigation Plan to address such deficiency as requested by HHSC. Immediately upon identifying a deficiency, HHSC may impose remedies and either actual or liquidated damages according to the severity of the deficiency. Refer to the HHSC **General Terms and Conditions** and **Attachment B-4** to the **ICM Contract Document, Deliverables/Liquidated Damages Matrix** for additional information. **Refer to Attachment B-1, Section 5.1.9 f**or additional information regarding HMO Readiness Reviews. Refer to **Attachment A, Section 4.08(c)** for information regarding Readiness Reviews of the HMO's Material Subcontractors.

RFP §5.2.18.2 modified by Version 1.1

At the beginning of each state fiscal year, the Contractor must submit for HHSC's review and approval any modifications to the following documents:

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

The Contractor must submit such modifications to HHSC according to the format and schedule identified the **Uniform Managed Care Manual**.

5.2.18.3 System-wide Functions

The Contractor's MIS system must include key business processing functions and/or features, which must apply across all subsystems as follows:

1. Process electronic data transmission or media to add, delete or modify Membership records with accurate begin and end dates;
2. Maintain a history of changes and adjustments and audit trails for current and retroactive data;
3. Maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure;
4. Relate and extract data elements to produce report formats (provided within the **Uniform Managed Care Manual**) or otherwise required by HHSC;

5. Ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS;
6. Maintain and cross-reference all Member-related information with the most current Medicaid provider number; and
7. Ensure that the MIS is able to integrate pharmacy data from HHSC's Drug Vendor file (available through the Virtual Private Network (VPN)) into the Contractor's Member data as well as other health care and Long Term Services and Supports claims data from DADS and from HHSC's Claims Administrator.

5.2.18.4 Health Insurance Portability and Accountability Act (HIPAA) Compliance

The Contractor's MIS system must comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, P.L. 104-191 (August 21, 1996), as amended or modified. The Contractor must comply with HIPAA EDI requirements. Contractor's enrollment files must be in the 834 HIPAA-compliant format. Eligibility inquiries must be in the 270/271 format.

The Contractor must provide its Members with a privacy notice as required by HIPAA. The Contractor must provide HHSC with a copy of its privacy notice for filing.

5.2.19 Fraud and Abuse

The Contractor is subject to all state and federal laws and regulations relating to Fraud, Abuse, and Waste in health care and Medicaid. The Contractor must cooperate and assist HHSC, DADS and any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected Fraud, Abuse or Waste. The Contractor 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 (CMS), the U.S. Department of Health and Human Services (DHHS), Federal Bureau of Investigation, TDI, or other units of state government. The Contractor must provide all copies of records free of charge.

The Contractor must submit a written Fraud and Abuse compliance plan to the Office of Inspector General at HHSC for approval (See **RFP Section 5.1** for requirements regarding timeframes for submitting the original plan.) The plan must ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's Fraud and Abuse compliance plan. The plan must include the name, address, telephone number, electronic mail address, and fax number of the individual(s) responsible for carrying out the plan.

The written Fraud and Abuse compliance plan must:

1. Contain procedures designed to prevent and detect potential or suspected Abuse, Fraud and Waste in the administration and delivery of services under the Contract;
2. Contain a description of the Contractor's procedures for educating and training personnel to prevent Fraud, Abuse, or Waste;
3. Include provisions for the confidential reporting of plan violations to the designated person within the Contractor's organization and ensure that the identity of an individual reporting violations is protected from retaliation;
4. Include provisions for maintaining the confidentiality of any patient information relevant to an investigation of Fraud, Abuse, or Waste;
5. Provide for the investigation and follow-up of any allegations of Fraud, Abuse, or Waste and contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating Fraud and Abuse compliance plan violations;
6. Require that confirmed violations be reported to the Office of Inspector General (OIG); and
7. Require any confirmed violations or confirmed or suspected Fraud, Abuse, or Waste under state or federal law be reported to OIG.

If the Contractor contracts for the investigation of allegations of Fraud, Abuse, or Waste and other types of program abuse by Members or Providers, the plan must include a copy of the subcontract; the names, addresses, telephone numbers, electronic mail addresses, and fax numbers of the principals of the subcontracted entity; and a description of the qualifications of the subcontracted entity. Such subcontractors must be held to the requirements stated in this Section.

The Contractor must designate executive and essential personnel to attend mandatory training in Fraud and Abuse detection, prevention and reporting. Designated executive and essential personnel means the Contractor staff persons who supervise staff in the following areas: Utilization Review, Appeals or Grievances, and Quality Improvement, and who are directly involved in the decision-making and administration of the Fraud and Abuse detection program within the Contractor. The training will be conducted by the OIG free of charge. The Contractor must schedule and complete training no later than 90 days after the Effective Date of the Contract. If the Contractor updates or modifies its written Fraud and Abuse compliance plan, the Contractor must train its executive and essential personnel on these updates or modifications no later than 90 days after the

The Contractor must designate an officer or director in its organization with responsibility and authority to carry out the provisions of the Fraud and Abuse compliance plan. The Contractor's failure to report potential or suspected Fraud, Abuse or Waste may result in sanctions, cancellation of the Contract, and/or exclusion from participation in the ICM Program. The Contractor must allow the OIG, HHSC, its agents, or other governmental units to conduct private interviews of the Contractor's personnel, subcontractors and their personnel, witnesses, and patients with regard to a confirmed violation. The Contractor's personnel and it subcontractors must cooperate fully by being available in person for interviews, consultation, grand jury proceedings, pre-trial conferences,

hearings, trials and in any other process, including investigations, at the Contractor's and subcontractors' own expense.

RFP §5.2.19 modified by Version 1.1

In accordance with Section 1902(a)(68) of the Social Security Act, the ICM Contractor must also:

1. Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the ICM Contractor, that provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
2. Include as part of such written policies, detailed provisions regarding the ICM Contractor's policies and procedures for detecting and preventing fraud, waste, and abuse.
3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the ICM Contractor's policies and procedures for detecting and preventing fraud, waste, and abuse.

Section 5.2.20 modified by Versions 1.1 and 1.3

5.2.20 Reporting Requirements

The Contractor must provide and must require its subcontractors to provide:

1. All information required under the Contract, including but not limited to, the reporting requirements or other information related to the performance of its responsibilities hereunder as reasonably requested by the HHSC; and

2. Any information in its possession sufficient to permit HHSC to comply with the Federal Balanced Budget Act of 1997 or other Federal or state laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats and instructions as specified by HHSC. Where practicable, HHSC may consult with Contractors to establish time frames and formats reasonably acceptable to both parties.

The Contractor's Chief Executive and Chief Financial Officers, or persons in equivalent positions, must certify that financial data and other measurement data has been reviewed by the Contractor and are true and accurate to the best of their knowledge after reasonable inquiry.

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 the following reports, at a minimum:

Affiliate Report – The Contractor must submit an Affiliate Report to HHSC if this information has changed since the last report submission. The report must contain the following:

1. A list of all Affiliates, and
2. For HHSC's prior review and approval, a schedule of all transactions with Affiliates that, under the provisions of the Contract, will be allowable as expenses in the FSR Report for services provided to the Contractor 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 Contractor for such services during the Contract Period.

Audit Reports – The MCO must comply with the Uniform Managed Care Manual's requirements regarding notification and/or submission of audit reports.

Audited Financial Statement –The Contractor must provide the annual audited financial statement, for each year covered under the Contract, no later than June 30. The Contractor must provide the most recent annual financial statements, no later than March 1.

Form CMS-1513 - The Contractor must file an original Form CMS-1513 prior to beginning operations regarding the Contractor'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.

FSR Reports – The Contractor must file quarterly and annual ICM Financial-Statistical Reports (FSR) in the format and timeframe specified by HHSC. HHSC will include FSR format and directions in the **Uniform Managed Care Manual**. Expenses reported in the FSRs must be reported in accordance with the Cost Principles Document in the **Uniform Managed Care Manual**. Quarterly FSR reports are due no later than 30 days after the end of the quarter and must provide information for the current quarter and year-to-date information through the current quarter. The first annual FSR report must reflect expenses incurred through the 90th day after the end of the fiscal year. The first annual report must be filed on or before the 120th day after the end of each fiscal year 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 fiscal year and must be filed on or before the 365th day following the end of each fiscal year.

HHSC will post all FSRs on the HHSC website.

HUB Reports – HHSC will employ "Best Practices" HUB reporting procedures, whereby HHSC will monitor the Contractor's HUB outreach efforts and the inclusion of HUBs and minority-owned businesses through its Client Services HUB Subcontracting guidelines. Upon contract award, the Contractor must attend a post-award meeting in Austin, Texas, at a time specified by HHSC, to discuss the development and submission of a Client Services HUB Subcontracting Plan for inclusion and the Contractor's good faith efforts to notify HUBs of subcontracting opportunities. The Contractor must maintain its HUB

Subcontracting Plan and submit monthly reports documenting the Contractor's Historically Underutilized Business (HUB) program efforts and accomplishments to the HHSC HUB Office. The report must include a narrative description of the Contractor's program efforts and a financial report reflecting payments made to HUBs. Contractors must use the formats included in HHSC's **Uniform Managed Care Manual** for the HUB monthly reports. The Contractor must comply with HHSC's standard Client Services HUB Subcontracting Plan requirements for all subcontractors.

Section 1318 Financial Disclosure Report - The Contractor 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 the end of each Contract Year and no later than 30 days after entering into, renewing, or terminating a relationship with an affiliated party.

Fraudulent Practices Report - Utilizing the HHSC-Office of Inspector General (OIG) Fraud referral form, the Contractor's assigned officer or director must report and refer all possible acts of Waste, Abuse or Fraud to the HHSC-OIG within 30 working days of receiving the reports of possible acts of Waste, Abuse or Fraud from the Contractor's Special Investigative Unit (SIU). The report and referral must include: an investigative report identifying the allegation, statutes/regulations violated or considered, and the results of the investigation; copies of program rules and regulations violated for the time period in question; the estimated overpayment identified; a summary of the interviews conducted; and all supporting documentation obtained as the result of the investigation. This requirement applies to all reports of possible acts of Waste, Abuse and Fraud.

Additional reports required by the Office of the Inspector General relating to Waste, Abuse or Fraud are listed in the **Uniform Managed Care Manual**.

QI Program Annual Summary Report - The Contractor must submit a QI Program Annual Summary in a format and timeframe as specified in the **Uniform Managed Care Manual**.

Summary Report of Member Complaints and Appeals - The Contractor must submit quarterly Member Complaints and Appeals reports. The Contractor must include in its reports Complaints and Appeals submitted to the Contractor and any subcontractor that provides Member services. The Contractor must submit the Complaint and Appeals reports electronically on or before 45 days following the end of the state fiscal quarter, using the format specified by HHSC in the **Uniform Managed Care Manual**.

Summary Report of Provider Complaints - The Contractor must submit Provider complaints reports on a quarterly basis. The Contractor must include in its reports complaints submitted by providers to the Contractor and any subcontractor that provides Provider services. The complaint reports must be submitted electronically on or before 45 days following the end of the state fiscal quarter, using the format specified by HHSC in the **Uniform Managed Care Manual**.

Hotline Reports - The Contractor must submit, on a quarterly basis, a status report for the Member hotline and the Provider hotline in comparison with the performance standards set out in **RFP Sections 5.2.13.8 and 5.2.11.2,** respectively. The Contractor shall submit such reports using a format to be prescribed by HHSC in consultation with the Contractor.

If the Contractor is not meeting a hotline performance standard, HHSC may require the Contractor to submit monthly hotline performance reports and implement corrective actions until the hotline performance standards are met.

RFP §5.2.20 modified by Version 1.1.

Medicaid Medical Check-ups Report – The Contractor must submit an annual report that identifies:

(1) the total number of new Members under the age of 21 who are still enrolled in the ICM Program after 90 days;

(2) the number and percent of new Members under the age of 21 still enrolled in the ICM Program after 90 days who get medical check ups within 90 days of enrollment into the ICM program;

(3) the total number of Members under the age of 21 who have been enrolled continuously in the ICM Program for 90 days or more (excluding the new Members); and

(4) the number and percent of Members under the age of 21 who have been enrolled continuously for 90 days or more in the ICM Program (excluding the new Members) who get timely, age-appropriate medical checkups.

The Contractor must also document and report those Members refusing to obtain the check-ups. The documentation must include the reason the Member refused the checkup or the reason the checkup was not received. For purposes of the Medicaid Medical Check-ups Report, “new Members” are Members who have not previously been enrolled in the HMO that is preparing the report.

The timeframe, format, and details of the report will be described in the **Uniform Managed Care Manual**.

Medicaid FWC Report – Beginning in September 2008, the Contractor must submit an annual report, in the timeframe and format described in the **Uniform Managed Care Manual,** about the identification of and delivery of services to children of Migrant Farmworkers (FWC). The report will include a description and results of the each of the following:

(1) the Contractor’s efforts to identify as many community and statewide groups that work with FWC as possible within its Service Areas;

(2) the Contractor's efforts to coordinate and cooperate with as many of such groups as possible; and

(3) the Contractor's efforts to encourage the community groups to assist in the identification of FWC.

The Contractor will maintain accurate, current lists of all identified FWC Members.

Provider Termination Report: The Contractor must submit a quarterly report that identifies any providers who cease to participate in the Contractor's provider network, either voluntarily or involuntarily. The report must be submitted to HHSC in the format specified by HHSC in the Uniform Managed Care Manual, no later than 30 days after the end of the reporting period.

5.3 Turnover Requirements

5.3.1 Introduction

Turnover is defined as the activities the Contractor must perform upon termination of the Contract, including the transition of Contract operations to HHSC or a subsequent contractor. During Turnover, the Contractor must ensure that HHSC, Members, Providers and other stakeholders do not experience any adverse impact from the transfer of services.

5.3.2 Transfer of Data and Information

The Contractor must transfer to HHSC or a subsequent contractor all data and information necessary to transition operations, including: data and reference tables; data entry software; third-party software and modifications; documentation relating to software and interfaces; functional business process flows; and operational information, including correspondence, documentation of ongoing or outstanding issues, operations support documentation, and operational information regarding Subcontractors. For purposes of this provision, "documentation" means all operations, technical and user manuals used in conjunction with the software, services and Deliverables, in whole or in part, that HHSC determines are necessary to view and extract application data in a proper format. The Contractor must provide the documentation in the formats in which such documentation exists at the expiration or termination of the Contract.

In addition, Contractor will provide to HHSC the following:

1. Data, information and services necessary and sufficient to enable HHSC to map all Model data from the Contractor's system(s) to the replacement system(s) of

HHSC or a successor contractor, including a comprehensive data dictionary as defined by HHSC.
2. All necessary data, information and services will be provided in the format defined by HHSC, and must be HIPAA compliant.

All of the data, information and services mentioned in this section shall be provided and performed in a manner by the Contractor using its best efforts to ensure the efficient administration of the ICM Program. The data and information must be supplied in media and format specified by HHSC and according to the schedule approved by HHSC in the Turnover Plan. The data, information and services provided pursuant to this section shall be provided at no additional cost to HHSC.

All relevant data and information must be received and verified by HHSC or the subsequent contractor. If HHSC determines that data or information are not accurate, complete, or HIPAA-compliant, HHSC reserves the right to hire an independent contractor to assist HHSC in obtaining and transferring all the required data and information and to ensure that all the data are HIPAA-compliant. The reasonable cost of providing these services will be the responsibility of the Contractor.

5.3.3 Turnover Services

Six months prior to the end of the Contract Period, including any extensions to such Contract Period, the Contractor must propose a Turnover Plan. If HHSC terminates the Contract prior to the expiration of the Contract Period, then HHSC may require the Contractor to propose the Turnover Plan sooner than six months prior to the termination date. In such cases, HHSC's notice of termination will include the date the Turnover Plan is due.

The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the Turnover Phase tasks. The Turnover Plan describes Contractor'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 Contractor during the transition to a subsequent contractor;
2. Cooperation with HHSC and the subsequent contractor in notifying Members of the transition and of their possible options, as requested and in the form required or approved by HHSC; and
3. Cooperation with HHSC and the subsequent contractor in transferring information to the subsequent contractor, as requested and in the form required or approved by HHSC.

The Turnover Plan must be approved by HHSC, and include at a minimum:

1. The Contractor's approach and schedule for the transfer of data and information, as described above.
2. The Quality Assurance process that the Contractor will use to monitor Turnover Phase activities.
3. The Contractor's approach to training HHSC or a subsequent contractor's staff in the operation of its business processes.

HHSC is not limited or restricted in the ability to require additional information from the Contractor or modify the Turnover Phase schedule as necessary.

5.3.4 Post-Turnover Services

Thirty (30) days following turnover of operations, the Contractor must provide HHSC with a Turnover Phase results report documenting the completion and results of each step of the Turnover Plan. The Turnover Phase will not be considered complete until this document is approved by HHSC.

If the Contractor does not provide the required data or information necessary for HHSC or the subsequent contractor to assume the operational activities successfully, the Contractor agrees to reimburse HHSC for all reasonable costs and expenses, including, but not limited to: transportation, lodging, and subsistence to carry out inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such records; and attorneys' fees and costs. This section does not limit HHSC's ability to impose remedies or damages as set forth in the Contract

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Version 1.0	n/a	February 15, 2007	Initial version of Attachment B-1, RFP Section 6. Includes all modifications negotiated by the Parties.
Revision	Version 1.1	November 16 , 2007	Contract Amendment One modified Attachment B-1, RFP Section 6 as follows: 1. Section 6.1.1.1 modified to clarify that HHSC may post information concerning poor performance on its website.
Revision	Version 1.2	February 1, 2008	Contract Amendment Two did not revise Attachment B-1, RFP Section 6 Payment Incentives and Disincentives.
Revision	Version 1.3	September 1, 2008	Contract Amendment Three did not revise Attachment B-1, RFP Section 6 Payment Incentives and Disincentives.

[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 Payment, Incentives and Disincentives

This section describes the performance incentives and disincentives related to HHSC's value-based purchasing approach. For information on how HHSC will pay the ICM Contractor, refer to **Article 10** of the **HHSC General Terms and Conditions**.

6.1 Performance Incentives and Disincentives

HHSC shall employ financial and non-financial performance incentives and disincentives in the Contract. These incentives and disincentives are subject to change by HHSC over the course of the Contract Period. The methodologies required to implement these strategies will be refined by HHSC after consultation with the Contractor.

6.1.1 Non-financial Incentives

6.1.1.1 Performance Profiling

HHSC intends to distribute information on key performance indicators to the Contractor on a regular basis, identifying the Contractor's performance, and comparing that performance to the state's HMO Contractors, and to HHSC standards and/or external benchmarks, as applicable. HHSC will recognize the Contractor for attaining superior performance and/or improvement by publicizing its achievements. For example, HHSC may post information concerning exceptional performance on its website, where it will be available to both stakeholders and members of the public. Likewise, HHSC may post its final determination regarding poor performance on its website.

Section 6.1.1.1 modified by Version 1.1

6.1.2 Financial Incentives and Disincentives

6.1.2.1 Performance-Based Rate: Administrative Fee at Risk-Inpatient Hospital Utilization

HHSC believes that inpatient Hospital Acute Care services are over-utilized by ICM Eligibles due to sub-optimal preventive care, chronic illness management and coordination of services. Effective as of the Operational Start Date, HHSC will place the Contractor at-risk for 9 percent of the Contractor Rate. In order to earn the full at-risk portion, the Contractor must achieve a 22 percent reduction in Inpatient Stay costs[1] per Member per month incurred by the Contractor's Members and paid for by HHSC compared to the fee-for-service Inpatient Stay costs per ICM Eligible per month in the 12 months prior to the ICM Program. The reduction must be achieved in Contract Year 1, and then sustained or increased during each of the subsequent Contract Years. HHSC

Section 6.1.2.1 modified by RFP Addendum No. 2.

[1] Excluding any Inpatient Stays in Dallas Service Area with a primary diagnosis that is psychiatric or chemical dependency in nature.

retains the right to vary the percentage of the Rate placed at risk in a given Contract Year by Contract amendment.

Portion of Payments at Risk	Contractor Retains	HHSC Recoups
Contractor achieves less than **20 %** reduction in Inpatient Stays	**91 %** of Payments	**9 %** of Payments
Contractor achieves **20 – 21.99 %** reduction in Inpatient Stays	**93 %** of Payments	**7 %** of Payments
Contractor achieves **22 % and above** reduction in Inpatient Stays	**100 %** of Payments	**0 %** of Payments

As noted in **Article 10** of **HHSC's General Contract Terms and Conditions**, HHSC will pay the Contractor monthly Payments based on the number of eligible and enrolled ICM Members. HHSC will calculate the monthly Payments by multiplying the number of Member Months times the Rate. At the end of Contract Year 1, HHSC will evaluate if the Contractor has demonstrated that it has achieved the 22 percent reduction in Inpatient Stay costs incurred by ICM Members and paid for by HHSC.

Should the Contractor achieve a reduction in Inpatient Stay costs of less than 20 percent in a Contract Year, the Contractor will retain 91 percent of Payments, and must reimburse HHSC for the remaining 9 percent. HHSC will recoup this amount by adjusting future monthly Payments downward, or collect such sum directly from the Contractor or its surety.

Should the Contractor achieve a reduction in Inpatient Stay costs of equal to or more than 20 percent, but less than 22 percent (i.e., 20 percent to 21.99 percent), the Contractor will retain 93 percent of payments, and must reimburse HHSC for the remaining 7 percent. HHSC will recoup this amount by adjusting future monthly Payments downward, or collect such sum directly from the Contractor or its surety.

Should the Contractor achieve a reduction in Inpatient Stay costs of 22 percent or more, the Contractor will retain 100 percent of Payments.

For Contract Year 1, HHSC will determine the extent to which the Contractor has achieved a reduction in Inpatient Stay costs by comparing the per-Member-per-month Inpatient Stay costs incurred by enrolled ICM Members during the Contract Year to the Inpatient Stay costs incurred per ICM Eligible residing in the Dallas and Tarrant Service Areas per month during the 12 months preceding the start of Contract Year 1, with appropriate adjustments made by HHSC for any changes that occurred in HHSC Hospital reimbursement rates between the 12 months preceding Contract Year 1 and Contract Year 1. HHSC will calculate settlements for Inpatient Stay costs after Contract Year 1 using three (3) months of completed Hospital paid data for the preliminary settlement and 11 months of completed data for the final settlement.

HHSC will continue in future Contract Years to compare Contract Year per-Member-per-month Inpatient Stay costs to the Inpatient Stay costs incurred per ICM Eligible residing

in the Dallas and Tarrant Service Areas per month during the 12 months preceding the start of Contract Year 1. HHSC will continue to make appropriate adjustments for any changes that occurred in HHSC Hospital reimbursement rates between the 12 months preceding Contract Year 1 and the most recently concluded Contract Year. HHSC will calculate settlements for Inpatient Stay costs after each Contract Year using three (3) months of completed Hospital paid data for the preliminary settlement and 11 months of completed data for the final settlement.

Contractor attempts to decrease Inpatient Stays in frequency and/or duration must not in any way comprise the health and safety of Members. The Contractor should anticipate that HHSC and its contracted EQRO may conduct audits of Contractor and Provider records at any time to ensure that this Contractual requirement is not violated.

6.1.2.2 Performance-Based Rate: Administrative Fee at Risk-Nursing Facility Utilization

HHSC has concern that inappropriate Hospital discharges to Nursing Facilities not be employed as a means to reduce Inpatient Stay costs and meet the requirements of the preceding section. As a result, HHSC will recoup up to 5 percent of the annual Payments should there be a statistically significant increase in Nursing Facility costs, incurred by Medicaid-only ICM Members and paid for by HHSC. Statistical significance will be assessed by HHSC using a t-test at a .05 confidence level. HHSC will recoup this amount by adjusting future monthly Payments downward, or collect such sum directly from the Contractor or its surety.

For Contract Year 1, HHSC will determine the extent to which the Contractor has prevented an increase in Nursing Facility costs by comparing the per-Member-per-month Nursing Facility stay costs by enrolled Medicaid-only ICM Members during the Contract Year to the Nursing Facility stay costs incurred by Medicaid-only ICM Eligibles residing in the Dallas and Tarrant Service Areas during the 12 months preceding the start of Contract Year 1, with appropriate adjustments made by HHSC for any changes that occurred in HHSC Nursing Facility reimbursement rates between the 12 months preceding Contract Year 1 and Contract Year 1.

HHSC will continue in future Contract Years to compare annual Nursing Facility stay costs to the Nursing Facility stay costs incurred by Medicaid-only ICM Eligibles residing in the Dallas and Tarrant Service Areas during the 12 months preceding the start of Contract Year 1. HHSC will continue to make appropriate adjustments for any changes that occurred in HHSC nursing reimbursement rates between the 12 months preceding Contract Year 1 and the most recently concluded Contract Year.

6.1.2.3 Performance-Based Rate: Quality

Section 6.1.2.3 modified by Version 1.0.

Beginning September 1, 2007, HHSC will place the Contractor at risk for 3 percent of the Payment for the performance of the Contractor's Services. HHSC retains the right to vary the percentage of the Payment placed at risk in a given Contract Year by Contract amendment.

As noted in **Article 10** of **HHSC's General Contract Terms and Conditions**, HHSC will pay the Contractor monthly Payments based on the number of eligible and enrolled Members. HHSC will calculate the monthly Payments by multiplying the number of Member Months times the Rate. At the end of each Contract Year, HHSC will evaluate if the Contractor has demonstrated that it has fully met the quality performance expectations for which the Contractor is at risk.

Should the Contractor fall short on some or all of the performance expectations, HHSC will adjust a future monthly Payment by an appropriate portion of the 3 percent at-risk amount, or collect such sum directly from the Contractor or its surety. Contractors will be able to earn variable percentages up to 100 percent of the 3 percent at-risk Payment. HHSC's objective is that the Contractor achieves performance levels that enable the Contractor to receive the full at-risk amount.

HHSC will determine the extent to which the Contractor has met the performance expectations by assessing the Contractor's performance relative to performance targets for the Contract Year (except in Contract Year 1, when performance will be assessed for the last 12 months of the Contract Year).

HHSC will identify no more than 10 performance indicators for which the Contractor shall be placed at risk in a given Contract Year. Some of the performance indicators may be common with those employed for HHSC's HMO Programs, while other performance indicators may apply only to the Contractor. It is also possible that the performance indicators will assess achievement of annual improvement goals (see **RFP Section 5.2.1.5**).

HHSC's performance indicators may include some or all of the following measures. The specific performance indicators, periods of data collection, and associated points will be detailed in the **Uniform Managed Care Manual**. The minimum percentage targets identified in this section were developed based, in part, on the HHSC ICM Program objective of ensuring access to care, past performance of HHSC STAR+PLUS contractors, and performance of Medicaid HMO contractors nationally on HEDIS measures of Medicaid managed care performance. The Performance Indicator Dashboard in the **Uniform Managed Care Manual** includes a more detailed explanation.

HHSC intends to initially place the Contractor at risk for performance relative to the following performance indicators:

Standard HHSC Performance Indicators: (20 points each for 40 total points)

1. The Member Services Hotline abandonment rate does not exceed 7 percent.
2. The Provider Services Hotline abandonment rate does not exceed 7 percent.

Additional ICM Performance Indicators all Members: (15 points each for 30 total points)

1. 77 percent of adult Members report no difficulty getting help from a Contractor Service Coordinator (12 points for 73-77 percent, 10 points for 68-72 percent).

2. 64 percent of adult Members report usually or always receiving Service Coordinator explanations that they can understand (12 points for 60-64 percent, 10 points for 56-60 percent).

Additional ICM Performance Indicators for non-Medicare Members: (15 points each for 30 total points)

1. 57 percent of adult Members report no problem with delays in getting approval from the Contractor (12 points for 52-56 percent, 10 points for 47-51 percent).
2. 48 percent of adult Members with self-reported needs for special therapies report having no problem accessing special therapies (12 points for 43-47 percent, 10 points for 39-43 percent).

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

Should Member survey-based indicators yield response rates deemed by HHSC to be too low to yield credible data, or should other quality indicators identify fewer qualifying Members than would support credible statistical significance testing as determined by HHSC, HHSC will reapportion points across the remaining measures.

Actual Contractor performance indicators will be rounded to the nearest whole number. HHSC will calculate performance assessment for the at-risk portion of the Rate by summing all earned points and converting them to a percentage. For example, if the Contractor earns 92 points, it will earn 92 percent of the at-risk portion of the Payment. HHSC will apply an assessment of 8 percent of the at-risk rate (i.e., 8 percent of 3 percent) as a reduction to the monthly Payment ninety days after the end of the Contract Year, or collect such sum directly from the Contractor or its surety.

HHSC will evaluate the performance-based Rate methodology annually in consultation with the Contractor. HHSC may then modify the methodology if it deems such changes necessary and appropriate to motivate, recognize, and reward the Contractor for performance. The modified methodology will be added to the HHSC **Uniform Managed Care Manual.**

6.1.2.4 Appropriate Hospital Utilization Challenge Award

Should the Contractor achieve the 22 percent reduction in Inpatient Stay costs incurred by ICM Members specified in **RFP Section 6.1.2.1**, the Contractor will be eligible to obtain a 35 percent share of the state savings[2] achieved beyond the 22 percent target, up to a maximum reduction of 40 percent, through the ICM Program's Appropriate Hospital Utilization Challenge Award. By way of example only, should the Contractor achieve a reduction in Inpatient Stay costs of 30 percent, it would share in the additional eight percent savings over the 22 percent target (i.e., 30% - 22% = 8%). If the additional eight percent savings in Inpatient Stay costs equal $10 million, then the state savings

[2] "State savings" means savings to State General Revenue funds.

would be $4 million (40% of $10 million). The Contractor would receive $1.4 million (35% of $4 million).

HHSC will determine the extent to which the Contractor has met and exceeded the performance expectation. Should HHSC determine that the Contractor exceeded the 22 percent target, HHSC will adjust a future monthly Payment(s) upward by 35 percent of the calculated savings.

The Contractor will be determined ineligible for the award and subject to contractual remedies including termination, should HHSC audit reveal that the Contractor has inappropriately averted or shortened Medically Necessary Inpatient Stay admissions and potentially endangered Member health and safety.

6.1.2.4.1 Community Return Challenge Award

Section 6.1.2.4.1 added by Version 1.0.

Should the Contractor increase the number of nursing facility resident Members returning to the community through the support services provided through the 1915(c) Community-Based Alternative (CBA) program (hereinafter "community returns"), the Contractor will be eligible to receive an additional per-member-per-month (PMPM) incentive up to $1.73.

HHSC will establish the benchmark number of community returns using historical DADS data for ICM Eligibles residing in the Dallas and Tarrant Service Areas (the "ICM Service Area") for the 12 month period preceding the Operational Start Date. HHSC will establish the benchmark no later than 90 calendar days following the Operational Start Date. Each Contract Year, the Contractor must increase the number of community returns by at least five percent (5%) over this benchmark. The Contractor will receive credit for a community return if an ICM Member residing in a nursing facility returns to the community for any period of time during the Contract Year through the 1915(c) CBA program. The Contractor will not receive credit for a community return if the Member returned to the community through the 1915(c) CBA program in a previous Contract Year.

If the Contractor meets or exceeds the community return goal in a Contract Year, it will earn the full $1.73 PMPM incentive. If the Contractor increases the number of community returns in a Contract Year, but does not meet the community return goal, it will be eligible for a pro rata share of the $1.73 PMPM incentive, rounded down to the next whole cent. HHSC will calculate the Contractor's performance with respect to this measure no later than 30 calendar days following the end of each Contract Year, and will pay the incentive in a lump sum no later than 60 calendar days following the end of each Contract Year.

By way of example only, should HHSC establish the benchmark number of community returns as 100, then the community returns goal will be 105 for each Contract Year. If, for Contract Year 1, the total number of community returns is 107, then the Contractor will have exceeded the community returns goal and will be entitled to the full $1.73 PMPM incentive. If, for Contract Year 2, the total number of community returns is 102, then the Contractor will have achieved 40% of the community return goal and will be

entitled to a $.69 PMPM incentive. If, for Contract Year 3, the total number of community returns is 100 or less, then the Contractor will not be entitled to the PMPM incentive.

The methodology described in this Section 6.1.2.4.1 assumes that HHSC or its designee will identify nursing facility residents who are reasonable candidates for community return, and routinely provide the Contractor with the names of such individuals. If, in a given Contract Year, the number of individuals referred by HHSC or its designee does not equal or exceed the community returns goal for that Contract Year, then the community returns goal for that Contract Year will be adjusted downward on a person-for-person basis.

By way of example only, should HHSC establish the benchmark number of community returns as 100, then the community returns goal will be 105 for each Contract Year. If, in Contract Year 1, HHSC or its designee refers 105 or more individuals to the Contractor, then the community return goal will remain 105 and the Contractor's entitlement to the PMPM incentive will be calculated as described above.

Alternatively, if HHSC or its designee refers only 104 individuals to the Contractor in Contract Year 1, then the community return goal will be adjusted to 104. If the total number of community returns in Contract Year 1 equals or exceeds 104, then the Contractor will have exceeded the community returns goal and will be entitled to the full $1.73 PMPM incentive. If the total number of community returns in Contract Year 1 is 102, then Contractor will have achieved 50% of the community return goal and will be entitled to a $.86 PMPM incentive.

After Contract Year 1, the Parties may amend the Agreement to adjust the benchmark, methodology, and/or PMPM incentive described in this Section 6.1.2.4.1 as the parties deem appropriate.

The incentives described in **RFP Sections 6.1.2.4.1** and **6.1.2.4** are separate and independent, and will not be combined for purposes of determining the maximum amount of payment to the Contractor per incentive. In addition, the any incentive earned pursuant to **RFP Sections 6.1.2.4.1** and **6.1.2.4** are separate and independent of the disincentives described in **RFP Sections 6.1.2.1-6.1.2.3** and **6.1.2.5**, and will not be at-risk for purposes of calculating potential recoupments.

6.1.2.5 Performance-Based Rate: 1915(C) Community-Based Alternative (CBA) Services for SSI Clients

Section 6.1.2.5 added by RFP Addendum No. 2, modified by Version 1.0.

As noted in **RFP Section 1.3.3.1**, the Contractor will be responsible for achieving cost savings necessary to fund the costs of additional 1915(c) Community-Based Alternative (CBA) services for SSI clients in the Dallas and Tarrant Service Areas. HHSC estimates that these additional CBA services will be provided to 628 clients per year at an all funds (state and federal funds) cost of $6.8 million a year. The cost savings necessary to fund the additional CBA services are in addition to the 22 percent reduction in Inpatient Stay costs addressed **RFP Section 6.1.2.1**. HHSC will calculate the additional savings based on total long term care costs (including CBA Waiver, DAHS, and LTSS). If these

additional savings are not realized, HHSC may recoup the lesser of: 9 percent of the Contractor Payments, or the actual all funds cost of the additional CBA services. The total amount of Contractor Payments that HHSC may recoup under this section and **RFP Section 6.1.2.1** shall not exceed 9 percent.

For Contract Year 1, HHSC will determine the extent to which the Contractor has achieved a reduction total long term care costs by comparing the per-Member-per-month long term care costs incurred by enrolled ICM Members during Contract Year 1 to the total long term care costs incurred per ICM Eligible residing in the Dallas and Tarrant Service Areas per month during the 12 months preceding the start of Contract Year 1. HHSC will make appropriate adjustments for any changes that occurred in HHSC long term care reimbursement rates between the 12 months preceding Contract Year 1 and Contract Year 1. HHSC will calculate settlements for the additional CBA services after Contract Year 1 using three (3) months of completed long term care cost data for the preliminary settlement and 11 months of completed long term care cost data for the final settlement.

HHSC will continue in future Contract Years to compare the per-Member-per-month long term care costs incurred by enrolled ICM Members during the most recently concluded Contract Year to the long term care costs incurred per ICM Eligible residing in the Dallas and Tarrant Service Areas per month during the 12 months preceding the start of Contract Year 1. HHSC will continue to make appropriate adjustments for any changes that occurred in HHSC long term care reimbursement rates between the 12 months preceding Contract Year 1 and the most recently concluded Contract Year. HHSC will calculate settlements for the additional CBA services after each Contract Year using three (3) months of completed long term care cost data for the preliminary settlement and 11 months of completed long term care cost data for the final settlement.

The following examples illustrate how HHSC will apply recoupments under this section and **RFP Section 6.1.2.1**.

- The Contractor achieves a 19 percent reduction in Inpatient Stay costs, which is subject to a recoupment of 9 percent of the Contractor Payment under **RFP Section 6.1.2.1**. Additionally, the Contractor does not achieve total long term care savings necessary to fund the additional CBA waiver services, which is subject to a recoupment of up to 9 percent of the Contractor Payment under **RFP Section 6.1.2.5**. The amount of the recoupment is limited to a total of 9 percent of the Contractor Payment.
- The Contractor achieves a 20 percent reduction in Inpatient Stay costs, which is subject to a recoupment of 7 percent of the Contractor Payment under **RFP Section 6.1.2.1**. Additionally, the Contractor does not achieve total long term care savings necessary to fund the additional CBA waiver services, which is subject to a recoupment of up to 9 percent of the Contractor Payment under **RFP Section 6.1.2.5.** HHSC will recoup 7 percent of the Contractor Payment, plus the lesser of: the actual all funds costs of the additional CBA services, or 2 percent of the Contractor Payment.

- The Contractor achieves a 22 percent reduction in Inpatient Stay costs, and is not subject to recoupment under **RFP Section 6.1.2.1**. The Contractor does not achieve total long term care savings necessary to fund the additional CBA waiver services, however, and is subject to a recoupment under **RFP Section 6.1.2.5** of the lesser of: the actual all funds cost of the additional CBA services, or 9 percent of the Contractor Payments.

6.2.2.5 Remedies and Liquidated Damages

All areas of responsibility and all requirements in the Contract will be subject to performance evaluation by HHSC. Any and all responsibilities or requirements not fulfilled may have remedies and HHSC will assess either actual or liquidated damages. Refer to **Attachment A** to the **ICM Contract Document, HHSC General Terms and Conditions** and **Attachment B-4** to the **ICM Contract Document, Deliverables/Liquidated Damages Matrix** for performance standards that carry liquidated damage values.

6.2.2.6 Financial Reporting Related to Incentives and Disincentives

Contractors will report actual Payments received on the Contractor FSR. Actual Payments received include all of the at-risk Rate Payments paid to the Contractor. Any performance assessment based on performance for a contract period will appear on the second final (334-day) Contractor FSR for that Contract Year.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Version 1.0	n/a	February 15, 2007	Initial version of Attachment B-2, Contractor Managed Services. Includes all modifications negotiated by the Parties.
Revision	Version 1.1	November 16, 2007	Contract Amendment did not revise Attachment B-2, Contractor Managed Services
Revision	Version 1.2	February 1, 2008	Contract Amendment Two did not revise Attachment B-2, Contractor Managed Services
Revision	Version 1.3	September 1, 2008	Contract Amendment Three modified Attachment B-2 to include an additional Contractor Managed services resulting from the Frew Settlement.

[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.

Contractor Managed Services

The Contractor Managed Services listed in this Attachment are subject to modification based on Federal and State laws and regulations and HHSC program policy updates.

Contractor Managed Services include Acute Care Services and Long Term Services and Supports for ICM Members. Some ICM Services are only available to certain ICM Members, such as Medicaid eligibles that are not dually eligible for Medicare, Medicaid eligible children under 21 and Medicaid eligibles meeting the Nursing Facility Level of Care criteria.

As noted below, ICM Members are provided with two enhanced benefits compared to Fee-for-Service Medicaid:

1. Waiver of the three-prescription per month limit for Medicaid-only Members; and
2. Inclusion of an annual adult well check for Members 21 years of age and over.

Acute Care Services for ICM Members

The following is a non-exhaustive, high-level listing of Acute Care Services for ICM Members. Bidders should refer to the current ***Texas Medicaid Provider Procedures Manual*** and the bi-monthly ***Texas Medicaid Bulletin*** for a more inclusive listing of limitations and exclusions that apply to each Medicaid benefit category. These documents can be accessed online at http://www.tmhp.com.

1. Annual adult well check (Medicaid-only Members 21 years and older only)
2. Unlimited medically necessary prescriptions (Medicaid-only Members only)
3. Ambulance services
4. Audiology services for Members 21 years and older
5. Behavioral Health Services (for Members in the Tarrant Service Area only) including detoxification services and psychiatry services, and counseling services for adults only
6. Birthing center services
7. Dialysis
8. Durable medical equipment and supplies
9. Emergency Services
10. Family planning services
11. Home health care services
12. Hospital services, inpatient and outpatient (30 day spell of illness limitation on inpatient services applies.)
13. Laboratory
14. Prenatal care
15. Primary care services
16. Radiology, imaging, and X-rays
17. Specialty physician services
18. Therapies – physical, occupational and speech
19. Transplantation of organs and tissues
20. Optometry, glasses and contact lenses
21. Chiropractic care

22. Podiatry

Acute Care Services modified by Version 1.3

Additional Acute Care Services for Children Under Age 21 Only

1. Inpatient and outpatient mental health services for children (in Tarrant Service Area only)
2. Outpatient chemical dependency services for children (in Tarrant Service Area only)
3. Medical check-ups and Comprehensive Care Program (CCP) Services for children through the Texas Health Steps Program
4. Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical check up for children 6 through 35 months of age.

LTSS provisions modified by Version 1.0

Long Term Services and Supports (LTSS)

The following is a high-level listing of Contractor Managed Long Term Services and Supports (LTSS) for ICM Members.

Additional information on Long Term Services and Supports listed in this Attachment can be found online at: http://www.dhs.state.tx.us/handbooks/ccad/ in the *Community Care for Aged and Disabled Handbook*, and at http://www.dhs.state.tx.us/handbooks/cba/ in the *Community Based Alternatives (CBA) Provider Manual*.

Traditional Medicaid Community-Based LTC Services

Primary Home Care (PHC). Provides assistance with the performance of activities of daily living and household chores. PHC does not include protective supervision. PHC services are non-medical.

Day Activity and Health Services (DAHS). Includes nursing and personal care services, physical rehabilitative services, nutrition services, transportation services, and other supportive services. These services are provided by facilities licensed by DADS. Except for holidays, these facilities must have services available at least ten hours a day, Monday through Friday.

Consumer Directed Services Financial Management Services. Financial management services assist a participant to manage and direct the self-directed services. The provider helps the Member develop a budget, provides payroll and tax functions, and provides the Member with guidance and support on being an employer. Financial management services are provided to a Member who chooses to self-direct services.

Service Responsibility Option (SRO). The Service Responsibility Option (SRO) is an option for consumer direction. SRO gives consumers control over selecting, training and supervising personal care attendants but the provider agency, the employer of record, keeps the fiscal functions and the responsibility for providing substitute attendants and administrative personnel functions. SRO is available in PHC.

Community-Based Alternatives (CBA) Waiver Services for those Members who meet CBA Waiver eligibility requirements

Note: Adult foster care, assisted living/residential care services, consumer directed services financial management services, emergency response services, home-delivered meals, out-of-home respite, and transition assistance services are provided though independent providers. All other services are provided through Home and Community Support Services Agencies. Personal assistant services, in-home respite services, and out-of-home respite services may be provided as Consumer Directed Services. Personal assistance services may also be provided using the Service Responsibility Option (SRO).

Adaptive aids, medical equipment, and medical supplies. Includes devices, controls, or medically necessary supplies that enable Members with functional impairments to perform activities of daily living or control the environment in which they live.

Adult foster care (AFC). A 24-hour living arrangement in an enrolled DADS foster home for Members who, because of physical or mental limitations, are unable to continue residing in their own homes. Services may include meal preparation, housekeeping, personal care, help with activities of daily living, supervision and the provision of or arrangement of transportation.

Assisted living services. A 24-hour living arrangement in licensed assisted living facilities in which personal care; home management; escort; social and recreational activities; twenty-four hour supervision; supervision of, assistance with, and direct administration of medications; and the provision or arrangement of transportation are provided.

Consumer Directed Services Financial Management Services. Financial management services assist a participant to manage and direct the self-directed services. The provider helps the Member develop a budget, provides payroll and tax functions, and provides the Member with guidance and support on being an employer. Financial management services are provided to a Member who chooses to self-direct services.

Dental Services. Dental services are those services provided by a dentist to preserve teeth and meet the medical need of the participant. These include emergency dental treatment procedures that are necessary to control bleeding, relieve pain and eliminate acute infection; operative procedures that are required to prevent the imminent loss of teeth; treatment of injuries to the teeth or supporting structures; and dentures and cost of fitting and preparation for dentures, including extractions, molds, etc. Payments for dental services are not made for cosmetic or routine dentistry.

Emergency response services. An electronic monitoring system for use by functionally impaired Members who live alone or are isolated in the community. In an emergency, the Member can press a call button to signal for help. The electronic monitoring system, which has a 24-hour, seven-day-a-week capability, helps insure that the appropriate persons or service agency respond to an alarm call from the Member.

Home delivered meals. Home delivered meals are provided to Members who are unable to prepare their own meals and for whom there are no other persons available to do so, or where the provision of a home delivered meal is the most cost-effective method of delivering a nutritionally adequate meal. Modified diets, where appropriate, will be provided to meet the Member's individual requirements.

In-home skilled nursing care. Includes but is not limited to the assessment and evaluation of health problems and the direct delivery of nursing tasks, providing treatments and health care

procedures ordered by a physician and/or required by standards of professional practice or state law, delegation of nursing tasks to unlicensed persons according to state rules promulgated by the Texas Board of Nurse Examiners, developing the health care plan, and teaching Members about proper health maintenance.

Minor home modifications. Modifications and/or improvements to a Member's residence to enable them to reside in the community and to ensure safety, security and accessibility.

Personal Assistant Services (PAS). Provide assistance with the performance of activities of daily living and household chores. PAS includes protective supervision and delegated nursing tasks performed by an unlicensed attendant.

Respite Services. Respite services are provided when participants are unable to care for themselves. Respite services are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the services. Respite services are available in the Member's home or place of residence; an adult foster care home; a Medicaid-certified nursing facility; and an assisted living facility.

Therapy (occupational, physical, speech). The full range of activities provided by an occupational or physical therapist; speech or language pathologist; or a licensed occupational or physical therapy assistant under the direction of a licensed occupational or physical therapist, within the scope of his state licensure.

Transitional Assistance Services (TAS). A maximum of $2500 to enhance the ability of Nursing Facility residents to transition to the community. TAS helps defray the costs associated with setting up a household for those Members establishing an independent residence. TAS includes but is not limited to payment of security deposits to lease an apartment, purchase of essential furnishings (e.g., table, eating utensils) and payment of moving expenses.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Version 1.0	n/a	February 15, 2007	Initial version of Attachment B-3, Performance Improvement Goals. Includes all modifications negotiated by the Parties.
Revision	Version 1.1	November 16, 2007	Contract Amendment did not revise Attachment B-3, Performance Improvement Goals
Revision	Version 1.2	February 1, 2008	Contract Amendment Two did not revise Attachment B-3, Performance Improvement Goals
Revision	Version 1.3	September 1, 2008	Revised Attachment B-3, to add newly negotiated FY2009 Performance Improvement Goals

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions
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Texas Health and Human Services Commission
Integrated Care Management (ICM)
Performance Improvement Goal Template
State Fiscal Year 2009
(September 1, 2008 – August 31, 2009)

A. Contractor Information

Plan Name: **Evercare**

Program: **ICM**

B. Overarching Goal	C. Sub Goals:
Goal 1: Improve Access to Primary Care Providers and Specialists	▪ Increase the number of PCPs in the network by 5% annually over baseline in underserved ICM counties, including: Navarro, Hood, Johnson, Kaufman, Rockwall, Hunt, Ellis, Denton, Parker, and Wise counties. ▪ Increase the number of Specialists in the network by 5% annually over baseline in underserved ICM counties, including: Navarro, Hood, Johnson, Kaufman, Rockwall, Hunt, Ellis, Denton, Parker, and Wise counties. ▪ Increase the number of provider locations with extended hours over the baseline by 2.
Goal 2: Improve Access to LTSS Providers	▪ Increase the total number of ICM Waiver services providers in the network by 3% annually over baseline. ▪ Increase the number of Consumer Directed Services (CDS) providers in the network by 5% annually over baseline. ▪ Increase Primary Home Care (PHC) providers by 3% annually over the baseline.
Goal 3: Improve Service Coordination	▪ 95% of all members with a face to face assessment occurring between 09-1-08 and 08-31-09 will receive information about the role of the Service Coordinator in addition to that found in the ICM member materials, such as the member handbook. ▪ All ICM service coordinators will participate in continuing education sessions a minimum of once each quarter.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Version 1.0	n/a	February 15, 2007	Initial version of Attachment B-4, Deliverables/Liquidated Damages Matrix. Includes all modifications negotiated by the Parties.
Revision	Version 1.1	November 16, 2007	Contract Amendment One did not revise Attachment B-4, Deliverables/Liquidated Damages Matrix
Revision	Version 1.2	February 1, 2008	Contract Amendment Two did not revise Attachment B-4, Deliverables/Liquidated Damages Matrix.
Revision	Version 1.3	September 1, 2008	Contract Amendment Three revised Attachment B-4 Deliverables/Liquidated Damages Matrix as follows: 1. RFP §5.2.7.8 Performance Standard is modified to replace the MDS-HC instrument with the Community Medical Necessity and Level of Care Assessment Instrument. 2. RFP §5.1 and 5.2.1General Requirement: Failure to Perform an Administrative Service is added. 3. RFP §5.2 General Requirement: Failure to authorize, arrange or coordinate an ICM Contractor Managed Service 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.

1 Derived from the Contract or HHSC’s **Uniform Managed Care Manual**.
2 Standard specified in Contract
3 Period during which HHSC will evaluate service for purposes of tailored remedies.
4 Measure against which HHSC will apply remedies.

Deliverables/Liquidated Damages Matrix

Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
RFP §5.1 -- Transition Phase Requirements RFP §5.2 -- General Scope	The Contractor must be operational no later than the agreed upon Operations Start Date. HHSC, or its agent, will determine when the Contractor is considered to be operational based on the requirements in Section 5.1 and 5.2 of the RFP.	Operations Start Date	Each calendar day of non-compliance.	HHSC may assess up to $10,000 per calendar day for each calendar day or portion thereof beyond the Operations Start date that the Contractor is not operational until the day that the Contractor is operational, including all systems.
RFP §5.1.5 Systems Readiness Review	The Contractor must submit to HHSC or to the designated Readiness Review Contractor the following plans for review, no later than March 6, 2007: • Joint Interface Plan; • Disaster Recovery Plan; • Business Continuity Plan; • Risk Management Plan; and • Systems Quality Assurance Plan.	Transition	Each calendar day of non-compliance, per report.	HHSC may assess up to $1,000 per calendar day or portion thereof for each day a deliverable is late, inaccurate or incomplete.
RFP §5.1.6 – Operations Readiness	Final versions of the Provider Directory must be submitted to HHSC no later than April 1, 2007.	Transition	Each calendar day of non-compliance.	HHSC may assess up to $1,000 per calendar day or portion thereof for each day the directory is late, inaccurate or incomplete.
RFP §§ 5and 6	All reports and deliverables as	Transition,	Each calendar day of	HHSC may assess up to $250 per

Section 5.1.6 modified by Version 1.0.

1 Derived from the Contract or HHSC's **Uniform Managed Care Manual**.
2 Standard specified in Contract
3 Period during which HHSC will evaluate service for purposes of tailored remedies.
4 Measure against which HHSC will apply remedies.

Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
Uniform Managed Care Manual	specified in Sections 5 and 6 must be submitted according to the timeframes and requirements stated in the Contract (including all attachments) and HHSC's Uniform Managed Care Manual. (Specific Reports or deliverables listed separately in this matrix are subject to the specified liquidated damages.)	Operations, and Turnover	non-compliance.	calendar day or portion thereof if the report/deliverable is late, inaccurate, or incomplete.
General Requirement: Failure to Perform an Administrative Service , Attachment B-1 RFP §5.1 and 5.2.1	The ICM Contractor fails to timely perform an ICM Contractor 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 per Program and SA.	HHSC may assess up to $5,000.00 per calendar day for each incident of non-compliance per Program and SA.
General Requirement: Failure to Authorize, Arrange or Coordinate a Managed Service Contract Attachement B-1 RFP §5.2	The ICM Contractor fails to timely authorize, arrange or coordinate an ICM Contractor Managed 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 day for each incident of non-compliance.

General Requirement Added by Version 1.3.

RFP 5.2.7.8 modified by Version 1.3.

1 Derived from the Contract or HHSC's **Uniform Managed Care Manual**.
2 Standard specified in Contract
3 Period during which HHSC will evaluate service for purposes of tailored remedies.
4 Measure against which HHSC will apply remedies.

Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
RFP 5.2.7.8	TheCommunity Medical Necessity and Level of Care Assessment Instrument must be completed and electronically submitted to HHSC in the specified format within 30 days of enrollment for every Member receiving LTSS and then each year by the anniversary of the Member's date of enrollment.	Transition, Operations, and Turnover	Per calendar day of non-compliance.	HHSC may assess up to $500 per calendar day or portion thereof of non-compliance for each day a report is late, inaccurate, or incomplete.
RFP §5.2.13.12 Marketing & Prohibited Practices Uniform Managed Care Manual	The Contractor may not engage in prohibited marketing practices.	Transition, Operations, and Turnover	Per incident of non-compliance.	HHSC may assess up to $1,000 per incident of non-compliance.
RFP §5.2.14 -- Member Complaint and Appeal Process Contract	The Contractor must resolve at least 98% of Member Complaints within 30 calendar days from the date the Complaint is received by the Contractor.	Operations and Turnover	Per reporting period.	HHSC may assess up to $250 per reporting period if the Contractor fails to meet the performance standard.
RFP §5.2.14 — Member Complaint and Appeal Process	The Contractor must resolve at least 98% of Member Appeals within 30 calendar days from the date the Appeal is filed with the Contractor.	Operations and Turnover	Per reporting period.	HHSC may assess up to $500 per reporting period if the Contractor fails to meet the performance standard.

1 Derived from the Contract or HHSC's **Uniform Managed Care Manual**.
2 Standard specified in Contract
3 Period during which HHSC will evaluate service for purposes of tailored remedies.
4 Measure against which HHSC will apply remedies.

Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
RFP §5.2.18 – Management Information System (MIS) Requirements	The Contractor's MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan.	Operations and Turnover	Per calendar day of non-compliance.	HHSC may assess up to $5,000 per calendar day or portion thereof of non-compliance
RFP §5.2.18.3 – Management Information System (MIS) Requirements: System-Wide Functions	The Contractor's MIS system must meet all requirements in Section 5.2.18.3.	Operations and Turnover	Per calendar day of non-compliance.	HHSC may assess up to $5,000 per calendar day or portion thereof of non-compliance.
RFP §5 2.20 Reporting Requirements Uniform Managed Care Manual	Financial Statistical Reports (FSR**)**: The Contractor must file quarterly and annual ICM FSRs. Quarterly reports are due no later than 30 days after the conclusion of each State Fiscal Quarter (SFQ). The first annual report is due no later than 120 days after the end of each Contract Year and the second annual report is due no later than 365 days after the end of each Contract Year.	Operations and Turnover	Per calendar day of non-compliance.	HHSC may assess up to $1,000 per calendar day or portion thereof that a quarterly or annual report is late, inaccurate or incomplete.
RFP §5.3.2 -- Transfer of Data	The Contractor must transfer all data regarding the provision of ICM Services to Members to HHSC or a	Operations and Turnover Measured at Time	Per incident of non-compliance (failure to provide data and/or	HHSC may assess up to $10,000 per calendar day or portion thereof that the data is late, inaccurate or

1 Derived from the Contract or HHSC's **Uniform Managed Care Manual**.
2 Standard specified in Contract
3 Period during which HHSC will evaluate service for purposes of tailored remedies.
4 Measure against which HHSC will apply remedies.

Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
	new Contractor, at the sole discretion of HHSC and as directed by HHSC. All transferred data must comply with the Contract requirements, including HIPAA.	of Transfer of Data and ongoing after the Transfer of Data until satisfactorily completed	failure to provide data in required format), per Contractor Program, per SA.	incomplete.
RFP §5.3.3 -- Turnover Services	Six months prior to the end of the contract period or any extension thereof, or by a date specified in HHSC's notice of termination, the Contractor must propose a Turnover Plan covering the possible turnover of the records and information maintained to either the State (HHSC) or a successor Contractor.	Operations and Turnover	Each calendar day of non-compliance.	HHSC may assess up to $1,000 per calendar day or portion thereof that the Plan is late, inaccurate, or incomplete.
RFP §5.3.4 – Post-Turnover Services	The Contractor must provide HHSC with a Turnover Results report documenting the completion and results of each step of the Turnover Plan 30 days after the Turnover of Operations.	Measured 30 days after the Turnover of Operations	Each calendar day of non-compliance.	HHSC may assess up to $250 per calendar day or portion thereof that the report is late, inaccurate or incomplete.
HHSC Terms and Conditions, Section 4.08 Subcontractors	The Contractor must notify HHSC in writing 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.	Transition, Operations, and Turnover	Each calendar day of non-compliance.	HHSC may assess up to $5,000 per calendar day or portion thereof of non-compliance.

1 Derived from the Contract or HHSC's **Uniform Managed Care Manual**.
2 Standard specified in Contract
3 Period during which HHSC will evaluate service for purposes of tailored remedies.
4 Measure against which HHSC will apply remedies.

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DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Version 1.0	n/a	February 15, 2007	Initial version of Attachment C-2, "Agreed Modifications to the Proposal." Includes all modifications negotiated by the Parties.
Revision	Version 1.1	November 16, 2007	Contract Amendment One did not revise Attachment C-2, Agreed Modifications to the Proposal
Revision	Version 1.2	February 1, 2008	Contract Amendment Two did not revise Attachment C-2, Agreed Modifications to the Proposal
Revision	Version 1.3	September 1, 2008	Contract Amendment Three did not revise Attachment C-2, Agreed Modifications to the Proposal

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions
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[3] Brief description of the changes to the document made in the revision.

Clarification/Modification Items

1. Section 4.6.1, Transmittal Letter

Which company (Evercare, United?) and which corporate officers will be responsible for the ICM contract?

Evercare of Texas, L.L.C. (Evercare) will be responsible for the ICM contract. Below is a complete list of the Evercare of Texas corporate officers:

- John R. Mach, Jr., M.D., President and Chief Executive Officer
- Sheila E. McMillan, Chief Operating Officer
- Glenda Coleman, M.D., Medical Director
- John William Kelly, Vice President, Tax Services
- Gerald J. Knutson, Vice President, Finance and Assistant Treasurer
- Gaye Adams Massey, Secretary
- Robert Worth Oberrender, Treasurer

2. Section 4.6.3, Material Subcontractors

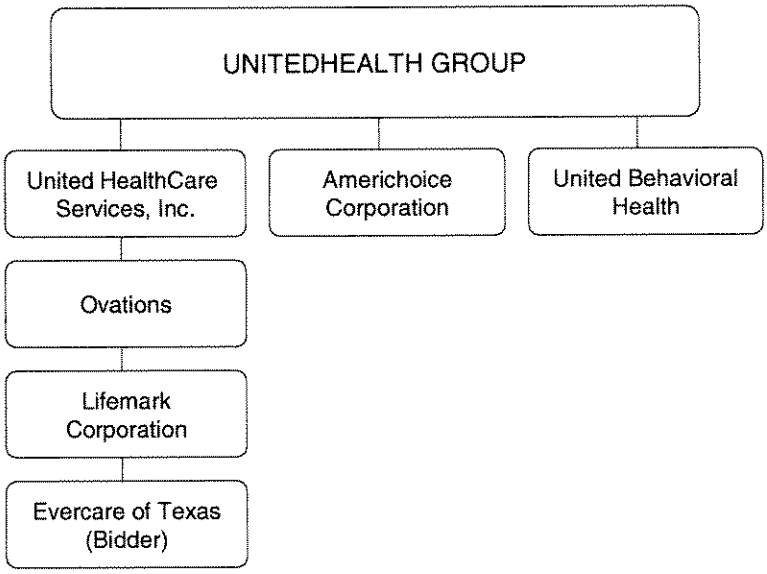
The organizational structure is a bit confusing. Please clarify.

Evercare is the bidder and is wholly owned by UnitedHealth Group. Its affiliates, which are also owned by UnitedHealth Group, include United Behavioral Health (UBH), United HealthCare

Services, Inc. (UHS) and AmeriChoice. A brief description of each material subcontractor follows:

- Evercare is a licensed HMO in Texas and will be ultimately responsible for the performance of all services and compliance with all requirements under the ICM Contract.
- UBH provides all behavioral health services for the benefit of Evercare.
- UHS will provide all administrative and management services for the benefit of Evercare.
- AmeriChoice will provide disease management services for the benefit of Evercare.

An organizational chart, providing a graphical depiction of these businesses follows.



3. Section 4.7.2.1, Organizational Overview
Will there be an office in both the Dallas and Tarrant service area?

Yes, Evercare will have two offices to manage the ICM program. One office will be located in the Dallas service delivery area and one will be in the Tarrant service delivery area.

4. Section 4.7.2.1, Organizational Overview
Which key personnel will be dedicated full-time to the contract?

Response to question 4 is considered confidential.

In our original response to this question, we outlined the regional staff led by Diane Schimmelbusch who will have responsibility for the ICM program. Regional staff will be located in Houston. However, Evercare recognizes the importance of having local staff dedicated to the success of the program. With that in mind, John Weymer has been hired as the executive director with operational responsibility for all Dallas/Fort-Worth (DFW) Evercare operations. If Evercare is awarded the ICM contract, additional staff will be hired in the DFW service area who will be dedicated full-time to the ICM program. The DFW based staff was included in our original cost proposal. To assist the State in comparing these documents, we have included both the revised/upgraded titles for the positions as well as the ICM RFP staffing title utilized in the original proposal. Key personnel are outlined below:

Title (Revised/Upgraded)	ICM RFP Title utilized in Cost Proposal	Name	Responsibility	% of Time Dedicated to ICM
Executive Director	Executive Director	John Weymer	Overall operational responsibility	75%
Medical Director	Medical Director	TBD	Oversight of clinical and quality programs	100% This is an increase from our original submission
Operations Analyst	Operations Analyst	TBD	Facilitate operational issues including data transfers with providers, HHSC partners and material subcontractors	100%
Utilization Management Manager	Utilization Management Manager	TBD	Responsible for all patient management functions	100%
Quality Improvement Specialist	Quality Improvement Specialist	TBD	Responsible for quality improvement activities for the ICM program	100%
Behavioral Health Coordinator	Utilization Management Specialist	TBD	Responsible for coordinating activities with NorthSTAR	100%
Provider Relations Manager	Provider Relations Representative	TBD	Responsible for network contracting and provider relations	100%
Member Advocate	Member Relations Representative	TBD	Responsible for assisting members resolve any issues	100%

5. Section 4.7.2.2, Key Contractor Personnel
Will there be full-time medical director whose time is devoted entirely to this contract?

Yes, we will have a full-time medical director whose time is devoted entirely to the ICM contract.

6. Section 4.7.2.3, Coordination with Other HHS Agencies and Vendors
What is the plan for reaching an agreement with NorthSTAR in order to coordinate Behavioral Health services in Dallas?

Evercare has met with Dr. Ed Miles, Executive Director and Dr. Alan LaGrone, Medical Director of North Texas Behavioral Health Authority to discuss coordination of physical and behavioral health services in the ICM should Evercare be awarded the ICM contract. In addition, we discussed the intent of both parties to begin to identify operational processes that need to be established in order to coordinate physical and behavioral health care in the event Evercare is chosen as the ICM provider. Ms. Rhonda Davis, Chief Operating Officer has signed a letter of intent with Evercare which outlines both parties intent to work together to coordinate behavioral health services for individuals in the ICM program. We have attached the letter of intent in confidential ***Attachment 1*** of this response.

In addition, Evercare has discussed coordination of physical and behavioral health services in the Dallas service delivery area with Robin Cunningham, Director of Provider Relations for ValueOptions, the HMO providing services under the NorthSTAR contract. We will be meeting with ValueOptions to discuss care and coordination of services for our mutual members. Please see confidential ***Attachment 2*** for a copy of a letter from ValueOptions discussing our upcoming meeting and the topics to be discussed. Further discussions are scheduled and Evercare expects to obtain a MOU if awarded to outline each organizations responsibilities regarding coordination of care.

7. Section 4.7.2.5, Electronic Health Information

Item #7 is deleted. The parties have agreed to pilot the telephonic verification system as described in the Contractor's proposal.

Only 37% of legacy LTSS providers have signed LOIs. Please provide a status update and detail the bidder's plans for including more LTSS providers.
Please note that we are responding to the question which is related to Section 4.7.3.3, Long Term Services and Supports Providers and not the referenced section of 4.7.2.5, Electronic Health Information.

Response to question 8 is considered confidential.
Evercare has increased the number of LTSS STP providers (originally recorded on Attachment N2 of our initial proposal) from 37 percent to 78 percent of all LTSS STP providers. Three hundred and eighteen (318) unique providers per service type have been contracted out of 410 total STPs in the service area.

It should also be noted that although we were particularly focused on follow-up with LTSS providers to specifically address the State's questions about the Evercare's LTSS network, in the period since our original submission Evercare has also procured an additional DSH Hospital LOI (Dallas Children's Medical Center), and 6 additional PCP-STP LOIs. The current STP ratios for LTSS, PCP and DSH providers are illustrated in the summary attachment.

We have also received letters of intent (LOIs) from LTSS providers outside of the LTSS STP list, including providers identified on the Texas Department of Aging and Disability Services (DADS) provider list. To offer the most robust network possible, we also targeted traditional LTSS provider types not listed on the LTSS STP list, including dialysis centers, DME providers, hospice providers and skilled nursing facilities. In total, we have increased our total network of LTSS providers to 545 unique providers by service type (which equates to 2849 LTSS provider locations). Please see confidential ***Attachment 3*** for a complete list of LTSS unique providers and list of LTSS provider locations.

If selected as the ICM contractor, we will continue to reach out to all LTSS Medicaid providers in the service delivery area to maximize the number of LTSS STP providers participating in the ICM program.

We have employed the following efforts to increase the receipt of LOIs:

- Phone contact was made with all 116 LTSS STP providers who previously signed an LOI. We verified demographic and service information to assure we accurately report all service categories and geographic regions covered by each LTSS provider. As a result of this exercise, Evercare has enhanced the service and geographic coverage of the proposed LTSS provider network.

- We actively recruited LTSS providers from the *LTSS Target List* which consists of all remaining LTSS STP providers without an LOI, as well as an additional 180 LTSS providers from the DADS list. The supplemental DADS list filled critical geographical or service gaps in the proposed network.

- The network development team is now focused exclusively on following up with all providers on the *LTSS Target List.*

  - Phone calls were made to every prospect on the *LTSS Target List.* LOIs and Frequently Asked Questions (FAQs) were sent via fax to every provider from whom we collected a valid fax number. One hundred and thirteen (113) LOIs were resent to LTSS providers as a result of these phone conversations.

  - A total of 230 LTSS unique providers were invalidated from the STP and DADS list of prospects because they cannot be located, despite multiple attempts to contact the provider by phone and/or mail. Of the total invalidated LTSS providers, 88 LTSS-STP providers were invalidated. When research leads to a dead end, the prospect is invalidated (removed from) the LTSS Target List database.

  - Our DFW network staff members are also meeting face to face with targeted LTSS providers to answer questions about the ICM program and maximize the LOI return rate.

  - To date, a total of 32 LTSS providers (representing 40 unique provider types) have declined to sign an LOI. Of this number, 22 are LTSS-STP providers. In general, the decline reason given as "Does not accept managed care" or "Waiting until State makes ICM award." Evercare will continue to follow-up with these providers if Evercare is selected as the ICM contractor.

- To assure we have complete geographic coverage of the service areas, our network staff created the table included as confidential ***Attachment 3.*** The table identifies the number of N2 LTSS provider types we have received an LOI from in every county of the service delivery area.

  Using our *LTSS Target List* we identified the number of potential prospects of each N2 LTSS provider type for each county. If the number of prospects is 0, this indicates there are no N2 provider types identified on the LTSS STP or DADS list for that county. We will continue to search for other Medicaid providers to cover these service areas.

Evercare will continue network development if selected as the ICM contractor and the same process will be used when converting LOIs to contracts, including:

- Immediate follow-up converting all LOIs to executed contracts. We will couple this with provider education and credentialing.

- Phone outreach and faxing of contracts/LOIs to all STP provider prospects. Our goal is to execute contracts / LOIs with all valid STP prospects.

- Specific to LTSS network growth, Evercare of Texas will hold in person meetings, and continue phone and fax outreach to all LTSS provider prospects to assure, if possible, that every N2 provider type is servicing every county in the service delivery area.

8. Section 4.7.3.2, Acute Care Providers
What is the bidder's plan for building out the Behavioral Health network in the Tarrant services area?

Response to question 9 is considered confidential.
Evercare's current network exceeds the access requirements of the ICM RFP for behavioral health providers in all counties as evidenced by the geo-access reports submitted with our original response. Evercare is partnering with United Behavioral Health (UBH) to provide both network services and coordinated behavioral health care management services. The current network consists of 399 individual clinicians, three County Mental Health Centers and 12 facilities and community-based providers (which provide inpatient and outpatient mental health / substance abuse services and wrap-around services). We will continue recruitment to ensure our network continues to meet or exceed the access requirements for all areas, including the most rural portions of the Tarrant service area.

UBH contracted individual clinicians by county are as follows: 94 in Tarrant, 74 in Denton, 2 in Wise, 10 in Parker, 10 in Hood and 9 in Johnson County. UBH has LOIs with three of the four MHMRAs that serve the Tarrant service area:

- Tarrant County MHMR Community Center serving Tarrant County (LOI)

- Pecan Valley MHMR Region serving Johnson, Parker and Hood Counties (LOI)

- Denton County MHMR Center serving Denton County (LOI)

- Helen Farabee Center MHMR serving Wise County (negotiating with provider to obtain an LOI and pursue full contracting)

Tarrant County: In addition to the MHMR, UBH has contracts with the following providers for behavioral health services:

- Baylor All Saints Medical Centers which provides mental health / substance abuse inpatient and outpatient services for adults.

- Harris Methodist Springwood which provides mental health / substance abuse inpatient and outpatient services for adults and adolescents.

- Huguley Memorial Hospital which provides mental health / substance abuse services, full continuum of inpatient and outpatient services for all ages.

- Millwood Hospital which provides mental health / substance abuse inpatient and outpatient services for adults, adolescents and children.
- Millwood Hospital – Excel Center which provides mental health / substance abuse outpatient services for adolescents and children.
- Sundance Behavioral Healthcare, Inc. which provides mental health outpatient services for children and adolescents.
- TRS Behavioral Care, Inc. which provides substance abuse inpatient and outpatient services for adolescents and adults at two locations.
- Cooks Children's Medical Center which provides mental health inpatient and outpatient services to children and adolescents.
- Valley Hope Associates which provides substance abuse inpatient and outpatient services to adults.

Denton County: in addition to the MHMR, UBH has contracts with two additional providers:

- TRS Behavioral Health which provides substance abuse partial hospitalization and intensive outpatient adult services.
- University Behavioral Health of Denton which provides mental health and substance abuse services for all ages.

Johnson County: UBH has an LOI with Pecan Valley MHMR. Walls Regional Hospital is the only hospital, and they do not offer behavioral health services.

Parker County: UBH has an LOI with Pecan Valley MHMR. The only hospitals in the county are Harris Methodist Northwest and Campbell Health System. Neither facility offers inpatient behavioral health services.

Hood County: UBH has an LOI with Pecan Valley MHMR. The only hospital in the county is Lake Granbury Medical Center, and they do not offer behavioral health services.

Wise County: UBH is attempting to obtain an LOI from Helen Farabee Center MHMR. Wise Regional has indicated that they will begin providing behavioral health inpatient services shortly. UBH will work to negotiate a contract as soon as those services are available.

UBH is continuing to identify additional services in Hood, Parker and Wise Counties. To ensure that members have access to inpatient services, the member will be transported to the nearest in-network provider or accommodations will be made for services at an out-of-network provider.

Wrap-Around Services for all Tarrant Service Area Counties: UBH has obtained an LOI with Adapt Texas, a provider of community-based behavioral health services including mobile crisis, in-home therapy, psychosocial rehab, emergency transportation, 24-hour crisis line and traditional outpatient mental health services including medication management for all ages.

Adapt currently works with NorthSTAR in the Dallas service area. It is our plan to have a contract which covers all or most of the Tarrant service area for these services.

UBH will continue network development including:

- Coordinating with the LMHAs and local family and consumer advocacy groups to identify new and additional services or providers for inclusion in the network.

- Pursuing contracts through telephone outreach and faxing to all behavioral health provider prospects in the Tarrant service area. Our goal is to contract with all valid behavioral health prospects who meet our credentialing criteria. Prospective providers will be identified through use of state listings, referrals and/or recommendations from Evercare, from the LMHAs, from family or consumer advocacy groups, professional associations, and other sources.

- In person meetings, telephone outreach, and/or faxing of contracts to all identified behavioral health provider prospects to assure, if possible, that every N1 provider type is servicing every county in the service delivery area.

Targeted outreach to behavioral health facilities, specialty groups and providers of wrap-around services to discuss expansion of current services as well as development of new services to maximize the behavioral health network especially in the rural counties.

Please see confidential ***Attachment 4*** for a copy of the updated N1 chart.

9. Section 4.7.3.3, Long Term Services and Supports Providers
The proposal includes only one home delivered meal provider and only one covered county, Collin. Please describe the bidder's plans for enrolling more home delivered meal providers.

Response to question 10 is considered confidential.
Evercare of Texas has significantly increased access to home delivered meals from the original RFP response. The original RFP response had coverage for home delivered meals in 3 counties. We have now procured LOIs from 11 Home Delivered Meals providers, 7 of which are STP providers. We have total of 25 locations for Home Delivered Meals providers with network coverage in all counties except Hood and Rockwall. In these counties the providers have indicated that they will not sign LOIs until an ICM contract is awarded. If Evercare is selected as the ICM contractor Evercare will re-contract these providers to obtain a contract.

	COLLIN	DALLAS	DENTON	ELLIS	HOOD	HUNT	JOHNSON	KAUFMAN	NAVARRO	PARKER	ROCKWALL	TARRANT	WISE
Home Delivered Meals	2	3	2	1		1	1	6	1	1		5	2

10. Section 4.7.7.1, Provider Training
The proposal does not include a Provider Training section. Please address this requirement.

Evercare's Experience

Evercare has nine years of experience conducting training for more than 3,000 providers and their staffs who participate in STAR+PLUS programs in the Harris service area. Our staff is specifically trained in Medicaid and Medicare as well as state and federal program rules and regulations. We use state of the art technology to inform and educate providers via entertaining presentations. We also distribute a *Quick Reference Guide* and other reference materials to serve as resource guides to help providers become familiar with how our relationship works. This experience will serve us well in helping health care providers provide high quality care to ICM members.

We host provider training seminars annually for physicians, hospitals, nursing homes, ancillary and long-term services and support (LTSS) providers in the Houston market. Topics include:

- Evercare welcome and introduction
- History of Evercare and the STAR+PLUS program
- Evercare products and services
- Value added benefits
- Service coordination
- Importance of verifying eligibility

- Disease management
- Managed care service delivery processes
- Contract requirements such as prior authorization, utilization review, and specialty referrals.

Because the STAR+PLUS program and the Money Follows the Person initiative both involve coordination of acute care and long-term services, special attention is given to education around long-term care supports.

Each provider services representative also conducts on-site provider Medicaid trainings every month as well as telephonic assistance to resolve issues in a timely manner. We feel that personalized attention in addition to annual meetings helps make sure that providers are current in their knowledge of billing modifications, changes in service delivery and current policies that impact their ability to serve the members as well as secure contracts.

Our approach to provider Medicaid training focuses on improving the member's quality of life and enhancing providers' practice of evidence-based medicine. We point out the benefits of the program from both a member and provider perspective. We emphasize the support that is available from Evercare's service coordinators in implementing, maintaining or maximizing the member's medical treatment plan. Because the STAR+PLUS trainings address the same services and populations that will be served under the ICM program, we are confident that this experience will enable us to offer outstanding provider training to providers in the ICM network.

Proposed ICM Provider Training Program

Types of Training Programs and Modality of Training

Prior to the effective date of the ICM program, Evercare will schedule specific trainings for all providers participating in the Evercare ICM service network, customizing sessions to accommodate the different provider types. The training program will be multifaceted, using both in-person instruction and written modules. Providers will have an opportunity to meet with Evercare staff members such as our medical director, our senior management team, service coordination team as well as staff members representing operations, sales, provider relations and quality management.

Sessions will be held in centralized locations to facilitate provider participation. On-site training will be provided upon the provider's request. We will also sponsor "Welcome" teleconferences to provide an orientation and question-and-answer period for providers whose schedules are more conducive to a teleconference format. If preferred, teleweb conferences can also be used.

In compliance with the requirements of **5.2.11.1** of the RFP, we will supplement training sessions with an ICM-specific *Provider Administrative Manual* that will be given to providers within five days of becoming a participating provider with Evercare and/or UBH. We will work closely with HHSC to ensure that the *Manual* complies with the Uniform Managed Care Manual requirements and to make certain that *Level of Care Guidelines* and clinical Best Practice Guidelines reflect all state, regional and local criteria.

The Manual will provide information on a range of topics regarding the ICM programs including ICM eligible populations and the roles of HHSC, DADS and the claims administrator, TMHP as well as sections that specifically pertain to:

- Covered benefits
- Eligibility
- How to reach us
- Contracting/provider relations
- Medical management
- Quality improvement
- Marketing guidelines
- Member's rights and responsibilities
- Authorization requirements, billing, claim appeals, etc.

These requirements and guidelines, along with the entire *Manual,* will be posted on our website to enable providers and their staff to access the material at any time. A draft of the *Manual* will be provided to HHSC for review and approval. HHSC's edits will be incorporated, and we will obtain a final "sign-off" from HHSC prior to forwarding the information for printing.

Other written material will include quarterly provider newsletters and ad hoc bulletins to educate providers and their staff about program changes, preventive medicine reminders, best practices in quality management and other key information.

Our medical director plays a key role in communicating up-to-date clinical information to network providers. In addition to utilizing the expertise of our own experienced staff, we regularly engage recognized experts in various health care specialties such as behavioral health treatment to make certain that we are promoting the most current treatment technologies and practices within our network.

As required in Section **5.2.11.1**, Evercare will make available to HHSC upon request any provider materials used for provider trainings, as well as the attendance rosters that were dated and signed by each attendee, or other written evidence of training of each provider and their staff.

Frequency of Provider Training

For new providers: Within 30 days of the contract becoming effective, Evercare will train all new providers on the ICM program, contractor managed services, and special needs of our membership. If needed, additional training will be conducted for specific requirements of the contract and the *Provider Administrative Manual.*

For existing providers in subsequent years: Providers will be offered ongoing training on significant changes in plan policies and procedures. At a minimum, this training will be provided on an annual basis. Provider relations representatives also conduct additional in-service education sessions periodically upon request. These sessions serve as refresher courses for providers or focus on a particular area of concern.

Provider services staff will continue to hold on-site trainings with providers each month to ensure timely communication of administrative and services changes. Providers will also be informed of changes in policies and procedures via quarterly newsletters and special mailings which are issued as needed.

Topics to be covered

Training topics may include, but are not limited to:

- The requirements of the ICM program
- Contractor managed services such as covered and non-covered services
- Role of the PCP, specialist and LTSS provider
- Information about the ICM eligible population, including those with special needs
- Service coordination and disease management programs
- Coordination and ADA compliance of care of children and adult members with special health care needs, disabilities and/or chronic conditions, wheelchair and handicap accessibility
- Continuity of care between the primary care team (PCP, service coordinator, family members, specialists and public entities and other community service programs)
- Verifying eligibility through various resource tools such as Medicaid 3087 ID Form, Evercare sample ID cards and the toll-free eligibility numbers for TMHP, Trailblazer Medicare and Evercare.
- Coordination of behavioral and physical health services such including value-added services such as dental, vision and transportation services
- Cultural and linguistic services such as the importance of non-discrimination and interpreter/translation services for members with special health care needs
- Evercare policies and procedures including:
  - Prior approvals
  - Utilization review and utilization management
  - Referral process (for both in- and out-of network referrals)
  - Quality assurance and participation in our Quality Improvement Program

- Fraud, waste and abuse
- Complaint and appeals process
- Member's rights and responsibilities
- Confidentiality and HIPAA Standards
- Medical record keeping and documentation standards such as advance directive notification
- Material highlighting Medicaid fee-for-service contract and program requirements for providing acute and community based long term support services

- Role of the state claims administrator, Texas Medicaid Healthcare Partnership (TMHP) and their claim and reimbursement processes via such resources as the Texas Provider Procedures Manual and the TMHP website
- Appointment and after-hours accessibility standards and on-call arrangements
- Long-term services and support
- Texas Health Steps (THSteps)
- Procedures for working with UBH and NorthSTAR for behavioral heath concerns and treatments
- Role of HHSC, DADS, and other agencies

Other general topics for provider trainings include a walk-through of the *Provider Administrative Manual* and the appendix for Texas ICM programming, information on how to reach us and other important contact telephone numbers, authorization procedures, level of care guidelines, billing procedures, and additional educational opportunities.

Providers Invited to Attend

All contracted providers, their clinical, front office and billing staff are invited to attend the training sessions. The training sessions will be developed to meet the unique needs of all provider types, with special emphasis on LTSS and STPs.

Maximizing Provider Participation

Provider network participation will be critical to the success of the ICM program. One key to maximizing provider participation will be to present topics that are of direct relevance and interest to the provider community. We will determine the topics by surveying our providers both formally and during on-site visits. We will send vibrant and eye-catching invitations emphasizing topics of interest to providers, such as our simplified authorization process and resolving billing issues.

Effective outreach prior to training is also of vital importance. To maximize participation during training, we will contact providers via mail, email and/or fax in advance of the scheduled training times. Reminder notifications will also be sent to providers to help maximize participation. To

accommodate provider schedules, training will be held on multiple dates and at various times; for example, we will provide training sessions over the lunch hour and offer free lunches to attendees. Training sites will be centrally located and easily accessible to providers in their service area. If providers are unable find a convenient time to attend training, we will arrange for a session in their office. Group practices will also be given the option to have one-on-one provider training in their offices. Consistent with Section **5.2.11.1**, we will maintain signed and dated attendance rosters for all trainings which we will make available to HHSC upon request.

Evaluation of Provider Training Programs

We will consistently evaluate each of our training programs to enhance the quality of the training sessions and better address the needs of our ICM members with the providers. Evercare will ask providers for feedback and suggest areas for improvement through a confidential and anonymous evaluation form distributed at the end of each training session. Participants will be asked to complete 10 to 15 questions about the quality of the training, usefulness of the information presented, and to provide suggestions for improvement. These surveys will be reviewed by the provider relations staff and used to improve future training sessions. For example, as a result of feedback, we changed the STAR+PLUS training location in Harris County to provide better parking and easier accessibility. In another example, when feedback indicated that providers were interested in receiving updates about relevant legislative changes, we incorporated those updates in our training.

Optional DVD Provider Training

Evercare recently developed an Orientation and Training DVD for physicians and their office staff. The DVD, along with a welcome packet is mailed to all newly contracted physicians within 30 days of their effective date with Evercare. Recognizing that time is of the essence to a busy office practice, the DVD was designed in a modular format allowing the viewer the opportunity to review specific modules/topics at their own pace and at the physician's option. In addition, as new office staff members are employed, the DVD can be shared amongst the team at any time. Modules include the following information:

- Brief Intro and review of their Welcome Packet contents
- Family of companies that comprise UnitedHealth Group
- Who Is Evercare?
- Service coordination and disease management
- Value added services
- How to reach us
- Verifying eligibility
- Authorization process
- Role of a primary care physician
- Role of a specialist physician
- Provider responsibilities
- THSteps provider responsibilities

- Provider training program
- Re-credentialing and onsite reviews
- Laboratory services
- Cultural competency and linguistic services
- Member's rights and responsibilities
- Claim submission guidelines
- Claim payment information
- Top Ten Reasons Claim Deny
- Claim appeals information
- Additional resources on our Web

11. Section 4.7.7.2, Provider Hotline
Will there be a dedicated hotline staff?

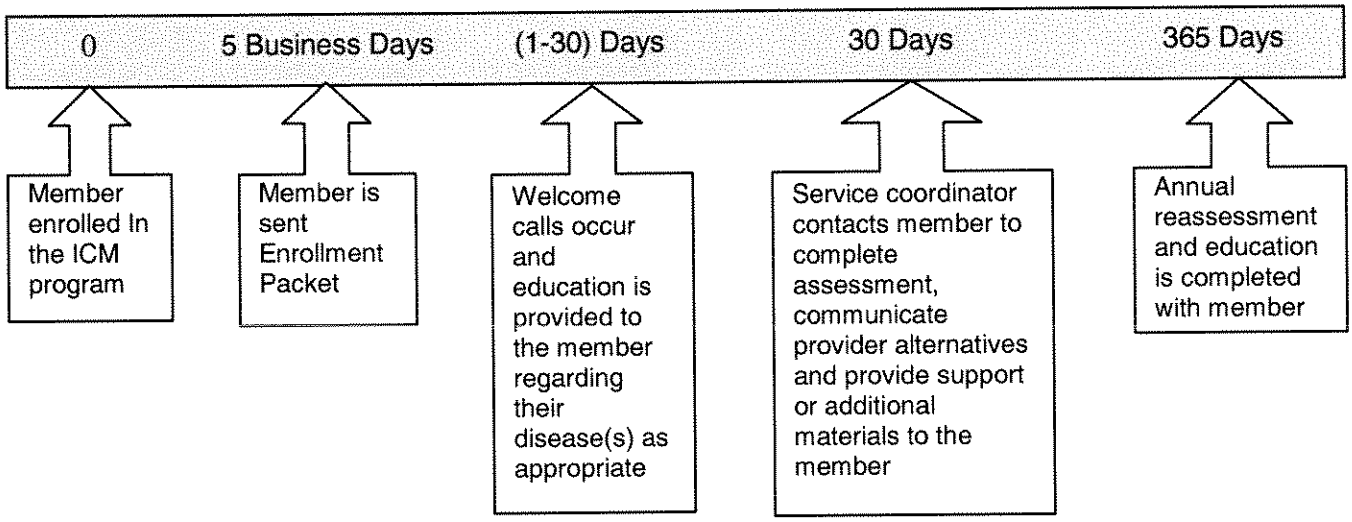
Evercare will train a designated team of call center staff, who will serve as a primary team, designated to the provider hotline for the ICM program. This team will also be cross trained on STAR+PLUS and other products. Our STAR-PLUS and other hotline staff will receive training on the ICM program so that they can provide overflow support for peak phone volume periods. Based on historical evidence, this is consistent with our current approach for our STAR+PLUS call center, and we believe it provides much better hotline capacity balancing and more reliable customer service than hotline staff units that are only trained on a single product because it significantly improves efficiencies in call load balancing. Smaller hotline staff groups that are assigned to the call volume for only one product may have little overflow support for peak phone volume periods. Cross trained staff (e.g.: equally capable on STAR+PLUS or ICM) can provide smoother handling of seasonal variations in call volume and can efficiently respond to increases in call volume related to start up periods or plan policy changes.

Cross trained call center units also provide geographic back up, in case of weather-related system problems or transient technical problems. Evercare's cross trained units are in multiple locations, based on membership volume. If one unit goes down due to technical problems, the call volume is automatically shifted to another cross trained unit, allowing routine hotline functioning while technical repairs are completed.

12. Section 4.7.8.3, Member Education
Please provide a proposed timeline for new Member orientation and education.

Evercare ICM Member Education Timeline

- Members are educated by their PCPs during routine office visits as well as during any emergency room visit.
- Members may call toll-free for additional information and receive educational materials.



Timing of New Members Orientation and Education

Evercare takes every opportunity to educate its members. From initial enrollment through accessing of care, we provide education to ensure the member receives the full benefit of participating in the ICM program. Each member receives easy-to-read, easy to understand information within the **first 5 business days** of enrollment into the Evercare plan.

At their initial contact which occurs within **30 days** of enrollment to the Evercare plan, the service coordinator continues the education process by reviewing the information received at enrollment, helping the member to further understand the program. We propose providing this member education outreach for the initial enrollment period and implementing a Welcome Call for new members.

New member orientation occurs within the **first 30 days** of enrollment into the ICM program.

13. Section 5.2.7.6, Initial Member Contact; Section 5.2.7.7, Functional Assessment Instruments
Please provide additional clarification of DADS' role in the approval of the 1915(c) Waiver components of the Service Plan.

Evercare will work with DADS to develop an approval process for the 1915(c) waiver

Components of the Service Plan in a manner that ensures timely access to services for the members.

14. Section 5.2.7.6, Initial Member Contact
Please provide additional clarification regarding additional individuals who may participate in the Service Plan development (PCP, LTSS or other provider; DADS representative; other parties chosen by the Member; and representatives of third-party resources).

Evercare works closely with the member and their family or representative to develop a service plan that accurately reflects the member's needs, values, strengths, wishes and abilities, as well as clinical treatment goals. Evercare will also include the member's PCP, and when appropriate, other providers, DADS representative, HCSSA, other community resources, and any other individuals the member wishes to include.

15. Section 5.2.12, Provider Complains and Appeals; Section 5.2.14, Member Complaint and Appeal Process
Please provide additional clarification of the vendor's planned approach for handling provider and member complaints and appeals, and referring complaints and appeals that do not relate to ICM Contractor actions to the appropriate entity.

We will coordinate with HHSC, DADS, and ACS to develop and implement a comprehensive process for handling member and provider complaints and appeals, including complaints regarding quality, service, access, or payment. Evercare will track and trend the complaints and will implement quality improvement initiatives as necessary.

16. Section 4.8.3, Optional Cost-Saving Strategies
(a) Please provide additional information/clarification regarding the vendor's proposed behavioral health pilot project, including how it will interface with the various MHMR centers' roles as mental health authorities.

Behavioral health will coordinate, collaborate and compliment existing services to provide comprehensive treatment services for members.

United Behavioral Health (UBH) has Care Advocates that interact with MHMR Case Managers per assigned member. UBH coordinates treatment teams during hospital admissions that enlist MHMR Case Workers and all service providers. UBH Field Care Advocates/Liaisons interact with MHMR to assist in coordinating community services and problem resolution. UBH has access to the CareOne system, Evercare's clinical platform, and enters behavioral health interventions as part of the comprehensive service plan. This facilitates the effective integration of physical and metal health services.

UBH also contracts with the local community mental health organizations. To facilitate communication, face-to-face meetings are scheduled every 8 weeks. Additional meetings can be arranged at the request of the community mental health center. UBH has developed and received approval from HHSC on LMHA contract appendix for STAR and STAR+PLUS and internal policy and procedures, copies of which are included with this submittal. It is UBH's intent to utilize the attached policies and procedures if chosen as the ICM contractor.

(b) Please provide more detailed information concerning the Evercare Partnership Plus program proposed as an optional cost-savings strategy.

The program has been piloted in two Ohio locations with a focus on the discharges from three high-volume hospitals in each city. The emphasis of the pilot was to provide focused and intensive service coordination during the acute hospital admission for those acute care cases where potential discharges include Long Term Acute Care (LTAC), Acute Rehab (AIR) or Skilled Nursing Facility (SNF) admits, and continuing throughout the duration of stay within LTACs, AIRs and SNFs.

Program results are outlined below

Results

- Data for the initial nine months of the pilot reflects success in reduction of LTAC admissions and length of stay (LOS), reduction in Acute Rehabilitation admissions and LOS, reduction in SNF admissions and LOS and increased diversion to home-based care. Readmission data on enrollees managed through EPP is not yet available.

Ohio EPP Savings To Date

	Pilot Timeframe	FTE	Annual FTE Cost
Ohio - Cincinnati	**September 2005 through May 2006**	**1**	**$102,260**
Ohio - Cleveland	**August 2005 through May 2006**	**1**	**$102,260**

Market	Pilot SNF Admits/ Discharges	Baseline SNF ALOS/ Market	EPP SNF ALOS/ Market	Average Days Saved/ Case	Total Days Saved/ Market	Average SNF Cost/day	Savings
Cincinnati 2005	121/107	21	15.7	5.3	567.1	$350	**$ 98,485**
Cincinnati 2006	188/185	21	15.8	5.2	962	$350	**$336,700**
Cleveland 2005	123/115	21	11.7	9.3	1069.5	$350	**$374,325**
Cleveland 2006	117/116	21	12.9	8.1	939.6	$350	**$328,860**

Market	Cases diverted to LLC/Market	Average Savings/ Diversion**	Total Diversion Savings/Market	Total SNF LOS Reduction Savings/Market	Total Savings/ Market
Cincinnati 2005	49	$ 9,000	**$ 441,000**	**$ 198,485**	**$ 639,485**
Cincinnati 2006	74	$ 9,000	**$ 666,000**	**$ 336,700**	**$ 1,002,700**
Cleveland 2005	26	$ 9,000	**$ 234,000**	**$ 374,325**	**$ 608,325**
Cleveland 2006	35	$ 9,000	**$ 315,000**	**$ 328,860**	**$ 643,860**
			$1,656,000	**$1,238,370**	

Gross EPP Savings from 8/1/05 through 5/31/06 both markets : $ 2,894,370

** Diversion savings based on overall savings from pilot diversions and averaged to $9,000 per diverted case

17. Section 4.8.3 Optional Cost-Savings Strategies: LifeSolutions Behavioral Disease Management

Additional information/clarification regarding the vendor's proposed behavioral health pilot project, including how it will interface with the various MHMR centers' roles as mental health authorities.

Behavioral health will coordinate, collaborate and compliment existing services to provide comprehensive treatment services for members.

United Behavioral Health (UBH) has Care Advocates that interact with MHMR Case Managers per assigned member. UBH coordinates treatment teams during hospital admissions that enlist MHMR Case Workers and all service providers. UBH Field Care Advocates/Liaisons interact with MHMR to assist in coordinating community services and problem resolution. UBH has access to the CareOne system, Evercare's clinical platform, and enters behavioral health interventions as part of the comprehensive service plan. This facilitates the effective integration of physical and metal health services.

UBH also contracts with the local community mental health organizations. To facilitate communication, face-to-face meetings are scheduled every 8 weeks. Additional meetings can be arranged at the request of the community mental health center. UBH has developed and received approval from HHSC on LMHA contract appendix for STAR and STAR+PLUS and internal policy and procedures, copies of which are included with this submittal. It is UBH's intent to utilize the attached policies and procedures if chosen as the ICM contractor.

18. Section 4.7.2.5, Electronic Health Information

HHSC requested more information on phase 3 of the Electronic Health Information pilot proposed. Below is an explanation of the eMedicalFiles process.

eMedicalFiles utilizes a user friendly biometric admission/discharge procedure – every time. Our program documents time, place and duration of the entitled patients visit and enables an audit trail for utilization review and fraud, abuse and waste reduction.

eMedicalFiles product increases the accuracy of initial captured information (demographic and clinical). We offer a completely portable Electronic Medical Record to provide Continuity of Care as the patient enters multiple points of service. The program includes online enrollment capability from home and/or onsite kiosks, resulting in ease and speed of patient access to entitled services and quick identification of repeat patients

eMedicalFiles complies with the HIPAA EDI, Privacy and Security final rules for protected health information. The program provides real-time insurance eligibility in seconds. Electronic data information transfers accurate demographic information to existing platforms by employing HL-7 messaging. eMedicalFiles privacy allows safe transfer of current life-saving medical and demographic information and protects all

information though biometrics, with or without smart cards, encryption and unique hardware (scanner/readers).

Electronic Medicare Record Benefits Features

- Enables coordination of care between all providers including the patient's self-treatment
- Reduces duplicative care and prescription errors
- Easy to use, reduces time allocated to record keeping and increases time available to spend with patient
- Can be accessed on any computer or PDA
- Drug interaction assessment software to safeguard against duplicative prescriptions and drug interactions for both prescription and over-the-counter drugs
- Practice management system to improve profitability by electronically integrating costly business processes including billing, collections, eligibility and authorization.

Fraud, Abuse & Waste Reduction

eMedicalFiles includes a biometric finger image which definitively identifies an authorized patient and prevents unauthorized use, including:

- Electronic medical record verifies the provision of medical services
- Authenticates the bill
- Prevents duplication of services
- Prevents doctor shopping
- Prevents duplication of prescriptions
- Reduces medications available for street sale
- Reduces duplicative billing, phantom billing and many other billing abuses
- Prevention can save the healthcare system billions of dollars by greatly reducing detection and prosecution costs and by eliminating many fraudulent and inaccurate claims from entering the healthcare system

19. Section 4.8.2, Component Pricing for Administrative Pilots

Please provide additional information concerning the revised, phased-in approach for the Electronic Health Information Pilot Project.

As provided in Section 4.7.2.5, it is anticipated that development work for Phases 1 and 2 of the project will occur over the seven months preceding pilot operation, beginning the effective date of the ICM Program.

Revised implementation timelines

- Phase 1 would be implemented by October 1, 2007
- Phase 2 would be implemented by September 1, 2008
- Phase 3 to be determined – Evercare proposes to work with HHSC on development of phase 3 in conjunction with hospitals who will participate. Timeframe to be determined.

20. Section 4.8.4, Primary Care, Case Management and Care Coordination Incentive Strategies

Evercare understands and agrees that funds will not be available from HHSC to implement primary care, case management and care coordination incentive strategies in described in Section 4.8.4 of Evercare's proposal during Contract Year One.

21. Assumptions

With the exception of the assumptions included in HHSC's RFP and therefore Evercare's original proposal, Evercare hereby deletes all assumptions included in its original proposal dated October 6, 2006.