Contract Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)
Subject: Amendment Four to the HHSC Managed Care Contract Document for the Foster Care Program

HHSC Contract No. 529-06-0293-00001D

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 Superior HealthPlan Network (MCO) a corporation organized under the laws of the State of Texas, having its principal place of business at: 2100 South IH-35, Suite 202, Austin, Texas 78704. HHSC and MCO may be referred to in this Amendment individually as a "Party" and collectively as the "Parties."

Part 2: Effective Date of Amendment:	Part 3: Contract Expiration Date	Part 4: Operational Start Date:
September 1, 2009	August 31, 2010	April 1, 2008

Part 5: Project Managers:

HHSC:

Scott Schalchlin
Director, Health Plan Operations
11209 Metric Boulevard, Building H
Austin, Texas 78758
Phone: 512-491-1866
Fax: 512-491-1969

MCO:

Director of Compliance and State Reporting,
Superior HealthPlan Network
2100 South IH-35, Suite 202
Austin, Texas 78704
Phone: 512-692-1465
Fax: 512-692-1474

Part 6: Deliver Legal Notices to:

HHSC:

HHSC General Counsel
4900 North Lamar Boulevard, 4th Floor
Austin, Texas 78751
Fax: 512-424-6586

MCO:

Executive Director, Superior HealthPlan Network
2100 South IH-35, Suite 202
Austin, Texas 78704
Phone: 512-692-1465
Fax: 512-692-1474

Part 7: Payment

Capitation Rate

Contract Year One will begin on the Contract Effective Date and end on August 31, 2008. After the Operational Start Date, HHSC will pay the MCO the Capitation Rate for each Member who is enrolled in the MCO as of the first day of the month. If a Member's Effective Date of Coverage occurs after the first day of the month, the MCO will not receive the Capitation Rate for the Member for the month.

For Contract Years One and Two and Three, HHSC will pay the MCO the following Capitation Rates, consisting of the following per-member-per-month (PMPM) components:

Part 7 Modified by Versions 1.1, 1.2 and 1.3

PMPM Component	Contract Year One -- April 2008-August 2008	Contract Year Two – SFY 2009	Contract Year Three – SFY 2010
Base Price	$639.37	$641.65	$718.34
Health Passport (HP)			
HP Base Price	$.91	$.91	$.91
Quest Lab PDF Report Download*	$.13	$.13	$.13
Total HP Cost	$1.04	$1.04	$1.04
Total Capitation Rate	$640.41	$642.69	$720.42

* See Attachment C-2, Item 25(g) for a description of this service.

The Parties will negotiate the Capitation Rates 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 Capitation Rate and the payment requirements.

Part 7 of the "HHSC Managed Care Contract Document for the Foster Care Program," effective February 23, 2007, required HHSC adopt a rule change regarding out-of-network children's hospital providers in the Foster Care Program (also known as the "STAR Health Program.") The Parties understand and agree that Amendment One removed this requirement, and that the Capitation Rate for Contract Year One is no longer conditioned upon a rule change.

One-Time Development Fee

In addition to the Capitation Payment, HHSC will pay the MCO a one-time development fee of **$629,333.00** for the Health Passport system. This one-time development fee is intended to reimburse the MCO for a portion of the actual costs associated with the development of the Health Passport, including without limitation the costs described in Attachment C-2, Items 25(i), 27(k) and 30. This amount was paid within 30 calendar days after the HMO's completion, and HHSC's approval, of the final Health Passport system design, specifications and configuration documents, as described in Attachment C-2, Item 27(k).

Bariatric Supplemental Payment: See Attachment A, "General Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Bariatric Supplemental Payment for the STAR Health Program. The Bariatric Supplemental Payment is $23,000.

Part 8: Contract Attachments:

A: General Contract Terms & Conditions, Version 1.4 (previously RFP Appendix A)

B: Scope of Work/Performance Measures

- B-1: HHSC RFP 529-06-0293, Sections 1-5, Version 1.4*
- B-2: Covered Services, Version 1.4 (previously RFP Appendix C)
- B-3: Value-added Services, Version 1.4
- B-4: Performance Improvement Goals, Version1.4 (previously RFP Attachment C-1)
- B-5: Deliverables/Liquidated Damages Matrix, Version1.4 (previously RFP Appendix B)

*All RFP attachments and appendices are incorporated herein by reference, with the exception of: RFP appendices A, B, C, D, E, F, H, I, and J; and RFP attachment C-1. All remaining references in the Agreement to RFP attachments and appendices not incorporated herein by reference are superfluous. In addition, HHSC will publish the Uniform Managed Care Manual with provisions applicable to the Foster Care Program on its website.

C: MCOs Proposal and Related Documents

C-1: MCO's Proposal
C-2: Agreed Modifications to the MCO's Proposal, Version 1.3

Part 10: Signatures:

The Parties have executed this Amendment 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: _____
Title: Executive Commissioner
Date: 8-28-09

MCO

By: _____
Title: Holly Munin
Date: 7/23/09 CEO Foster Care

Texas Health & Human Services Commission

General Contract Terms & Conditions for the Foster Care Program

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	February 23, 2007	Initial version of the General Terms & Conditions that includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2008	Article 2 is modified to correct and align definition for Clean Claim with the UMCM. Article 2 is modified to add the definitions for Non-Urban County and Urban County. Article 2 is modified to clarify the definition for Pre-Appeal. Article 2 is modified to reflect legislative changes required by SB 10 to the definition for Value-added Services. Section 4.09(c) is modified to add a cross-reference to Attachment B-1, Sections 4.1.1.1, Additional HMO Readiness Reviews and 4.1.22, Management Information System Requirements Section 5.02(c) is modified to require that the DNF will be picked up every day. Section 5.02(g) is modified to correct the name of the Daily Eligibility file. Section 10.09 (c) is modified to remove the word “administrative” from the title of UMCM chapter reference. Section 10.09 (d) is modified to increase the Experience rebate loss carry forward from 1 year to 2 years. Section 10.09 (e) (4) is modified to remove the word “administrative” from the title of UMCM chapter reference. Section 10.16 is added to clarify the required pass through of physician rate increases for all programs to comply with HHSC directives. Section 17.01 is amended to clarify the insurance requirements for the MCO and Network Providers and to remove the insurance requirements for Subcontractors.
Revision	1.2	September 1, 2008	Table of Contents, Section 4.05 is modified to change “DFPS Liaisons” to “STAR Health Liaisons”. Table of Contents, is modified to add Section 9.07 and Section 10.09.01. Table of Contents, Section 10.08 is intentionally left blank. Article 2 is modified to update the definition of Affiliate, to correspond to the definition in the UMCC. Article 2 is modified to update the definition of Allowable Expenses. Article 2 is modified to add a definition for Daily Notification File (DNF).

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Article 2 is modified to delete the definition for Delivery Supplemental Payment. Article 2 is modified to add a definition for Dental Home. Article 2 is modified to update the definition of DFPS Liaisons which are now referred to as STAR Health Liaisons. Article 2 is modified to add a definition for Financial Statistical Report (FSR). Article 2 is modified to delete the definition for Rate Cell. Section 4.02 is modified to change "DFPS Liaisons" to "STAR Health Liaisons". Section 4.05 is modified to change "DFPS Liaisons" to "STAR Health Liaisons". Section 09.07 is added to require the HMOs to notify HHSC of legal and other proceedings, and related events. Section 10.08, Delivery Supplemental Payment is deleted in its entirety and the section intentionally left blank. Section 10.09(a) is modified to correct a typographical error. Section 10.09 (b) is modified to change the heading in the table from 'Experience Rebate as a % of Revenues' to 'Pre-tax Income as a % of Revenues'. Section 10.09 (c) (1) is modified to remove the word "administrative" from the title of UMCM chapter reference and to include treatment of the new Incentives and Disincentives within the Experience Rebate determination. In addition, several clarifications have been made with respect to the continuing accrual of any unpaid interest. Section 10.09 (e) is modified to address change in way Experience Rebate is calculated and Payments are rendered. Section 10.09 (f) is modified to address change in way Interest is calculated for Experience Rebate.
Revision	1.3	June 1, 2009	Article 2 is modified to add the definition for Bariatric Supplemental Payment. Article 2 is modified to add definition for CONNECTIONS. Article 2 is modified to remove "emancipated minor" and "substitute care"from the definition for Target Population and clarify the age range for young adults. Section 4.02 is modified to add item d) regarding dedicated staff and item e) regarding training for dedicated staff. Section 4.05 is modified to clarify responsibilities of the STAR Health Liaison. Section 4.09 is revised to add item (b)(6) to require a pre-

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			delegation audit before functions can be delegated to a subcontractor. Section 5.03 is modified to add item (b)(4) to clarify movement from STAR+PLUS to STAR Health; add item (e) regarding movement from STAR Health due to SSI status; and add item (f) regarding effective date of SSI status. These clarifications to existing policies and processes will be effective 9/1/08. Section 10.09 is modified to remove the 1% performance based rate placed at-risk language from the contract. Section 10.17, Bariatric Supplemental Payment is added.
Revision	1.4	September 1, 2009	All references to "THSteps" are changed to "Texas Health Steps" Article 2 definition for Health Passport is modified Article 2 is modified to add the definition for Rate Period 3 Section 7.02 is modified to match Civil Action No. as it appears on Consent Decree document being referenced. Section 10.09(a) is amended to chage 2% to a specified percentage. Section 10.09(b) is amended to reflect the change in the SFY 2010 shariing tier structure for the Experience Rebate. Section 10.09(d) is amended to clarify the two year loss carry forward. Section 10.09(e) is amended to clarify the required documentation for non-scheduled payments. Section 12.15 is added to establish a pre-termination process Section 17.01(a) is modified to provide clarification of required insurance coverage, including deletion of Standard Worker's Section 17.01(b) is modified to correctly identify the type of professional liability coverage required. Section 17.01(c)(4) is modified to require that HHSC is named as loss payee of insurance coverage. Section 17.01(c)(5) is modified to require continuous coverage during Term of Contract. Section 17.01(c)(6) is modified to require notification prior to reduction in coverage and to add provision to insurance policy requiring 30-day notice prior to reduction in, cancellation, or non-renewal of, the policy. Section 17.02(a) is modified to align the performance bond requirements with insurance practices by requiring one bond with a defined term and amount and to require annual renewal of the bond.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 17.02(b) is added to establish a process for release of previous performance bonds received by HHSC.

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

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

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

TABLE OF CONTENTS

Article 1. Introduction

Section 1.01 Purpose.

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

Section 1.02 Risk-based contract.

This is a Risk-based contract.

Section 1.03 Inducements.

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

(1) MCO is an exclusive provider benefit plan that arranges for the delivery of health care services, is currently licensed as such in the State of Texas and is fully authorized to conduct business in the Service Area;

(2) MCO and the MCO Administrative Service Subcontractors have the skills, qualifications, expertise, financial resources and experience necessary to provide the Services and Deliverables described in the RFP, MCO's Proposal, and this Contract in an efficient, cost-effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities;

(3) MCO has thoroughly reviewed, analyzed, and understood the RFP, has timely raised all questions or objections to the RFP, and has had the opportunity to review and fully understand HHSC's current program and operating environment for the activities that are the subject of the Contract and the needs and requirements of the State during the Contract term;

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

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

Section 1.04 Construction of the Contract.

(a) Scope of Introductory Article.

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

(b) References to the "State."

References in the Contract to the "State" shall mean the State of Texas unless otherwise specifically indicated and shall be interpreted, as appropriate, to mean or include HHSC and other agencies of the State of Texas that may participate in the administration of the 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, rules, regulations, and manuals in this Contract are deemed references to these documents as amended, modified, or supplemented from time to time during the term of this Contract.

Section 1.05 No implied authority.

The authority delegated to MCO 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 MCO any authority related to this program unless directed through HHSC. MCO may not rely upon implied authority, and specifically is not delegated authority under this Contract to:

(1) make public policy;

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

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

MCO 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 MCO Program(s), as directed by HHSC.

Section 1.06 Legal Authority.

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

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

Article 2. Definitions

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

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

Action means:

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

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

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

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

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

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

An Adverse Determination is one type of Action.

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

Acute Care Hospital means a hospital that provides acute care services. Acute Care Hospitals can be General Hospitals.

Adjudicate means to deny or pay a Clean Claim.

Administrative Services see MCO Administrative Services.

Administrative Services Contractor see HHSC Administrative Services Contractor.

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

Affiliate means any individual or entity that meets *any* of the following criteria: 1) owns or holds a five percent (5.0%) or greater interest in the MCO (either directly, or through one or more intermediaries); 2) in which the MCO owns or holds a five percent (5.0%) or greater interest (either directly, or through one or more intermediaries); 3) any parent entity; or subsidiary entity of the MCO, regardless of the organizational structure of the entity; 4) any entity that has a common parent with the MCO (either directly, or through one or more intermediaries); 5) any entity that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the MCO; or, 6) any entity that would be considered to be an affiliate by any Securities and Exchange Commission (SEC) or Internal Revenue Service (IRS) regulation, Federal Acquisition Regulations (FAR), or by another applicable regulatory body.

Definition for Affiliate modified by Version 1.2

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

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

Definition for Allowable Expenses modified by Version 1.2

AAP means the American Academy of Pediatrics.

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

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

Authorized Representative means any person or entity acting on behalf of the Member and with the Member's written consent in the Complaint and Appeals process.

Auxiliary Aids and Services includes:

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

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

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

Definition for Bariatric Supplemental Payment Added by Version 1.3

Bariatric Supplemental Payment means a one-time per bariatric surgery supplemental payment.

Behavioral Health Hotline means the toll-free number operated by the MCO to handle routine behavioral-health related calls.

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

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

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

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

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

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

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

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

Caregiver means the DFPS-authorized caretaker for a Member, including the Member's's foster parent(s), relative(s), or 24-hour child-care facility staff.

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

Case Management Services means the provision of Case Management Services by DFPS or its contractors to a Member for whom DFPS has been appointed temporary or permanent manageing conservator. Case Management Services include caseworker-Member visits, family visits, the convening of Family Group Conferences, the development and revision of the Case Plan, the coordination and monitoring of services needed by the Member and family, and the assumption of court-related duties, including preparing court reports, attending judicial hearings and permanency hearings, and ensuring that the Member is progressing toward permancency within state and federal mandates.

Case Plan means the plan developed in accordance with 40 T.A.C. §700.1330 and related law. The purpose of the Case Plan, which includes the Member's service plan and the family's service plan if applicable, is to establish a structured, time-limited plan for providing services and to ensure that activities and services progress as quickly as possible toward achieving the most appropriate permanent placement for the Member. DFPS Staff are responsible for developing the Case Plan.

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

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

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

(1) ranges in age from birth up to but not including age nineteen (1<19) years;

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

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

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

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

Children's Hospital means a Hospital that offers its services exclusively to children. Services provided at Children's Hospitals include clinical care, research, and pediatric medical education focused specifically on children.

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

Definition for Clean Claim modified by Version 1.1

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

(1) 837 Professional Combined Implementation Guide;

(2) 837 Institutional Combined Implementation Guide;

(3) 837 Professional Companion Guide; or

(4) 837 Institutional Companion Guide.

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

CMS means the Centers for Medicare and Medicaid Services, which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

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

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

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

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

Comprehensive Care Program: See definition for Texas Health Steps.

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

(1) Confidential 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 MCO, or participating State agencies for the purpose of fulfilling a duty or obligation under this Contract and that has not been disclosed publicly.

Definition for CONNECTIONS Representatives Added by Version 1.3

CONNECTIONS Representatives means dedicated MCO staff located in each regional office, who are responsible for Service Coordination functions that include:

(1) assisting Members, Caregivers, and Medical Consenters with coordination of care needs to include the scheduling of appointments and transportation;

(2) conducting outreach efforts; and

(3) educating Members, Caregivers, Medical Consenters regarding Service Coordination services.

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

Contract (or Agreement) means this formal, written, and legally enforceable contract 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 (ie, September 1 to August 31 of the following calendar year) under the Contract.

Contractor (or MCO) means the managed care organization that is a party to this Contract.

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 MCO.

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.

Covered Services means Health Care Services the MCO must arrange to provide to Members, including all services required by the Contract, state and federal law, and all Value-added Services negotiated by the Parties (see **Attachment B-3 to the Managed Care Contract** relating to "Value-added Services"). Covered Services include, without limitation, Acute Care, Behavioral Health Services, dental Services, pharmacy services, vision services, and court-ordered medical services.

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

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

Definition for Daily Notification File (DNF) Added by Version 1.2

Daily Notification File (DNF) means the file used to provide notification on a daily basis to the STAR Health MCO and the Vendor Drug Contractor concerning each new client that is taken DFPS conservatorship. The STAR Health MCO and the Vendor Drug Contractor should begin providing STAR Health services to the member upon receipt of the DNF. This is not an eligibility file.

Date of Disenrollment means the last day of the month in which the Member loses Medicaid eligibility.

Day means a calendar day unless specified otherwise.

Definition for Delivery Supplemental Payment Removed by Version 1.2

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

Definition for Dental Home Added by Version 1.2

Dental Home means a dental provider who is responsible for providing initial and primary dental care to Members, and for maintaining the continuity of dental care.

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

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.

Definition for DFPS Liaison changed to STAR Health Liaison by Version 1.2

DFPS Staff means the administrators and employees of DFPS. For the limited purpose of this RFP, references to DFPS Staff in the context of Substitute Care Services and Case Management Services may also refer to personnel of Independent Administrators and the Substitute Care and Case Management Service providers in an outsourced region. This definition shall not, however, be construed to afford persons who are not employed by the State of Texas any of the protections or rights of state employees.

Disabled Person or Person with Disability means a person who qualifies for Medicaid services because of a Disability.

Disability means a physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

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

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

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

Disproportionate Share Hospital (or 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.

DSHS means the Texas Department of State Health Services or its successor agency .

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

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

EDI means electronic data interchange.

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

Effective Date of Coverage means the date of entry into DFPS conservatorship.

Eligibles means individuals eligible to enroll in the 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) that renders Members incapable of controlling, knowing or understanding the consequences of their actions.

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

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

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

(2) serious impairment to bodily functions;

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

(4) serious disfigurement; or

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

Encounter means a Covered Service or group of Covered Services delivered by a Provider to a Member during a visit between the Member and Provider.

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

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

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

Exclusive Provider Benefit Plan (or EPP) means a type of health care plan offered by an issuer that arranges for or provides benefits to covered persons through a network of exclusive providers, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or approved referral.

Experience Rebate means the portion of the MCO's Net Income before Taxes that is returned to the State in accordance with **Section 10.09** ("Experience Rebate").

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

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

External Quality Review Organization (or EQRO) means the entity that contracts with HHSC to provide external review of access to and quality of heatlh care provided to Members of HHSC's MCO 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.

Family Group Conference (or FGC) is a planned, professionally facilitated meeting for the purpose of making decisions regarding a Member's placement and permanency plan. FGC participants can include immediate and extended family members, friends and significant people in the community, DFPS Staff and other professionals working with the family, and the Member, if appropriate. At the FGC, professionals share information, concerns, and resources with the family. The family then meets alone to develop the family service plan. DFPS confirms whether the plan meets legal requirements, adding any necessary elements. Finally, the family signs the DFPS service plan, which is submitted to the court.

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

Definition for Financial Statistical Report (FSR) Added by Version 1.2

Financial Statistical Report (FSR) means the report completed by the MCO, and submitted to HHSC, which details revenues, expenses, income, member-months, ratios, and related monthly and year-to-date financial data pertaining to the financial performance and results of the Contract.

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.

FPL means the Federal Poverty Level.

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

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

FSR means Financial Statistical Report.

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.

Heatlh Care Service Plan means an individualized plan developed with and for Members with Special Health Care Needs. The Heatlh Care Service Plan includes, but is not limited to, the following:

(1) the Member's history;

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

(3) short and long term needs and goals;

(4) a treatment plan to address the Member's physical, psychological, and emotional health care problems and needs including a list of services required, their frequency, and a description of who will provide such services.

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

Health Care Services means the Acute Care, Behavioral Health care and health-related services that an enrolled population might reasonably require in order to be maintained in good health, including, at a minimum, Emergency Services and inpatient and outpatient services.

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

Definition for Health Passport Modified by Version 1.4

Health Passport means an electronic health record system used to document information regarding medical services provided to a Member.

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

HEDIS means the Health Plan Employer Data and Information Set, which 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.

HHSC Uniform Managed Care Manual means the manual published by or on behalf of HHSC that contains policies and procedures required of an MCO participating in the Program.

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

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

Intermediate Care Facility for the Mentally Retarded (ICF-MR) means and intermediate care facility for persons with mental retardation that

provides residential care and services for those individuals based on their functional needs.

Independent Administrator (or IA) means an independent agency selected by DFPS to:

(1) secure, coordinate and manage Substute Care Services and Case Management Services in a geographically designated area of the state; and

(2) ensure Continuity of Care for a Member referred to the IA by DFPS and the Member's family from the day a Member enters the child protective services system until the Member leaves the system.

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.

Initial Contract Period means the Effective Date of the Contract through August 31, 2010.

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

Integrated Primary Care (or IPC) means an approach to care that integrates Behavioral Health Services into primary care during the regular provision or primary care services. IPC occurs at the same time and by the same provider, or by the Beharvioral Health Services provider seeing the Member in tandem with the PCP.

JCAHO means Joint Commission on Accreditation of Health Care Organizations.

Joint Interface Plan (or JIP) means a document used to communicate basic system interface information. This information includes, without limitation: 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 MCO's interfaces required to conduct business under this Contract. The JIP must address the coordination with each of the MCO'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 MCO Personnel means the critical management and technical positions identified by the MCO in accordance with **Article 4**.

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

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

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.

Major Population Group means any population, which represents at least 10% of the Medicaid population in a county in the Service Area served by the MCO.

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

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

(1) enroll with the MCO; or

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

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

Material Subcontractor (or Major Subcontractor) means any entity that contracts with the MCO for all or part of the MCO Administrative Services, where the value of the subcontracted MCO Administrative Service(s) exceeds $100,000, or is reasonably expected to exceed $100,000, per State Fiscal Year. Providers in the MCO's Provider Network are not Material Subcontractors.

MCO (or Contractor) means the managed care organization that is a party to this Contract.

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

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.

Medical Consenter means the person who may consent to medical care for the Member under Chapter 266 of the Texas Family Code.

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

Medical Home Services Model means an enhanced approach to the Medical Home whereby primary care is accessible, continuous,

comprehensive, family-centered, coordinated, compassionate, and culturally effective.

Medically Necessary means:

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

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

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

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

(d) consistent with the diagnoses of the conditions;

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

(f) are not experimental or investigative; and

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

(2) Behavioral Health Services that are:

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

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

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

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

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

(f) are not experimental or investigative; and

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

Member means a person who:

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

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

Member Hotline means the toll-free telephone line operated by the MCO that responds to inquiries from Members, DFPS Staff, Caregivers and Medical Consenters.

Member Materials means all written materials produced or authorized by the MCO and distributed to Members or potential members containing information concerning the MCO Program. Member Materials include, but are not limited to, Member ID cards and Member Handbooks and Provider Directories,.

Member Month means one Member enrolled with the MCO 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 MCO for the purpose of informing Members about Covered Services provided by the Model.

Member(s) with Special Health Care Needs (or MSHCN) includes a Child or Children with a Special Health Care Need (CSHCN) and any Member age nineteen or over (≥19) who:

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

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

MIS means Management Information System.

Model (or Program) means the Comprehensive Health Care Model for Foster Care that is administered by HHSC and the subject matter of this Agreement.

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

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

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

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

Non-capitated Services means the Texas Medicaid programs and services that are excluded

from MCO Covered Services, but Members are eligible to receive from Texas Medicaid providers on a Fee-for-Service basis. Non-capitated Services are identified in Section 4 of the RFP.

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

Definition for Non-Urban County Added by Version 1.1

Non-Urban County means any county with fewer than 50,000 residents as reported by the Texas Association of Counties at: http://www.county.org/. Also referred to as "rural county".

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.

Nurse Hotline means the toll-free telephone line operated by the MCO that Providers, Members, DFPS Staff, Caregivers, and Medical Consenters can call for clinical information, guidance on specialty referrals or requests for specialty Provider consultations.

OB/GYN means obstetrician-gynecologist.

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

Operational Start Date means the first day on which an MCO is responsible for providing Covered Services to Members in exchange for a Capitation Payment under the Contract. The Operational Start Date applicable to this Contract is included in the **Managed Care Contract document**.

Operations Phase means the period of time when MCO is responsible for providing the Covered Services and all related Contract functions. The Operations Phase begins on the Operational Start Date.

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

Parties means HHSC and MCO, collectively.

Party means either HHSC or MCO, individually.

Pended Claim means a claim for payment that requires additional information before the claim can be adjudicated as a Clean Claim.

Performance Indicator Dashboard means a contract monitoring tool used by HHSC and updated quarterly by HHSC to measure the MCO's progress on a number of performance measures.

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

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

Definition for Pre-Appeal Modified by Version 1.1

Pre-Appeal means the process by which the MCO seeks to resolve disagreements with Medical Consenters, Caregivers, DFPS Staff, and Members regarding potential denial or limited authorization of a requested service that does not appear to meet criteria for medical necessity.

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

PCP Team means a Member's PCP, other Providers, and the Member's Medical Consenter, who agree to function as an interdisciplinary team. If requested by the Member's Medical Consenter, the Member's Caregiver may be included in the PCP Team. The PCP Team may also include a Member's DFPS caseworker and MCO Service Coordinator.

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

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

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

Provider Hotline means the toll-free telephone line for Provider inquiries.

Provider Network or Network means all Providers that have contracted with the MCO.

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

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.

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

Definition for Rate Cell Removed by Version 1.2; 1.4

Rate Period 1 means the period of time beginning on the Operational Start Date and ending on August 31, 2008.

Rate Period 2 means the period of time beginning on September 1, 2008 and ending on August 31, 2009.

Rate Period 3 means the priod of time beginning on September 1, 2009 and ending on August 31, 2010.

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

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

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

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

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

Risk Management Plan means the written plan developed by the MCO, and approved by HHSC, that describes the MCO's methods for managing risks that emanate from the product, processes, resources, and constraints.

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

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

Scope of Work means the description of Services and Deliverables specified in the Contract, including without limitation the RFP and the MCO's Proposal, and any agreed modifications to these documents.

SDX means State Data Exchange.

SED means severe emotional disturbance.

Service Area means all counties in the State of Texas.

Service Coordination is an Administrative Service performed by the MCO to coordinate services and information, such as medical information for court hearings, at the request of a Medical Consenter, Caregiver, Member, DFPS Staff, or PCP; coordinate Non-capitated Services; and coordinate with DFPS Case Management Services.

Service Coordinator(s) perform the functions of Service Coordination.

Service Management is a clinical service performed by the MCO to facilitate development of a Health Care Service Plan and coordination of clinical services among a Member's PCP and specialty providers to ensure Members with Special Health Care Needs have access to, and appropriately utilize, Medically Necessary Covered Services.

Service Manager(s) perform the functions of Service Management.

Services mean the tasks, functions, and responsibilities assigned and delegated to the MCO under this Contract.

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

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

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

Special Hospital means any inpatient Hospital that is not a General 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.

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.

Definition for STAR Health Liaison changed from DFPS Liaison by Version 1.2

STAR Health Liaison means the designated MCO staff person who will serve as the point-of-contact to answer questions and resolve issues with DFPS regarding the Model. The STAR Health Liaison will coordinate with the MCO and DFPS to ensure effective and efficient response by the MCO to operational issues and other concerns of DFPS.

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

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

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

Subsidiary means an Affiliate controlled by the MCO directly or indirectly through one or more intermediaries.

Substitute Care means the placement of a child or young adult who is in the conservatorship of DFPS in care outside the child's or young adult's home. The term includes foster care, institutional care, adoption or placement with a relative of the child or young adult.

Substitute Care Services means services provided to or for children or young adults in Substitute Care and their families, including the recruitment, training and management of foster parents, the recruitment of adoptive families, and the facilitation of the adoption process, family reunification, independent living, emergency shelter, residential group care, foster care, therapeutic foster care, and post-placement supervision, including relative placement. The term does not include the regulation of facilities under Subchapter C, Chapter 42, Texas Human Resources Code.

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, who 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 the written plan developed by the MCO, and approved by HHSC, that describes the processes, techniques, and tools that the MCO will use for assuring that the MIS systems meet the Contract requirements.

T.A.C. means Texas Administrative Code.

Definition for Target Population Modified by Version 1.3

Target Population means children and young adults in one of the following categories: (1) DFPS conservatorship, (2) young adults age 18-22 who voluntarily agree to continue in a foster care placement, or (3) young adults age 18 through the month of their 21st birthday, who have exited foster care and are participating in the foster care youth transitional Medicaid program.

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 is the name adopted by the State of Texas for the federally mandated 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 EPSDT).

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

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

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

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

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

TP 45 means Type Program 45, which is a Medicaid program eligibility code assigned to newborns (under 12 months of age) who are born to mothers who are Medicaid eligible at the time of the child's birth.

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

Turnover Phase includes all activities the MCO 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 MCO, and approved by HHSC, to be employed during the Turnover Phase.

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

Definition for Urban County Added by Version 1.1

Urban County means any county with 50,000 or more residents as reported by the Texas Association of Counties at: http://www.county.org/

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.

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

Definition for Value-added Services modified by Version 1.1

Value-added Services means additional services for coverage beyond those specified in Attachment B-2. Value-added Services may be actual Health Care Services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improve health outcomes among Members. Value-added Services that promote healthy lifestyles should target specific weight loss, smoking cessation, or other programs approved by HHSC. Temporary phones, cell phones, additional transportation benefits, and extra Home Health Services may be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.

Waste means practices that are not cost-efficient.

Article 3. General Terms & Conditions

Section 3.01 Contract elements.

(a) Contract documentation.

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

(b) Order of documents.

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

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

(2) **Attachment A** to the **Managed Care Contract document**– "**General Terms and Conditions**," and all amendments thereto;

(3) **Attachment B** to the **Managed Care Contract document**, RFP "Scope of Work/Performance Measures," and all attachments and amendments thereto;

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

(5) **Attachment C** to the **Managed Care Contract document,** "MCO's Proposal," and all attachments and amendments 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. MCO 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 MCO to resolve any MCO claims for payment that represent accepted Services or Deliverables that are pending at the time funds become unavailable. HHSC shall make best efforts to provide reasonable written advance notice to MCO 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 MCO 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) MCO may use the name of HHSC, the State of Texas, any HHS Agency, and the name of the HHSC MCO 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 MCO submits the information to HHSC for review and comment. If HHSC has not responded within seven (7) calendar days, the MCO 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 MCO's performance under the Contract.

(b) MCO will provide HHSC with one (1) electronic copy of any information described in Subsection 3.07(a) prior to public release. MCO 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 MCO is required by law to report such information, or

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

(3) Member Materials (the MCO 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 MCO.

MCO 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 MCO 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.

MCO 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 MCO'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. MCO 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 MCO that HHSC has elected to renegotiate certain terms of the Contract. Upon MCO's receipt of any notice pursuant to this Section, MCO 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 MCO's Services and/or Deliverables provided during any period of the Contract, HHSC may at any time issue requests for proposals or offers to other potential contractors for performance of any portion of the Scope of Work covered by the Contract or Scope of Work similar or comparable to the Scope of Work performed by MCO under the Contract.

(c) Termination rights upon reprocurement.

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

Section 3.11 RFP errors and omissions.

MCO will not take advantage of any errors and/or omissions in the RFP or the resulting Contract. MCO 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, MCO 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.

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

Section 3.14 Time of the essence.

In consideration of the need to ensure uninterrupted and continuous HHSC MCO 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 **Managed Care Contract** document. In addition, legal notices must be sent to the Legal Contact identified in the **Managed Care Contract** document.

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

Article 4. Contract Administration & Management

Section 4.01 Qualifications, retention and replacement of MCO employees.

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

(a) Designation of Key Personnel.

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

Section 4.02 modified by Version 1.2

(1) Member Services;

(3) Management Information Systems;

(4) Health Passport Management;

(3) Claims Processing,

(5) Provider Network Development and Management;

(6) Benefit Administration and Prior Authorization;

(7) Service Management;

(8) Service Coordination;

(9) Quality Improvement;

(10) Behavioral Health Services;

(11) Dental Services;

(12) Financial Functions;

(13) Reporting;

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

(15) Medical Director as defined in **Section 4.04** ("Medical Director"); and

(16) STAR Health Liaison as defined in **Section 4.05.**

(b) Support and Replacement of Key Personnel.

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

(c) Notification of replacement of Key Personnel.

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

d) Dedicated Staff

Section 4.02(d) Added by Version 1.3

The MCO agrees to maintain staff dedicated exclusively to serving the STAR Health Program in the following areas:

(1) Regional staff:

(A) Behavioral Health and Physical Health Service Managers and Service Coordinators;

(B) STAR Health Liaisons;

(C) CONNECTIONS staff; and

(D) Member Advocates;

(2) Member and Nurse Hotline staff;

(3) Behavioral Health Hotline staff;

(4) Complaints and Appeals staff;

(5) Health Passport staff; and

(6) Regional Internal Trainers.

e) Training for dedicated staff

Section 4.02(e) Added by Version 1.3

Staff identified in Section 4.02(d) must receive foster care-specific training during employee orientation, and as needed thereafter. Training curriculum must include the following components, at a minimum:

(1) differences and similarities between managing the care for a child in foster care and managing the care for the other Medicaid populations;

(2) vital timelines in the evaluation and delivery of services to Members;

(3) the roles and responsibilities of MCO staff in interfacing with DFPS Staff and the court system;

(4) the legacy foster care medical and behavioral health management system and how it changed with the STAR Health Program; and

(5) symptoms and treatment of childhood medical and behavioral health conditions commonly seen in the foster care population, such as the effect of abuse and neglect on the developing brain, fetal alcohol syndrome, and shaken baby syndrome.

***Section 4.03* Executive Director.**

(a) The MCO must employ a qualified individual to serve as the Executive Director for its HHSC MCO Program(s). Such Executive Director must be employed full-time by the MCO, be primarily dedicated to HHSC MCO Program(s), and must hold a Senior Executive or Management position in the MCO's organization, except that the MCO may propose an alternate structure for the Executive Director position, subject to HHSC's prior review and written approval.

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

(1) ensuring the MCO'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 MCO to establish time

frames and formats reasonably acceptable to the Parties;

(3) attending and participating in regular HHSC MCO 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 MCO 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 MCO's performance and resolve issues, and

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

Section 4.04 Medical Director.

(a) The MCO must have a qualified individual to serve as the Medical Director for its HHSC MCO Program(s). The Medical Director must be currently licensed in Texas by 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 MCO 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 MCO 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 STAR Health Liaison

Section 4.05 modified by Versions 1.2 and 1.3

The MCO must employ a qualified individual to serve as the full-time STAR Health Liaison for the MCO. The STAR Health Liaison is responsible for coordinating with the MCO and DFPS to promptly resolve any issues identified by the MCO, DFPS or HHSC that arise related to the Model or to the individual health care of a Member. The STAR Health Liaison will also take a leading role in identifying training for the MCO and DFPS staff related to the managed care program.

Section 4.06 Responsibility for MCO personnel and Subcontractors.

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

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

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

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

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

(f) MCO 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 MCO pursuant to this Contract or any judgment rendered against the MCO. HHSC's liability to the MCO'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) MCO understands that HHSC does not assume liability for the actions of, or judgments

rendered against, the MCO, its employees, agents or Subcontractors. MCO agrees that it has no right to indemnification or contribution from HHSC for any such judgments rendered against MCO or its Subcontractors.

Section 4.07 Cooperation with HHSC and state administrative agencies.

(a) Cooperation with Other MCOs.

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

(b) Cooperation with state and federal administrative agencies.

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

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

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

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

Section 4.08 Conduct of MCO personnel.

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

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

Section 4.09 Subcontractors.

Section 4.09 modified by Versions 1.1 and 1.3

(a) MCO 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 MCO's employees, and for purposes of this Contract such work will be deemed work performed by MCO. 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) MCO 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;

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

(6) the MCO must demonstrate that a Material Subcontractor assuming delegated function(s) satisfies all requirements of a pre-delegation audit before the applicable functions can be delegated. The MCO must conduct the audit, which must include at a minimum: a standard audit tool approved by HHSC, site visit, and file review (if applicable), staff interviews, and scoring to ensure compliance is achieved.

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

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

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

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

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

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

(6) a Readiness Review is requested by HHSC.

The MCO must submit information required by HHSC for each proposed Material Subcontractor as indicated in **Section 3 ("Managed Care Contract")**. Refer to **Attachment B-1, Sections 4.1.1.1**, Additional HMO Readiness Reviews **and 4.1.22**, Management Information System Requirements for additional information regarding MCO Readiness Reviews during the Contract Period.

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

(e) MCO must identify any Subcontractor that is a subsidiary or entity formed after the Effective Date of the Contract, whether or not an Affiliate of MCO, substantiate the proposed Subcontractor's ability to perform the subcontracted Services, and certify to HHSC that no loss of service will occur as a result of the performance of such Subcontractor. The MCO will assume responsibility for all contractual responsibilities whether or not the MCO performs them. Further, HHSC considers the MCO 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 MCO 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 MCO pays to or receives from the Subcontractor.

(i) MCO 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, MCO must submit a copy to HHSC no later than five (5) Business Days after execution.

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

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

Section 4.10 HHSC's ability to contract with Subcontractors.

The MCO 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 MCO.

Section 4.11 MCO Agreements with Third Parties

(a) If the MCO 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 MCO'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 MCO 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 MCO pays to or receives from the third party.

(d) MCO 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, MCO 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, MCO 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 MCO 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 Provider Contracts, or agreements with utility or mail service providers.

Article 5. Member Eligibility & Enrollment

Section 5.01 Eligibility Determination

The State or its designee will make eligibility determinations for each potential enrollee for the Program.

Section 5.02 Member Enrollment & Disenrollment.

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

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

Section 5.02(c) Modified by Version 1.1

(c) The HHSC Administrative Services Contractor or DFPS will electronically transmit to the MCO new Member information and change information applicable to active Members on a daily basis via the Daily Notification File. The Daily Notification File will be uploaded by the MCO 7 days a week, inclusive of holidays. DFPS will send the MCO information concerning new Members on a daily basis, including the Member's name, social security number if known, and name and address of the Member's Caregiver or Medical Consenter.

(d) Members will be enrolled in the MCO on the Effective Date of Coverage. Individuals already eligible for Texas Medicaid managed care or Fee-for-Serivce programs or the CHIP program on the Effective Date of Coverage with the MCO will be disenrolled from such Texas Medicaid or CHIP programs, effective the day prior to the Effective Date of Coverage with the MCO.

(e) The HHSC Administrative Services Contractor will notify "opt-in" Members of their right to disenroll from the MCO and receive services through Fee-for-Service.

(f) A Member's disenrollment from the MCO will be effective on the Date of Disenrollment, except as provided in **Section 5.03(c).**

Section 5.02(g) Modified by Version 1.1

(g) The MCO must assign each Member a PCP within one day of receiving notification of the Member's enrollment via the Daily Eligibility File. DFPS, the Member's Medical Consenter, or the Member can change the PCP designation at any time.

(h) The MCO will begin providing Covered Services to all Members across the State of Texas on the Operational Start Date. HHSC will not phase in enrollment.

Section 5.03 Span of Coverage

Section 5.03 Modified by Version 1.3

(a) General

The MCO must accept all persons who choose to enroll as Members in the MCO or who are assigned as Members in the MCO by HHSC, without regard to the Member's previous coverage, health status confinement in a health care facility, or any other factor.

(b) Inpatient Hospital.

If a Member's Effective Date of Coverage occurs while the Member is confined in a Hospital, the MCO is responsible for the Member's costs of Covered Services as follows:

(1) If the Member is receiving services through the Texas Medicaid Fee-for-Service or PCCM programs prior to the Effective Date of Coverage, then the Texas Medicaid Fee-for-Service program will pay all facility charges until the Member is discharged from the Hospital or loses Medicaid eligibility. The MCO will be responsible for all professional charges on the Effective Date of Coverage with the MCO.

(2) If the Member is receiving services through a STAR health maintenance organization (STAR HMO) prior to the Effective Date of Coverage, then the STAR HMO will pay all facility charges until the Member is discharged from the Hospital or loses Medicaid eligibility. The MCO will be responsible for all professional charges on the Effective Date of Coverage with the MCO.

(3) If the Member is receiving services through a STAR+PLUS HMO prior to the Effective Date of Coverage, responsibility for claims incurred during the Inpatient Stay will be divided as follows: (1) the STAR+PLUS HMO will continue to pay Hospital facility charges for Behavioral Health Covered Services until the earlier of the date of Discharge or loss of Medicaid eligibility, (2) and the Medicaid FFS program will continue to pay Hospital facility charges for non-Behavioral Health Covered Services until the earlier of the date of Discharge or loss of Medicaid eligibility, and (3) beginning on the Effective Date of Coverage, the STAR Health MCO will pay for all other Covered Services.

(4) If the Member is receiving services through a Texas Children's Health Insurance (CHIP) managed care health maintenance organization or CHIP exclusive provider organization prior to the Effective Date of Coverage, then the MCO will be responsible for all facility charges and all professional charges on the Effective Date of Coverage with the MCO.

If a Member is disenrolled while the Member is confined in a Hospital, the MCO's responsibility for the Member's costs of Covered Services terminates on the Date of Disenrollment.

(c) Nursing Homes and Intermediate Care Facilities for Mental Retardation (ICF-MR).

Medicaid recipients in a nursing home or ICF-MR are not included in the Model. Members who enter a nursing home or ICF-MR will be disenrolled on the date of entry into a nursing facility or ICF-MR.

(d) Verification of Member Eligibility.

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

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

When a STAR Health member becomes qualified for SSI, HHSC may allow the STAR Health member to move to FFS or STAR+PLUS as set forth in Section 5.03(f). If such a change in the plan type occurs during an Inpatient Stay, the MCO's responsibility for the Member's costs of Covered Services terminates on the Date of Disenrollment.

(f) Effective Date of SSI Status:

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

(1) prospectively move to Medicaid FFS (if the Member is a child in any part of the State); or

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

HHSC will not retroactively disenroll a Member from the STAR Health Program.

Article 6. Service Levels & Performance Measurement

Section 6.01 Performance measurement.

Satisfactory performance of this Contract will be measured by:

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

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

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

Section 6.02 Service Management and Coordination Staffing.

(a) During the first twelve (12) month period following the Operational Start Date, HHSC and the MCO will meet at least quarterly to review the adequacy of the MCO's staffing of the Service Management and Service Coordination functions. After the first twelve (12) months, the Parties will negotiate the frequency of such staffing reviews; however, the reviews must occur at least annually.

(b) As a result of the staffing reviews described in Section 6.02(a), the Parties may mutually agree to increase, decrease, reallocate, or reassign MCO staffing. In addition, should a review reveal that the MCO's performance is not satisfactory, as measured by Section 6.01, HHSC may require the MCO to make reasonable adjustments in staffing, including increase, reallocate, or reassign MCO staffing.

Article 7. Governing Law & Regulations

Section 7.01 Governing law and venue.

This Contract is governed by the laws of the State of Texas and interpreted in accordance with

Texas law. Provided MCO 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 MCO responsibility for compliance with laws and regulations.

Section 7.02 Modified by Version 1.4

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

(1) Titles XIX of the Social Security Act;

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

(3) 42 C.F.R. Parts 417 and 457, as applicable;

(4) 45 C.F.R. Parts 74 and 92;

(5) 48 C.F.R. Part 31, or OMB Circular A-122, as applicable;

(6) 1 T.A.C. Part 15, Chapters 361, 370, 371, 391, and 392;

(7) consent decree, *Frew, et al. v. Hawkins, et al.*, U.S. District Court, Eastern District of Texas, Paris Division, Civil Action No. 3:93CV65;

(8) 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;

(9) all administrative rules governing the Program that are adopted in the Texas Administrative Code; and

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

(b) The Parties acknowledge that the federal and/or state laws, rules, regulations, policies, or guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that affect the performance of the Scope of Work may change from time to time or be added, judicially interpreted, or amended by competent authority. MCO acknowledges that the MCO Programs will be subject to continuous change during the term of the Contract and, except as provided in Section 8.02, MCO 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 MCO was selected, in part, because of its expertise, experience, and knowledge concerning applicable Federal and/or state laws, regulations, policies, or guidelines that affect the performance of the Scope of Work. In keeping with HHSC's reliance on this knowledge and expertise, MCO is responsible for identifying the impact of changes in applicable Federal or state legislative enactments and regulations that affect the performance of the Scope of Work or the State's use of the Services and Deliverables. MCO must timely notify HHSC of such changes and must work with HHSC to identify the impact of such changes on how the State uses the Services and Deliverables.

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

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

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

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

Section 7.03 TDI status and solvency.

(a) TDI Status

MCO must be an exclusive provider benefit plan approved by TDI in accordance with 28 T.A.C. §§3.9201-3.9212.

(b) Solvency

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

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

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

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

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

Section 7.04 Immigration Reform and Control Act of 1986.

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

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

(a) MCO 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.

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

(e) MCO 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.

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

(a) Pro-Children Act of 1994.

MCO 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.

MCO 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.

MCO 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.

MCO 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.

MCO 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.

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

Article 8. Amendments & Modifications

Section 8.01 Mutual agreement.

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

Section 8.02 Changes in law or contract.

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

Section 8.03 Modifications as a remedy.

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

Section 8.04 Modifications upon renewal or extension of Contract.

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

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

Section 8.05 Modification of HHSC Uniform Managed Care Manual.

(a) HHSC will provide MCO with at least thirty (30) days advance written notice before implementing a substantive and material change in the **HHSC Uniform Managed Care Manual** (a change that materially and substantively alters the MCO'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 MCO with a reasonable amount of time to comment on such changes, generally at least ten (10) Business Days. HHSC is not required to provide advance written notice of changes that are not material and substantive in nature, such as corrections of clerical errors or policy clarifications.

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

(c) Changes will be effective on the date specified in HHSC's written notice, which will not be earlier than the MCO's response deadline, and such changes will be incorporated into the **HHSC Uniform Managed Care Manual**. If the MCO has raised an objection to a material and substantive change to the **HHSC Uniform Managed Care Manual** and submitted a notice of termination in accordance with **Section 12.04(d),** HHSC will not enforce the policy change during the period of time between the receipt of the notice and the date of Contract termination.

Section 8.06 CMS approval of Contracts.

The implementation of amendments, modifications, and changes to theContract 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. MCO

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.

MCO agrees to maintain, and require its Subcontractors to maintain, supporting financial information and documents that are adequate to ensure that payment is made and the Experience Rebate is calculated in accordance with applicable Federal and State requirements, and are sufficient to ensure the accuracy and validity of MCO invoices. Such documents, including all original claims forms, will be maintained and retained by MCO 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, MCO 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) MCO 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) MCO Program personnel from HHSC or its designee;

(4) The Office of Inspector General;

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

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

(7) A State or Federal law enforcement agency;

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

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

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

Section 9.03 General Access to Accounting Records

(a) The MCO 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 MCO 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 reasonably 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 MCO. Except in the case of unannounced inspections or audits, the state or federal government will provide reasonable advance written notice of such inspections or audits, as determined by the state for federal government.

(3) At the MCO's expense, 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 MCO agrees to reimburse HHSC for all costs, including, but not limited to transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, and reproduction functions 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 MCO'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 Services, Deliverables and inspections.

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

(2) MCO Software and Equipment.

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

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

(2) the Services and Deliverables provided;

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

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

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

(c) MCO 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 MCO, HHSC discovers a payment error or overcharge, HHSC will notify the MCO of such error or overcharge. HHSC will be entitled to recover such funds as an offset to future payments to the MCO, or to collect such funds directly from the MCO. MCO 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 MCO have resulted in errors in payments to the MCO or errors in the calculation of the Experience Rebate, the MCO will indemnify HHSC for any losses resulting from such errors, including the cost of audit.

Section 9.05 SAO Audit

The MCO 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 MCO 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 MCO will ensure that this clause concerning the authority to audit funds received indirectly by Subcontractors through MCO and the requirement to cooperate is included in any Subcontract it awards, and in any third party agreements described in **Section 4.11 (a-b)**.

Section 9.06 Response/compliance with audit or inspection findings.

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

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

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

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

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

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

Section 9.07 Added by Version 1.2

The MCO 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." (3) debt defaults, if not cured within 30 days, including notifications of non-compliance, but excluding notifications initiated by the MCO or its Affiliates against unaffiliated third parties;

Article 10. Terms & Conditions of Payment

Section 10.01 Calculation of monthly Capitation Payment.

(a) This is a Risk-based contract. The MCO will provide Health Care Services for Members on a fully insured basis. HHSC will calculate the fixed monthly Capitation Payments by multiplying the number of Members enrolled on the first day of the month by the Capitation Rate. HHSC will not pay a Capitation Payment for new Members during the first month of coverage unless the Member's Effective Date of Coverage occurs on the first day of the month. In consideration of the Monthly Capitation Payment(s),

the MCO agrees to provide the Services and Deliverables described in this Contract.

(b) The Capitation Rate for Contract Year 1 is included in the **HHSC Managed Care Contract** document.

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

(d) Information or data, including complete and accurate Encounter Data, as requested by HHSC for rate-setting purposes, must be provided to HHSC: (1) within thirty (30) days of receipt of the letter from HHSC requesting the information or data; and (2) no later than March 31st of each year.

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

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

(2) an amount for administering the program

(3) an amount for the MCO's Risk margin; and

(4) pass-through funds for high-volume providers.

HHSC will employ or retain qualified actuaries to perform data analysis and calculate the Capitation Rates for each Rate Period.

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

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

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

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

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

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

(1) equitably adjust Capitation Payments 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* Certification of Capitation Rates.**

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

***Section 10.04* Modification of Capitation Rates.**

The Parties expressly understand and agree that the agreed Capitation Rates are subject to modification in accordance with **Article 8** ("Amendments and Modifications,") if changes in state or federal laws, rules, regulations or policies affect the rates or the actuarial soundness of the rates. HHSC will provide the MCO 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 MCO does not accept the rate change, either Party may terminate the Contract in accordance with **Article 12** ("Remedies and Disputes").

***Section 10.05* Capitation Structure.**

(a) Capitation Rate development: Capitation Rates after Rate Period 1.

HHSC will establish base Capitation Rates for the Rate Periods following Rate Period 1 by analyzing historical Encounter Data and financial data. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information.

(b) Value-added Services.

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

***Section 10.06* MCO input during rate setting process.**

(1) MCO must provide certified Encounter Data and financial data as prescribed in **HHSC's Uniform Managed Care Manual**. Such information may include, without limitation: claims lag information, capitation expenses, and stop loss reinsurance expenses. HHSC may request clarification or for additional financial information from the MCO. HHSC will notify the MCO of the deadline for submitting a response, which will include a reasonable amount of time for response.

(2) HHSC will allow the MCO to review and comment on data used by HHSC to determine base

Capitation Rates. This will include Fee-for-Service data for Rate Periods 1 and 2. HHSC will notify the MCO of deadline for submitting comments, which will include a reasonable amount of time for response. HHSC will not consider comments received after the deadline in its rate analysis.

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

Section 10.07 Adjustments to Capitation Payments.

(a) Recoupment.

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

(1) the Member is enrolled into the MCO in error, and the MCO provided no Covered Services to the Member during the month for which the payment was made;

(2) the Member moves outside the United States, and the MCO has not provided Covered Services to 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 MCO may appeal the recoupment or adjustment of capitations in the above circumstances using the HHSC dispute resolution process set forth in **Section 12.12**, ("Dispute Resolution").

Section 10.08 Intentionally Left Blank by Version 1.2

Section 10.08 This section was intentionally left blank.

Section 10.09 Experience Rebate

(a) MCO's duty to pay.

Section 10.09 Modified by Versions 1.1; 1.2, 1.3, and 1.4

At the end of each Rate Period beginning with Rate Period 1, the MCO must pay an Experience Rebate to HHSC if the MCO's Net Income before Taxes is greater than the percentage specified below of the total Revenue for the period. The Experience Rebate is calculated in accordance with the tiered rebate method set forth below based on the consolidated Net Income before Taxes in the MCO's Service Area, as measured by any positive amount on the Financial-Statistical Report (FSR) as reviewed and confirmed by HHSC.

(b) Graduated Experience Rebate Sharing Method.

(1) Rate Periods 1 and 2

Pre-tax Income as a % of Revenues	MCO Share	HHSC Share
≤ 2%	100%	0%
> 2% and ≤ 6%	65%	35%
> 6% and ≤ 9%	40%	60%
> 9% and ≤ 14%	15%	85%
> 14%	0%	100%

For Rate Period 1 and Rate Period 2 HHSC and the MCO will share the Net Income before Taxes as follows, unless HHSC provides the MCO an Experience Rebate Reward in accordance with Section 4 of the RFP and **HHSC's Uniform Managed Care Manual**:

(i) The MCO will retain all Net Income before Taxes that is equal to or less than 2% of the total Star Health Revenues received by the MCO.

(ii) HHSC and the MCO will share that portion of the Net Income before Taxes that is over 2% but less than or equal to 6% of the total Star Health Revenues received with 65% to the MCO and 35% to HHSC.

(iii) HHSC and the MCO will share that portion of the Net Income before Taxes that is over 6% but less than or equal to 9% of the total Star Health Revenues received with 40% to the MCO and 60% to HHSC.

(iv) HHSC and the MCO will share that portion of the Net Income before Taxes that is over 9% but less than or equal to 14% of the total Star Health Revenues received with 15% to the MCO and 85% to HHSC.

(v) HHSC will be paid the entire portion of the Net Income before Taxes that exceeds 14% of the total Star Health Revenues.

(2) Rate Period 3 and after.

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

For Rate Period 3 and thereafter, HHSC and the MCO will share the Net Income before Taxes for the STAR Health Program as follows:

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

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

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

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

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

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

(c) Net income before taxes.

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

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

(i) the payment of an Experience Rebate;

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

(iii) financial incentives; and

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

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

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

(d) Carry forward of prior Rate Period losses.

Losses incurred by MCO for one Rate Period may be carried forward to the next Rate Period, and applied as an offset against pre-tax net income. Prior losses may be carried forward for two contiguous Rate Periods for this purpose.

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

(e) Settlements for payment.

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

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

(2) The next scheduled payment will be an adjustment to the Primary Settlement, if required, and will be paid on the same day that the 334-day FSR Report is submitted to HHSC if the adjustment is a payment from the MCO to HHSC. Section 10.09(f) describes the interest expenses associated with any payment after the Primary Settlement.

The MCO may make non-scheduled payments at any time to reduce the accumulation of interest under Section 10.09(f) For any non-scheduled payments prior to the 334-day FSR, the MCO is not required to submit a revised FSR, but is required to submit an Experience Rebate calculation form and an adjusted summary page of the FSR. The FSR summary page is labeled "Summary Income Statements (Dollars), All Coverage Groups Combined (FSR, Part I)."

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

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

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

Payment within this 30-day timeframe will not relieve the MCO of any interest payment obligation that may exist under Section 10.09(f).

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

(f) Interest on Experience Rebate.

1) Interest on *any* Experience Rebate owed to HHSC will be charged beginning 35 days after the due date of the Primary Settlement, as described in Section 10.09(e)(1). Thus, any Experience Rebate due or paid on or after the Primary Settlement will accrue interest starting at 35 days after the due date for the 90-day FSR Report. For example, any Experience Rebate payment (s) made in conjunction with the 334-day FSR, or as a result of audit findings, will accrue interest back to 35 days after the due-date for submission of the 90-day FSR.

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

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

(3) Any interest obligations that are incurred pursuant to Section 10.09 that are not timely paid will be subject to accumulation of interest as well, at the same rate as applicable to the underlying Experience Rebate.

(4) All interest assessed pursuant to Section 10.09 will continue to accrue until such point as a payment is received by HHSC, at which point interest on the amount received will stop accruing. If a balance remains at that point that is subject to interest, then the balance will continue to accrue interest. If interim payments are made, then any interest that may be due will only be charged on amounts for the time period during which they remained unpaid. By way of example only, if $100,000 is subject to interest commencing on a given day, and a payment is received for $75,000 27 days after the start of interest, then the $75,000 will be subject to 27 days of interest, and the $25,000 balance, along with any unpaid interest, will continue to accrue interest until paid. The accrual of interest as defined under Section 10.09(f) will not stop during any period of dispute. If a dispute is resolved in the MCO's favor, then interest will only be assessed on the revised unpaid amount.

(5) If the MCO incurs an interest obligation pursuant to Section 10.09 for an Experience Rebate payment due on or after September 1, 2008, HHSC will assess such interest at 12% per annum, compounded daily. If any interest rate stipulated hereunder is found by a court of competent jurisdiction to be outside the range deemed legal and enforceable, then in such specific case the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

(6) Any such interest expense incurred pursuant to Section 10.09 is not an Allowable Expense for reporting purposes on the FSR.

(g) In the event that the MCO achieves a net profit in Rate Period 1 or any subsequent Rate Period, the Parties agree to enter into good faith negotiations to develop reasonable financial incentives for the MCO's Providers for the following Rate Period.

***Section 10.10* Payment by Members.**

Medicaid MCOs and their Network Providers are prohibited from billing or collecting any amount from a

Member for Health Care Services covered by this Contract. MCO must inform Members of costs for non-covered services, and must require its Network Providers to:

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

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

Section 10.16 Added by Version 1.1

Section 10.11 Restriction on assignment of fees.

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

Section 10.12 Liability for taxes.

HHSC is not responsible in any way for the payment of any Federal, state or local taxes related to or incurred in connection with the MCO's performance of this Contract. MCO 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 MCO or any taxes levied on employee wages.

Section 10.13 Liability for employment-related charges and benefits.

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

Section 10.14 No additional consideration.

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

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

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

Section 10.15 Federal Disallowance

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

Section 10.16 Required Pass Through of Physician Rate Increases

(a) The MCO's physician fee schedules must reflect the physician rate increases funded through Legislative Appropriations during the 80th Regular Legislative Session. The MCO must pass on all appropriated targeted physician rate increases to physicians serving its Members.

(b) The Medicaid Fee Schedule in effect on September 1, 2007 (the "updated Medicaid Fee Schedule") will include the legislatively-mandated physician rate increases based on the age of the Member, under 21 and over 21. The MCO must pay the appropriate rate for the age of the Member on the date of service.

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

(d) If, under the terms of a Network Provider contract in place prior to September 1, 2007, the MCO pays for physician services based on a percentage of the Medicaid Fee Schedule, then the MCO must pay for physician services provided on or after September 1, 2007 based on the same percentage of the updated Medicaid Fee Schedule. By way of example only, if prior to September 1, 2007, the MCO paid for physician services at110% of the Medicaid Fee Schedule, then the MCO will pay for physician services provided on or after September 1, 2007 at 110% of the updated Medicaid Fee Schedule.

(e) If, under the terms of a Network Provider contract in place prior to September 1, 2007, the MCO uses benchmarks other than the Medicaid Fee Schedule (e.g. rates that are a percentage of Medicare) to pay for physician services, then for physician services provided on or after September 1, 2007, the MCO must increase its rates by 25% for services to Members under 21 and by 10% for

Members age 21 and over. The MCO must provide HHSC with a copy of both the prior and new Network Provider agreements and demonstrate how the new rates are 125% or 110%, depending on the age of the Member, of the former rates.

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

Section 10.17 Added by Version 1.3

Section 10.17 ***Bariatric Supplemental Payment.***

(a) For dates of service on or after September 1, 2008, the MCO will receive a Bariatric Supplemental Payment (BSP) from HHSC for each properly reported and documented bariatric surgery recorded under the group of procedure codes defined as allowable for bariatric reimbursement, as designated in the Texas Medicaid Providers Procedures Manual, including Texas Medicaid Bulletins. The amount of the one-time per surgery BSP payment is identified in the **HHSC Managed Care Contract** Document.

(b) MCO must submit a monthly BSP Report as described in **Attachment B-1, Section 4** to the **HHSC Managed Care Contract** Document, in the format and timeframe prescribed in **HHSC's Uniform Managed Care Manual**.

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

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

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

Article 11. Disclosure & Confidentiality of Information

***Section 11.01* Confidentiality.**

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

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

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

(g) The obligations in this Section shall not restrict any disclosure by the MCO pursuant to any applicable law, or by order of any court or government agency, provided that the MCO 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) MCO 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. MCO acknowledges that any publication or disclosure of HHSC's Confidential Information to others may cause immediate and irreparable harm to HHSC and may constitute a violation of State or federal laws. If MCO, 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 MCO all damages and liabilities caused by or arising from MCO's, its Subcontractors', consultants', or agents' failure to protect HHSC's Confidential Information. MCO 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 MCO'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 MCO.

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

Section 11.03 Member Records

(a) MCO must comply with the requirements of state and federal laws, 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 MCO, to another entity, as consistent with federal and state laws and applicable releases.

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

Section 11.04 Requests for public information.

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

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

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

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

(1) Immediately notify HHSC; and

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

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

(1) represent MCO in such resistance;

(2) to retain counsel to represent MCO; or

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

(e) If a court of competent jurisdiction orders MCO 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, MCO 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 MCO 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 MCO as confidential or proprietary, which action or proceeding identifies the other Party such information without such Party's consent.

Article 12. Remedies & Disputes

Section 12.01 Understanding and expectations.

The remedies described in this Section are directed to MCO's timely and responsive performance of the Services and production of Deliverables, and the creation of a flexible and responsive relationship between the Parties. The MCO 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.

MCO 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 MCO in writing of specific areas of MCO 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 Covered Services.

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

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

(3) MCO's proposed cure of a non-material deficiency is subject to the approval of HHSC. MCO'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 MCO 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) MCO'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 MCO in writing of HHSC's final disposition of HHSC's concerns. If HHSC accepts MCO'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 MCO's proposed Corrective Action Plan; or

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

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

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

(A) Excuse MCO's prior substandard performance;

(B) Relieve MCO 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-5, Managed Care Contract document, "Deliverables/Liquidated Damages Matrix;"**

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

(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 MCO;

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

(A) Violates a material provision of the Contract;

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

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

(3) HHSC will provide notice to MCO 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 MCO 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 MCO'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 MCO'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 MCO in accordance with and for failure to meet any aspect of the responsibilities of the Contract and/or to meet the specific performance standards identified by the HHSC in **Attachment B-5, Managed Care Contract document, "Deliverables/Liquidated Damages Matrix."** Liquidated damages will be assessed if HHSC reasonably determines such failure is the fault of the MCO (including the MCO'S Subcontractors and/or consultants), and will not be assessed if HHSC determines the failure is materially caused or contributed to by HHSC or its agents. If at any time, HHSC determines the MCO 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 MCO's nonperformance, including financial loss as a result of project delays. Accordingly, in the event MCO fails to perform in accordance with the Contract, HHSC may assess liquidated damages as provided in this Section.

(3) If MCO fails to perform any of the Services described in the Contract, HHSC may assess liquidated damages for each occurrence of a liquidated damages event, to the extent consistent

with HHSC's tailored approach to remedies and Texas law.

(4) HHSC may elect to collect liquidated damages:

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

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

(f) Equitable Remedies

(1) MCO acknowledges that, if MCO 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 MCO breached (or attempted or threatened to breach) any such obligations, MCO 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 MCO 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 MCO has committed a material breach of the Contract;

(B) HHSC has reason to believe that MCO 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 MCO knew, or should have known of, Fraud, Abuse, Waste, malfeasance, or nonfeasance by any party concerning the Contract, and the MCO failed to take appropriate action; or

(D) HHSC determines that suspension of the Contract in whole or in part is in the best interests of the State of Texas or the HHSC Programs.

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

(A) Be delivered in writing to MCO;

(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 MCO or describe actions that MCO 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 MCO:

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

(2) *Failure to adhere to laws, rules, ordinances, or orders.*

HHSC may terminate this Contract if a court of competent jurisdiction finds MCO failed to adhere to any laws, ordinances, rules, regulations, or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of MCO'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 MCO breaches confidentiality laws with respect to the Services and Deliverables provided under this Contract.

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

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

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

(1) MCO 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 State and/or Federal law.

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

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

(7) *Judgment and execution.*

(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 MCO, and MCO 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 MCO, 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 MCO:

(1) Files for bankruptcy;

(2) Becomes or is declared insolvent, or is the subject of any proceedings related to its liquidation, insolvency, or the appointment of a receiver or similar officer for it;

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

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

(B) MCO 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 MCO 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 MCO'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 MCO'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 MCO has materially breached the Contract. HHSC will provide at

least thirty (30) days advance written notice of such termination.

Section 12.04 Termination by MCO.

(a) Failure to pay.

MCO may terminate this Contract if HHSC fails to pay the MCO undisputed charges when due as required under this Contract. Retaining premium, recoupment, sanctions, or penalties that are allowed under this Contract or that result from the MCO's failure to perform or the MCO'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 MCO 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 MCO cannot proceed with termination of the Contract under this Article.

(b) Change to HHSC Uniform Managed Care Manual.

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

(c) Change to Capitation Rate.

If HHSC proposes a modification to the Capitation Rate that is unacceptable to the MCO, the MCO may terminate the Contract. MCO 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, MCO must give HHSC at least ninety (90) days written notice of intent to terminate. The termination date will be calculated as the last day of the month following ninety (90) days from the date the notice of intent to terminate is received by HHSC.

Section 12.05 Termination by mutual agreement.

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

Section 12.06 Effective date of termination.

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

Section 12.07 Extension of termination effective date.

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

Section 12.08 Payment and other provisions at Contract termination.

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

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

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

Section 12.10 Turnover assistance.

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

If HHSC terminates the Contract for cause, the MCO 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 MCO. 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 MCO'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.* MCO'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 MCO'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, MCO must submit written notice to HHSC that specifically states that MCO 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 MCO'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 MCO'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 MCO'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) *MCO'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 MCO 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 MCO.

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

(1) Defects in Services or Deliverables;

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

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

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

(c) MCO will not be liable to HHSC for any loss, damages or liabilities attributable to or arising from the failure of HHSC or any state agency to perform a service or activity in connection with this Contract.

Section 12.15 Pre-termination Process

Section 12.15 Added by Version 1.4

The following process will apply when HHSC terminates the Agreement for any reason set forth in Section 12.03(b), "Termination for cause," other than Subpart 6, "Termination for Non-appropriation of Funds." HHSC will provide the HMO with reasonable advance written notice of the proposed termination, as it deems appropriate under the circumstances. The notice will include the reason for the proposed termination, the proposed effective date of the termination, and the time and place where the parties will meet regarding the proposed termination. During this meeting, the HMO may present written information explaining why HHSC should not affirm the proposed termination. HHSC's Associate Commissioner for Medicaid and CHIP will consider the written information, if any, and will provide the HMO with a written notice of HHSC's final decision affirming or reversing the termination. An affirming decision will include the effective date of termination.

The pre-termination process described herein will not limit or otherwise reduce the parties' rights and responsibilities under Section 12.13, "Dispute Resolution;" however, HHSC's final decision to terminate is binding and is not subject to review by the State Office of Administrative Hearings under Chapter 2260, Texas Government Code.

Article 13. Assurances & Certifications

Section 13.01 Proposal certifications.

MCO 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.

MCO agrees to comply with applicable state and federal laws, rules, and regulations regarding conflicts of interest in the performance of its duties under this Contract. MCO 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.

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

(2) Provides the MCO 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, MCO 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. MCO affirms that it has neither given, nor intends to give, at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, at any time during the procurement process or in connection with the procurement process except as allowed under relevant state and federal law.

(c) Continuing duty to disclose.

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

(2) The disclosure will include a description of the action(s) that MCO 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 MCO 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.

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

Section 13.04 HHSC personnel recruitment prohibition.

MCO 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 MCO for this Contract.

Unless authorized in writing by HHSC, MCO 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.

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

Section 13.07 Certification regarding status of license, certificate, or permit.

Article IX, Section 163 of the General Appropriations Act for the 1998/1999 state fiscal biennium prohibits an agency that receives an appropriation under either Article II or V of the General Appropriations Act from awarding a contract with the owner, operator, or administrator of a facility that has had a license, certificate, or permit revoked by another Article II or V agency. MCO certifies it is not ineligible for an award under this provision.

Section 13.08 Outstanding debts and judgments.

MCO certifies that it is not presently indebted to the State of Texas, and that MCO is not subject to an outstanding judgment in a suit by State of Texas against MCO for collection of the balance. For purposes of this Section, an indebtedness is any amount sum of money that is due and owing to the State of Texas and is not currently under dispute. A false statement regarding MCO'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 MCO and no additional approval, authorization or consent of any governmental or regulatory agency is required to be obtained in order for MCO to enter into this Contract and perform its obligations under this Contract.

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

Section 14.02 Ability to perform.

MCO warrants that it has the financial resources to fund the capital expenditures required under the Contract without advances by HHSC or assignment of any payments by HHSC to a financing source.

Section 14.03 Minimum Net Worth.

The MCO has, and will maintain throughout the life of this Contract, minimum net worth to the greater of (a) $1,500,000; (b) an amount equal to the sum of twenty-five dollars ($25) times the number of all enrollees including Members; or (c) an amount that complies with standards adopted by TDI. Minimum net worth means the excess total admitted assets over total liabilities, excluding liability for subordinated debt issued in compliance with Chapter 843 of the Texas Insurance Code.

Section 14.04 Insurer solvency.

(a) The MCO must be and remain in full compliance with all applicable state and federal solvency requirements for basic-service health maintenance organizations, including but not limited to, all reserve requirements, net worth standards, debt-to-equity ratios, or other debt limitations. In the event the MCO fails to maintain such compliance, HHSC, without limiting any other rights it may have by law or under the Contract, may terminate the Contract.

(b) If the MCO becomes aware of any impending changes to its financial or business structure that could adversely impact its compliance with the requirements of the Contract or its ability to pay its debts as they come due, the MCO must notify HHSC immediately in writing.

(c) The MCO must have a plan and take appropriate measures to ensure adequate provision against the risk of insolvency as required by TDI. Such provision must be adequate to provide for the following in the event of insolvency:

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

(2) payments to unaffiliated health care providers and affiliated heatlh care providers whose Contracts do not contain Member "hold harmless" clauses acceptable to the TDI;

(3) continuation of Covered Services for the duration of the Contract Period for which a capitation has been paid for a Member;

(4) provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI and the Contract.

Should TDI determine that there is an immediate risk of insolvency or the MCO is unable to provide Covered Services to its Members, HHSC, without limiting any other rights it may have by law, or under the Contract, may terminate the Contract.

Section 14.05 Workmanship and performance.

(a) All Services and Deliverables provided under this Contract will be provided in a manner consistent with the standards of quality and integrity as outlined in the Contract.

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

(c) MCO will perform the Services and provide the Deliverables in a workmanlike manner, in accordance with best practices and high professional standards used in well-managed operations performing services similar to the services described in this Contract.

Section 14.06 Warranty of deliverables.

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

Section 14.07 Compliance with Contract.

MCO will not take any action substantially or materially inconsistent with any of the terms and conditions set forth in this Contract without the express written approval of HHSC.

Section 14.08 Technology Access

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

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

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

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

(b) For purposes of this Section, the phrase "equivalent access" means a substantially similar ability to communicate with or make use of the technology, either directly by features incorporated within the technology or by other reasonable means such as assistive devices or services that would constitute reasonable accommodations under the Americans with Disabilities Act or similar State or Federal laws. Examples of methods by which equivalent access may be provided include, but are not limited to, keyboard alternatives to mouse commands and other means of navigating graphical displays, and customizable display appearance.

(c) In addition, all technological solutions offered by the MCO 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) MCO warrants that all Deliverables provided by MCO 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) MCO 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 MCO in writing of the claim, provide MCO a copy of all information received by HHSC with respect to the claim, and cooperate with MCO in defending or settling the claim. HHSC will not unreasonably withhold, delay or condition approval of counsel selected by the MCO.

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

***Section 15.02* Exceptions.**

MCO 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 MCO or its Subcontractors, or modifications made by HHSC or its contractors working at MCO's direction or in accordance with the specifications; or

(b) The combination, operation, or use of the item with other items if MCO 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 MCO.

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

(2) "**MCO Proprietary Software**" means: (i) software developed by the MCO prior to the Effective Date of the Contract, or (ii) software, modifications to software, or independent software developed by the MCO after the Effective Date of the Contract that is not developed for HHSC in connection with the Contract with funds received from HHSC.

(3) "**Third Party Software**" means software that is: developed for general commercial use; available to the public; or not developed for HHSC. Third Party Software includes without limitation: commercial off-the-shelf software; operating system software; and application software, tools, and utilities.

(4) "**Foster Care Program Hardware**" means hardware for which its total cost was paid for with funds received by HHSC and that was purchased by MCO in connection with the Contract.

(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, Foster Care Program Hardware and the Deliverables provided by the MCO, including without limitation the Custom Software and associated documentation. For purposes of this Section 15.03, the Deliverables will not include MCO Proprietary Software or Third Party Software. MCO 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) MCO will furnish such Deliverables, upon request of HHSC, in accordance with applicable State law. All Deliverables, in whole and in part, will be deemed works made for hire of HHSC for all purposes of copyright law, and copyright will belong solely to HHSC. To the extent that any such Deliverable does not qualify as a work for hire under applicable law, and to the extent that the Deliverable includes materials subject to copyright, patent, trade secret, or other proprietary right protection, MCO 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) MCO 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. MCO 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. MCO 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 MCO 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 MCO under or resulting from the Contract. Such data will include all results, technical information, and materials developed for and/or obtained by HHSC from MCO in the performance of the Services hereunder, including but not limited to all reports, surveys, plans, charts, recordings (video and/or sound), pictures, drawings, analyses, graphic representations, computer printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the Services performed as a result of the Contract.

(e) Proprietary Notices

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

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

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

Article 17. Insurance & Bonding

Section 17.01 modified by Versions 1.1 and 1.4

***Section 17.01* Insurance Coverage.**

(a) Statutory and General Coverage

MCO will maintain, at the MCO's expense, the following insurance coverage

(1) Business Automobile Liability Insurance for all owned, non-owned, and hired vehicles for bodily injury and property damage;

(2) Comprehensive General Liability Insurance of at least $1,000,000.00 per occurrence and $5,000,000.00 in the aggregate (including Bodily Injury coverage of $100,000.oo per each occurrence and Property Damage Coverage of $25,000.00 per occurrence); and

(3) If MCO's current Comprehensive General Liability insurance coverage does not meet the above stated requirements, MCO will obtain Umbrella liability insurance to compensate for the difference in the coverage amounts. If Umbrella Liability Insurance is provided, it shall follow the form of the primary coverage.

(b) Professional Liability Coverage.

(1) MCO must maintain, or cause its Network Providers to maintain, Professional Liability Insurance for each Network Provider of $100,000.00 per occurrence and $300,000.00 in the aggregate, or the limits required by the hospital at which the Network Provider has admitting privileges.

(2) MCO must maintain an Excess Professional Liability (Errors and Omissions) Insurance Policy for the greater of $3,000,000.00 or an amount (rounded to the nearest $100,000.00) that represents the number of Members enrolled in the MCO in the first month of the applicable State Fiscal Year multiplied by $150.00, not to exceed $10,000,000.00.

(c) General Requirements for All Insurance Coverage

(1) Except as provided herein, all exceptions to the Contract's insurance requirements must be approved in writing by HHSC. HHSC's written approval is not required in the following situations:

(A) An MCO or a Network Provider is not required to obtain the insurance coverage described in Section 17.01 if the MCO or Network Provider qualifies as a state governmental unit or municipality under the Texas Tort Claims Act, and is required to comply with, and subject to the provisions of, the Texas Tort Claims Act.

(B) An MCO may waive the Professional Liability Insurance requirement described in Section 17.01(b)(1) for a Network Provider of Community-based Long Term Care Services. An MCO may not waive this requirement if the Network Provider provides other Covered Services in addition to Community-based Long Term Care Services, or if a Texas licensing entity requires the Network Provider to carry such Professional Liability coverage. An MCO that waives the Professional Liability Insurance requirement for a Network Provider pursuant to this provision is not required to obtain such coverage on behalf of the Network Provider.

(2) The MCO or the Network Provider is responsible for any and all deductibles stated in the insurance policies.

(3) Insurance coverage must be issued by insurance companies authorized to conduct business in the State of Texas.

(4) With the exception of Professional Liability Insurance maintained by Network Providers all insurance coverage must name HHSC as an additional insured. In addition with the of Professional Liability Insurance maintained by Network Providers and Business Automobile Liability Insurance all insureance coverage must name HHSC as a loss payee

(5) Insurance coverage kept by the MCO must be maintained in full force at all times during the Term of the Contract, and until HHSC's final acceptance of all Services and Deliverables. Failure to maintain such insurance coverage will constitute a material breach of this Contract.

(6) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must have extended reporting periods of two years. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, the Contract Effective Date.

(7) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must provide that prior written notice to be given to HHSC at least thirty (30) calendar days before coverage is reduced below minimum HHSC contractual requirements, canceled, or non-renewed. The MCO must submit a new coverage binder to HHSC to ensure no break in coverage.

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

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

(10) If the MCO, or its Network Providers, desire additional coverage, higher limits of liability, or other modifications for its own protection, the MCO or its Network Providers will be responsible for the acquisition and cost of such additional protection. Such additional protection will not be an Allowable Expense under this Contract.

(11) HMO will require all insurers to waive their rights of subrogation against HHSC for claims arising from or relating to this Contract.

(d) Proof of Insurance Coverage

(1) Except as provided in Section 17.01(d)(2), the MCO must furnish the HHSC Project Manager original Certificates of Insurance evidencing the required insurance coverage on or before the Effective Date of the Contract. If insurance coverage is renewed during the Term of the Contract, the MCO must furnish the HHSC Project Manager renewal certificates of insurance, or such similar evidence, within five (5) Business Days of renewal. The failure of HHSC to obtain such evidence from the MCO will not be deemed to be a waiver by HHSC and the MCO will remain under continuing obligation to maintain and provide proof of insurance coverage.

(2) The MCO is not required to furnish the HHSC Project Manager proof of Professional Liability Insurance maintained by Network Providers on or

before the Effective Date of the Contract, but must provide such information upon HHSC's request during the Term of the Contract.

Section 17.02 modified by Version 1.4

***Section 17.02* Performance Bond.**

(a) Beginning on the Operational Start Date of the Contrac the MCO must obtain a performance bond with a one (1) year term. The performance bond must be renewable and renewal must occur no later than the first day of each subsequent State Fiscal Year. The performance bond must continue to be in effect for one (1) year following the expiration of the final renewal period. MCO must obtain and maintain the annual performance bonds in the form prescribed by HHSC and approved by TDI, naming HHSC as Obligee, securing MCO's faithful performance of the terms and conditions of this Contract. The performance bonds must comply with Chapter 843 of the Texas Insurance Code and 28 T.A.C. §11.1805. ~~I~~ At least one performance bond must be issued~~.~~The amount of the performance bond(s) should total $100,000.00 for the MCO Program covered under this Contract. Performance bonds must be issued by a surety licensed by TDI, and specify cash payment as the sole remedy. MCO must deliver the initial performance bond to HHSC prior to the Operational Start Date of the Contract, and each renewal prior to the first day of the State Fiscal Year.

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

***Section 17.03* TDI Fidelity Bond**

The MCO will secure and maintain throughout the life of the Contract a fidelity bond in compliance with Chapter 843 of the Texas Insurance Code and 28 T.A.C. §11.1805. The MCO must promptly provide HHSC with copies of the bond and any amendments or renewals thereto.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Version 1.0	n/a	February 23, 2007	Initial version of Attachment B-1, RFP Section 1. Includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2008	Section 1.2 is modified to add a cross reference to Attachment C-2, Agreed Modifications to the Proposal.
Revision	1.2	September 1, 2008	Contract Amendment did not revise Attachment B-1, RFP Section 1, "General Information".
Revision	1.3	June 1, 2009	Section 1.1 is modified to remove emancipated minors and to add upper age limit for young adults who have exited foster care and are participating in the transitional Medicaid program and to remove the 1% performance-based rate placed at-risk language from the contract. Section 1.2 is modified to remove the reference to Attachment C-2 and to add upper age limit for requirement to provide an initial THSteps dental check-up. Section 1.3.5 is modified to conform to the changes made to the definition of Target Population in Attachment A, Article 2
Revision	1.4	September 1, 2009	All references to "check-ups" are changed to "checkups" All references to "THSteps" are changed to "Texas Health Steps"

[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 GENERAL INFORMATION

1.1 Mission and Purpose

Section 1.1 modified by Versions 1.0 and 1.3

The purpose of this procurement is to contract with a single Managed Care Organization (MCO) to develop a statewide Comprehensive Health Care Model for Foster Care in the Target Population[1] (the "Model"). The Target Population includes the following children and young adults in Substitute Care: children and young adults in the Department of Family and Protective Services (DFPS) conservatorship, and young adults age 18-22 who voluntarily agree to continue in a foster care placement, and young adults age 18-21 who have exited foster care and are participating in the foster care youth transitional Medicaid program.

Children and young adults in the Target Population frequently have complex physical health, behavioral health and developmental needs. In 2005, the Texas Legislature addressed the special health care needs of the Target Population in Senate Bill 6[2]. Effective September 1, 2005, this law requires the Health and Human Services Commission (HHSC) to design a comprehensive, cost-effective medical services delivery model to meet the Target Population's physical and behavioral health needs.[3]

HHSC is soliciting proposals from four types of vendors:

- Health Maintenance Organizations (HMOs);
- Exclusive Provider Plans (EPPs);
- Approved Non-profit Health Corporations (ANHCs); and
- Prepaid Inpatient Health Plans (PIHPs).

As set forth in **RFP Section 2.4,** all four types of vendors will establish a Network of Providers, and must be licensed or approved by the Texas Department of Insurance (TDI) prior to contract execution. HHSC will contract with the first three types of vendors on a

[1] The definitions for terms that are capitalized in the document are found in **HHSC's General Contract Terms and Conditions**. These terms may also be defined within the text of the document.
[2] Senate Bill 6, 79th Legislature, Regular Session, 2005.
[3] Section 1.65 of Senate Bill 6, codified in Texas Family Code, Chapter 266, effective September 1, 2005

capitated, risked-based arrangement. The HMO, EPP, or ANHC will pay Network Providers directly for the delivery of Covered Services to Members. HHSC will pay a PIHP on a per-Member per-month basis to manage and coordinate the delivery of Covered Services to Members; however, HHSC will pay the PIHP Network Providers for the delivery of Covered Services pursuant to HHSC's existing Medicaid contracts with such Providers. The Bidder may propose to serve all counties as an HMO, EPP or ANHC, all counties as a PIHP Contractor, or some counties as an HMO, EPP or ANHC and some counties as a PIHP Contractor, as long as the bid covers all counties in the state.

HHSC's mission in this procurement is:

- To deliver integrated physical and Behavioral Health Services, centralize Service Coordination, and effectively manage health care data and information.
- To provide the Target Population with a consistent source of health care through a Medical Home.
- To improve health care outcomes through enhanced quality of services.

HHSC and the selected MCO will develop a name for the Model.

1.2 Mission Objectives and Priorities

Section 1.2 Modified by Versions 1.1 and 1.3

HHSC believes that its current Fee-for-Service system provides valuable services to Texas Medicaid beneficiaries in the Target Population. However, HHSC and its stakeholders believe that significant opportunities for improvement remain. To this end, HHSC's mission, objectives and priorities for the Model include:

- **Network Adequacy and Access to Care**

  It is HHSC's intent that all Members have timely access to quality care through a Provider Network designed to meet the needs of the Target Population. The MCO will be accountable for creating and maintaining a Network capable of delivering all Covered Services to Members throughout the State of Texas. The MCO shall provide Members with access to qualified Network Providers within the travel distance and waiting time for appointment standards defined in this

RFP. HHSC will especially focus on Members' access to dental and Behavioral Health Services.

- **Behavioral Health Services**
  The MCO will focus on access to, and delivery of, Behavioral Health Services. Members must have timely access to Medically Necessary Behavioral Health Services, such as mental health and Chemical Dependency Treatment and counseling, as well as timely and appropriate follow-up care. Contract requirements emphasize the importance of integration of care and formal, regular communication between Providers for Members who need assessment and evaluation for behavioral health concerns, or who are receiving both primary physical health and Behavioral Health Services. The Provider Network must include Providers experienced in treating victims of child abuse and neglect.

- **Service Management and Service Coordination**
  The MCO will be responsible for ensuring coordinated and integrated health care for Members through a Medical Home. Service Managers will assist PCPs in managing clinical services for Members with needs that require specialty care. The MCO will be responsive to inquiries and requests from DFPS Staff and Members' Caregivers. The Service Coordinators will provide information to DFPS Staff and Members' Caregivers, and assist these parties with accessing non-clinical services.

- **Medical Home**
  HHSC is committed to providing a consistent source of health care for the Target Population through a Medical Home. The MCO will be responsible for developing and upholding the Medical Home model through the management and coordination of Health Care Services.

- **Timeliness of Initial Texas Health Steps Visit**

  Except as provided below, the Network Providers must provide an initial Texas Health Steps screening checkup within 21 days of enrollment for Members under age 18. Network Providers must provide the Texas Health Steps medical checkup within 14 days of enrollment for newborns. Finally, Network Providers must provide an initial Texas Health Steps dental checkup within 60 days of enrollment for Members ages six months through the month of their 21st birthday.

Section 1.2 Timeliness of Initial THSteps Visit modified by Versions 1.0 1.3 and 1.4

- **Health Passport**

  The MCO will be responsible for developing and maintaining a Health Passport for Members to ensure that health information provided to DFPS Staff, the court system, Network Providers, and others is timely, portable, and readily accessible.

- **Timeliness of Claim Payment**

  A key element of an HMO's, EPP's, or ANHC's success will be its ability to ensure that Network Providers receive timely and fair payment for services rendered. Such MCOs must have the ability to pay Clean Claims and Appealed claims on a timely basis, as well as resolve Pended Claims in a timely manner. HHSC will require strict adherence to basic claims processing standards. This objective will not apply to a PIHP, which is not responsible for claims payment under the Model.

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 is 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:

- The DFPS investigates reports of abuse and neglect of children, provides services to children and families in their own homes, works with other agencies to provide clients with specialized services, places children in Substitute Care, provides services to help youth in the Target Population make the transition to adulthood, and places children in adoptive homes.
- The Department of State Health Services (DSHS) provides health services programs and also provides treatment and prevention for mental illness and substance abuse in its public health framework.
- The Department of Aging and Disability Services (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 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.

HHSC coordinates administrative functions for the HHS agencies, determines eligibility for health and human services programs, and administers Texas Medicaid and the Children's Health Insurance Program (CHIP). The MCO will work with HHSC, DFPS, other HHS agencies, and their contractors to ensure the delivery of a coordinated and comprehensive health care system for the Target Population.

1.3.2 Project Overview

Children and young adults in the Target Population are often in poor health. While they may have multiple and complex physical health, mental health, and developmental needs, they also have health needs similar to those of all children, requiring well-child health care, immunizations and the treatment of acute childhood illnesses. Children and young adults in the Target Population may have health problems associated with poverty, such as low birth weight and malnutrition. They are also at risk for conditions associated with parental

neglect, physical or sexual abuse, parental substance abuse or mental illness, and the separation and loss associated with out-of-home care.[4]

Despite efforts to prevent child abuse and neglect, DFPS reported that there were 34,312 children and young adults in the Target Population in Texas in 2004.[5] HHSC estimates that, on average in State Fiscal Year (SFY) 2005, there were 24,837 persons from the Target Population receiving Medicaid services each month. Currently, Texas uses both public and private facilities to provide residential services for children in the managing conservatorship of the state.

The Model addresses the Target Population's health care needs by providing a comprehensive statewide Model that will deliver integrated physical and Behavioral Health Services, centralize service coordination, and effectively manage health care data and information.

1.3.3 Child Protective Services and Substitute Care in Texas

Through its Child Protective Services (CPS) Program, DFPS provides child welfare services to the state's children and families. CPS is responsible for conducting civil investigations of reported child abuse and neglect; protecting children from abuse and neglect; promoting the safety, integrity, and stability of families; and providing permanent placements for children who cannot safely remain with their own families.[6] State law requires anyone who suspects a child is being abused and/or neglected to report their concerns to the DFPS abuse hotline (1-800-252-5400).

When child safety can be reasonably assured, CPS provides in-home services to help stabilize the family and reduce the risk of future abuse or neglect. When it is not safe for children to live with their own families, CPS petitions the court to remove the children from their homes. CPS may temporarily place a child with relatives, a verified substitute family, an emergency shelter, a specialized group home, a residential treatment center, or other

[4] Sheryl Dicker and Elysa Gordon, "Connecting Health Development and Permanency: A Pivotal Role for Child Welfare Professionals," *Permanency Planning Today*, March 2000, http://www.courts.state.ny.us/ip/justiceforchildren
[5] Texas Department of Family and Protective Services, "2004 Data Book," page 152.
[6] Texas Department of Family and Protective Services, "2004 Annual Report," page 9.

licensed residential child-care facilities. CPS is required to provide all medical, dental, and therapeutic services needed by the child.[7]

After CPS removes children from their home and places the children in the state's custody, CPS works with parents, Caregivers, and professionals to ensure that children live in a stable, nurturing environment and do not remain in Substitute Care. Whether the plan is for a child to return home, to be adopted, or to live independently, CPS works to avoid unnecessary delays in permanency. When it is not possible for a child to return home, the court may terminate the parent's rights and legally make the child available for adoption.[8]

Please note that pursuant to Chapter 45 of the Texas Human Resources Code, DFPS will outsource its Substitute Care Services and Case Management Services. DFPS will contract with private entities to provide or ensure the provision of Substitute Care Services and Case Management Services on a statewide basis by September 1, 2011. DFPS will either contract directly with private entities for the aforementioned services or contract with Independent Administrators (IAs) to manage, procure, and ensure the provision of these services in HHSC's regions. Accordingly, the sections of this RFP that refer to "DFPS Staff" in the context of Substitute Care Services and Case Management Services may also refer to the personnel of outsourced private entities or IAs and the Substitute Care and Case Management Service providers in an outsourced region.

DFPS issued its RFP for the project on May 1, 2006. The RFP is posted on the following web page: http://www.dfps.state.tx.us/Documents/about/Outsourcing/2006-05-01_RFP_IA.pdf
For more general information on DFPS outsourcing, please see:
http://www.dfps.state.tx.us/About/Outsourcing/default.asp.

1.3.4 Overview of Substitute Care and Medicaid in Texas

Currently, when a child is placed in the state's custody, he or she becomes eligible to receive Medicaid services through the Fee-for-Service system. Because more than half of all children placed in the state's custody are already enrolled in Medicaid prior to Substitute

[7] Texas Department of Family and Protective Services, "2004 Annual Report," page 11.
[8] Texas Department of Family and Protective Services, "2004 Annual Report," page 12.

Care placement, many of these children are already participating in one of HHSC's managed care service delivery models. HHSC currently provides Medicaid services to eligible recipients through two different managed care delivery systems.[9] In both managed care systems, Medicaid recipients have a Medical Home through a designated Primary Care Provider (PCP) from whom they receive primary care and obtain referrals to specialty care.

In the health maintenance organization (HMO) model, Contractors receive capitated payments from the state and pay providers negotiated rates to provide services to enrollees. In the primary care case management (PCCM) model, PCPs receive a fee per-member-per-month from the state for coordinating their patients' care, and provider claims are paid on a Fee-for-Service basis through the state's Medicaid claims administrator.

1.3.4.1 CHIP

CHIP is HHSC's program to help Texas families obtain affordable coverage for their uninsured children (ages 0 through 18). CHIP's principal objective is to provide primary and preventative health care to low-income, uninsured children in Texas who are not served by or eligible for other state-assisted health insurance models.

HHSC operates CHIP through two managed care models. HHSC contracts with HMOs in eight urban areas of the state, and an Exclusive Provider Organization (EPO) in 170 rural counties.

1.3.5 Eligible Population

Section 1.3.5 modified by Version 1.0 and 1.3

The following groups (referred to hereinafter as "the Eligible Population" or the "Target Population") will be eligible to participate in the Model: children and young adults in DFPS conservatorship, young adults age 18-22 who voluntarily agree to continue in a foster care placement, and young adults age 18 through the month of their 21st birthday, who have

[9] HHSC currently uses the HMO model in seven metropolitan areas of the state. HHSC recently conducted a Medicaid procurement that will expand HMO services into an additional area. Please refer to HHSC RFP #529-04-272 for additional information. Effective September 1, 2005, HHSC also expanded the PCCM into 197 additional rural counties.

exited foster care and are participating in the foster care youth transitional Medicaid program.

1.4 RFP Overview

Section 2 of the RFP describes HHSC's strategy and approach for conducting this procurement. **Sections 3** through **5** of the RFP set forth the Scope of Work the MCO will be responsible for providing during the Contract Term, otherwise known as the "Mission Results." Bidders should be aware that additional requirements regarding the Scope of Work/Mission Results are located in **General Terms and Conditions** and in the **Uniform Managed Care Manual**. **Section 6** of the RFP includes general instructions and requirements for developing proposals. Finally, **Section 7** of the RFP sets forth HHSC's criteria for evaluating proposals.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	February 23, 2007	Initial version of Attachment B-1, RFP Section 2. Includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2008	Contract Amendment did not revise Attachment B-1, RFP Section 2"Procurement Strategy & Approach"
Revision	1.2	September 1, 2008	Contract Amendment did not revise Attachment B-1, RFP Section 2"Procurement Strategy & Approach"
Revision	1.3	June 1, 2009	Section 2.16 is modified to correct the dates of transition activities, readiness review, and operational start date in the procurement schedule chart.
Revision	1.4	September 1, 2009	Section 2.3 is amended to change the required number of performance goals.

[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.

2 PROCUREMENT STRATEGY AND APPROACH

2.1 Best Value Procurement

This procurement is conducted as a competitive negotiation in accordance with HHSC administrative rules codified at Title 1, Texas Administrative Code (TAC), Chapter 391.

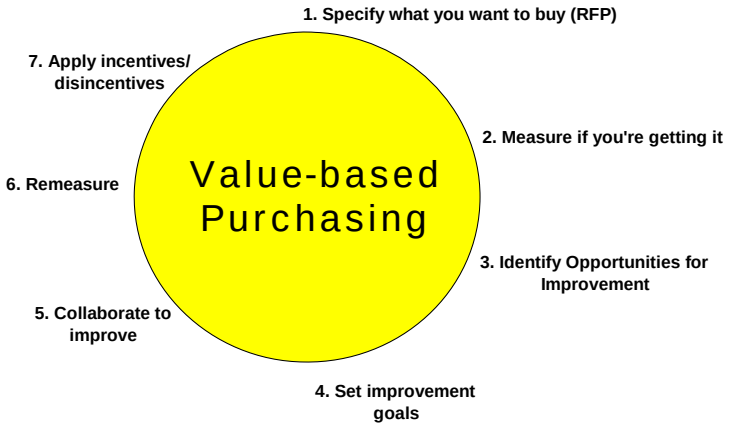
Section 2155.144, Texas Government Code, obligates HHSC to purchase goods and services on the basis of "best value." HHSC rules define best value as the optimum combination of economy and quality that is the result of fair, efficient, and practical procurement decision-making and that achieves health and human services procurement objectives (see 1 TAC §391.31). HHSC will evaluate proposals using the best value criteria set forth in **Section 7.2** of this RFP, and will contract with one MCO.

2.2 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 MCO are as follows:

1. Improve the specificity of desired MCO services and outcomes.
2. Prioritize attention to those aspects of MCO performance that are most important to HHSC and to the Members.
3. Create better, data-based measurement and accountability on key performance dimensions.
4. Accelerate the MCO's performance improvement.
5. Recognize and reward the MCO's excellence and improvement, and apply disincentives when there is poor performance.
6. Improve the manner in which HHSC collaborates with the MCO.
7. Facilitate the development of improved, streamlined contract management practices and processes.

2.3 HHSC Model Management Strategy

As part of the VBP initiative, HHSC has identified MCO performance requirements (see **RFP Section 4**) and top priorities that it expects the MCO to address (see **RFP Section 1.2**).

Section 2.3 modified by Version 1.4

HHSC has further focused its performance measurement efforts by developing a "Performance Indicator Dashboard," which is a series of performance measures that identify key aspects of performance that HHSC will review to ensure MCO accountability (see the **Uniform Managed Care Manual**). The Performance Indicator Dashboard is not an all-inclusive set of performance measures; HHSC will measure other aspects of MCO performance as well. Rather, the Performance Indicator Dashboard assembles performance indicators that assess many of the most important dimensions of MCO performance, and includes measures that, when publicly shared, will also serve to incentivize MCO excellence.

The MCO's management and reporting procedures must align with the VBP model's analytical, data-based, and strategic approach to ensuring accountability.

HHSC will seek to accelerate improvement efforts in areas of high priority, including those identified in **RFP Section 1.2.** As described in **RFP Section 4.1.1**, HHSC's method for accelerating improvement will be to annually establish with the MCO a series of performance improvement goals. The MCO will be committed to making its best efforts to achieve the established goals.

HHSC will collaborate with the MCO to establish approximately three to five goals per year. HHSC may set two to three goals; HHSC and the MCO will negotiate the remaining annual goals. These goals will be highly specified and measurable. They may be comprised of both administrative service and clinical service goals, but generally no more than two goals will address administrative service. The goals will reflect areas that present significant opportunities for performance improvement. Once finalized, the goals will become part of the MCO's annual plan for its Quality

Assessment and Performance Improvement (QAPI) Program, as defined in **RFP Section 4.1.7**.

HHSC staff will conduct semiannual goal review meetings with senior MCO management twice a year. The MCO will receive written feedback from HHSC after these meetings. For a sample template for annual performance goals and measures see **RFP Attachment C-1.**

HHSC recognizes the importance of applying a variety of financial and non-financial incentives and disincentives for demonstrated MCO performance. It is HHSC's objective to recognize and reward both excellence in MCO performance, and improvement in performance, within existing state and federal financial constraints. It is likely that this approach will be modified over time based on several variables, including accumulated experience by HHSC and the MCO, changes in the status of state finances, and changes in MCO performance levels. **RFP Section 4.1.34** 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.** MCO performance relative to the annual performance improvement goals may be used by HHSC to identify and reward excellence and improvement by the MCO in subsequent years.

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

2.4 Eligible Bidders

Eligible Bidders include insurers who can offer a statewide Exclusive Provider Benefit Plan (EPP) approved by the Texas Department of Insurance (TDI). An EPP is a benefit plan issued by an insurance company authorized to do business in Texas that complies with the TDI requirements for EPPs found in 28 TAC §§ 3.9201 – 3.9212 and Texas Insurance Code Chapter 1701.

Eligible Bidders also include insurers that are licensed by the TDI as an HMO in accordance with Chapter 843 of the Texas Insurance Code, or a certified approved non-profit health corporation (ANHC), formed in compliance with Chapter 844 of the Texas Insurance Code.

Finally, Eligible Bidders can include a Prepaid Inpatient Health Plan (PIHP), an entity provides, arranges for, or otherwise has responsibility for the provision of any Covered Services for Members. This contractor must meet all federal regulatory requirements for PIHPs as described in 42 C.F.R., Chapter IV, Part 438, and must be licensed by the TDI as a Utilization Review Agent (URA).

A Bidder that has submitted its application for certificate of authority to do business in Texas under Chapter 3 of the Insurance Code and who is seeking approval of TDI's requirements for issuing EPPs prior to the proposal due date is eligible to respond to this RFP. A Bidder that has submitted its application for licensure as an HMO or for certification as an ANHC prior to the proposal due date is also eligible to respond to this RFP. Prior to the contract execution, however, the Bidder must obtain the following documents:

- For an EPP, a valid certificate of authority, evidence of TDI approval of the EPP Network, and a certification that TDI-approved policies will be issued. A Bidder that is bidding on some counties as an EPP cannot use its certificate of authority as an EPP to serve the remainder of counties in the state, but must have a separate URA certificate to serve these counties.
- For an HMO or ANHC, a certificate of authority from TDI to operate as an HMO or an ANHC throughout the State of Texas (See **RFP Section 6.13**). A Bidder that is bidding on some counties as an HMO or ANHC cannot use its certificate of authority as an HMO or ANHC to serve the remainder of counties in the state, but must have a separate URA certificate to serve these counties.
- For a PIHP, a certificate from TDI to operate as a URA in accordance with Chapter 4201 of the Texas Insurance Code.

Failure to submit these documents to HHSC on or before Contract execution will result in the cancellation of the award.

For more information on the reasons for HHSC's disqualification of Bidders, see **RFP Sections 2.12.2**, **2.13**, **2.19,** and **7.3**.

2.5 Contract Term

Section 2.5 modified by Version 1.0

The Contract will be effective February 23, 2007 and will continue through August 31, 2010. 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 Initial Contract Period will be subject to good faith negotiation between the Parties.

2.6 Contract Development

Appendix A of the RFP includes HHSC's standard **Managed Care Contract**. The Managed Care Contract includes a listing of all documents that will become part of the Agreement between HHSC and the MCO, including the **General Terms and Conditions**.

2.7 Definition of Terms

Section 2.7 modified by Version 1.0

Capitalized terms shall have the meaning described in the **General Terms and Conditions**, unless the context clearly indicates otherwise. For example, the word "Provider," when capitalized refers to an in-network provider. When the word "provider" is not capitalized, the connotation is all providers, whether in-network or out-of-network.

2.8 Contract Price/Type

HHSC will award a single Contract under this procurement for a statewide Model. Bidders must propose to serve all counties in Texas. HHSC will pay an HMO, EPP or ANHC based upon a capitated fee structure (see the **General Terms and Conditions**. HHSC will pay a PIHP on a per-Member per-month basis to manage and coordinate the delivery of Covered Services to Members.

2.9 Contract Terms and Conditions

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.

2.10 Basic Philosophy: Contracting for Results

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

2.11 External Factors

External factors such as budgetary and resource constraints could affect the project. The 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 funds are available to reasonably fulfill the requirements of this RFP. However, if funds become unavailable, HHSC reserves the right to withdraw this RFP or terminate the resulting contract without penalty.

2.12 Legal and Regulatory Constraints

2.12.1 Delegation of Authority

Bidders should be aware that state and federal law generally limit HHSC's ability to delegate certain decisions to an MCO, including but not limited to:

1. Policy-making authority.
2. Final decision-making authority regarding acceptance of contracted services.

2.12.2 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 MCO 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.
- 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 MCO 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 and reject any proposal due to potential or actual conflicts, or to terminate the Contract due to a conflict of interest.

2.12.3 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 6.13.1.1**, 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.
- The annual rate of compensation for the employment at the time of termination.

2.12.4 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.

2.13 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 HHSC's use of the evaluation methodology and evaluation process as described in **Section 7.2** of this RFP.
3. It accepts without reservation or limitation as lawful and binding HHSC'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 the Contract, it accepts without reservation or limitation the contractual language set forth in **HHSC's Managed Care Contract**, including the **General Terms and Conditions**. 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 6.13.1.1**. 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.

2.14 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 an MCO to carry out the duties and functions of the Model under Title XIX of the Social Security Act; §12.011 and §12.021, Texas Health and Safety Code; Chapter 266, Texas Family 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.

2.15 HHSC Point of Contact

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

Texas Health and Human Services Commission
Alice Hanna, Project Manager
11209 Metric Boulevard, Building H
Austin, Texas 78758
Phone: (512) 491-1315
Fax: (512) 491-1969; E-mail address: alice.hanna@hhsc.state.tx.us

The mailing address is:

Texas Health and Human Services Commission
Procurement – Mail Code H-350
P.O. Box 85200
Austin, Texas 78708-5200
ATTN: Alice Hanna, Project Manager

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

Texas Health and Human Services Commission
Alice Hanna, Project Manager
11209 Metric Boulevard, Building H
Austin, Texas 78758
Phone: (512) 491-1315
Fax: (512) 491-1969

E-mail address: alice.hanna@hhsc.state.tx.us

All communications relating to this RFP must be directed to the HHSC point-of-contact named above. All other communications between a Bidder and HHSC and the HHS agencies, their agents, employees or contractors concerning this RFP are prohibited. In no instance is a Bidder to discuss cost information contained in a proposal with the HHSC point of contact or any other staff. Failure to comply with this requirement may result in HHSC's disqualification of the proposal.

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

2.16 Procurement Schedule

Section 2.16 modified by Versions 1.0 and 1.3

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 HHSC website at http://www.hhsc.state.tx.us/about_hhsc/BusOpp/BO_opportunities.html.

Procurement Activity	Date
Draft RFP Release Date	Wednesday, March 1, 2006
Comments Due on Draft RFP	5:00 p.m., Wednesday, March 22, 2006
Final RFP Release Date	Wednesday, July 19, 2006
Bidder Questions Due For Consideration at HHSC Bidder Conference	5:00 pm, Monday July 24, 2006

Procurement Activity	Date
Bidder Conference	1:00-3:00 p.m. Monday, July 31, 2006 *Location:* Health and Human Services Commission Braker Center – Lone Star Conf Room 11209 Metric Blvd., Bldg. H. Austin, Texas, 78758
Final Bidder Questions Due (Bidders may not submit a question more than once)	5:00 pm, Wednesday, August 2, 2006
HHSC Response to Bidder Questions	Wednesday, August 16, 2006
Mandatory Letter of Intent Due	5:00 pm, Wednesday, August 16, 2006
Proposals Due	5:00 pm, Thursday, September 21, 2006
Deadline for Withdrawal of Proposals	5:00 pm, Thursday, September 21, 2006
Tentative Contract Awards	On or after February 1, 2007
Anticipated Contract Signing	February 23, 2007
Transition Activities	February 23, 2007 through March 31, 2008
Readiness Review	Monday, March 17, 2008 through Monday, , 2008
Operational Start Date	Tuesday, April 1, 2008

2.17 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 addenda issued by HHSC. Bidders should

check HHSC's website frequently for notice of matters affecting the procurement at http://www.hhsc.state.tx.us/about_hhsc/BusOpp/BO_opportunities.html .

2.18 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.

2.19 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.

2.20 Bidder Protest Procedures

Texas Administrative Code, Title 1, Chapter 392, Subchapter C outlines Bidder protest procedures.

2.21 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 .

2.22 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, Texas Government Code, Chapter 552, unless a Bidder can demonstrate that the identified part(s) of the proposal falls within one or more of the Public Information Act's exceptions to required public disclosure. If a Bidder believes that a part of a proposal is excepted from required public disclosure under the Public Information Act, the Bidder must specify the part and the exception(s) that it believes applies, with specific detailed reasons. A Bidder may not copyright the entire proposal package.

HHSC will process any request for information comprising all or part of a Bidder's proposal in accordance with the procedures prescribed by the Public Information Act. Bidders should consult the Attorney General's web site (www.oag.state.tx.us) for information concerning application of the Public Information Act and proprietary Bidder information.

2.23 Inducements

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

2.24 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 23, 2007	Initial version of Attachment B-1, RFP Section 3. Includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2008	Sections3.4.2, 3.4.5, and 3.4.7 are modified to add a cross reference to Attachment C-2 Agreed Modifications to the Proposal. Section 3.3 is modified to change the dates for the end of the Transition Phase and the anticipated Operational Start Date. Section 3.4.1 is modified to change the anticipated date for the beginning of Readiness Review. Section 3.4.4 is modified to change the time requirement for submission of documents from 10 to 15 days. Section 3.4.5 is modified to change the timeframe for completion of Fraud and Abuse training. Section 3.4.7 is modified to add a cross-reference to Attachment B-1, Sections 4.1.1.1, Additional HMO Readiness Reviews and 4.1.22, Management Information System Requirements
Revision	1.2	September 1, 2008	Contract Amendment did not revise Attachment B-1, RFP Section 3 "Transition Phase Requirements"
Revision	1.3	June 1, 2009	Section 3.4.1 is modified to correct the date of commencement of Readiness Review. Section 3.4.2 is modified to correct the references to Attachment C-2. Section 3.4.2.1 is added to require the MCO to allow HHSC to attend meetings between the MCO and its Material Subcontractors and/or to receive the minutes from these meetings, and to require certain monitoring of their Material Subcontractors. References to additional information in Attachment C-2 is added. Section 3.4.5 is modified to correct the references to Attachment C-2.
Revision	1.4	September 1, 2009	Contract Amendment did not revise Attachment B-1, RFP Section 3 "Transition Phase Requirements"

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

3 Transition Phase Requirements

3.1 Introduction

This Section presents the Scope of Work for the Transition Phase of the Contract, which includes those activities that must take place between the Contract Effective Date and the Operational Start Date.

If the Bidder uses a Material Subcontractor, the Bidder must describe in detail how the Bidder will coordinate with the Material Subcontractor to fulfill the Transition Phase requirements, the specific responsibilities the Material Subcontractor will have during the Transition Phase, and what specific management tools and strategies the Bidder will use to provide oversight of the Material Subcontractor's performance to ensure Contract requirements are met.

The Transition Phase will include a Readiness Review, which must be completed prior to the Operational Start Date. If the MCO fails to demonstrate operational readiness during the Readiness Review, HHSC may, at its discretion, postpone the Operational Start Date and/or assess contractual remedies, including liquidated damages. Refer to the **General Terms and Conditions** and the **Deliverables/Liquidated Damages Matrix** for additional information.

3.2 Transition Phase Scope

Section 3.2 modified by Version 1.0

The MCO must meet the Readiness Review requirements established by HHSC in order for enrollment to begin timely. The MCO will provide all materials required to complete the Readiness Review by the dates established by HHSC and its contracted Readiness Review Vendor.

3.3 Transition Phase Schedule and Tasks

Section 3.3 modified by Versions 1.0 and 1.1

The Transition Phase will begin on the Contract Effective Date, currently anticipated to be February 23, 2007. The Transition Phase must be completed by March 31, 2008 in order to meet the anticipated Operational Start Date of April 1, 2008.

3.4 Transition Phase Tasks

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

3.4.1 Contract Start-Up and Planning

Section 3.4.1 modified by Versions 1.0, 1.1, and 1.3

At the beginning of the Transition Phase, HHSC and the MCO will work together to:

- Define project management and reporting standards.
- Establish communication protocols between the MCO, HHSC, DFPS Staff, other HHS agencies, and HHSC's other contractors.
- Establish contacts with other HHSC contractors.
- Establish a schedule for key activities and milestones.
- Clarify expectations for the content and format of contract deliverables.
- Identify sites that the MCO may visit for MCO staff training.

The MCO will be responsible for developing a written work plan, referred to as the Transition/Implementation Plan, which will be used to monitor progress throughout the Transition Phase. A summary of the Transition/Implementation Plan should be included in the Bidder's proposal, as described in **Section 6.13.1.10.12, item 2** of the RFP. An updated and detailed Transition/Implementation Plan will be due to HHSC upon commencement of Readiness Review, March 17, 2008, with updates every 14 days, or as often as determined necessary by HHSC during Readiness Review. The Transition/Implementation Plan must comply with all deadlines established in this Section.

3.4.2 Administration and Key MCO Personnel

Section 3.4.2 modified by Versions 1.0, 1.1, and 1.3

Refer to **Attachment C-2, Section 2, Question c; Attachment C-2, Section 3, Question a; Attachment C-2, Section 4, Questions a and j; Attachment C-2, Section 27,**

Question d; and **Attachment C-2, Section 28** for additional information regarding Modifications to the Proposal.

No later than the Contract Effective Date, the MCO must designate and identify Key MCO Personnel that meet the requirements described in the **General Contract Terms & Conditions** (**Article 4**)**.** The MCO will supply HHSC with resumes of each Key MCO Personnel as well as organizational information that has changed relative to the MCO's proposal, such as updated job descriptions and updated organizational charts, (including updated Management Information System (MIS) job descriptions and an updated MIS staff organizational chart), if applicable. For Service Coordinators and Service Managers, the MCO must also provide information on the anticipated maximum caseload per Service Coordinator and Service Manager (i.e., number of Members per Service Coordinator and number of Members per Service Manager). If the MCO is using a Material Subcontractor(s), the MCO must also provide the organizational chart for such Material Subcontractor(s).

3.4.2.1 Material Subcontractors

Section 3.4.2.1 Added by Version 1.3

Refer to Attachment C-2, Section 2, Question c; and **Attachment C-2, Section 12, Questions a, b, and c** for additional information regarding Modifications to the Proposal.

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

1. the requirements for performance of all delegated functions with which the entity must comply;
2. the MCO's responsibilities for the financial oversight of a Material Subcontractor who has an at-risk contract with the MCO for the provision of covered services;

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

The MCO will maintain quarterly and annual documentation as to the compliance of the Material Subcontractor with all requirements defined in the monitoring plan. This documentation will contain evidence that appropriate actions were taken, as necessary, to correct any noncompliance.

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

3.4.3 Organizational and Financial Readiness Review

In order to complete an organizational and financial Readiness Review and assess the most current corporate environment, HHSC will require that the MCO update the organizational and financial information submitted in its proposal. See **Section 6.13.1.6** of the RFP for a list of Financial Statements, Corporate Background and Status, Corporate Experience, and Material Subcontractor Information the MCO must update for the Readiness Review.

3.4.3.1 System Testing and Transfer of Data

The MCO must have hardware, software, network and communications systems with the capability and capacity to handle and operate all MIS systems and subsystems identified in **RFP Section 4.1**. For example, the MCO's MIS system must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as indicated in **RFP Section 4.1.22.4**.

During this Readiness Review task, the MCO will accept into its system any and all necessary data files and information available from HHSC or its contractors. The MCO will install and test all hardware, software, and telecommunications required to support the Contract. The MCO will define and test modifications to the MCO's system(s) required to support the business functions of the Contract.

The MCO will produce data extracts and receive all electronic data transfers and transmissions. The MCO must be able to demonstrate the ability to produce the 837-Encounter file.

If any errors or deficiencies are evident, the MCO will develop resolution procedures to address problems identified. The MCO will provide HHSC, or its designated Readiness Review vendor, with test data files for systems and interface testing for all external interfaces. This includes testing of the required telephone lines for Providers and Members and any necessary connections to the HHSC Administrative Services Contractor and the External Quality Review Organization (EQRO). The HHSC Administrative Services Contractor will provide enrollment test files to the MCO. The MCO will demonstrate its system capabilities and adherence to Contract specifications during Readiness Review.

3.4.4 System Readiness Review

Section 3.4.4 modified by Versions 1.0 and 1.1

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

The MCO must submit descriptions of interface and data and process flow for each key business process described in **RFP Section 4.1.22.3**, System-wide Functions.

The MCO must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. The MCO must develop and submit the following plans to HHSC for review and approval at the beginning of Readiness Review activities and within 15 Business Days of HHSC's written request:

1. Joint Interface Plan.
2. Disaster Recovery Plan.
3. Business Continuity Plan.
4. Risk Management Plan.
5. Systems Quality Assurance Plan.

3.4.4.1 Demonstration and Assessment of System Readiness

The MCO must provide documentation on systems and facility security and demonstrate HIPAA compliance. The MCO shall also provide HHSC with a summary of all recent external audit reports, including findings and corrective actions, relating to the MCO's proposed systems, including any SAS70 audits that have been conducted in the past three years. The MCO shall promptly make additional information on the detail of such system audits available to HHSC upon request.

In addition, HHSC will provide to the MCO a test plan that will outline the activities that need to be performed by the MCO prior to conducting the Readiness Review. The MCO must be prepared to assure and demonstrate system readiness of the MCO and its Subcontractors. The MCO must execute system readiness test cycles to include all external data interfaces, including those with Subcontractors.

HHSC, or its agents, may independently test whether the MCO's MIS has the capability to administer the Model. This Readiness Review of the MCO's MIS will include a desk review

and an onsite review of the MCO or its Subcontractors. HHSC may request from the MCO additional documentation to support the provision of Covered Services. Based in part on the MCO's assurances of systems readiness, information contained in the Proposal, additional documentation submitted by the MCO, and any review conducted by HHSC or its agents, HHSC will assess the MCO's understanding of its responsibilities and the MCO's capability to assume the MIS functions required under the Contract.

The MCO 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 MCO documents to HHSC's satisfaction that the deficiency has been corrected within ten (10) calendar days of such deficiency notification by HHSC, no Corrective Action Plan is required.

3.4.5 Operations Readiness

Section 3.4.5 modified by Versions 1.0, 1.1, and 1.3

Refer to **Attachment C-2, Section 1, Question b; Attachment C-2, Section 8; Attachment C-2. Section 10, Question e;** and **Attachment C-2, Section 18, Question c** for additional information regarding Modifications to the Proposal.

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

To assist HHSC with determining whether the MCO is prepared to meet the Operational Start Date, the MCO must:

1. Develop new, or revise existing, operations procedures and associated documentation to support the MCO's proposed approach to conducting operations activities in compliance with the contracted Scope of Work.
2. Submit a listing of all contracted and credentialed Providers, in an HHSC approved format, including a description of additional contracting and

Credentialing activities scheduled for completion before the Operational Start Date. Submit updated GeoAccess maps and comparable tables to demonstrate compliance with access and travel distance requirements.

3. Prepare and implement a Member Services staff training curriculum and a Provider training curriculum.
4. Prepare a Coordination Plan documenting how the MCO will coordinate its business activities with those activities performed by HHSC contractors and the MCO's Subcontractors, if any. The Coordination Plan will include identification of coordinated activities and protocols for the Transition Phase.
5. Develop and submit to HHSC a plan for providing Behavioral Health Services, including oversight and management of any subcontracted Behavioral Health Services. The plan shall also address strategies, structures and incentives for coordinating behavioral and physical Health Care Services at the organizational and practitioner level.
6. Develop and submit to HHSC a communication plan for ongoing coordination with HHSC, DFPS Staff, and their contractors that includes strategies for sharing information and resolving issues.
7. Develop and submit to HHSC the draft Member Handbook, draft Provider Manual, draft Provider Directory, and draft Member Identification Card for HHSC's review and approval. The materials must at a minimum meet the requirements specified in **RFP Section 4** and include the Critical Elements defined in the **HHSC Uniform Managed Care Manual**.
8. Develop and submit to HHSC the MCO's proposed Complaint and Appeals processes that meet requirements specified in **RFP Section 4**.
9. Provide sufficient copies of the final Provider Directory to the HHSC Administrative Services Contractor (ASO) in adequate time to meet the enrollment schedule, no later than 90 calendar days prior to the Operational Start Date.
10. Demonstrate toll-free telephone systems and reporting capabilities for the NurseHotline, the Member Hotline, the Behavioral Health Hotline, and the

Provider Hotline. See **RFP Section 4** for requirements related to these hotlines.

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 4.1.23** for the requirements of the plan, including requirements for special investigation units. As part of the Fraud and Abuse compliance plan, the MCO must:

    - Designate executive and essential personnel to attend mandatory training in Fraud and Abuse detection, prevention and reporting. Executive and essential personnel means MCO staff persons who are directly involved in the decision-making and administration of the Fraud and Abuse detection program within the MCO and who supervise staff in the following areas: data collection; Provider enrollment or disenrollment; Encounter Data; claims processing (required for HMO, EPP, or ANHC only); Prior Authorization; Utilization Review; Appeals, Complaints or grievances; and quality assurance. The training will be conducted by the Office of Inspector General, Health and Human Services Commission, and will be provided free of charge. The MCO must schedule and complete training no later than 60 days prior to the Operational Start Date.
    - Designate an officer or director within the organization responsible for ensuring the provisions of the Fraud and Abuse compliance plan are implemented.
    - The MCO is held to the same requirements and must ensure that, if this function is subcontracted to another entity, the Subcontractor also meets all the requirements in this section and the Fraud and Abuse section as stated in **RFP Section 4.1.23**.

During the Readiness Review, HHSC may request from the MCO certain operating procedures and updates to document the provision of Covered Services. HHSC will assess the MCO's understanding of its responsibilities and the MCO's capability to assume the functions required under the Contract, based in part on the MCO's written notification of

operational readiness, information contained in the Proposal, and in Transition Phase documentation submitted by the MCO.

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

3.4.6 Assurance of System and Operational Readiness

In addition to successfully providing the Deliverables described in **RFP Section 4.1.22.2,** the MCO must assure HHSC that all processes, MIS systems, and staffed functions are ready and able to successfully assume responsibilities for operations prior to the Operational Start Date. In particular, the MCO must assure that Key MCO Personnel, Member Services staff, Provider Services staff, and MIS staff are hired and trained; MIS systems and interfaces are in place and functioning properly; communications procedures are in place; Provider Manuals are distributed; and that Provider training sessions occur according to the schedule approved by HHSC.

3.4.7 Post-Transition

Section 3.4.7 modified by Version 1.1

Refer to **Attachment C-2, Section 26** for additional information regarding Modifications to the Proposal.

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

The MCO must:

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

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

1. Impose contractual remedies, including liquidated damages.
2. Pursue other equitable, injunctive, or regulatory relief.

Refer to **Attachment B-1, Sections** 4.1.1.1, Additional HMO Readiness Reviews **and** 4.1.22, Management Information System Requirements for additional information regarding HMO Readiness Reviews during the Operations Phase.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	February 23, 2007	Initial version of Attachment B-1, RFP Section 4. Includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2008	Sections 4.1.1, 4.1.2, 4.1.2.2,4.1.3, 4.1.4, 4.1.4.1, 4.1.4.2, 4.1.4.3, 4.1.4.5, 4.1.4.7, 4.1.4.9.2, 4.1.4.11, 4.1.5, 4.1.5.3, 4.1.5.6, 4.1.7.2, 4.1.7.3, 4.1.7.4, 4.1.7.5, 4.1.7.6, 4.1.7.8, 4.1.8, 4.1.9, 4.1.11, 4.1.12, 4.1.13, 4.1.14, 4.1.16, 4.1.17, 4.1.18.2, 4.1.18.4, 4.1.18.5, 4.1.22.5, 4.1.25, 4.1.26.3, 4.1.27, and 4.1.31.10 are modified to add a cross reference to Attachment C-2 Agreed Modifications to the Proposal. Section 4.1.1 is modified to change Rate Period 1 to SFY 2009. New Section 4.1.1.1, Additional HMO Readiness Reviews, is added to require the HMOs to pay for any additional readiness reviews beyond the original ones conducted before the Operational Start Date. Section 4.1.2.1 is modified to reflect legislative changes required by SB 10. Section 4.1.4.1 is modified to reflect legislative changes required by SB 10. Section 4.1.4.5 is modified to require PCPs either be THSteps providers or to refer members due for a THSteps checkup to a THSteps provider. Section 4.1.4.11 is modified to align the requirements with those in the Uniform Managed Care Contract. Section 4.1.5.1 is modified to clarify the requirements for sending out enrollment packets. Section 4.1.5.2 is modified to clarify the requirements for sending out Member ID Cards and to remove the DFPS Person ID and PCP's address from the Member Identification (ID) Card. Section 4.1.5.4 is modified to clarify responsibility for mailing Provider Directories and the requirements for meeting weight limits. Section 4.1.5.5 is modified to add a requirement that all HMOs must list Home Health Ancillary providers on their websites, with an indicator for Pediatric services. Section 4.1.5.6 is modified to comply with the Frew litigation corrective action plans and to align the requirements with those in the Uniform Managed Care Contract.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section 4.1.5.7 is modified to comply with the Frew litigation corrective action plans. Section 4.1.9 is modified to require the MCO to contract with ECI Providers to provide initial ECI screening services to Members under the age of three. Section 4.1.12 is modified to change the BH report from quarterly to monthly, to require the MCO to make available the means for DFPS to access and provide a copy of Health Passport records, and to correct the citation of the Texas Family Code. Section 4.1.18 is modified to change the BH report from quarterly to monthly and to clarify the clinical notes requirement. Section 4.1.18.4 is modified to correct the RFP Section reference and to comply with the Frew litigation corrective action plans. Section 4.1.21.1 is modified to reflect legislative changes required by SB 10, to remove the requirement that the Claims Lag Report separate claims by service categories, and to eliminate the plan's responsibility to submit the actuarial certification on the 90 day FSR. Section 4.1.22 is modified to update the cross-references to sections of the contract addressing remedies and damages and to add cross-references to sections of the contract addressing Readiness Reviews. Section 4.1.22.1 is modified to remove the requirement to report THSteps medical and dental check-ups in a manner consistent with federal reporting requirements in the CMS 416 format. Section4.1.23 is modified to comply with the new federal law that requires entities that receive or make Medicaid payments of at least $5 million annually to educate employees, contractors and agents and to implement policies and procedures for detecting and preventing fraud, waste and abuse. The new law is Section 6032 of the Deficit Reduction Act of 2005, now codified as Section 1902(a)(68) of the Social Security Act. Section 4.1.24.2 is modified to require Claims Summary Reports be submitted by claim type and to comply with the Frew litigation corrective action plans by adding a new Medicaid Medical Check-ups Report. Section 4.1.26.3 is modified to comply with Frew litigation correction action plans and to remove requirement to document and electronically submit outreach efforts to the HHSC

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Administrative Services Contractor Section 4.1.26.5 is modified to require the Provider to coordinate with the Regional Health Authority. Section 4.1.26.8 is modified to change the reference from Texas Department of Transportation Medical Transportation to Medicaid Medical Transportation and to add Personal Care Services for persons under age 21. Section 4.1.28 is modified to include Municipal Health Department's Public Clinics. Section 4.1.31.5 is amended to reflect the new fair hearings process for Medicaid Members that will be effective 9/1/07. Section 4.1.31.6 is modified to comply with the settlement agreement in the *Alberto N.* litigation. The existing provisions are renumbered. Section 4.1.33 is modified to remove the outdated reference to 42 C.F.R. 434.28. Section 4.1.34 is modified as a result of SB 10 legislation and the Frew litigation to prohibit HMOs from passing down financial disincentives or sanctions to providers. Section 4.1.34.1 is modified as a result of the Frew litigation to allow HHSC to post information regarding poor HMO performance on the HHSC website. Section 4.1.34.2.2 modified to clarify language regarding the Performance Indicator Dashboard and the reapportionment of points for the 1% at-risk premium and to correct the dates. Section 4.1.34.3 modified to align the requirements with those in the Uniform Managed Care Contract and to change the date. New Section 4.1.34.5 added as a result of the Frew litigation to clarify requirements for additional incentives and disincentives.
Revision	1.2	September 1, 2008	Sections 4.0, 4.1.2, 4.1.3, 4.1.4.5, 4.1.4.12, 4.1.5.6, 4.1.7.5, 4.1.7.8, 4.1.7.9, 4.1.8, 4.1.12, 4.1.16, 4.1.16.1, 4.1.16.2, 4.1.17, 4.1.18, 4.1.18.2, 4.1.18.8, 4.1.20, 4.1.21, 4.1.21.1, 4.1.22.1, 4.1.22.3, 4.1.22.5, 4.1.23, 4.1.24, 4.1.24.2, 4.1.25, 4.1.26.1, 4.1.26.2, 4.1.26.4, 4.1.26.5, 4.1.28, 4.1.29.2, 4.1.31.2, 4.1.31.3, 4.1.31.7, 4.1.32,4.1.31.2.1, and 4.1.31.3 have been modified to delete references to PIHP and/or ANHC. Section 4.0 has been modified to change the Operational Start

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Date and the date on which Member enrollment began. Section 4.1.1 is modified to delay the implementation of Performance Improvement Goals until SFY 2010. Section 4.1.2.1 is modified to notify the Medical Consenter of the Value-added Services or change in VAS. Section 4.1.2.2 is modified to remove 'caregiver' and add 'Medical Consenter'. Section 4.1.3 is modified to delete "Emergency Services and crisis" from the hotline reference and to include the Medical Consenter and Caregiver in the list of those not responsible for any payment for Medically Necessary Covered Services. Section 4.1.4 is modified to update NPI language. Section 4.1.4.1 is modified to delete 'Pharmacy Access', "OB/GYN Access" is modified to remove Caregivers, and "Other Specialist Provider Access" is modified to add Medical Consenters. Section 4.1.4.5 is modified to add DFPS caseworker to persons to whom information on specialty care recommendations is provided by the PCP team and to delete paragraph on the possibility of allowing providers in the Medicaid Fee-for-Service program to bill for more prolonged services often needed by MSHCN as it describes a process never explored. Section 4.1.4.11 is modified to add a requirement for the MCO to cover HHSC costs associated to monitoring hotlines. Section 4.1.5.1 is modified to require that all substantive revisions to Member Materials must be approved by HHSC. Section 4.1.5.2 is modified to state that the caregiver will receive the Member ID Card and the Medical Consenter will choose the PCP. Section 4.1.5.3 is modified to add DFPS staff, Caregivers, and Medical Consenters to "Members" regarding creating new Member Handbooks and inserts that inform about changes in covered services and to delete DFPS staff and add Caregiver for receipt of Medical Consent process information. Section 4.1.5.4 is modified to add DFPS staff and Caregivers to those able to request a Provider Directory and delete the reference to Administrative Services Contractor. Section 4.1.5.6 is modified to specify that Caregivers who are not Medical Consenters will not have access to personal health

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			information through the Nurse or Member Hotlines and to reference the caller verification processes. In addition, it added a requirement for the MCO to cover HHSC costs associated with monitoring both hotlines. Section 4.1.7 is modified to add Dental Home Model language and to add DFPS staff to persons able to offer QI activity input. Section 4.1.9 is modified to delete 'Caregivers' and add 'DFPS staff' to be able to refer to local ECI service Providers. In addition it is modified to fix typographical error of repeating consenter phrase, and delete Caregiver from giving consent. Section 4.1.11 is modified to remove references to the UMCM and add a reference to 40 TAC Part 19, § 700 Subchapter W and to delete "Caregiver" from the list of those with access to care and coordination of services. In addition, it is modified to clarify the Pre-Appeals process and delete detailed language around meeting requirements. Section 4.1.12 is modified to add reference the contract in addition to UMCM and to delete previously stricken language. Section 4.1.13 is modified to delete "Caregiver" from the list of those who can confer with Service Management staff. Section 4.1.14 is modified to add timeframe and expectations for completion of Health Care Service Plans and definition of Priority 1, 2 and 3 Members, to delete "Caregiver" from and add "DFPS Caseworker" to the list of those who can render approval for medical care, move the "out of place" statement from Section 4.1.18.4 to this section, and add requirement to authorize refusals of participation in service management. In addition, it is modified to add "DFPS staff" to those the MCO must coordinate with for medical and behavioral health needs and delete "caregiver" from those MCO can share clinical information with. Section 4.1.15 is modified to correct a typographical error and to change from TxDOT to HHSC Medical Transportation Program. Section 4.1.16 is modified to add DFPS Staff, Caregiver, and Medical Consenter to those requiring education and assistance through the Disease Management programs and to require the MCO to evaluate new members and ensure continuity of care with any previous Disease Management services in accordance with requirements in the UMCM. Section 4.1.17 is modified to add language regarding dental varnish and dental home model and to add Texas Academy of

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			General Dentistry to the list of associations to recruit from. Section 4.1.18 is modified to add Medical Consenters to the list of those able to access information in the Health Passport. Section 4.1.18.3 is modified to delete Caregiver from the list of those who can choose a provider. Section 4.1.18.4 is modified to add "Providers" to the list of those who may call the BH hotline, to specify that Caregivers who are not Medical Consenters will not have access to personal health information through the hotline, to reference the caller verification process, to move the sentence "The 24 hour behavioral health hotline…" to the end of the paragraph, and to align the BH Hotline standards with those in the Uniform Managed Care contract. In addition, the section is modified to remove "crisis" from name of hotline, to add a requirement for the MCO to pay HHSC costs incurred for monitoring activities, and to remove Footnote 2 "This seems out of place." and move the "out of place" statement to the end of paragraph 3 in Attachment B-1, Section 4.1.14. Section 4.1.19 is modified to delete the stricken language pertaining to Pharmacy Services and replace it with new language regarding Vision Services and Vision Network. Section 4.1.19.1 is deleted in its entirety. Section 4.1.19.2 is deleted in its entirety. Section 4.1.19.3 is deleted in its entirety. Section 4.1.19.4 is deleted in its entirety. Section 4.1.19.5 is deleted in its entirety. Section 4.1.19.6 is deleted in its entirety. Section 4.1.19.7 is deleted in its entirety. Section 4.1.21 is modified to clarify the language in this section. Section 4.1.21.1 is modified to clarify the reporting requirements for the Affiliate Report, to delete the DSP Report, and to clarify the reporting requirements for FSR Reports. Section 4.1.22.4 is modified to include Medical Consenter receiving privacy notice. Section 4.1.24.2 is modified to add "Audit Reports" deliverable. Section 4.1.26.2 is modified to add Medical Consenter to those who may choose a provider and receive information regarding

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			family planning services. Section 4.1.26.3 is modified to un-capitalize enrollment when it stands alone, to add a definition of enrollment for this Section, to change transportation program to HHSC from TXDOT, and to require the MCO outreach staff to ensure that Members, Caregivers and Medical Consenters have access to the HHSC Medical Transportation Program. Section 4.1.26.3.1 is added to require the MCO to educate THSteps providers on the availability of the Oral Evaluation and Fluoride Varnish (OEVS) Medicaid benefit. Section 4.1.27 is modified to narrow the definition of STP and to require the MCO to recruit all STPs from this list on an ongoing basis. Section 4.1.30 is modified to remove Caregiver from those able to access the Fair Hearing process. Section 4.1.31 is modified to remove Caregiver from those able to access Complaint and Appeals and Fair Hearing processes and to allow caregivers to file complaints on behalf of the Member with authorization from the Medical Consenter. Section 4.1.31.1 is modified to remove Caregiver from those able to access Complaint and Appeals and Fair Hearing processes and to remove the requirement for the MCO to cooperate with the HHSC Administrative Services Contractor to resolve complaints. Section 4.1.31.2 is modified to remove Caregiver from those able to access the Member Pre-Appeal process. Section 4.1.31.3 is modified to remove Caregiver from those able to access Appeals processes and to require the MCO to seek information and participation from the Caregiver and DFPS Contractors when appropriate during the appeal process. Section 4.1.31.4 is modified to remove the Caregiver from those who are able to access the Appeals process. Section 4.1.31.5 is modified to remove the Caretaker from those who are able to access Fair Hearing processes. Section 4.1.31.6 is modified to remove the Caregiver from those who are able to access the Appeals process. Section 4.1.31.7 is modified to remove the Caregiver from those who are able to access the Appeals process. Section 4.1.31.9 is modified to remove the Caregiver from those

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			who are able to access the Appeals process. Section 4.1.31.10 is modified to remove the Caregiver from those who are able to access Member Advocates. Section 4.1.32 is modified to clarify when the MCO should seek Third Party Recovery. Section 4.1.33 is modified to delete reference to 42 C.F.R. §434.28 and to add medical consenters, DFPS staff, and Caregivers to those notified in case of changes in state or federal laws relating to advance directives.
Revision	1.3	June 1, 2009	Section 4.1.1 is modified to delete the reference to Attachment C-2. Section 4.1.1 is modified to delete the measure for Access to the Medical Home Services Model and to add a second measure for Access to BH Services. Section 4.1.2 is modified to delete the references to Attachment C-2. Section 4.1.2.2 is modified to delete the references to Attachment C-2. Section 4.1.3 is modified to correct the reference to Attachment C-2. Section 4.1.4 is modified to correct the reference to Attachment C-2, and to include performance standards for out of network utilization. Section 4.1.4.1 is modified to correct the reference to Attachment C-2. Section 4.1.4.2 is modified to correct the reference to Attachment C-2. Section 4.1.4.3 is modified to revise the telemedicine requirements. Section 4.1.4.5 is modified to correct the reference to Attachment C-2. Section 4.1.4.7 is modified to require foster care specific questions on the credentialing profile sheet for primary care, specialty care, behavioral health care and dental Providers. Section 4.1.4.9.2 is modified to correct the reference to Attachment C-2, include training requirements, to delete statement about resources and organizations, and add requirement for web

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			based training modules for additional provider training. Section 4.1.4.11 is modified to correct the reference to Attachment C-2. Section 4.1.5 is modified to delete the reference to Attachment C-2. Section 4.1.5.3 is modified to delete the reference to Attachment C-2. Section 4.1.5.5 is modified to require the MCO to update their online provider directory twice a month. Section 4.1.5.6 is modified to correct the reference to Attachment C-2. Section 4.1.5.6 is modified to require on-call clinicians. Section 4.1.7.2 is modified to delete the reference to Attachment C-2. Section 4.1.7.5 is modified to correct the reference to Attachment C-2. Section 4.1.7.6 is modified to delete the reference to Attachment C-2, and require that all provider members of the Foster Care Medical Advisory Committee (FCMAC) have experience working with the foster care population. Section 4.1.7.7 is modified to add the reference to Attachment C-2. Section 4.1.7.8 is modified to remove the reference to Attachment C-2. Section 4.1.7.9 is modified to correct the acronym for CAHPS. Section 4.1.8 is modified to correct the reference to Attachment C-2. Section 4.1.8 is modified to require an automated review of psychotropic medication parameters. Section 4.1.9 is modified to delete the reference to Attachment C-2. Section 4.1.11 is modified to delete the reference to Attachment C-2, require the MCO to have a dedicated STAR Health Liaison co-located in each DFPS regional office housing a Well-Being Specialist, to add the requirement for the MCO to provide training to DFPS staff, to require background checks for staff members with direct contact with Members, and to require court orders relating to medical care to be provided to SHN within one business

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			day of receipt. Section 4.1.12 is modified to correct the reference to Attachment C-2, and is reformatted to add sub-sections 4.1.12.1 Required Features and Data Elements, 4.1.12.2 Usage Requirements, and 4.1.12.3 Health Passport Reporting Requirements. Subsection 4.1.12.1 is modified to require retention of records until the Member reaches age 26 and to remove Forensic Assessments from the Health Passport. Subsection 4.1.12.3 is modified to list the reports HHSC and SHPN agreed upon as weekly deliverables and ad hoc reporting. Section 4.1.13 is modified to delete the reference to Attachment C-2. Section 4.1.14 is modified to delete the reference to Attachment C-2. Section 4.1.14 is modified to delete repeated sentence and to add the parameters around which DFPS has agreed to supply their case plans to Superior. Section 4.1.15 is modified to add the reference to Attachment C-2 and to include the method of determining number of staff and office locations. Section 4.1.16 is modified to add additional disease management requirements for the second operational year. Section 4.1.18 is modified to add a requirement to encourage greater inpatient capacity in Network Hospitals, to add new authorization requirements, and to change access requirements for the Health Passport. Section 4.1.18.2 is modified to delete the reference to Attachment C-2. Section 4.1.18.4 is modified to correct the reference to Attachment C-2. Section 4.1.18.5 is modified to correct the reference to Attachment C-2. Section 4.1.23 is modified to clarify that a written Fraud and Abuse compliance plan must be submitted annually and to list the legal citations. Section 4.1.24.2 is modified to add Bariatric Supplemental Payment Reports. Section 4.1.26.3 is modified to add age ranges to requirements to

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			provide the THSteps medical and dental screenings and to require the MCO to implement a process for recruitment of THSteps enrolled PCPs. Section 4.1.26.6 is modified to require TB screening for all members. Section 4.1.31.1 is modified to remove the word "caregivers". Section 4.1.31.2 is modified to add detailed process requirements. Section 4.1.31.3 is modified to remove reference to DFPS Contractor. Section 4.1.31.10 is modified to delete the reference to Attachment C-2. Section 4.1.34.2.2 is deleted in its entirety Section 4.1.34.3 is deleted in its entirety
Revision	1.4	September 1, 2009	All references to "check-ups" are changed to "checkups" All references to "Medicaid Provider Procedures Manual" are changed to "Texas Medicaid Provider Procedures Manual" All references to "THSteps" are changed to "Texas Health Steps" Section 4.1.1 is amended to change the overarching goals and to delete the sub goal language. Section 4.1.2.1 is amended to conform to Uniform Managed Care Contract to allow the HMO to change or add Value-Added Services twice a year. Section 4.1.3.1 is modified to change "well-child checkups" to "Texas Health Steps medical checkups"; to remove the reference to annual physicals for children ages 7 and 9 as they are now included in the Texas Health Steps periodicity schedule; and to change the beginning age for dental checkups from "one year" to "six months". Section 4.1.4.1 is revised to provide additional clarity as it relates to Qualified Mental Health Providers – Community Services (QMHP-CS). Section 4.1.4.9.2 is modified to include reference to Section 4.1.26.3. Section 4.1.5.6 is modified to add the Medical Transportation Program. Section 4.1.12.1 is amended to require notification of scheduled

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			downtime. Section 4.1.12.2 is amended to change "If" to "When" and delete the words "leaves conservatorship and" and add "for all users except DFPS staff" in the first sentence. Section 4.1.17 is amended to clarify age range for First Dental Home. Section 4.1.22.1 is amended to remove "quarterly" from the reports to courts of law and the reference to RFP Attachment K. Section 4.1.24.2(a) is modified to remove "Long Term Services and Supports" and add "Dental" from list of claim types. Section 4.1.24.2 (h) is modified to remove the references to "annual", and change "90-Day FREW Report" to "Frew 90-Day Reports". Section 4.1.24.2 Reports (l) Frew Quarterly Monitoring Report is added. Section 4.1.24.2 Reports (m) Frew Health Care Provider Training Report is added. Section4.1.26.2 is amended to prohibit HMO from requiring pre-authorization for family planning services. Section 4.1.26.3 is amended to remove the requirement for annual physicals for children ages 7 and 9 as they are now included in the Texas Health Steps periodicity schedule; add "Corrective Action Orders" to the training requirements; change "again within two weeks from the time of birth" to "in accordance with the Texas Health Steps periodicity schedule"; to spell out the acronym for ACIP; and change "two-week follow-up" to "newborn follow ups". Section 4.1.34.6 Frew Incentives and Disincentives 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.

4 OPERATIONS PHASE REQUIREMENTS AND GENERAL SCOPE OF WORK

Section 4 modified by Versions 1.0 and 1.2

HHSC will select an MCO to provide statewide Health Care Services to Program Members. The MCO must be appropriately licensed by the Texas Department of Insurance (TDI) to provide Health Care Services in all counties in the State of Texas.

The MCO will begin providing Covered Services to Members on the Operational Start Date, April 1, 2008. Member enrollment activities will begin on February 29, 2008.

4.1 Administration and Contract Management

The MCO must comply, to the satisfaction of HHSC, with (1) all provisions set forth in the Contract, and (2) all applicable provisions of state and federal laws, rules, regulations, and waivers.

4.1.1 Performance Evaluation

Section 4.1.1 Modified by Versions 1.1, 1.2, 1.3, and 1.4

The MCO must identify and propose to HHSC, in writing, no later than May 1st of each State Fiscal Year (SFY), annual MCO Performance Improvement Goals for the next SFY, as well as measures and timeframe for demonstrating that such goals are being met. Performance Improvement Goals must be based on HHSC priorities and identified opportunities for improvement (see **RFP Attachment C-1, Sample Improvement Goal Template**). The Parties will negotiate such Performance Improvement Goals, the measures that will be used to assess goal achievement, and the timeframe for completion, which will be incorporated into the Contract. If HHSC and the MCO cannot agree on the Performance Improvement Goals, measures, or timeframe, HHSC will set the goals, measures, or timeframe.

HHSC has established three goals for the MCO. HHSC and the MCO will negotiate no less than two sub goals for each of these goals prior to SFY 2010:

2. Improve Access to Behavioral Health Services

3. Improve the Quality of and/or Access to Specific MCO Performance Goal Regarding Dental Services, evaluated using the measures negotiated by HHSC and the MCO.

The MCO must participate in semi-annual contract status meetings (CSMs) with HHSC for the primary purpose of reviewing progress toward the achievement of annual Performance Improvement Goals and Contract requirements. HHSC may request additional CSMs, as it deems necessary to address areas of noncompliance and other issues. HHSC will provide the MCO with reasonable advance notice of additional CSM's, generally at least five (5) Business Days.

The MCO must provide to HHSC, no later than 14 Business Days prior to each semi-annual CSM, one electronic copy of a written report detailing and documenting the MCO's progress toward meeting the annual Performance Improvement Goals and set areas of noncompliance.

HHSC will track MCO performance on the Performance Improvement Goals. HHSC will also track other key facets of MCO performance through the use of the Performance Indicator Dashboard (see **Uniform Managed Care Manual)**. HHSC will compile the Performance Indicator Dashboard based on MCO submissions, data from the External Quality Review Organization (EQRO), and other data available to HHSC. HHSC will share the Performance Indicator Dashboard results with the MCO on a quarterly basis.

4.1.1.1 Additional MCO Readiness Reviews

Section 4.1.1.1 added by Version 1.1

During the Operations Phase, if the MCO chooses to make a change to any operational system or undergoes any major transition, it may be subject to an additional Readiness Review(s). HHSC will determine whether the proposed changes will require a desk review and/or an onsite review. The MCO is responsible for all costs incurred by HHSC or its authorized agent to conduct an onsite Readiness Review.

Refer to **Attachment B-1, Section 3.4.7** and **Attachment B-1, Section 4.1.22** for additional information regarding HMO Readiness Reviews. Refer to **Attachment A, Section 4.09(c)** for information regarding Readiness Reviews of the MCO's Material Subcontractors.

4.1.2 Covered Services

Section 4.1.2 Modified by Versions 1.1, 1.2, and 1.3

For an MCO that is an HMO or EPP, the MCO is responsible for authorizing, arranging, coordinating, and providing Covered Services in accordance with the requirements of the Contract. The MCO must provide Medically Necessary Covered Services to all Members beginning on the Member's Effective Date of Coverage. The MCO must also comply with DFPS requirements related to Covered Services in laws, rules and regulations, including requirements for assessments and court ordered services (see http://www.dfps.state.tx.us/Site_Map/rules.asp), as amended or modified during the Contract Term. DFPS is currently amending some of its rules.

The MCO must not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any Member. The MCO must provide full coverage for Medically Necessary Covered Services to all Members without regard to the Member's:

1. Previous coverage, if any, or the reason for termination of such coverage.
2. Health status, including preexisting conditions and prior diagnosis.
3. Confinement in a health care facility.
4. Any other reason.

The Span of Coverage requirements found in **HHSC's General Terms and Conditions** will apply.

Except for those services identified in **RFP Section 4.1.26.8** as Non-capitated Services, the MCO must provide Covered Services described in the Texas Medicaid Provider Procedures Manual (**Provider Procedures Manual**), as amended or modified during the Contract term, as well as the Covered Services described in all Texas Medicaid Bulletins, which update the Provider Procedures Manual.

The MCO must allow Covered Services to be provided by an Out-of-Network (OON) provider if a Network Provider is not available to provide the services.

Covered Services are subject to change due to changes in federal and state laws, rules or regulations; changes in Medicaid policy; and changes in medical practice, clinical protocols, or technology.

4.1.2.1 Value-added Services

Section 4.1.2.1 modified by Versions 1.1, 1.2, and 1.4

The MCO may propose additional services for coverage. These are referred to as "Value-added Services." Value-added Services may be Health Care Services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improved health outcomes among Members. These may include family and/or community support services and supports that may be identified through a wraparound service delivery approach provided to youth with complex mental health needs. The wraparound process is an individualized, strengths-and-needs based service approach provided pursuant to the DSHS Targeted Case Management Program aimed at identifying all the needs of the child, young adult, and/or family and flexibly assisting them in obtaining services that meet those needs. Please see **RFP Attachment L** for more information on the wraparound process. Value-added Services that promote healthy lifestyles should target specific weight loss, smoking cessation, or other programs approved by HHSC. Temporary phones, cell phones, additional transportation benefits, and extra Home Health Services may be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.

Value-added Services must be offered to all Members for whom the services are appropriate. Value-added Services that are approved by HHSC during the contracting process will be included in the Contract's Scope of Work.

The MCO must provide Value-added Services at no additional cost to HHSC. The MCO must not pass on the cost of the Value-added Services to providers. The MCO must specify the conditions and parameters regarding the delivery of the Value-added Services in the MCO's Member Handbook, and must clearly describe any limitations or conditions specific to the Value-added Services.

The MCO will be given the opportunity to add or enhance Value-added Services twice per State Fiscal Year, with changes to be effective September 1 and March 1. The MCO will also be given the opportunity to delete or reduce Value-added Services once per State Fiscal Year, with changes to be effective September 1. HHSC may allow additional modifications to Value-added Services if Covered Services are amended by HHSC during a State Fiscal Year. The MCO's request to add, enhance, delete, or reduce a Value-added Service must be submitted to HHSC by April 15 of each year to be effective September 1 for the following contract period. A second request to add or enhance Value-added Services must be submitted to HHSC by October 15 each year to be effective March 1.

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

1. Define and describe the proposed Value-added Service.
2. Identify the category or group of Members eligible to receive the Value-added Service if it is a type of service that is not appropriate for all Members.
3. Note any limits or restrictions that apply to the Value-added Service.
4. If the Value-added Service is not a Health Care Service or benefit, specify which staff will determine whether a Member is eligible to receive the Value-added Service.
5. Identify the Providers or other person(s) responsible for providing the Value-added Service, including any limitation on Provider or other persons' capacity, if applicable.
6. Describe how the MCO will identify the Value-added Service in administrative data (including Encounter Data), or will otherwise document delivery of the Value-added Service.
7. Propose how and when the MCO will notify Providers and Members about the availability of such Value-added Service.
8. Describe how a Member may obtain or access the Value-added Service.
9. Include a statement that the MCO will provide such Value-added Service for the full term of the Rate Period.

The MCO cannot include a Value-added Service in any material distributed to Members until the Parties have amended the Contract to include that Value-added Service. The MCO must offer a Value-added Service for at least 12 months. If a Value-added Service is deleted by amendment, the MCO must notify the Medical Consenter of each Member receiving the service that the service is no longer available through the MCO. Similarly, if a Value-added Service is added by amendment, the MCO must notify the Medical Consenter of each Member of the availability of that service.

4.1.2.2 Case-by-Case Added Services

Section 4.1.2.2 Modified by Versions 1.1, 1.2, and 1.3

At the discretion of the MCO, the MCO may offer to individual Members additional benefits that are outside the scope of Covered Services on a case-by-case basis, such as partial hospitalization as a less restrictive alternative to an Inpatient Stay at a psychiatric Hospital. The MCO may provide these services based on Medical Necessity, cost-effectiveness, the wishes of the Member/Member's Medical Consenter, and the potential for improved health status of the Member.

4.1.3 Access to Care

Section 4.1.3 modified by Versions 1.1, 1.2 and 1.3

Refer to **Attachment C-2, Section 10 Questions a, b, d, and f** for additional information regarding Modifications to the Proposal.

All Covered Services must be available to Members on a timely basis in accordance with appropriate guidelines for physical and Behavioral Health Services, consistent with generally accepted practice parameters, and based on the requirements in the Contract. The MCO must comply with the access requirements as established by the TDI for HMOs doing business in Texas. These access requirements will also apply to an MCO that is an EPP.

The MCO must contractually require Providers to comply with medical consent requirements in Texas Family Code §266.004 that require the Member's Medical Consenter to consent to the provision of medical care. See **RFP Attachment H**. A Provider does not need the medical consent of the Member's Medical Consenter to provide Emergency Services for a Member that has an Emergency Medical Condition. The MCO must contractually require the Provider to notify the Medical Consenter about the provision of Emergency Services no later than the second Business

Day after providing Emergency Services, as required by Texas Family Code §266.009. The notification must be documented in the Member's Health Passport.

The MCO must provide coverage for Emergency Services to Members 24 hours a day and seven days a week, without regard to prior authorization or the Emergency Service provider's contractual relationship with the MCO. The MCO's policy and procedures must comply with all applicable state and federal laws and regulations, whether the provider is in Network or Out-of-Network. For an MCO that is an HMO or EPP, Covered Services, claims adjudication methodology, and reimbursement performance for Emergency Services must also comply with all applicable state and federal laws and regulations, whether the provider is in Network or Out-of-Network. The MCO is not responsible for payment for unauthorized non-emergency services provided to a Member by Out-of-Network providers.

The MCO must require and ensure that PCPs are accessible to Members 24 hours a day, seven days a week and that its Network Primary Care Providers (PCPs) have after-hours telephone availability that is consistent with **RFP Section 4.1.4.5.**

The MCO must also have a Behavioral Health Services Hotline available 24 hours a day, seven days a week, toll-free throughout the state. The Behavioral Health Hotline must address routine and crisis Behavioral Health calls. The Behavioral Health Services Hotline must meet the requirements described in **RFP Section 4.1.18.4**.The MCO must provide coverage for Emergency Behavioral Health Services in compliance with 42 C.F.R. §438.114, and as described in more detail in **RFP Section 4.1.18.4**. The MCO may coordinate with or provide Emergency Services and crisis Behavioral Health Services through mobile crisis teams.

If Medically Necessary Covered Services, including Medically Necessary Covered Behavioral Health Services, are not available through Network Providers, the MCO must allow DFPS Staff, the Medical Consenter, or the Network Provider to request a referral to an Out-of-Network physician or provider. The MCO must provide such services within the timeframes specified in **RFP Section 4.1.25** and within the time appropriate to the circumstances and Member's need. In such circumstances, an MCO that is an HMO or EPP must fully reimburse the Out-of-Network provider in accordance with

Out-of-Network requirements found in 1 T.A.C. §353.4. The Member, the Medical Consenter, and/or the Caregiver will not be responsible for any payment for Medically Necessary Covered Services.

4.1.3.1 Waiting Times for Appointments

Section 4.1.3.1 modified by Version 1.4

Through its Provider Network composition and management, the MCO must ensure that appointments for the following types of Covered Services are provided within the timeframes specified in the list below. In all cases below, "day" is defined as a calendar day.

1. Emergency Services, including Behavioral Health Services, must be provided upon Member presentation at the service delivery site, including at Out-of-Network and out-of-state facilities.
2. Urgent care, including urgent specialty care and urgent behavioral health care, must be provided within 24 hours of request.
3. Routine primary care must be provided within 14 days of request.
4. Initial and routine outpatient behavioral health visits must be provided within 14 days of request.
5. Routine specialty care 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 Care Services, Texas Health Steps medical checkups, must be offered to Members in accordance with the American Academy of Pediatrics (AAP) periodicity schedule, as modified by the Texas Health Steps Program requirements, which are published in the **Texas Medicaid Provider Procedures Manual**. For newly enrolled Members, Texas Health Steps medical checkups must be offered as soon as practicable, but in no case later than 14 days of enrollment for newborns and no later than 21 days of enrollment for all other Members. For newly enrolled Members, dental checkups must be offered as soon as practicable, but in no case later than 60 days of enrollment for children ages six months and above.

4.1.4 Provider Network

Section 4.1.4 modified by Versions 1.1, 12, and 1.3

Refer to **Attachment C-2, Section 9, Question g; Attachment C-2, Section 10, Questions a, b, d and e** for additional information regarding Modifications to the Proposal.

The MCO must recruit and enter into written contracts with properly credentialed Providers of various types appropriate for delivering services in the Model. The MCO must recruit, enroll, train and support a statewide Provider Network. The Provider contracts must comply with the Contract's requirement, including those set forth in **Uniform Managed Care Manual**.

The MCO must maintain a Provider Network sufficient to provide all Members with access to the full range of Covered Services required under the Contract. The MCO must ensure its Providers and Subcontractors meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable laws, rules and regulations related to the Contract. Medicaid MCOs utilizing Out-of-Network providers to render services to their Members must not exceed the utilization standards established in 1 T.A.C. §353.4. HHSC may modify this requirement for Medicaid MCOs that demonstrate good cause for noncompliance, as set forth in §353.4(e)(3).

The Provider Network must be responsive to the linguistic, cultural, and other unique needs of individuals based on national origin or disability, or other special populations served by the Model. The Provider Network must have the capacity to communicate with Members in English and in languages of other Major Population Groups making up 10 percent or more of the Eligible Population in the state. As of the date of issuance of the RFP, Spanish is the only language that meets this criterion. The MCO must ensure Members who are deaf or hearing impaired have the ability to communicate with Providers through sign language interpreter services.

All Providers: All Providers must be licensed in the State of Texas to provide the Covered Services for which the MCO is contracting with the Provider, and not be under sanction or exclusion from the Medicaid Program. All Providers must be enrolled as Medicaid providers and have a Texas Provider Identification Number (TPIN). Effective May 23, 2008, all Providers must also have a National Provider Identification Number (NPI) (see 45 C.F.R. Part 162, Subpart D). This also includes

Atypical Provider Identification Numbers (APIs). However, Providers are not required to serve Medicaid populations that are not included in the Model.

Inpatient Hospital and medical services: The MCO must ensure that General, Special and Psychiatric Hospitals are available and accessible to provide Covered Services to Members 24 hours per day, seven days per week, within the MCO's Network throughout the state.

Children's Hospitals/Hospitals with specialized pediatric services: The MCO must ensure Member access to Hospitals designated as Children's Hospitals by Medicare (see **RFP Attachment G** for a listing of Children's Hospitals) and Hospitals with specialized pediatric services, such as teaching Hospitals and Hospitals with designated children's wings, are available and accessible to provide Covered Services to Members 24 hours per day, seven days per week, throughout the state. Provider Directories and Member Materials must clearly distinguish between Hospitals designated as Children's Hospitals and Hospitals with specialized pediatric services.

Trauma: The MCO must ensure Member access to DSHS designated Level I and Level II trauma centers within the state or Hospitals meeting the equivalent level of trauma care in the state. For additional information on the EMS Trauma System in Texas, click on this link: http://www.tdh.state.tx.us/hcqs/ems/Etrahosp.htm .

Transplant centers: The MCO must ensure Member access to HHSC-designated transplant centers or centers meeting equivalent levels of care. A list of HHSC-designated stem cell transplant centers can be found in **RFP Attachment F** in the Procurement Library. HHSC-designated transplant centers also include members of the United Network for Organ Sharing (UNOS), which can be accessed at http://www.unos.org/members/search.asp .

Hemophilia centers: The MCO must ensure Member access to hemophilia centers supported by the Centers for Disease Control (CDC). A list of these hemophilia centers can be found at http://www.cdc.gov/ncbddd/hbd/htc_list.htm .

Outpatient Behavioral Health Service Provider Access: The MCO must ensure Member access to outpatient Behavioral Health Service Providers in the Network, including psychiatrists and child psychiatrists; Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient Hospital departments; licensed social workers (LCSWs); licensed marriage and family therapists (LMFTs); licensed professional counselors; Qualified Mental Health Professionals (QMHPs) working under the authority of a Local Mental Health Authority and as defined in TAC Title 25, Part 1, Chapter 412; licensed adolescent chemical dependency treatment facilities; and licensed chemical dependency counselors (LCDCs) with experience treating adults and adolescents.

Physician services: The MCO must ensure that PCPs are available and accessible 24 hours per day, seven days per week, within the Provider Network. The MCO must contract with a sufficient number of participating physicians and specialists within the state to comply with the access requirements described in **RFP Section 4.1.3** and meet the needs of Members for all Covered Services.

The MCO must ensure that an adequate number of participating physicians, including hospitalists, have admitting privileges at one or more participating Acute Care Hospital in the Provider Network to ensure that necessary admissions are made. In no case may there be fewer than one Network PCP with admitting privileges available and accessible 24 hours per day, seven days per week for each Acute Care Hospital in the Provider Network.

The MCO must ensure that an adequate number of participating specialty physicians have clinical practice privileges at one or more participating Network Hospitals, including psychiatric Hospitals, to ensure necessary admissions. The MCO shall require that all physicians who admit to Hospitals maintain Hospital access for their patients through appropriate call coverage.

Laboratory services: The MCO must ensure that Network reference laboratory services must be of sufficient size and scope to meet the non-emergency and emergency needs of Members and the access requirements in **RFP Section 4.1.3**. Reference laboratory specimen procurement services must facilitate the provision of clinical diagnostic services for physicians, Providers and Members

through the use of convenient reference satellite labs, strategically located specimen collection, and the use of a courier system under the management of the reference lab. Texas Health Steps requires that laboratory specimens obtained, as part of a Texas Health Steps medical checkup visit must be sent to the DSHS Laboratory, unless the Texas Medicaid Provider Procedures Manual provides otherwise.

Diagnostic imaging: The MCO must ensure that diagnostic imaging services are available and accessible to all Members in accordance with the access standards in **RFP Section 4.1.3**. The MCO must ensure that diagnostic imaging procedures that require the injection or ingestion of radiopaque chemicals are performed only under the direction of physicians qualified to perform those procedures.

Home health services: The MCO must have contracts with home health Providers so that all Members will have access in their home to at least one such Provider for home health Covered Services.

4.1.4.1 Access to Network Providers

Refer to **Attachment C-2, Section 10, Questions f, g, and h** for additional information regarding Modifications to the Proposal.

Section 4.1.4.1 modified by Version 1.0 to delete Pharmacy access requirement, 1.1, 1.2, 1.3, and 1.4

The MCO shall have Network Providers in sufficient numbers, and with sufficient capacity, to provide timely access to regular and preventive pediatric care and Texas Health Steps services to all Members in accordance with the waiting times for appointments in **RFP Section 4.1.3.1**.

PCP Access: At a minimum, the MCO 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 19.

Dental Access: At a minimum, the MCO must ensure that all Members have access to dental services and a Network dentist within 75 miles of the Member's residence.

OB/GYN Access: At a minimum, the MCO must ensure that the following Members have access to a Network OB/GYN within 75 miles of the Member's residence:

1. Female Members who may have experienced sexual abuse.
2. Female Members of childbearing age.

The MCO must allow female Members or their Medical Consenters to select both a PCP and an OB/GYN within its Network. The Member or their Medical Consenter may also select an OB/GYN to act as the Member's PCP. A female Member who has selected an OB/GYN, or whose Medical Consenter has selected 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 MCO must ensure that all Members have access to an outpatient Behavioral Health Service Provider in the Network within 30 miles of the Member's residence for Members in a county with more than 50,000 residents, or within 75 miles of the Member's residence for Members in a county with 50,000 or fewer residents. Please see the following website for the 2005 estimated county population size: http://www.txcip.org/tac/census/index.php .

Outpatient Behavioral Health Service Providers must include psychiatrists and child psychiatrists; Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient Hospital departments; LCSWs; LMFTs; licensed professional counselors; Qualified Mental Health Professionals (QMHPs) working under the authority of a Local Mental Health Authority and as defined in TAC Title 25, Part 1, Chapter 412; licensed adolescent chemical dependency treatment facilities; and licensed chemical dependency

counselors (LCDCs) with experience treating adults and adolescents. A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined bythe Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412 Subchapter G, Division 1, §412.303(31). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician knowledgeable and trained in the area of community-based psychosocial rehabilitation services, and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.

Other Specialist Provider Access: At a minimum, the MCO must ensure that all Members have access to a Network specialist provider within 75 miles of the Member's residence for each medical specialty, in accordance with **RFP Section 6.13.1.10.1**. In addition, all Members or their Medical Consenters 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 MCO must ensure that all Members have access to an Acute Care Hospital in the Provider Network within 30 miles of the Member's residence. The MCO also must ensure that Members have access by transfer to an appropriate Network or Out-of-Network facility providing the needed level of care.

All other Covered Services: At a minimum, the MCO must ensure that all Members have access to at least one Network Provider for each of the remaining Covered Services described in **Attachment B-2 to the Contract Document** within 75 miles of the Member's residence. This access requirement includes, but is not limited to, specialists, Hospitals with specialized children's services, Children's Hospitals and Special Hospitals, Psychiatric Hospitals, diagnostic and therapeutic services, and single or limited service health care physicians or Providers.

The MCO is not precluded from making arrangements with physicians or providers outside the state for Members to receive a higher level of skill or specialty than the level available within the state, including but not limited to, treatment of cancer, burns, and cardiac diseases.

HHSC may consider exceptions to the above access-related requirements if the MCO submits data that indicates Covered Services are not available to the Member within the required distance.

4.1.4.2 Monitoring Access

Section 4.1.4.2 Modified by Versions 1.1 and 1.3

Refer to **Attachment C-2, Section 9, Question c;** and **Attachment C-2, Section 18, Question c** for additional information regarding Modifications to the Proposal.

The MCO is required to systematically and regularly verify that Covered Services furnished by Network Providers are available and accessible to Members in compliance with the standards described in **RFP Sections 4.1.3** and **4.1.4**. For Covered Services furnished by PCPs, the MCO must also comply with standards described in **RFP Section 4.1.4.5**.

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

4.1.4.3 Telemedicine Access

Refer to **Attachment C-2, Section 10, Question f** for additional information regarding Modifications to the Proposal.

Section 4.1.4.3 modified by Versions 1.0, 1.1, and 1.3

Telemedicine is defined by the **Texas Medicaid Managed Care Manual**. The MCO must contract with Providers with telemedicine capabilities to increase access to primary and specialty care. The MCO must include in its hard copy and electronic Provider Directory information on Providers with telemedicine capabilities. RFP Section 4.1.18.1, Behavioral Health Network, provides additional information regarding telemedicine.

The MCO will determine the exact number and locations of all telemedicine end points and the number of rural Providers who will commit to working with the MCO's telemedicine contractors. The MCO will outreach to their telemedicine Providers to encourage the increase and availability of end points in medically underserved areas. In addition, the MCO will actively recruit additional rural providers in order to increase Member access to the services that telemedicine can provide.

4.1.4.4 Provider Contract Requirements

The MCO is prohibited from requiring a Provider or Provider group to enter into an exclusive contracting arrangement with the MCO as a condition for participation in its Provider Network.

The MCO's contract with health care Providers must be in writing; must be in compliance with applicable federal and state laws, rules and regulations; and must include minimum requirements specified in the **General Terms and Conditions** and **HHSC's Uniform Managed Care Manual**.

4.1.4.5 Primary Care Providers and the Medical Home

Section 4.1.4.5 Modified by Versions 1.1, 1.2, and 1.3

Refer to **Attachment C-2, Section 7** for additional information regarding Modifications to the Proposal.

The MCO must provide Medical Home services for Members through PCPs or Specialty Care Providers.

The MCO must promote, monitor, document, and make best efforts to ensure that PCPs and Specialty Care Providers comply with the use of the Medical Home Services Model, which is an approach to providing comprehensive primary care and is defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. Information, guidelines and characteristics for the Medical Home Services Model are available in **RFP Attachment D**.

The MCO must also promote the development of Integrated Primary Care (IPC) at the Member's Medical Home. IPC involves the integration of Behavioral Health Services into primary care during the regular provision of primary care services where appropriate. IPC

occurs at the same time and by the same Provider ideally, or by the Behavioral Health Services provider seeing the Member in tandem with the PCP. The MCO must regularly measure Member behavioral health improvement using psychometrically-sound instruments. The ICP is a model distinct from co-location of services, which is considered to be parallel care rather than integrated care. IPC is also distinct from sequential care, which denotes behavioral health care that occurs either before or after the primary care and at the same or a different location. Information on IPC, integrated physical and mental health care, and other useful resources and tools can be found in **RFP Attachment N**.

As a Medical Home, the PCP works with Members, Medical Consenters, Caregivers, Providers, Service Coordinators, Service Managers and other state and non-state entities to assure that all the Member's medical and behavioral health needs are met. This includes screening, identification, and referral to Medically Necessary services, and assessment and coordination of non-clinical services that impact the Member's health.

The MCO'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 (CNMs) 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. Section 533.005(a)(13), Texas Government Code, requires the MCO to use Pediatric and Family Advanced Practice Nurses practicing under the supervision of a physician as PCPs in its Provider Network.

An internist or other Provider who provides primary care to adults only is not considered an age-appropriate PCP choice for a Member under age19. An internist or other Provider who provides primary care to adults and children may be a PCP for Members if:

1. The Provider assumes all MCO PCP responsibilities for such Members in a specific age group under age 19.

2. The Provider has a history of practicing as a PCP for the specified age group as evidenced by the Provider's primary care practice including an established patient population under age 19 and within the specified age range.
3. The Provider has admitting privileges to a local Hospital that includes admissions to pediatric units.

For Members with Special Health Care Needs (MSHCN) that require services from specialists and/or behavioral health Providers, the PCP may choose to use an interdisciplinary team approach to managing the Member's care. The PCP and other Providers that agree to function as an interdisciplinary team would constitute a PCP Team. If requested by the PCP Team, the MCO must assign a Service Coordinator or Service Manager to assist the PCP Team. The PCP Team must include the Medical Consenter, and, if appropriate, a young adult Member. If requested by the Member's Medical Consenter, the Member's Caregiver may be included in the PCP Team. The PCP Team may also include a Member's DFPS caseworker and MCO Service Coordinator or MCO Service Manager. The PCP Team must:

1. Develop specialty care and support service recommendations to be incorporated into the Member's Health Care Service Plan, including evaluation and coordination of prescriptions ordered by the PCP Team and other Providers.
2. Participate in Hospital discharge planning.
3. Participate in pre-admission Hospital planning for non-emergency hospitalizations.
4. Provide information to the Medical Consenter, Caregiver, DFPS caseworker, and, if applicable, the young adult Member concerning the specialty care recommendations.

The PCP for a MSHCN, or for a Member with Disabilities, Special Health Care Needs, or Chronic or Complex Conditions, may be a specialist physician who agrees to provide PCP services to the Member. The specialist physician must agree to perform all PCP duties required in the Contract and such PCP duties must be within the scope of the specialist's license. The Medical Consenter, Caregiver or Member may initiate the request through the MCO for a specialist to serve as a PCP for MSHCN or a Member with Disabilities, Special Health Care Needs, or Chronic or Complex

Conditions. The MCO shall process such requests in accordance with 28 T.A.C. Part 1, Chapter 11, Subchapter J. Specialists may limit the number of Members for which they will serve as a PCP.

PCPs must either have admitting privileges at a Hospital that is part of the MCO's Provider Network or make referral arrangements with a Provider who has admitting privileges to a Network Hospital. The MCO may cover this requirement through the use of hospital lists.

The MCO must contractually require that PCPs are accessible to Members 24 hours a day, 7 days a week. The MCO is encouraged to include in its Network sites that offer primary care services during evening and weekend hours. The following are acceptable and unacceptable telephone arrangements for contacting PCPs after their normal business hours.

Acceptable PCP after-hours coverage:

1. The PCP's office telephone is answered after-hours by an answering service that meets language requirements of the Major Population Groups and can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
2. The PCP's 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.
3. The PCP's 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 PCP's office telephone is only answered during office hours.
2. The PCP's office telephone is answered after-hours by a recording that tells patients to leave a message.

3. The PCP's office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed.
4. Returning after-hours calls outside of 30 minutes.

The MCO must contractually require PCPs:

1. To either be enrolled as Texas Health Steps providers or refer Members due for a Texas Health Steps checkup to a Texas Health Steps provider;
2. To provide Members with preventive services in accordance with the Texas Health Steps periodicity schedule published in the **Texas Medicaid Provider Procedures Manual**; and
3. To refer for follow-up assessments or interventions clinically indicated as a result of the Texas Health Steps checkup, including the developmental and behavioral components of the screening.

Specialists who serve as PCPs are encouraged, but not required, to be Texas Health Steps providers. The MCO must contractually require PCPs to submit information from Texas Health Steps forms and documents to the Health Passport. The MCO must also contractually require PCPs to provide Members with preventive services in accordance with the U.S. Preventive Services Task Force requirements. The MCO must make best efforts to ensure that PCPs comply with these periodicity requirements for children and young adult Members. Best efforts must include, but not be limited to, Provider education, Provider reviews, monitoring, and feedback activities.

The MCO must contractually require PCPs to assess the medical and behavioral health needs of Members for referral to specialty care providers and provide referrals as needed. Members, Caregivers or Medical Consenters can access behavioral health treatment without prior approval from the PCP. PCPs must coordinate Members' care with specialty care providers after referral. The MCO must make best efforts to ensure that PCPs assess Member needs for referrals and make such referrals. Best efforts must include, but not be limited to, Provider education activities and review of Provider referral patterns.

4.1.4.6 PCP Notification

The MCO must furnish each PCP with a current list of Members enrolled or assigned to that PCP no later than five Business Days after the MCO receives the Enrollment File. The MCO 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.

4.1.4.7 Provider Credentialing and Recredentialing

Section 4.1.4.7 modified by Versions 1.0, 1.1, and 1.3

Refer to **Attachment C-2, Section 12, Questions a, b, and c** for additional information regarding Modifications to the Proposal.

The MCO must review, approve and periodically recertify the credentials of all participating physician Providers and all other licensed Providers who participate in the MCO's Provider Network.
The MCO 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 the MCO's Credentialing and recredentialing processes must be consistent with recognized MCO industry standards such as those provided by NCQA and relevant state and federal regulations including 28 T.A.C. §11.1902, and 42 C.F.R. §438.214(b). 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 Provider. The recredentialing process must occur at least every three years.

The Credentialing profile sheet that is completed by a primary care, specialty care, behavioral health care, or dental Provider's office during the Credentialing and Recredentialing process must include foster care specific questions that address to the Provider's experience with conditions that are prevalent in the foster care population, such as the treatment of physical and/or sexual abuse, developmental disabilities, and post-traumatic stress disorder.

The recredentialing process must take into consideration Provider performance data including, but not limited to, Member Complaints and Appeals, quality of care, and Utilization Review.

4.1.4.8 Board Certification Status

The MCO must maintain a policy that encourages participation of board certified PCPs and specialty physicians in the Provider Network. The MCO must make information on the percentage of board-certified PCPs and board-certified specialty physicians in the Network, by specialty, available to HHSC upon request.

4.1.4.9 Provider Manual, Materials and Training

The MCO must produce Provider Manuals and training materials in compliance with state and federal laws, and requirements of the **General Contract Terms and Conditions**. The MCO must make available any Provider materials to HHSC upon request.

During Readiness Review, the MCO must collaborate with HHSC and DFPS and receive HHSC's approval when developing the Provider Manual and training materials. After Readiness Review, the MCO must collaborate with HHSC and DFPS and receive HHSC's approval on any substantive changes to these documents prior to their publication and use. The MCO must provide training to Providers and their staff regarding the requirements of the Contract and special needs of Members. MCO training must include the need for Providers and their staff to address Medical Consenters, Caregivers, DFPS Staff and Members with dignity, sensitivity and respect.

4.1.4.9.1 Provider Manual

The MCO must issue the Provider Manual(s), including any necessary specialty manuals (e.g., behavioral health) to all existing Network Providers. For newly contracted Providers, the MCO must issue copies of the Provider Manual(s) within five Business Days from inclusion of the Provider into the Network. The Provider Manual must contain sections relating to special requirements of the Model and the Target Population in compliance with the requirements of this Contract.

The MCO must include information regarding coordination with DFPS, as discussed in **RFP Section 4.1.11**.

4.1.4.9.2 Provider Trainings

Section 4.1.4.9.2 modified by Versions 1.0, 1.1, 1.3, and 1.4

Refer to **Attachment C-2, Section 1, Question b** for additional information regarding Modifications to the Proposal.

The MCO will seek to partner with groups that provide direct services to the foster care population, or represent direct service providers in order to deliver effective training programs to Providers. The MCO will collaborate with DFPS and law enforcement agencies to provide Providers with additional insight into the STAR Health Program.

The MCO will hire a minimum of two internal trainers who have experience in health care and in behavioral health for the Target Population. The MCO will provide training on an ongoing basis through web-based sessions and regional outreach. The MCO will design its training program to ensure that participating Providers understand the unique needs of the Target Population, including the sensitivities associated with the Foster Care population and expectations surrounding care and coordination for this population.

Provider training must be completed within 30 days of the Operational Start Date and within 30 days of contracting with a new Provider. The MCO must provide ongoing training to new and existing Providers as required by the MCO or HHSC to comply with the Contract. The MCO must maintain and make available to HHSC upon request enrollment or attendance rosters dated and signed by each attendee or other written evidence of training of Providers and their staff.

The MCO must establish ongoing Provider training that addresses, but is not limited to, the following issues:

1. Covered Services and the Provider's responsibilities for providing and/or coordinating such services. Special emphasis must be placed on areas that vary from commercial coverage rules (e.g., early intervention services, therapies and Durable Medical

Equipment (DME)/medical supplies); making referrals; and coordination with Non-capitated Services.

2. Medical Home Services Model (see **RFP Attachment D**) and the Integrated Primary Care Model (see www.integratedprimarycare.com and **RFP Attachment N**).
3. Relevant requirements of the Contract, including the Health Passport.
4. Availability of Service Management and Service Coordination.
5. Availability of Disease Management.
6. The MCO's quality assurance and performance improvement program and the Provider's role in such a program.
7. The MCO's policies and procedures, especially regarding Network and Out-of-Network referrals.
8. Training for PCPs must include services available and required components of the Texas Health Steps program as referenced in 4.1.26.3 Texas Health Steps (EPSDT) Medical and Dental.
9. Population-specific issues related to the Target Population, including:
    (a) Health Passport, as defined in **RFP Section 4.1.12**.
    (b) Coordinating care with:
        i. Medical Consenters;
        ii. Guardians ad litem;
        iii. Case workers;
        iv. Attorneys ad litem;
        v. Judges;
        vi. Law enforcement officials;
        vii. Other involved parties from DFPS and other state agencies.
    (c) Requirements for providing Health Care Services to the Target Population, including:
        i. Medical consent requirements as defined in Texas Family Code and DFPS policies (see **RFP Attachment H**);
        ii. Required timelines for Health Care Services as defined in DFPS policies;

iii. Specific medical information required for judicial review of medical care under Texas Family Code §266.007;

iv. Compliance with the *Psychotropic Medication Utilization Parameters for Foster Children* found at http://www.dshs.state.tx.us/mhprograms/psychotropicMedicationFosterChildren.shtm .

v. Evidence-based behavioral health treatment interventions.

(d) Specific behavioral and physical health needs of the Target Population.

The MCO must make available to Network Providers a variety of web-based training modules. Such trainings will include those suggested by HHSC and DFPS, such as the effect of abuse and neglect on the developing brain, the effect of intrauterine assault, fetal alcohol syndrome, and shaken baby syndrome. The MCO will consult with experts in the field, including its foster care Medical Advisory Committee, to determine which additional topics may be relevant to Providers in providing services to the Target Population.

4.1.4.10 Continuing Education Credits

The MCO is encouraged to inform and arrange for access to training programs to provide continuing education credits for Providers. The MCO may coordinate with national and local provider associations to deliver continuing education training. Continuing education training must focus on enhancing Provider understanding of the complex and special physical and behavioral health care needs of the Target Population. To improve Provider access to these continuing education training programs, the MCO must make every effort to allow Providers to complete training programs through the Internet.

4.1.4.11 Provider Hotline

Section 4.1.4.11 modified by Versions 1.1, 1.2, and 1.3

Refer to **Attachment C-2, Section 13** for additional information regarding Modifications to the Proposal.

The MCO must operate a toll-free telephone line for Provider inquiries from 8 a.m. to 5 p.m. local time for all areas of the state, Monday through Friday, except for state-approved holidays. The Provider Hotline must be staffed with personnel who are knowledgeable about Covered Services, Non-capitated Services, and Value-added Services as applicable. The content of Provider Hotline staff training related to EPSDT is subject to HHSC approval.

The MCO 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 a Member with an Urgent Condition or an Emergency Medical Condition. The MCO must have a process in place to handle after-hours inquiries from Providers seeking to verify enrollment for a Member with an Urgent Condition or an Emergency Medical Condition, provided, however, that the Providers must not require such verification prior to providing Emergency Services. Refer to **RFP Section 4.1.5.6** for information regarding Provider access to the 24-hours Nurse Hotline.

The MCO must ensure that the Provider Hotline meets the following minimum performance requirements:

1. Ninety-nine percent 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 two minutes or less.
4. The call abandonment rate is seven percent or less.

The MCO must conduct ongoing call quality assurance to ensure these standards are met. The MCO must monitor its performance regarding Provider Hotline standards and submit performance reports summarizing call center performance for the Hotline as indicated in **RFP Section 4.1.24.2**. If the MCO subcontracts with a Behavioral Health Organization (BHO) that is responsible for Provider Hotline functions related to Behavioral Health Services, the BHO's Provider Hotline must meet the requirements in **RFP Section 4.1.18.4** and the MCO must provide performance reports regarding its performance.

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

4.1.4.12 Provider Reimbursement

Section 4.1.4.12 modified by Version 1.2

This subsection applies only to an MCO that is an HMO or EPP. The MCO must pay for all Medically Necessary Covered Services provided to all Members. The MCO must pay Out-of-Network providers using the Medicaid methodology as defined by HHSC in 1 T.A.C. § 353.4, and ensure that claims payment is timely and accurate as described in **RFP Section 4.1.22.5**. The MCO must require federal tax identification numbers from all participating Providers. The Provider may use the federal tax identification number of the residential treatment center (RTC) where he or she is an employee and provides services. The MCO is required to do back-up withholding from all payments to Providers who fail to give federal tax identification numbers or who give incorrect numbers.

4.1.4.13 Termination of Provider Contracts

Unless prohibited or limited by applicable law, as soon as possible and at least 30 days prior to the effective date of the MCO's termination of a Provider's contract, the MCO must provide written notice that the Provider will no longer be a part of the Network to the HHSC Administrative Services Contractor and affected 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.

4.1.5 Member Services

Section 4.1.5 Modified by Versions 1.1 and 1.3

The MCO must maintain a Member Services Department to assist Members in obtaining Covered Services. The MCO 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 (Refer to **RFP Section 4.1.5.6,** Nurse and Member Hotline Requirements).

4.1.5.1 Member Materials

Section 4.1.5.1 modified by Versions 1.0, 1.1, and 1.2

The MCO must design, print and distribute Member identification (ID) cards, a welcome letter, and a Member Handbook to Members. The MCO must auto-assign a PCP to the Member and include the name of the PCP on the Member's ID card. No later than the fifth Business Day following receipt of the Daily Eligibility File, the MCO must mail a Member's ID card and enrollment packet (welcome letter, Provider Directory, Member Handbook, and informational and training materials on how to access the Health Passport) to the Caregiver for each new Member. When a Caregiver represents two or more new Members, the MCO is required to send only one enrollment packet to the Caregiver. When an enrollment packet has not been mailed to a Caregiver's address in three (3) or more months, the MCO will send a new enrollment packet to that Caregiver.

Each time a Member moves to a new placement, the MCO will send a new Member ID card and welcome letter to the new Caregiver's address.

In cases in which the Caregiver of the Member is not designated as the Medical Consenter, the MCO is responsible for mailing the designated Primary Medical Consenter a welcome letter and PCP change form for each Member. This mailing should occur no later than the fifth Business Day following receipt of the Daily Notification File.

The MCO is responsible for mailing materials only to those Members or Caregivers for whom valid address data are contained in the Daily Eligibility File and Medical Consenters for whom valid address data are contained in the Daily Notification File.

The MCO welcome letter must provide Members with information regarding the Program and how to locate more detailed information in their Member Handbooks. The welcome letter must provide the name of the PCP the MCO has auto-assigned to the Member and provide information regarding how Members may:

- Access their PCP.
- Change their PCP.
- Seek help scheduling Texas Health Steps appointments.

- Access the Member and Nurse Hotlines, including hotline numbers.
- Provide information to the MCO regarding the Member's special health care needs and specific services the MCO may need to coordinate.
- Access Service Management and Service Coordination services.

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. HHSC will provide the MCO with reasonable notice when the enrolled population reaches the "Major Population Group" threshold. All Member Materials must be available in a format accessible to the visually impaired, which may include large print, Braille, CDs and audiotapes.

The MCO must submit Member Materials, and all substantive revisions, to HHSC for approval prior to use or distribution. HHSC will identify any required changes to the Member Materials within 15 Business Days from receipt of those materials. If HHSC has not responded to the MCO by the end of the fifteenth Business Day, the MCO may proceed to use the submitted materials. HHSC reserves the right to require discontinuation of any Member Materials that violate the terms of the Contract, including the **Uniform Managed Care Manual**.

4.1.5.2 Member Identification (ID) Card

Section 4.1.5.2 Modified by Versions 1.1 and 1.2

The MCO must provide a Member ID card to the Caregiver for each enrolled Member within five days of notification by the Daily Eligibility File. All Member ID cards must, at a minimum, include the following information:

1. The Member's name.
2. The Member's Medicaid number, if known.
3. The effective date of the PCP assignment.
4. The PCP's name and telephone number.
5. The name of the MCO.
6. The 24-hour, seven (7) day a week toll-free Member services telephone number and Behavioral Health Hotline number,

7. Any other critical elements identified in the **Uniform Managed Care Manual**.

The MCO must reissue the Member ID card if a Member, DFPS Staff, Caregiver or Medical Consenter reports a lost card; there is a Member name change; if the Member, their Medical Consenter, or DFPS Staff requests a new PCP; the Member moves to a new placement; or for any other reason that results in a change to the information disclosed on the Member ID card.

4.1.5.3 Member Handbook

Section 4.1.5.3 modified by Versions 1.0, 1.1, 1.2, and 1.3

HHSC must approve the Member Handbook, and any substantive revisions, prior to publication and distribution.

The Member Handbook must, at a minimum, meet the Member Materials requirements specified by **RFP Section 4.1.5.1** above and must include critical elements in the **Uniform Managed Care Manual**, including the Member Pre-Appeals, Member Complaints and Member Appeals processes.

The MCO must produce a revised Member Handbook, or an insert informing Members and their Caregivers, of changes to Covered Services, upon HHSC notification and at least 30 days prior to the effective date of such change in Covered Services. In addition to modifying the Member Materials for new Members, the MCO must notify the Members and the Caregivers of all existing Members of the Covered Services change during the timeframe specified in this subsection.

The Member Handbook must be written to provide Members and their Caregivers with information regarding the medical consent process. The Member Handbook should also provide the information necessary for Medical Consenters to understand their roles in: (1) the Member's treatment planning and care decisions, and (2) providing consent to the provision of services.

4.1.5.4 Provider Directory

Section 4.1.5.4 modified by Versions 1.1 and 1.2

The Provider Directory and any substantive revisions must be approved by HHSC prior to publication and distribution. Substantive revisions do not include changes to PCP information or clerical corrections.

The Provider Directory must, at a minimum, meet the Member Materials requirements specified by **RFP Section 4.1.5.1** above and must include critical elements in the **Uniform Managed Care Manual**. The Provider Directory must include only Network Providers credentialed by the MCO in accordance with **RFP Section 4.1.4.7.**

The MCO must update the hard copy Provider Directory quarterly. The MCO must make such update available to existing Members, Caregivers, DFPS staff, and/or Medical Consenters on request. The MCO must, at least annually, include written and verbal offers of such Provider Directory in its Member outreach and education materials.

The MCO must design and print the Provider Directory, and deliver a sufficient number of Provider Directories to the HHSC Enrollment Broker Contractor for distribution to Members for the initial mailing 90 days prior to the Operational Start Date. The MCO is responsible for all subsequent Provider Directory mailings. HHSC, the Enrollment Broker and the MCO will meet to identity methods for reducing the MCO's administrative costs of producing new Provider Directories including the development of regional, rather than statewide, Provider Directories. If the MCO divides the state into more than one area for the purposes of publishing separate Provider Directories, HHSC must approve the coverage stipulated in each Provider Directory. The MCO must meet the weight limit requirements established by HHSC for the mailing of the directories by the Enrollment Broker. If the MCO exceeds the weight limit, the MCO will be subject to actual costs of the extra expense for the Enrollment Broker to mail the directories.

4.1.5.5 Internet Website

Section 4.1.5.5 modified by Versions 1.1 and 1.3

The MCO must develop and maintain, consistent with HHSC standards and §843.2015 of the Texas Insurance Code and other applicable state laws, a website to provide general information about the Program, the Provider Network, customer services, and the Complaints and Appeals process. The MCO must ensure that Members have access to the most current and accurate information concerning the MCO's Network Provider participation. To comply with this requirement, at least twice per month the MCO must update provider information in either: (1) its online Provider Directory, or (2) its online Provider search functionality, if applicable. The

online Provider Directory or online Provider search functionality must designate Providers with open versus closed panels. The MCO may develop a page within its existing website to meet the requirements of this section. The MCO's website must also:

- List Home Health Ancillary providers on their websites, with an indicator for Pediatric services if provided;
- Maintain an updated Member Handbook; and
- Include a link to the MCO contract located on the HHSC website.

The website's content for Members must be:

1. Written in Major Population Group languages and updated as Major Population groups reach the 10 percent threshold.
2. Culturally appropriate.
3. Written for understanding at the 6th grade reading level.
4. Geared to the health needs of Members.

The website's content for Providers must provide:

1. Training program schedules and topics and directions for Provider enrollment in training, including continuing education credits for training on issues related to the Target Population.
2. Information on how to apply to become a Network Provider.
3. Information on cultural competency and how to provide culturally sensitive care.
4. Information on the 24-hour Nurse Hotline and how to seek specialty consultations and referrals.
5. Links to DFPS policies and information required of Providers to meet the needs of the Target Population.

To minimize download and wait times, the website must avoid tools or techniques that require significant memory or disk resources or require special intervention on the customer side to install plug-ins or additional software. Use of proprietary items that would require a specific browser 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.

4.1.5.6 Nurse and Member Hotline Requirements

Section 4.1.5.6 modified by Versions 1.1, 1.2, 1.3, and 1.4

Refer to **Attachment C-2, Section 13** or additional information regarding Modifications to the Proposal.

The MCO must operate a toll-free Nurse Hotline that Providers, Members, DFPS Staff, Caregivers, and Medical Consenters can call 24 hours a day, seven days a week. The Nurse Hotline must be staffed with nurses who are knowledgeable about the Model, Covered Services, Non-capitated Services, the Target Population, the child welfare system, Medical Consenter requirements, and Provider resources. Nurses must be available 24 hours per day and able to respond to calls from Providers, Members, DFPS Staff, Caregivers, and Medical Consenters seeking clinical information, guidance on specialty referrals or requests for specialty Provider consultations. Nurses must have access to an on-call licensed Behavioral Health clinician 24 hours per day to assist with crisis calls. Only those persons who can identify themselves through the caller verification process approved by HHSC may obtain personal health information through the Nurse hotline. At a minimum, the MCO's Member Service representatives must be:

1. Knowledgeable about Covered Services, including Behavioral Health Services, Texas Health Steps, the Medical Transportation Program, pharmacy, dental and vision.
2. Knowledgeable about the Medical Home Services Model and Integrated Primary Care Model, and able to identify PCPs who Members may access who operate according to these models.
3. Able to answer technical and non-technical questions pertaining to the role of the PCP.
4. Able to answer clinical and non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services.
5. Knowledgeable and trained in issues related to child abuse and how to assist Members and Medical Consenters seeking care and services.
6. Able to give information about Providers in a particular geographical area.

7. Trained regarding Cultural Competency.
8. Trained to triage and assist Members with Special Health Care Needs and Medical Consenters, DFPS Staff, and Caregivers.
9. Able to answer clinical and non-clinical questions pertaining to accessing services that the MCO does not provide or arrange for (such as Non-capitated Services for an MCO that is an HMO or EPP; community and social service resources; and community-based case management services for which the Target Population may be eligible).
10. Able to respond to Provider questions regarding specialty referrals and to arrange for consultations with MCO clinical staff, Service Coordinators or Service Managers, or other Providers. For example, a PCP with a Member in their office may call with a need for an immediate consult with MCO clinical staff or a behavioral health Provider.
11. Able to respond to questions regarding the Disease Management programs included in the Model.
12. Trained regarding: a) emergency prescription process and what steps to take to immediately address Members' problems when pharmacies do not provide a 72-hour supply of emergency medicines. The 24-hour nurse hotline will attempt to respond immediately to problems concerning emergency medicines by means at its disposal, including explaining the rules to Members so that they understand their rights and, if need be, by offering to contact the pharmacy that is refusing to fill the prescription to explain the 72-hour supply policy and DME processes. ; and b) DME processes for obtaining services and how to address common problems.

In addition, the MCO must operate a toll-free Member Hotline that Members, DFPS Staff, Caregivers and Medical Consenters can call 24 hours a day, seven (7) days a week. The Member Hotline must be staffed with personnel who are knowledgeable about the Model, Covered Services, Non-capitated Services, the Target Population, the child welfare system, and Medical Consenter requirements between the hours of 8:00 a.m. to 5:00 p.m. local time for all areas of the state, Monday through Friday, excluding state-approved holidays. Only those persons who can identify

themselves through the caller verification process approved in writing by HHSC may obtain personal health information through the Member hotline.

The MCO must ensure, at a minimum, that after business hours and on weekends and holidays, the Member Hotline is answered by an automated system that provides callers with Member Hotline operating hours, instructions regarding how to access the Nurse Hotline and instructions as to what to do in cases of emergency. All recordings must be in English and in Spanish, and in the language of a Major Population Group if the group reaches the 10 percent threshold. The Member Hotline must provide an after hours voice mailbox where callers may leave messages. The MCO's Member Services representatives must return Member calls received by the automated system on the next Business Day.

The MCO must ensure that its Member Service representatives treat all callers with dignity and respect the callers' need for privacy. At a minimum, the MCO's Member Service representatives must be:

1. Knowledgeable about Covered Services, including Behavioral Health Services, Texas Health Steps, the Medical Transportation Program, pharmacy, dental and vision.
2. Trained regarding: a) the emergency prescription process and what steps to take to immediately address problems when pharmacies do not provide a 72-hour supply of emergency medicines; and b) DME processes for obtaining services and how to address common problems.
3. Able to answer non-technical questions pertaining to the role of the PCP and about the Medical Home Services Model and Integrated Primary Care Model.
4. Able to answer non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services.
5. Knowledgeable and trained in issues related to child abuse and how to assist Members and Medical Consenters seeking care and services.
6. Able to give information about Providers in a particular geographical area.
7. Knowledgeable about Fraud and Abuse requirements to report any conduct that, if substantiated, may constitute Fraud and Abuse in the Program.

8. Trained regarding Cultural Competency.
9. Trained regarding the process used to confirm the status of Members with Special Health Care Needs and how to transfer these Members or their Medical Consenters to Service Managers so Members may be clinically triaged and enrolled in Service Management.
10. Trained to triage calls to the appropriate MCO staff person.
11. Able to answer non-clinical questions pertaining to accessing services that the MCO does not provide or arrange for (such as Non-capitated Services for an MCO that is an HMO or EPP); community and social service resources; and community-based service management services for which the Target Population may be eligible).
12. Trained to refer callers to Covered Services and Non-capitated Services, as appropriate.
13. Able to provide information on Member Appeals and Complaints.

Nurse Hotline and Member Hotline services must meet Cultural Competency requirements and must appropriately handle calls from English and Spanish-speaking callers, and calls in languages of a Major Population Group if the group reaches the 10 percent threshold, as well as calls from individuals who are deaf or hard-of-hearing. To meet these requirements, the MCO must employ Member Services representatives who speak Spanish and other Major Population Group languages, or must secure the services of other contractors, such as the ATT language line, as necessary to meet these requirements.

For both Hotlines, the MCO must process all incoming correspondence and telephone inquiries in a timely and responsive manner. The MCO cannot impose maximum call duration limits and must allow calls to be of sufficient length to ensure adequate information is provided to the Providers, Medical Consenters, DFPS Staff, Caregivers, and Members. The MCO must ensure that both toll-free Hotlines meet the following minimum performance requirements:

1. At least 99 percent of calls are answered by the fourth ring or an automated call pick-up system.
2. At least 80 percent of calls must be answered by toll-free line staff within 30 seconds.

3. The call abandonment rate is seven percent or less.
4. The average hold time is two minutes or less.

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

Members, DFPS Staff, Caregivers, and Medical Consenters may access the Nurse Hotline and the Member Hotline through the same toll-free number, but must be given the option to direct their calls based on whether they are related to a clinical or non-clinical issue, an emergent issue, or a routine issue. However, the MCO must report hotline call statistics separately for both the Member Hotline and the Nurse Hotline. The Nurse and Member Hotlines must be dedicated to serving only the Members, DFPS Staff, Caregivers and Medical Consenters. Staff trained to manage general calls may provide back-up to dedicated Hotline staff during peak periods or in cases of emergency, in order to maintain Hotline performance standards and respond to urgent Member calls, but at least 95 percent of calls must be answered by dedicated Hotline staff.

The MCO must monitor its performance regarding the Nurse and Member Hotline standards and submit performance reports summarizing call center performance for the Nurse and Member Hotlines as indicated in **RFP Section 4.1.24** and the **Uniform Managed Care Manual.**

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

4.1.5.7 Member Education

Section 4.1.5.7 modified by Version 1.1

The MCO must, at a minimum, develop educational materials and implement health education initiatives that educate Medical Consenters, Members, DFPS Staff, Caregivers, guardians ad litem, judges and attorneys ad litem about:

1. How the MCO system operates, including the role of the PCP, referrals for services using Network Providers, and access to Out-of-Network providers.

2. Covered Services, including any Value-added Services offered by the MCO, and limitations placed on such Value-added Services.
3. The value of screening, preventive care, and other Medical Home services.
4. How to obtain services, including:

    - How to contact the MCO's Hotlines.
    - The MCO's Complaint, grievance and Appeals policies and procedures.
    - How to request a Medicaid Fair Hearing.
    - Emergency Services.
    - OB/GYN and specialty care.
    - Behavioral Health Services.
    - Medical Transportation Program (MTP) Services.
    - Dental services.
    - Disease Management programs.
    - Service Management for Members with Special Health Care Needs, pregnant Members and other special populations.
    - Service Coordination.
    - Early Childhood Intervention (ECI) Services.
    - Texas Health Steps medical and dental checkups.
    - Suicide prevention.
    - Identification and health education related to Obesity.
    - Pharmacy. Including how to obtain 72-hour supplies of emergency prescriptions from pharmacies enrolled with HHSC as Medicaid providers.
    - Vision.
    - Information maintained in the Health Passport.

The MCO must provide a range of health promotion and wellness information and activities for Medical Consenters, Members, DFPS Staff, Caregivers, guardians ad litem, judges, and attorneys ad litem in formats that meet their needs. The MCO must implement and assess innovative education strategies for wellness care and immunization, as well as general health promotion and

prevention. Such education strategies must be approved by HHSC. The MCO must conduct wellness promotion programs to improve the health status of its Members. The MCO may cooperatively conduct health education classes for all Members with one or more managed care organizations also contracting with HHSC. The MCO must work with its Providers to integrate health education, wellness and prevention training into the care of each Member.

The MCO also must provide condition and disease-specific information and educational materials to Members, Medical Consenters, DFPS Staff or Caregivers, including information on its Service Management, Service Coordination and Disease Management programs described in **RFP Sections 4.1.14, 4.1.15 and 4.1.16.** Condition and disease specific information must be oriented to various groups within the Target Population, such as persons with Disabilities and non-English speaking Members, as appropriate to the Model.

4.1.5.8 Cultural Competency Plan

The MCO must have a comprehensive written Cultural Competency Plan describing how the MCO will ensure culturally competent services, and provide Linguistic Access and Disability-related Access. The Cultural Competency Plan must describe how the individuals and systems within the MCO will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions, as well as those with Disabilities in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves dignity. Modifications and amendments to the plan must be submitted to HHSC no later than 30 days prior to implementation of such changes. The Plan must also be made available to the MCO's Provider Network.

4.1.6 Marketing and Prohibited Practices

The MCO and its Subcontractors must adhere to the Marketing policies and procedures, including provisions relating to Marketing Materials, as set forth by HHSC in the **HHSC Uniform Managed Care Manual**.

4.1.7 Quality Assessment and Performance Improvement

Section 4.1.7 modified by Version 1.2

The MCO must provide for the delivery of quality care with the primary goal of improving the health status of Members and, where the Member's condition is not amenable to improvement, maintaining

the Member's current health status by implementing measures to minimize further decline in condition or deterioration of health status. The MCO must work in collaboration with Providers to actively implement the Medical Home Services Model, an Integrated Primary Care Model for medical needs, and the Dental Home model for dental needs. The MCO also must work in collaboration with Providers to improve the quality of care provided to Members, consistent with the Quality Improvement Goals and all other requirements of the Contract. The MCO must provide mechanisms for Members, Caregivers, Medical Consenters, DFPS staff, and Providers to offer input into the MCO's Quality Improvement activities.

4.1.7.1 QAPI Program Overview

The MCO must develop, maintain, and operate a quality assessment and performance improvement (QAPI) Program consistent with the Contract, TDI requirements (including 28 T.A.C. §11.1901(a)(5) and §11.1902), and the Medicaid requirements of 42 C.F.R. §438.240.

The MCO must have on file with HHSC an approved plan describing its QAPI Program, including how the MCO will accomplish the activities required by this section. The MCO must submit a QAPI Program Annual Summary in a format and timeframe specified by HHSC or its designee. The MCO must keep physicians participating in the QAPI Program and other Network Providers informed about the QAPI Program and related activities. The MCO must include in Provider contracts a requirement securing cooperation with the QAPI.

The MCO must approach all clinical and non-clinical aspects of QAPI activities based on principles of Continuous Quality Improvement (CQI)/Total Quality Management (TQM) and must:

1. Evaluate performance using objective quality indicators.
2. Foster data-driven decision-making.
3. Recognize that opportunities for improvement are unlimited.
4. Solicit Member, Caregiver, Medical Consenter and Provider input on performance and QAPI activities.
5. Support continuous ongoing measurement of clinical and non-clinical effectiveness and Member satisfaction.

6. Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements.
7. Support re-measurement of effectiveness and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.
8. Involve Providers, Members, DFPS Staff, Caregivers and other stakeholders in the quality management and improvement process.

4.1.7.2 QAPI Program Structure

Section 4.1.7.2 modified by Versions 1.1 and 1.3

The MCO must maintain a well-defined QAPI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. The MCO must designate a senior executive responsible for the QAPI Program and the Medical Director must have substantial involvement in QAPI Program activities. At a minimum, the MCO must ensure that the QAPI Program structure:

1. Is organization-wide, with clear lines of accountability within the organization.
2. Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, other clinicians, and non-clinicians.
3. Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities.
4. Evaluates the effectiveness of clinical and non-clinical initiatives.

4.1.7.3 Clinical Indicators

Section 4.1.7.3 Modified by Version 1.1

Refer to **Attachment C-2, Section 19, Question b** for additional information regarding Modifications to the Proposal.

The MCO must engage in the collection of clinical indicator data for Health Care Services. The MCO must use such clinical indicator data in the development, assessment, and modification of its QAPI Program.

4.1.7.4 Behavioral Health Services Integration into QAPI Program

Section 4.1.7.4 Modified by Version 1.1

Refer to **Attachment C-2, Section 9, Question c** for additional information regarding Modifications to the Proposal.

The MCO must integrate Behavioral Health Services into its QAPI Program and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services to Members.

The MCO must measure clinical change (e.g., symptom reduction and functional improvement) using psychometrically sound instruments, as an outcome measure for each Member receiving Behavioral Health Services. Measurements must occur at intake, termination, and quarterly throughout treatment, or more frequently if indicated by a Member's condition.

The MCO must collect data, monitor, and evaluate improvements to physical health outcomes resulting from Behavioral Health Services integration into the Member's overall care.

4.1.7.5 Clinical Practice Guidelines

Section 4.1.7.5 Modified by Versions 1.1, 1.2, and 1.3

Refer to **Attachment C-2, Section 19, Question b** for additional information regarding Modifications to the Proposal.

The MCO must adopt not fewer than four evidence-based clinical practice guidelines that apply to the Target Population, two for physical health and two for behavioral health. Such practice guidelines must be based on valid and reliable clinical evidence; consider the needs of the MCO's Members; be based on clinical best practices specifically for the treatment of the Target Population; be adopted in consultation with Providers; and be reviewed and updated periodically, as appropriate. The MCO must develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program. The MCO must disseminate the practice guidelines to all affected Providers and, upon request, to Medical Consenters, DFPS Staff, Caregivers, and Members.

The MCO must take steps to encourage that Providers adopt the clinical practice guidelines, and must demonstrate its measurement of compliance with the guidelines. HHSC's goal is that Providers apply the guidelines consistently for all Members. To improve Provider Compliance with use of clinical practice guidelines, the MCO must employ substantive Provider motivational incentive strategies, such as financial incentives (for Providers contracting with an MCO that is an HMO or EPP) and non-financial incentives. The MCO's decisions regarding Utilization Review, Member education, coverage of services, and other areas included in the practice guidelines must be consistent with the MCO's clinical practice guidelines.

4.1.7.6 Medical Advisory Committee

Section 4.1.7.6 Modified by Versions 1.1 and 1.3

The MCO will establish Medical Advisory Committees comprised of community providers and other physical health and behavioral health experts, and chaired by the MCO. The MCO will require that all provider members of the Foster Care Medical Advisory Committee (FCMAC) have experience working with the Target Population. The MCO may either establish separate and multiple Medical Advisory Committees, which will be composed of members with specific expertise in major areas, such as dental and Behavioral Health Services, or one Medical Advisory Committee that is composed of various provider types to enable it to provide specialized review, expertise and consultation on a variety of health issues. The Medical Advisory Committees will perform the following functions:

- Assist the MCO in developing, reviewing and revising clinical practice guidelines, based on clinical best practices and community standards.
- Assist the MCO in reviewing general clinical practice patterns and assessing Provider compliance with clinical guidelines.
- Assist the MCO, HHSC and the state's External Quality Review Organization (EQRO) in developing Quality Improvement strategies and studies.

4.1.7.7 Provider Review

Section 4.1.7.7 Modified by Version 1.3

Refer to **Attachment C-2, Section 21, Question b** for additional information regarding Modifications to the Proposal.

The MCO must review the clinical and service practice patterns of its PCPs and other Providers at least annually. As part of its QAPI Program, the MCO must describe the methodology it uses to identify which and how many Providers to target for review activities and to identify measures to use for reviewing such Providers.

Provider review 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 Target Population.
2. Including the Medical Advisory Committees in reviewing general Provider practice patterns and preparing recommendations for categories of Providers who are not in compliance with clinical practice guidelines.
3. Establishing PCP, Provider or group Benchmarks for areas reviewed, where applicable. The MCO can compare the performance of its Providers to providers delivering similar types of services in other states.
4. Providing feedback to individual PCPs and Providers regarding the results of their performance and the overall performance of the Provider Network.

4.1.7.8 Network Management

The MCO must:

Section 4.1.7.8 Modified by Versions 1.1, 1.2, and 1.3

1. Use the results of its Provider review activities to identify areas of improvement for individual PCPs and Providers, and/or groups of Providers.
2. Establish Provider-specific Quality Improvement goals for priority areas in which a Provider or Providers do not meet established MCO standards or improvement goals.
3. Develop and implement incentives to motivate Providers to improve performance on profiled measures, which may include financial incentives (for Providers contracting with an MCO that is an HMO or EPP) and non-financial incentives.
4. At least annually, measure and report to HHSC on the Provider Network and individual Providers' progress, or lack of progress, towards such improvement goals,

and submit a plan to HHSC for quarterly monitoring of Providers who are not meeting goals.

5. Implement action plans and modify incentives for Providers who are not meeting improvement goals and conduct quarterly evaluations of the Provider's progress until the Provider has met improvement goals or the MCO determines the Provider should be terminated.

4.1.7.9 Collaboration with the External Quality Review Organization (EQRO)

Section 4.1.7.9 Modified by Versions 1.2 and 1.3

The MCO will collaborate with HHSC's EQRO to develop studies, surveys, or other analytical approaches to be conducted by the EQRO. The purpose of the studies, surveys, or other analytical approaches is to assess the quality of care and service provided to Members and to identify opportunities for MCO improvement. To facilitate this process, the MCO will supply claims and Encounter Data to the EQRO in a format identified by HHSC in consultation with the MCO. The MCO will also supply medical records for focused clinical reviews conducted by the EQRO. The MCO must cooperate with any data validation studies conducted by the EQRO. The MCO must also work collaboratively with HHSC and the EQRO to annually measure selected Health Plan Employer Data and Information Set (HEDIS) measures that require chart reviews, and to collect Member satisfaction survey utilizing standardized tools such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tool. Examples of HEDIS and CAHPS measures that HHSC will use to monitor and evaluate the MCO are found on the Performance Indicator Dashboard in the **Uniform Managed Care Manual**. Studies may include an analysis of the MCO's ability to develop the Medical Home Services Model and Integrated Primary Care Model in its Network of PCP Providers.

4.1.8 Utilization Review

Section 4.1.8 Modified by Versions 1.1, 1.2, and 1.3

Refer to **Attachment C-2, Section 22, Questions a, and c** for additional information regarding Modifications to the Proposal.

The MCO must have a written Utilization Review (UR) program description, which includes, at a minimum:

1. Procedures to evaluate the need for Medically Necessary Covered Services, including Behavioral Health Services.
2. The clinical review criteria used, the information sources, and the process used to review and approve the provision of Covered Services, including Behavioral Health Services.
3. The method for periodically reviewing and amending the UR clinical review criteria.
4. The staff position functionally responsible for the day-to-day management of the UR function.

The MCO must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate in making UR determinations. The Utilization Review should specifically assess prescribing patterns for psychotropic medications against the *Psychotropic Medication Utilization Parameters for Foster Children* found at http://www.dshs.state.tx.us/mhprograms/psychotropicMedicationFosterChildren.shtm . The MCO will maintain the ability to assess prescribing patterns for psychotropic medications through both an automated and manual process. Utilization Reviews that require direct contact with the actual Provider must be scheduled at times convenient to the Provider's schedule, so as not to interrupt regular clinical care duties.

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

- Within three Business Days after receipt of the request for authorization of services.
- Within one Business Day for concurrent hospitalization decisions.
- Within one (1) hour for post-stabilization or life-threatening conditions, except that for Emergency Medical Conditions and Emergency Behavioral Health Conditions, the MCO must not require prior authorization.

The MCO's UR Program must include written policies and procedures to:

1. Ensure consistent application of review criteria that are compatible with Members' needs and situations.

2. Ensure that determinations to deny or limit services are made by physicians under the direction of the Medical Director.
3. Ensure appropriate personnel are available to respond to Utilization Review inquiries 8:00 a.m. to 5:00 p.m. local time throughout the state, Monday through Friday, with a telephone system capable of accepting Utilization Review inquiries after normal business hours. The MCO must respond to calls within one Business Day.
4. Ensure confidentiality of clinical information.
5. Ensure that quality is not adversely impacted by financial and reimbursement related processes and decisions.
6. Routinely assess the effectiveness and the efficiency of the UR Program.
7. Evaluate the appropriate use of medical technologies, including medical procedures, drugs and devices.
8. Target areas of suspected inappropriate service utilization.
9. Detect over- and under-utilization.
10. Routinely generate reports regarding Provider utilization patterns and compliance with Utilization Review criteria and policies.
11. Compare Member and Provider utilization with norms for comparable individuals.
12. Routinely monitor inpatient admissions, emergency room use, ancillary, and out-of-state services.
13. Provide for peer-to-peer consultation among the MCO's Providers and between Providers and the MCO's clinical staff.
14. Ensure that when Members are receiving Behavioral Health Services from the LHMA the MCO is using the same UR guidelines as those prescribed by DSHS for use by LHMAs and published at: http://www.dshs.state.tx.us/mhprograms/RDM.shtm.
15. Refer suspected cases of Provider or Member Fraud and Abuse to the Office of Inspector General (OIG) as required by **RFP Section 4.1.23**.

Qualified medical professionals must supervise UR Program staff making preauthorization and concurrent review decisions.

4.1.9 Early Childhood Intervention (ECI)

Section 4.1.9 modified by Versions 1.0, 1.1, 1.2, and 1.3

The MCO must educate Network Providers regarding their responsibility under federal laws (e.g., 20 U.S.C. §1435 (a)(5); 34 C.F.R. §303.321(d)) to screen, identify and refer any Member under age three suspected of having a developmental delay or Disability, or who is at risk of delay, to the designated ECI program for assessment and evaluation. The Providers must refer such Members within two Business Days from the day the Provider identifies the Member. The MCO must use written educational materials developed or approved by the DARS Division for Early Childhood Intervention Services for these "child find" activities. Eligibility for ECI services will be determined by the local ECI program using the criteria contained in 40 T.A.C. §108.25.

The MCO must contract with qualified ECI Providers to provide ECI services to Members under age three who have been determined eligible for ECI services. The MCO must permit the Members' Medical Consenter and DFPS staff to refer Members to local ECI service Providers without requiring a referral from the Member's PCP. The MCO's policies and procedures, including its Provider Manual, must include written policies and procedures for allowing such referral to ECI Providers.

The MCO must coordinate and cooperate with local ECI programs in the development and implementation of the Individual Family Service Plan (IFSP), including ECI Targeted Case Management services and other Non-capitated Services required by the Member's IFSP. The IFSP is an agreement developed by the interdisciplinary team that consists of the ECI Case Manager, the Medical Consenter, and other professionals who participated in the Member's evaluation or who are providing direct services to the Member, and the family and/or Caregiver as appropriate. The team may include the Member's PCP, Service Manager, and/or Service Coordinator with approval from the Medical Consenter. The IFSP identifies the Member's present level of development based on assessment, describes the services to be provided to the child to meet the needs of the child and the family, and identifies the person or persons responsible for each service required by the IFSP. If the Medical Consenter gives consent, the ECI Provider shall transmit the IFSP to the MCO and the PCP to enhance coordination with the implementation of the IFSP.

Cooperation with the ECI program includes providing medical diagnostic procedures and providing medical records required to perform developmental assessments and developing the IFSP within the

45-day timeline established in federal rule (34 C.F.R. §303.342(a)). The MCO must require compliance with these requirements through Provider contract provisions. The MCO must not withhold authorization for the provision of such medical diagnostic procedures or prescriptions for therapy services authorized by the IFSP. The MCO must promptly provide the ECI program relevant medical records.

4.1.10 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) - Specific Requirements

The MCO must, by contract, require its Providers to coordinate with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin. The MCO must make referrals to WIC of Members potentially eligible for WIC. The MCO may use the nutrition education provided by WIC to satisfy certain health education requirements of the Contract.

4.1.11 Coordination with Department of Family and Protective Services (DFPS)

Section 4.1.11 modified by Versions 1.0, 1.1, 1.2, and 1.3

DFPS has statutory responsibility for the care of children and young adults who have been removed from the home for abuse and neglect and placed in the conservatorship of DFPS. It is essential to the success of this initiative that the MCO and DFPS develop a positive and productive relationship to ensure that the Target Population receives the best possible physical and behavioral health outcomes.

The MCO will have a dedicated STAR Health Liaison co-located in each of the DFPS regional offices housing a Well-Being Specialist who will coordinate with DFPS to develop work flows and processes, including those related to the transmission of clinical and non-clinical Member information.

The MCO must cooperate and coordinate with DFPS for the care of a child or young adult who is receiving services from or has been placed in DFPS conservatorship. The MCO Service Coordinators and Service Managers must be available to provide information to and assist Members, Medical Consenters and DFPS Staff with access to care and coordination

of services as required in **RFP Sections 4.1.14** and **4.1.15**, including development of the Case Plan. The MCO will also provide training opportunities including web-based and trainings at the regional level to DFPS staff.

The MCO must require Service Managers, Service Coordinators, Member Advocates, CONNECTIONS Representatives, and any other staff positions that may have direct contact with Members or Member information to pass a background check as a condition of hire, and every two years thereafter. Such staff members will not be placed in contact with Members, nor be permitted to co-locate in DFPS offices or access Member information, until DFPS has completed the initial background check. All staff not having passed a background check, and all staff alleged to have committed a criminal offence that would prohibit him or her from having contact with Members pursuant to DFPS regulations in 40 Texas Administrative Code, Chapter 745, Subchapter F, Division 3, will be removed from all STAR Health functions in which direct contact with Members or Member information is expected.

The MCO must establish a process to work with and respond timely to DFPS Staff requests for assessments to establish residential placements for Members. This request may be made only after DFPS Staff determines that a Member meets the criteria for intense, specialized, or moderate level of characteristics, outlined in 40 T.A.C. Part 19, Chapter 700, Subchapter W, "Level-of-Care Service System." The MCO's Service Coordination operations must be organized to give top priority to assisting DFPS with scheduling these assessments. Assessments may include psychosocial, psychological, psychiatric, neurological, physical or other assessments that would assist DFPS or its agent determine a Member's level of needs for placement purposes.

For Members exhibiting an intense level of characteristics, the MCO must work with DFPS Staff to determine which assessment(s) it will authorize, and schedule the requested assessment(s) within three (3) Business Days. The MCO must provide the resulting diagnosis and recommendations from the Provider performing the assessment to DFPS staff within two (2) Business Days. For Members exhibiting a specialized level of characteristics or a moderate level of characteristics, the MCO must work with DFPS Staff to determine which assessment(s) it will authorize and schedule the requested

assessment(s) within five (5) Business Days. The MCO must provide the resulting diagnosis and recommendations from the Provider performing the assessment to DFPS staff within two (2) Business Days.

The MCO must contractually require Providers to testify in court as needed for child protection litigation. The MCO must comply with all provisions related to Covered Services, including Behavioral Health Services, in court order (Order) entered by a court of continuing jurisdiction placing a child or young adult under DFPS conservatorship. Court orders relating to the medical care, including behavioral health care, of a Member, will be transmitted by DFPS to the MCO. For urgent/time-sensitive court orders, the DFPS regional Well-Being Specialist may contact their corresponding regional STAR Health Liaison directly to provide a copy of a newly issued court order.

The MCO cannot deny, reduce, or controvert the Medical Necessity of any Health Care Service included in an Order. Any modification or termination of court-ordered services must be presented and approved by the court having jurisdiction over the matter.

If there is a dispute over the Medical Necessity of any Covered Services, the Member, the Member's Medical Consenter, or DFPS Staff, as appropriate, will use the HHSC Fair Hearing process or the MCO Complaint and Appeal processes as described in **RFP Sections 4.1.31** and **4.1.29.**

The MCO must include information in its Provider Manuals and training materials regarding:

1. MCO and Provider respective roles and responsibilities with regard to assessments, Service Coordination, Disease Management and Service Management Responsibilities (See **RFP Appendix G**).
2. DFPS policy related to Medical Consenter and the release of confidential information.
3. Providing medical records to DFPS.
4. Scheduling medical and Behavioral Health Services appointments.
5. Recognition of abuse and neglect, and the mandatory reporting requirements under the Texas Family Code.

The MCO, HHSC, and DFPS, have developed a Pre-Appeals process that will be initiated by the MCO prior to issuing a denial for any service request and in situations where sufficient information is not present to authorize services.

The MCO, DFPS and HHSC will meet on a schedule determined by HHSC to address issues and concerns that arise during the Transition and Operations Phases. HHSC may require the MCO to revise processes and procedures, modify trainings or educational materials, or make other Program changes as a result of these meetings. The meetings will provide an ongoing opportunity to improve communication and share information between HHSC, DFPS Staff, Members, Providers, Caregivers and Medical Consenters, and the MCO. These meetings may also serve to update Model requirements and streamline processes as necessary.

Pursuant to Chapter 45 of the Human Resources Code (HRC), DFPS will outsource its Substitute Care Services and Case Management Services. DFPS will contract with private entities to provide or ensure the provision of Substitute Care Services and Case Management Services on a statewide basis by September 1, 2011. DFPS will either contract directly with private agencies for the aforementioned services or contract with Independent Administrators (IAs) to manage, procure, and ensure the provision of these services in HHSC's defined administrative regions. Accordingly, the sections of this RFP that refer to "DFPS Staff" in the context of Substitute Care Services and Case Management Services may also refer to the personnel of outsourced private entities or IAs and the Substitute Care and Case Management Service providers in an outsourced region.

DFPS issued its RFP for the project on May 1, 2006. The RFP can be found on the following web page: http://esbd.tbpc.state.tx.us/1380/sagency.cfm .

For more information on outsourcing generally, please see: http://www.dfps.state.tx.us/About/Outsourcing/default.asp .

4.1.11.1 Training for Law Enforcement Officials and Judges

Section 4.1.11.1 modified by Version 1.0

The MCO must provide training for law enforcement officials, judges, district and county attorneys representing DFPS, and attorneys and guardians ad litem regarding the requirements of the Contract and special needs of Members. HHSC and DFPS may also participate in these trainings. The MCO must submit a training plan that includes proposed locations, dates of trainings and training materials to HHSC 30 days prior to the Operational Start Date. The MCO may update training materials annually, at a minimum, and more often if a change in law or policy alters the content of the training materials.

The MCO must include the following issues in its training materials:

1. Role of law enforcement officials, judges, district and county attorneys representing DFPS, and attorneys ad litem as it relates to the behavioral and health care needs of the Target Population.
2. Covered Services.
3. Health Passport.
4. Coordination of care with:
    a) Caregivers and Medical Consenters.
    b) Guardians ad litem and attorneys ad litem
    c) Caseworkers.
    d) Judges.
    e) Law enforcement officials.
    f) Other involved parties from DFPS and other state agencies
5. Requirements for providing Health Care Services to the Target Population including:
    a) Medical consent requirements as defined in the contract and in DFPS policies.
    b) Required timelines for Health Care Services as defined in the contract and in DFPS policies.
    c) Legal review of Member needs, treatment plans and health care progress as part of court hearings.
    d) Other DFPS policies as required.
6. Specific behavioral and medical health needs of the Target Population.

4.1.12 Health Passport

Section 4.1.12 modified by Versions 1.0, 1.1, 1.2, and 1.3; and reformatted by Version 1.3 to add Subsections 4.1.12.1, 4.1.12.2, and 4.1.12.3

Refer to **Attachment C-2, Section 25, Questions c, e, f, g, h, and i** for additional information regarding Modifications to the Proposal.

The MCO will develop and maintain a web-based Health Passport system to provide an electronic health record for each Member. The Health Passport will facilitate Service Management and Continuity of Care for Members, as well as streamline data sharing and coordination between the Members' Providers and DFPS. The Health Passport will function as an easily accessible, paperless repository of information related to each Member, his or her Providers, medical services rendered, and pertinent administrative documentation.

4.1.12.1 Required Features and Data Elements

Section 4.1.12 .1 added by Version 1.3 and modified by Version 1.4

The Health Passport must be structured in a manner to provide the data in a summarized, user-friendly, printable format and must employ hierarchical security measures to limit access to designated persons as defined by HHSC in the Contract or the **Uniform Managed Care Manual**. The Health Passport must be available 24 hours per day, seven days per week, except during limited scheduled system downtime. Routine scheduled downtime must be posted on the MCO website. The MCO must communicate non-routine scheduled downtime to HHSC and the DFPS Help Desk before the scheduled downtime occurs. The Health Passport must be implemented by the Operational Start Date, and will be tested during Readiness Review.

HHSC recognizes that electronic health record (EHR) systems are an innovative and evolving technology and that formal standards for EHR functionality and interoperability are still in development. ASTM International, an international standards development organization, is developing a standard for a comprehensive patient care summary called the Continuity of Care Record (CCR). Health Level Seven (HL7), a non-profit standards development organization accredited by the American National Standards Institute, has proposed a draft document architecture to represent health care encounter information in a standardized format. Both HL7 and the CCR offer insight into the essential functions and features required of a basic EHR. In designing

the Health Passport, the MCO should incorporate the standards proposed by CCR and HL7 until a full normative standard has been accepted by an accredited standards development organization.[1]

The Health Passport must be maintained in a web-based electronic format with the following minimum system functions and features:

1. Advanced security capabilities to protect patient confidentiality and comply with security and privacy rules adopted by the U.S. Department of Health and Human Services (HHS) under HIPAA, 45 C.F.R. §§164.302-.318; 164.500-.534.
2. Retention of records until the later of; (1) the Member reaches age 26, or (2) the timeframe prescribed in Attachment A, "General Contract Terms and Conditions," §9.01, "Financial record retention and audit."
3. Role-based access to Health Passport data by designated parties as defined by HHSC. The Member's designated PCP and additional providers must be clearly identifiable by role in the Health Passport.
4. Additional security layer for cases deemed sensitive by DFPS to allow access only by personnel as designated by DFPS.
5. Secure user access to prevent unauthorized use of data, data loss, tampering and destruction. The Health Passport must provide audit trail functionality to include security audits (logging of Health Passport access attempts) and data audits (logging when, and by whom, records are created, viewed, updated, extracted, or deleted). The MCO is required to report any security breach in the Health Passport system to HHSC and DFPS within 24 hours of the breach.
6. Integration of the Health Passport with the 24-hour Nurse Hotline and Behavioral Health Hotline to allow case-specific access to Health Passport records by designated hotline staff.
7. Sorting and printing capacity supported at a record and/or data category basis.
8. Ad hoc reporting functionality.

[1] Information on the HL 7 Draft Standard for Trial Use (DSTU) can be found at http://www.hl7.org/ehr/. Information on the CCR can be found at www.astm.org.

9. Transferability and exportability of the complete Health Passport database in a file format designated by HHSC.

The MCO and HHSC will consult on any additional features that HHSC or the MCO deems necessary as they are developing the Health Passport.

The MCO is required to include the following data items in the Health Passport:

1. Member-specific information including, but not limited to name, address of record, and date of birth, race/ethnicity, gender and other demographic information, as appropriate, for each Member.
2. Name and address of each Member's Primary Care Physician, Caregiver and Medical Consenter with clear designation of Member's authorized Medical Consenter.
3. Name and contact information of each Member's DFPS caseworker as well as non-medical personnel such as Service Coordinator and Service Manager, as appropriate.
4. Acquisition and retention of the Member's Medicaid ID is required, but due to a lag in the assignment of the Medicaid ID number, the MCO shall utilize and retain the Member's DFPS personal identification number ("Person ID") to identify and link each Member to a unique Medicaid ID once it has been assigned. Both of these values shall be available and distinguishable in the Health Passport. The MCO may choose to assign an additional unique identifier for each Member for internal use, if appropriate.
5. Description and quarterly update of each Member's individual Health Care Service Plan, including the plan of treatment to address the Member's physical, psychological, and emotional health care problems and needs.
6. Provider-specific information including, but not limited to, name of Provider, professional group, or facility, Provider's address and phone number, and Provider type including any specialist designations and/or credentials.
7. Record of each service event with a physician or other Provider, including routine checkups conducted in accordance with the Texas Health Steps program. Record

should include the date of the service event, location, Provider name, the associated problem(s) or diagnosis, and treatment given, including drugs prescribed.

8. Record of future scheduled service appointments and referrals. Note: Referrals and future scheduled appoints are not currently separately manageable or editable within the Passport. If this information is ever requested to be portrayed in more detail/different design by HHSC at a later date, this functionality will be further scoped out by the MCO and HHSC at no additional cost to HHSC.
9. Record of all diagnoses applicable to the Member, with emphasis on behavioral health diagnoses utilizing either the DSM IV-R or ICD9 national code sets as based on claims submitted.
10. Record of current and/or past medications and doses (including psychoactive medications), and where available, the prescribing physician, date of prescription(s) and target symptoms.
11. Record and results of all Texas Health Steps medical, dental, and behavioral health exams, including all required information from Texas Health Steps forms.
12. Monthly progress notes from behavioral health exams or treatments. A Provider must submit notes at more frequent intervals if necessary to document significant changes in a Member's treatment or progress. Notes should include the following:
    - Primary and secondary (if present) diagnosis.
    - Assessment information, including results of a mental status exam, or assessments used for residential placement purposes.
    - Brief narrative summary of Member's progress or status.
    - Scores on each outcome rating form(s).
    - Referrals to other providers or community resources.
    - Any other relevant care information.
13. Listing of Member's known health problems and allergies.
14. Complete record of all immunizations, supplemented by and exchangeable with data from ImmTrac, the Texas Immunization Registry that meets the requirements of Chapter 161, Texas Health and Safety Code.
15. Listing of Member's Durable Medical Equipment and Supplies (DME) shall be reflected in the claims or "Visits" module of the Health Passport.

16. Record of notification within two (2) Business Days of the provision of Emergency Services to a Member if the Medical Consenter did not provide consent.
17. Any utilization of an informational code set, such as ICD-9, should provide the used code value as well as an appropriate and understandable code description. This is applicable to codes pertaining to a service event, health care provider, and Member records.

The Health Passport may contain additional information proposed by the contractor and approved by HHSC.

4.1.12.2 Usage Requirements

Section 4.1.12 .2 added by Version 1.3 and modified by Version 1.4

The MCO and the Member's Providers, as appropriate, will be responsible for updating each Member's Health Passport with the required medical information. The MCO must contractually require Providers to submit information for the Health Passport. The MCO shall design an efficient system that will allow Providers to either input data directly into the Health Passport at the point of service through a web-based interface or submit the required information to the MCO for entry into the Health Passport.

The MCO may design the Health Passport in such a way as to allow for electronic communication via the Health Passport among the Member's Network Providers for Service Management and service planning purposes.

If the status of an authorized user of the Health Passport changes, the MCO must terminate the user's access to the Health Passport system within 24 hours of notification of the user's change in status. Examples of status changes include a Provider leaving the MCO's Network, or a DFPS employee leaves employment with DFPS. When a Member is disenrolled from the MCO, web access to the Member's Health Passport shall be suspended for all users. However the MCO shall retain the Member's records in a manner such that the Health Passport may be readily reinstated should the Member return to conservatorship and be re-enrolled in the MCO. Before web access is suspended, DFPS will be responsible for providing a copy (paper or electronic) of the Member's

authorized Health Passport records to the parties specified in Texas Family Code §266.006(f). In the event that DFPS cannot access a Member's Health Passport record before web access is suspended, the MCO will make available the means for DFPS to access the Member's Health Passport records or will provide to DFPS an electronic and/or hard copy as requested by DFPS.

The MCO shall retain a Member's Health Passport records beyond the date that the Member has been disenrolled from the MCO or has aged out of foster care, until the Member reaches age twenty-six (26). The MCO must ensure that Health Passport data is readily exportable in the designated file format to allow archiving by HHSC and DFPS.

To facilitate Service Management, the MCO will provide a daily upload to HHSC/DFPS of designated Health Passport data, as determined by HHSC, via the use of an exchange File Transfer Protocol (FTP) site that will be designated by HHSC.

The MCO must develop instructional and training materials for Health Passport users, including web-based materials.

4.1.12.3 Health Passport Reporting Requirements

Section 4.1.12 .3 added by Version 1.3

The MCO is required to report to HHSC on measures of Health Passport usage and compliance by Providers. The MCO must produce the following deliverables for this purpose:

New vs. Returning User—The MCO will submit this deliverable on a weekly basis. The report must include the following data elements:

1. The total number of users that accessed the system within a specific date range, and the names of such users.
2. The total number of unique users who accessed the Health Passport each day within the selected date range.
3. Whether each user was successful in accessing a Member's record.

Full Access Report—The MCO will submit this deliverable on a weekly basis. The report must include the following data elements:

1. The names of the Providers or users' that accessed the system within a specific date range.
2. The number of times each user accessed the system within a selected date range.
3. The position type that each user accessed the system under (ex. community physician, non-prescribing physician, or prescribing physician).
4. The clinical event that was accessed by each user.

Unique Patients Viewed Report—The MCO will submit this deliverable on a weekly basis. The report must include the following data elements:

1. Members whose record was accessed within a selected date range.
2. The names of the Providers or users who accessed each record.
3. The date and time of each access.
4. The section and specific fields of each Member record that was viewed.

Excessive Usage Report—The MCO will submit this deliverable on a weekly basis. The report is utilized to show users who have exceeded the typical number of log-ons to the Health Passport system. The MCO will maintain standardized usage thresholds for each user type (ex. Medical Consenter, DFPS Caseworker, physician, etc.) that will be used to measure excessive usage. The MCO will review a user exceeding his or her assigned threshold in a given week to ensure the user's use of the Health Passport is appropriate. The MCO will refer situations involving the possible abuse of the Health Passport system to HHSC and/or DFPS for their additional review. This report will include a list of the users that exceed the usage threshold within a specified date range.

User Access by Date Report—The MCO will submit this deliverable on a weekly basis. The report must include the following data elements:

1. A list of the Providers or users of the system on an identified date.
2. The number of times each user has accessed the system.
3. The number of searches performed by each user.
4. The names of each Member whose record was accessed.
5. The date and time of each access to a Member record.

The MCO will allow HHSC to request up to 24 ad hoc reports per Contract Year that are outside of the scope of the standard reports. The MCO will provide these ad hoc reports dependent upon data availability and at no additional cost to HHSC.

4.1.13 Services for Members with Special Health Care Needs

Section 4.1.13 Modified by Versions 1.1, 1.2, and 1.3

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

- Members with Special Health Care Needs (MSHCN).
- Children with Severe Emotional Disturbance (SED).
- Members with disabilities or chronic or complex physical, behavioral health and chemical dependency conditions, including high-cost catastrophic cases.
- Members with high-risk pregnancies.

The MCO must reach out to Members who have been identified by DFPS Staff, Caregivers, Medical Consenters or Providers as Members with Special Health Care Needs (MSHCN) and refer these Members, Medical Consenters, and DFPS Staff to the MCO's Service Management for appropriate triage, assessment and enrollment.

DFPS currently contracts with Youth for Tomorrow to identify service levels for the Target Population for the purposes of determining placement. DFPS will provide this information to the MCO in the event this information is helpful in designing Health Care Service Plans for Members. (In outsourced regions, the Independent Administrator will determine service levels for placement purposes. HHSC will notify the MCO whether service level information will be available from the outsourced regions.)

The MCO will determine whether the Member requires Service Management and special services. The MCO must provide information to the HHSC Administrative Services Contractor that identifies Members who the MCO has assessed to be MSHCN. The information must be provided to HHSC as specified in the Joint Interface Plan found in the **Uniform Managed Care Manual**, and updated with newly identified MSHCN by the 10th day of each month.

In the event that a MSHCN is disenrolled from the MCO and enrolled in another health plan, such as in STAR, CHIP, PCCM or commercial insurance, the MCO must provide the receiving health plan

with information concerning the results of the MCO's identification and assessment of that Member's needs, to prevent duplication of those activities. To ensure Continuity of Care, if a MSHCN is transitioning from another health plan, the MCO must contact the Member's prior health plan and request information regarding the Member's needs, current medical necessity determinations, authorized care and treatment plans. To ensure Continuity of Care for a MSHCN receiving services authorized in a treatment plan by their prior health plan, the Service Manager will authorize the Member to continue with his or her provider, and allow an Out-of-Network authorization to ensure the Member's condition remains stable and services are consistent to meet the Members needs. The Out-of-Network authorization will continue until the authorized treatment plan is completed or the MCO can provide comparable services to transition the Member to a Provider who will be able to meet the Member's complex needs.

For services to CSHCN, the MCO must have Network PCPs and specialty care Providers that have demonstrated experience with CSHCN and SED in pediatric specialty centers such as Children's Hospitals, teaching Hospitals, and tertiary care centers, and in community mental health centers or other venues for treatment of SED.

The MCO must provide access to PCPs and specialty care Providers with experience serving MSHCN, including SED and Members who have experienced trauma, physical or sexual abuse and/or neglect. Such Providers must be board-qualified or board-eligible in their specialty. The MCO may request exceptions from HHSC for approval of traditional Providers who are not board-qualified or board-eligible but who otherwise meet the MCO's Credentialing requirements.

The MCO must have a mechanism in place to allow MSHCN to have direct access to specialists as appropriate for the Members' conditions and identified needs, such as a standing referral to a specialty physician. The MCO must also provide MSHCN with access to non-primary care physician specialists as PCPs, as required by 28 T.A.C. §11.900 and **RFP Section 4.1.4.5.** The MCO is responsible for working with MSHCN, DFPS Staff, Caregivers, Medical Consenters and Providers to develop a seamless package of care in which primary, Acute Care, and specialty service needs are met through a Health Care Service Plan that is understandable to the Member, or, when applicable, the Member's Caregiver or Medical Consenter.

Members with Special Health Care Needs, Caregivers, Medical Consenters, DFPS Staff and Providers may request Service Management from the MCO. The MCO must assess whether Service Management is needed and provide it when appropriate. The MCO must also identify Members who would benefit from Service Management and contact the Member, Caregiver, DFPS Staff and Medical Consenter to request their participation in Service Management.

The MCO must provide information and education in its Member Handbook and Provider Manual about treatment planning available for MHSCN, including the availability of Service Management as required in **RFP Section 4.1.14.**

4.1.14 Service Management

Section 4.1.14 Modified by Versions 1.1, 1.2, and 1.3

The MCO must provide Service Management to facilitate the provision of integrated Covered Services to meet the special preventive, primary Acute Care, and specialty health care needs appropriate for treatment of the individual Member's condition(s). The MCO Service Managers must identify Members who may benefit from Service Management, conduct an assessment and provide Service Management when appropriate. The MCO must contact the identified Member, Caregiver, DFPS Staff or Medical Consenter to communicate the benefits of Service Management and encourage the Member's participation in Service Management. Service Management is not solely for MSHCN. PCPs, PCP Teams, Caregivers, Medical Consenters, and DFPS Staff can request Service Manager assistance at any time to coordinate health care planning and the integrated delivery of primary and specialty clinical services.

To ensure Continuity of Care for MSHCN receiving services authorized in a treatment plan by their prior health plan, the MCO and Service Managers will work with the Member's current PCP and specialists to ensure the Member's condition remains stable and services are consistent to meet the Members ongoing needs. The Service Manager will authorize the transitioning Member's Out-of-Network providers to continue with the current treatment plan authorized by the Member's prior health plan until the authorized Health Care Service Plan is completed or the MCO can provide comparable services to transition the Member to a Provider who will be able to meet the Member's complex needs.

The MCO will complete Service Management assessments for all new Members to establish the degree to which Service Management is needed. Health Care Service Plans must be completed for new Members whose assessment indicates a need for Service Management within 30 days of receipt of the Member on the Daily Notification file.

The MCO will complete a new Service Management assessment each time a Member moves to a new placement. If the assessment indicates the need for Service Management, a Health Care Service Plan must be completed or updated by the MCO within 30 days of notification of the Member's move to a new placement.

The MCO will develop a process by which Members' Health Care Service Plans are reviewed and updated on a regular basis. The Health Care Service Plan for Members with a Severe Emotional Disturbance (SED) must include a contingency crisis plan.

The MCO must provide information and education in its Member Handbook and Provider Manual explaining how a Members, Caregivers and Medical Consenters may access Service Management. The MCO is responsible for providing Service Management to assist in developing a Health Care Service Plan for Members enrolled in Service Management, and to facilitate access to clinical treatment and services recommended by the PCP Team and approved by the DFPS Caseworker, Member, or their Medical Consenter. A refusal to utilize Service Management and the development of a Health Care Service Plan for a Member must be authorized by the DFPS caseworker.

Service Managers will work with the PCP Team to avoid separate and fragmented evaluations, Health Care Service Plans and treatment. The MCO's Service Management process and procedures for assisting Members must include how the Service Manager will:

1. Work with DFPS staff, Members, Medical Consenters, PCPs, specialists, other Providers and Disease Management staff to ensure that the Member's medical and behavioral health needs are coordinated.

2. Screen, identify and share with Members, DFPS Staff, Medical Consenters, and PCP Teams clinical information and options for Medically Necessary Services to be included in the Member's Health Care Service Plan.
3. Identify Members who are suspected of having a Severe Emotional Disturbance (SED) and arrange for an assessment using the Texas Recommended Assessment Guidelines (TRAG) or other appropriate standardized clinical instrument.
4. Work with the Member, DFPS Staff, Caregiver and Medical Consenter to assist them in accessing Non-capitated Services.
5. Prepare and present specialty care recommendations to the PCPs and specialists or PCP Teams to consider including in the Member's Health Care Services Plan.
6. Participate in Hospital pre-admission planning for non-emergency hospitalizations and discharge planning.
7. Evaluate and report Member's clinical progress and adherence to the Health Care Service Plan and include this information in the Health Passport after discussing with the PCP or PCP Team and other parties involved in the health Care planning process.
8. Provide information, and involvement from MCO staff, as requested by DFPS Staff to facilitate development of the DFPS Case Plan and coordination with DFPS Case Management Services, including participation in DFPS family group conferences.
9. Encourage behavioral health providers to use evident-based practices (EVPs) and confirm that behavioral health providers and PCPs are sharing information as required in **RFP Section 4.1.18.2**.
10. Serve as a Member Advocate as indicated in **RFP Section 4.1.31.1**.
11. Provide other clinical Service Management functions as required to meet Member's health care needs.

The MCO Service Managers may request and review DFPS case plans, safety plans and permanency plans during the Service Plan development and monitoring process under the following circumstances:

- The Member has had two or more psychiatric hospitalizations within the last year.
- The Member has had four or more placements within the last year.

- The Member has had one or more suicide attempts within the last year.
- The Member has had more than 2 runaway incidents from placements within the last year.
- The Member has had an incident of sexually acting out on another youth within the last year.
- The Member had four or more triggered reviews within the last 90 days as a result of the use of emergency behavior interventions.

4.1.15 Service Coordination

Refer to **Attachment C-2, Section 4, Question a** and **Attachment C-2, Section 19, Question a** for additional information regarding Modifications to the Proposal.

Section 4.1.15 modified by Versions 1.0, 1.2, and 1.3

The MCO must implement a systematic administrative process to coordinate access to services, including Non-capitated Services, and information at the request of a Member, DFPS Staff, Caregiver, Medical Consenter, or PCP. The MCO must also coordinate with DFPS Case Management Services, whose function is to enlist the involvement of community organizations that may not be providing Covered Services but are otherwise important resources to help Members in maintaining health and well-being.

The MCO's Service Coordination process and procedures for assisting Members, Caregivers and Medical Consenters must include how the MCO will:

1. Facilitate access to primary, dental and specialty care and support services, including assisting Members, Caregivers and Medical Consenters with locating Providers and scheduling appointments as necessary.
2. Expedite the scheduling of assessments used to determine residential placements as requested by DFPS, and as required in **RFP Section 4.1.11**. The MCO must give top priority to this function in its Service Coordination operations.
3. Clarify and provide access to information regarding the prior authorization process.
4. Clarify Model requirements and processes, including the Member Pre-Appeals and Appeals processes and how the MCO will provide assistance with navigating these processes.
5. Educate the MCO's staff regarding of the following process:

When medical information is required by DFPS and/or necessary for court hearings, and the Provider has not timely responded to a DFPS request and/or a court's subpoena or request for such information, the MCO's Provider Relations Representatives must timely contact the Provider in question to encourage him or her to provide the requested information. The Provider Relations Representative must remind the Provider of his or her legal obligations to produce such information, including those obligations arising out of the Network Provider agreement with the MCO.

6. Coordinate with DFPS Case Management Services, which facilitate referrals and access to services provided by other agencies and community resources.
7. Assist Members, Caregivers and Medical Consenters with other coordination needs as needed.
8. Coordinate the sharing of health information between Providers and other Programs, such as ECI.
9. Ensure coordination with and referral to the DSHS Children and Pregnant Women Case Management Program, per the *Frew v, Hawkins, et. al.* consent decree.
10. Ensure Members with transportation needs for medical appointments receive assistance through the HHSC's Medical Transportation Program.
11. Share information with DFPS Forensic Assessment Centers (a procurement for these services through DFPS is anticipated in SFY 2006).
12. Represent the MCO at meetings with Community Resource Coordination Groups (CRCGs).

The MCO will contact all Members, Caregivers and Medical Consenters upon enrollment to notify them of the availability of Service Coordination and its functions. The MCO will provide additional outreach about the availability of Service Coordination (such as additional phone calls and/or mailings) to Caregivers and Medical Consenters of Members identified by DFPS as having special health care needs, to parents of children in their own home, and to Caregivers and Medical Consenters of Members in relative placements. The MCO will also encourage Caregivers and Medical Consenters to use Service Coordination services.

Members, DFPS Staff, Caregivers, Medical Consenters, or PCPs may request Service Coordination from the MCO. A Service Coordinator will contact the Member, DFPS Staff, Caregiver, Medical Consenter, and/or PCP by the next Business Day upon receipt of a request for Service Coordination.

The MCO will maintain an adequate number of Service Management and Service Coordination personnel and management having expertise in physical health, behavioral health, and the Target Population to meet the needs of the population, as measured by the timely completion of assessments and Health Care Service Plans and successful coordination of services as required by RFP Sections 4.1.14 and 4.1.15. The MCO will continue to assess the staff's ability to complete these functions in a timely nature, and will take corrective action as necessary.

The MCO's Service Management and Coordination model will offer specialized teams having additional expertise to assist those experiencing acute episodes and/or severe complex conditions.

The MCO will maintain a sufficient number of regional offices in which Service Management and Service Coordination teams will be housed. Regional offices will be located in areas throughout the state that are determined by agreement between the MCO and HHSC to have the greatest member density.

4.1.16 Disease Management

Section 4.1.17 Modified by Versions 1.1, 1.2, and 1.3

Refer to **Attachment C-2, Section 19, Question b** for additional information regarding Modifications to the Proposal.

The MCO must provide, or arrange to have provided to Members, comprehensive Disease Management services consistent with state statutes and regulations. Such Disease Management services must be part of a person-based approach to Disease Management and holistically address the needs of Members with multiple chronic conditions. The MCO must develop and implement

Disease Management services that relate to chronic conditions that are prevalent in Members. In the first year of operations, the MCO must have Disease Management Programs that address Members with Chronic or Complex Conditions. See **RFP Attachment B** for a list of the most common diagnoses in the Target Population. In the second year of operations, the MCO must evaluate the priority needs of the Target Population with the goal of determining the relevancy and impact of additional or alternative disease management programs. HHSC will not identify the Members with Chronic or Complex Conditions. The MCO must implement policies and procedures to ensure that Members that require Disease Management services are identified and enrolled in a Disease Management program.

The MCO must develop and maintain screening and evaluation procedures for the early detection, prevention, treatment, or referral of Members at risk for or diagnosed with Chronic Conditions identified the MCO as candidates for Disease Management. The MCO must ensure that all Members identified for Disease Management are enrolled into a Disease Management Program with the opportunity to opt out of these services within 30 days while still maintaining access to all other Covered Services.

The Disease Management Program(s) must include:

- Patient self-management or family/Caregiver care management education.
- Provider education.
- Evidence-based models and minimum standards of care.
- Standardized protocols and participation criteria.
- Physician-directed or physician-supervised care.
- A continuum of interventions to address individualized need.
- Mechanisms to modify or change interventions that are not proven effective.
- Mechanisms to monitor the clinical and financial impact of the Disease Management Program over time.

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

The MCO must provide designated staff to implement and maintain Disease Management Programs and to assist participating Members and their Medical Consenters in accessing Disease Management services. The MCO must educate Members, Caregivers, Medical Consenters, DFPS staff, and Providers about the MCO's Disease Management Programs and activities. Additional requirements related to the MCO's Disease Management Programs and activities are found in the **HHSC Uniform Managed Care Manual**.

For all new Members not previously enrolled in the MCO and who require Disease Management services, the MCO must evaluate and ensure continuity of care with any previous Disease Management services in accordance with the requirements in the **Uniform Managed Care Manual**.

4.1.16.1 Disease Management Services and Participating Providers

Section 4.1.16.1 modified by Version 1.2

This subsection applies only to an MCO that is an HMO or EPP. At a minimum, the MCO must:

1. Implement a system for Providers to request specific Disease Management interventions.
2. Give Providers and Service Managers information, including information about differences between recommended prevention and treatment and actual care received by Members enrolled in a Disease Management Program, and information concerning such Members' adherence to a Health Care Service Plan.
3. For a Member enrolled in a Disease Management Program, provide reports on changes in a Member's health status to their PCP and Service Manager.

4.1.16.2 Disease Management Evaluation

Section 4.1.16.2 modified by Version 1.2

This subsection applies only to an MCO that is an HMO or EPP. HHSC or its EQRO will evaluate the MCO's Disease Management Program. The MCO must provide all information HHSC deems necessary for such evaluation.

4.1.17 Dental Services and Dental Network

Section 4.1.17 Modified by Versions 1.1, 1.2, and 1.4

Refer to **Attachment C-2, Section 10, Question a** for additional information regarding Modifications to the Proposal.

The MCO must provide the delivery of all dental Medically Necessary Covered Services as described in the Texas Medicaid Provider Procedures Manual. Dental services must comply with the Texas Health Steps Dental Policy and Procedures and periodicity schedule, and the Texas Medicaid Bulletins. The MCO must ensure the Target Population receives a Texas Health Steps dental exam within 60 days of enrollment for Members six months of age and older. The MCO must recruit and maintain an adequate dental Provider Network, including dentists for First Dental Home for children 6 months through 35 months and Members with Special Health Care Needs. Dental services include, without limitation, periodontics, orthodontics, endodontics, pediatric dentistry, and other services included in the **Texas Medicaid Provider Procedures Manual**.

The MCO must enroll, train and support a statewide Network of dental Providers who understand and are responsive to the Target Population's special health and dental care needs. The MCO must undertake an aggressive dentist recruitment strategy in collaboration with the Texas Dental Association (TDA), the Texas Academy of Pediatric Dentists (TAPD), Texas Academy of General Dentistry, the Gulf State Dental Association, the Hispanic Dental Association, and any other interested dental provider organization to the extent these organizations are willing to commit to assistance in the dental provider outreach and recruiting effort.

Dentists providing emergency dental services outside the State of Texas are required to be located in the United States and licensed in the state that the Member received the Emergency Services.

4.1.18 Behavioral Health Services

Section 4.1.18 Modified by Versions 1.1, 1.2, and1.3

The MCO must provide or arrange for the delivery of all Medically Necessary community-based, rehabilitative, and inpatient Hospital Behavioral Health Services. Behavioral Health Services include Covered Services for the treatment of mental, emotional, or clinical dependency disorders. As is allowed in Medicaid Fee-for-Service, the MCO must cover up to three five-day extensions in a Psychiatric Hospital after treatment is completed if DFPS Staff is in the process of finalizing the

Member's placement. The MCO will encourage all contracted Psychiatric Hospitals that have psychiatric bed capacity to expand their inpatient behavioral health service capacity. Prior authorization processes for Behavioral Health Services must recognize the intensive and/or ongoing need for these services often present among the Target Population, and should not be unnecessarily burdensome to Providers or Members. Therefore, the MCO will not require prior authorization for all outpatient medication management services, and prior authorization will not be required for the first ten outpatient behavioral health sessions, to include the initial evaluation. The MCO must comply with DFPS rules and licensing standards regarding the provision of Covered Services, including certain Behavioral Health Services, to the Target Population. Information on these requirements is available at http://www.dfps.state.tx.us/Site_Map/rules.asp. The MCO also must comply with 28 T.AC. Part 1, Chapter 3, Subchapter HH, regarding standards for chemical dependency treatment. Medicaid Behavioral Health Services are described in further detail in the Texas Medicaid Provider Procedures Manual and the Texas Medicaid Bulletins.

Mental health rehabilitative services are also a Covered Service. HHSC will work with DSHS to assure providers of mental health rehabilitative services are aware that this service is a Covered Service under the Model. The MCO must comply with requirements related to mental health rehabilitative services found in 25 T.A.C. Part 1, Chapter 419 Subchapter L, and 25 T.A.C. Part 1, Chapter 412, Subchapter G. DSHS, through the Local Mental Health Authorities (LMHAs), administers the Resiliency and Disease Management (RDM) program for children with SED and adults with serious mental illness. Please see the following website for information on the RDM program: http://www.dshs.state.tx.us/mhprograms/RDM.shtm. The MCO must allow the LMHA to conduct the RDM assessment and must provide Covered Services that support RDM treatment protocols when accessing mental health rehabilitative services through LMHAs.

The MCO may provide Behavioral Health Services not only in offices and clinics, but also in schools, homes, and other locations as appropriate. A continuum of services, as indicated by the behavioral health needs of Members, must be available. The MCO must include Providers in its Network who utilize evidence-based practices (EBPs) and promote Provider use of EBPs.

Behavioral health assessments must include a primary and secondary (if present) diagnosis using the Diagnostic and Statistical Manual – IV-TR multi-axial classification. Because behavioral health and substance abuse problems commonly occur in Members, the MCO must screen all such Members for both types of problems. Diagnostic information and outcome measurement information must be documented in the Member's Health Passport.

The MCO must contractually require behavioral health providers to:

1. Evaluate each Member's progress using a standardized outcome measurement instrument, to be provided by the MCO, at intake, quarterly at a minimum, and at termination of the Health Care Service Plan, or as significant changes are made in the Health Care Service Plan.
2. Document the outcome measurement scores in the Health Passport.
3. Function as a member of the PCP Team by coordinating with the PCP and Service Manager as appropriate.
4. Testify in court as needed for child protection litigation.

The MCO must contractually require behavioral health providers to provide the following information for the Health Passport:

1. Primary and secondary (if present) diagnosis.
2. Assessment information, including results of a mental status exam.
3. Brief narrative summary of clinical visits/progress.
4. Scores on each outcome rating form(s).
5. Referrals to other providers or community resources.
6. Health Care Service Plans and referrals to other providers.
7. Any other relevant care information.

The behavioral health provider must also submit an initial and monthly (or more frequently, if a Member's medical condition indicates) narrative summary report of a Member's behavioral health

status for inclusion in the Health Passport. This information will be available to the Member's Providers, the Service Management Team, and DFPS staff.

The MCO must contractually require that PCPs use the Texas Health Steps behavioral health forms, at a minimum, for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. Members must be screened for behavioral health problems, including possible substance abuse or chemical dependency. The PCP must submit completed Texas Health Steps screening and evaluation results to the MCO to include in the Health Passport.

Children and young adults in the Target Population often have been victims of severe physical and emotional trauma, including sexual abuse. Provider services should be evidence-based and demonstrated through research to be effective with these traumas, and with other disorders and conditions prevalent in the Target Population. Behavioral health treatment may require family counseling, when family reunification is planned.

4.1.18.1 Behavioral Health Network

Due to the significant behavioral health needs of the Target Population, appropriate access to behavioral health treatment is considered a critical component of effective health care for this population. The MCO must contract with behavioral health providers specializing in treatment of issues that are common to children and young adults in the Target Population such as abuse, neglect, sexual offender behavior, and exposure to complex and multiple traumas, in order to meet the behavioral health needs of the Target Population. To the extent available, the Network must include Providers that utilize EBPs specific to the diagnoses of the Target Population.

Provider Network capacity and distribution must permit Members to have ready access to services as specified in **RFP Sections 4.1.3 and 4.1.4.**

The Network must include psychiatrists and child psychiatrists; Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient Hospital departments; licensed social workers (LCSWs); licensed marriage and family therapists (LMFTs); licensed professional counselors; Qualified Mental Health Professionals

(QMHPs) working under the authority of a Local Mental Health Authority and as defined in TAC Title 25, Part 1, Chapter 412; licensed adolescent chemical dependency treatment facilities; and licensed chemical dependency counselors (LCDCs) with experience treating adults and adolescents. The Network must include Providers who are trained in screening and treating co-occurring mental health and substance abuse disorders. The Network must also include Providers who are experienced in treating physical and sexual abuse and in providing sex offender treatment, such as registered sex offender treatment Providers. Because many children in the Target Population are very young, the Network must include Providers with expertise in treating young children. The Network must also include Providers knowledgeable about the diagnosis and treatment of developmental disabilities, children dually diagnosed with mental retardation and mental health issues, children with autism, and children with fetal alcohol syndrome.

The MCO must use available televideo technology, i.e., telemedicine, to increase access to specialty behavioral health assessment and treatment providers.

To best address the special needs of the Target Population and provide effective treatment, Network Providers must be culturally competent and sensitive to Member issues. The MCO must ensure equal access to services by all racial and ethnic populations, and improve service delivery to underserved populations. The Network must also include clinicians and early intervention specialists who use evidence-based treatments for disorders common to the Target Population. To the extent possible, the diversity of the Network should reflect the cultural groups of children and young adults in the Target Population.

4.1.18.2 Coordination between the Behavioral Health Services Provider and the PCP

Section 4.1.18.2 Modified by Versions 1.1, 1.2, and 1.3

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

The MCO must provide training to Network PCPs on how to screen for and identify behavioral health disorders, the MCO's referral process for Behavioral Health Services and clinical coordination requirements for such services. The MCO must include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions. See **RFP Attachment N** for related information and resources.

The MCO shall develop and disseminate policies regarding clinical coordination and the sharing of Member information between Behavioral Health Service Providers and PCPs, as clinically indicated. The MCO must require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment. The MCO must require that PCPs and Behavioral Health Service Providers engage in an appropriate level of communication and consultation necessary to properly assess, evaluate, refer and/or treat a Member with both a physical health and behavioral health condition. The MCO must develop in concert with PCPs, child psychiatrists and other relevant behavioral health Providers a simple communication format for sharing information between behavioral health Providers and PCPs and other subspecialty Providers, and require the use of such form for sharing necessary information among the PCP Team. The MCO must educate all Members of the PCP Team to understand the role of Service Coordinator and Service Manager in the coordination and sharing of health information and status. Behavioral Health Service Providers may only provide physical Health Care Services if they are licensed in Texas to do so.

The MCO must require that behavioral health Providers and PCPs send each other initial and quarterly (or more frequently if clinically indicated, directed by a PCP Team, or court-ordered) summary reports of a Members' physical and behavioral health status, as agreed to by the PCP Team members. The reports must include information required for judicial review of medical care under Texas Family Code §266.007. This requirement must be specified in Provider contracts, handbooks and manuals.

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

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

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

MCO training for PCPs must include the use of valid screening and assessment instruments as well as the use of the Texas Health Steps Forms. The MCO must provide training to Network PCPs on identifying and referring Members three years of age and older suspected of having a developmental delay or developmental disability, SED, mental illness, or chemical dependency. The MCO must ensure that PCPs have valid screening and assessment instruments to identify and refer children to Providers specializing in evaluations to determine whether a child or young adult has a developmental disability, or is at risk for or has a serious emotional disturbance or mental illness. The MCO must also ensure that Members who may need access to ICF/MRs and home and community-based 1915(c) waiver services receive the appropriate evaluation and psychometric testing required for admission to these facilities or approval of waiver services.

The MCO must provide training to Network PCPs on identifying and referring Members for behavioral health assessments and for neuropsychological assessments to determine if Members have suffered trauma to the brain. The MCO will provide information on evidence-based

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

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

4.1.18.3 Self-referral for Behavioral Health Services

Section 4.1.18.3 Modified by Version 1.2

The MCO must permit Members, DFPS Staff, or Medical Consenters to participate in the selection of appropriate behavioral health providers. The MCO must allow Members or their Medical Consenters to self refer to any Network Behavioral Health Services Provider. If the Member has not been assessed as needing Behavioral Health Services, the MCO must require an assessment to authorize treatment. The MCO policies and procedures, Provider Manual, and Member Handbook must clearly specify how the Member may self-refer for services.

4.1.18.4 Behavioral Health Hotline and Emergency Services

Section 4.1.18.4 modified by Versions 1.1, 1.2, and 1.3

Refer to **Attachment C-2, Section 1** for additional information regarding Modifications to the Proposal.

This Section discusses Behavioral Health Hotline functions pertaining to Member hotlines. Behavioral Health Provider Hotline requirements are referenced in **RFP Section 4.1.4.11**.

The MCO must operate a toll-free Behavioral Health Hotline to handle routine behavioral-health related calls. The MCO cannot impose maximum call duration limits, and must allow that calls can be of sufficient length to provide adequate information to Members, DFPS Staff, Providers, Caregivers and Medical Consenters. Only those persons who can identify themselves through the caller verification process approved by HHSC may obtain personal health information through the

Behavioral Health Services hotline. Hotline services must meet Cultural Competency requirements and provide linguistic access to all Members, including interpretive services required for effective communication. Hotline staff must be trained regarding: a) emergency prescription process and what steps to take to immediately address Members' problems when pharmacies do not provide a 72-hour supply of emergency medicines; and b) DME processes for obtaining services and how to address common problems. The 24-hour behavioral health hotline will attempt to respond immediately to problems concerning emergency medicines by means at its disposal, including explaining the rules to Members so that they understand their rights and, if need be, by offering to contact the pharmacy that is refusing to fill the prescription to explain the 72-hour supply policy processes.

The MCO must conduct ongoing quality assurance activities to ensure the following standards are met:

1. At least 99 percent of calls are answered by the fourth ring or an automated call pick-up system.
2. At least 80 percent of calls are answered within 30 seconds.
3. The call abandonment rate is seven percent or less.
4. The average hold time is 2 minutes or less.

The MCO must monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated in **RFP Section 4.1.24** and the **Uniform Managed Care Manual**.

The MCO must have a Behavioral Health Services Hotline, answered by a live voice, staffed by trained personnel and available 24 hours per day, 7 days a week, toll-free throughout the state which addresses routine and crisis Behavioral Health calls. The hotline must be staffed by or have access to qualified behavioral health professionals to assess emergencies. Clinicians staffing the Behavioral Health Services Hotline must be available to accept emergency and crisis calls. The MCO may operate one hotline to handle emergency and crisis calls and routine calls as long as requirements related to emergency and crisis calls are met. Routine calls received from Providers,

Members, DFPS Staff, Caregivers and Medical Consenters on an emergency hotline after normal business hours will be returned the next Business Day. The MCO may use mobile crisis teams to provide on-site emergency response services.

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

4.1.18.5 Local Mental Health Authority (LMHA)

Section 4.1.18.5 Modified by Versions 1.1 and 1.3

The MCO must provide Medically Necessary Covered Services to Members with severe and persistent mental illness (SPMI) and SED, whether or not they are also receiving other non-covered services through the LMHA. LMHAs are the primary providers of mental health rehabilitative services in Texas. The MCO must enter into written contracts with all LMHAs in Texas that describe the process(es) that the MCO and LMHAs will use to coordinate services for Members with SPMI or SED. The contracts will:

1. Describe the Behavioral Health Services indicated in detail in the **Provider Procedures Manual** and in the **Texas Medicaid Bulletin**, including the amount, duration, and scope of basic and Value-added Services, and the MCO's responsibility to provide these services.
2. Describe criteria, protocols, procedures and instrumentation for referral of Members from and to the MCO and the LMHA.
3. Describe processes and procedures for referring Members with SPMI or SED to the LMHA for assessment and determination of eligibility for mental health rehabilitative services.
4. Describe processes and procedures for coordinating the MCO's Service Management and Service Coordination with the LMHA's targeted service management services so that duplication of services does not occur.
5. Describe processes and procedures to be used for the provision of mental health rehabilitative services.

6. Describe how the LMHA and the MCO will coordinate providing Behavioral Health Services to Members with SPMI or SED.
7. Establish clinical consultation procedures between the MCO and LMHA including consultation to effect referrals and ongoing consultation regarding the Member's progress.
8. Establish procedures to authorize release and exchange of clinical treatment records.
9. Establish procedures for coordination of assessment, intake/triage, Utilization Review and care for persons with SPMI or SED.
10. Establish procedures for coordination of inpatient psychiatric services (including Court- ordered Commitment of Members in state psychiatric facilities within the LMHA's catchment area).
11. Establish procedures for coordination of Emergency Services and urgent services to Members.
12. Establish procedures for coordination of care and transition of care for new Members who are receiving treatment through the LMHA.
13. Establish that when Members are receiving Behavioral Health Services from the LMHA the MCO is using the same Utilization Review guidelines as those prescribed for use by LMHAs by DSHS. The guidelines are published at: http://www.dshs.state.tx.us/mhprograms/RDM.shtm.

4.1.18.6 Follow-up after Hospitalization for Behavioral Health Services

The MCO must require, through Provider contract provisions, that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. The MCO must ensure that, within 24 hours, Behavioral Health Service Providers contact Members who have missed appointments to reschedule appointments.

4.1.18.7 Chemical Dependency

The MCO must comply with 28 T.A.C. §3.8001 *et seq*., regarding Utilization Review for Chemical Dependency Treatment. Chemical Dependency Treatment must conform to the standards set forth in 28 T.A.C. Part 1, Chapter 3, Subchapter HH.

4.1.18.8 Court-ordered Services

Section 4.1.18.8 Modified by Version 1.2

The MCO must provide inpatient psychiatric services to Members 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 MCO is not obligated to cover placements as a condition of probation, which are authorized by the Texas Family Code.

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

Section 4.1.19 Pharmacy Services is deleted by Version 1.0 (the Parties agree that the Pharmacy Services described in this Section 4.1.19 are not included in the Scope of Work) and replaced with Section 4.1.19 Vision Services and Vision Network by Version 1.2

4.1.19 Vision Services and Vision Network

The MCO must provide the delivery of all Medically Necessary Covered Services for vision as described in the Texas Medicaid Provider Procedures Manual. The MCO must recruit and maintain an adequate vision network, including optometrists for Members with Special Health Care Needs.

The MCO must enroll, train and support a statewide Network of vision Providers who understand and are responsive to the Target Population's special health and vision care needs. The MCO must undertake an aggressive recruitment strategy.

Vision providers providing emergency vision services outside the State of Texas are required to be located in the United States and licensed in the state that the Member received the Emergency Services.

4.1.20 Financial Requirements for Covered Services

Section 4.1.20 modified by Version 1.2

RFP Section 4.1.20 applies only to an MCO that is an HMO~~,~~ or EPP. The MCO must pay for or reimburse providers for all Medically Necessary Covered Services provided to all Members. The MCO is not liable for cost incurred in connection with Health Care Services rendered prior to the Member's Effective Date of Coverage in the MCO.

A Member may receive collateral health benefits under a different type of insurance such as workers compensation or personal injury protection under an automobile policy. If a Member is entitled to coverage for specific services payable under another insurance plan, and the MCO paid for such Covered Services, the MCO may obtain reimbursement from the responsible insurance entity not to exceed 100 percent of the value of Covered Services paid to providers.

4.1.21 Accounting and Financial Reporting Requirements

Section 4.1.21 modified by Version 1.2

The MCO's accounting methods, records, and supporting information related to all aspects of the Contract must be accumulated in accordance with, and conform to, the cost principles contained in the Cost Principles for Expenses chapter in the Uniform Managed Care Manual. HHSC will not recognize services that cannot be properly substantiated by the MCO and verified by HHSC.

The MCO must:

1. Maintain accounting records separate and apart from other corporate accounting records.
2. For an MCO that is an HMO or EPP, maintain records for all claims payments, refunds and adjustment payments to Network Providers and Out-of Network Providers, and capitation payments.
3. Maintain records on interest income and payments for administrative services or functions.
4. For an MCO that is an HMO or EPP, maintain separate records for medical and administrative fees, charges, and payments.

5. Maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts.
6. Within 60 days after Contract execution, submit an accounting policy manual that includes all proposed policies and procedures the MCO will follow during the duration of the Contract. Substantive modifications to the accounting policy manual must be prior approved by HHSC.

The MCO agrees to pay for all reasonable costs incurred by HHSC to perform an examination, review or audit of the MCO's records pertaining to the Contract.

4.1.21.1 Financial Reporting Requirements

Section 4.1.21.1 modified by Versions 1.1 and 1.2

HHSC will require the MCO to provide financial reports to support Contract monitoring as well as state and federal reporting requirements. All financial information and reports are property of HHSC and will be public record, except that member specific information included in financial information or reports will not be public record. HHSC's **Uniform Managed Care Manual** will govern the timing, format and content for the following reports.

Audited Financial Statements – The MCO must provide the annual audited financial statement, for each year covered under the Contract, no later than June 30. For an MCO that is an HMO or EPP, the MCO must provide the most recent annual financial statements, as required by the TDI for each year covered under the Contract, no later than March 1.

Affiliate Report – The MCO must submit an Affiliate Report to HHSC if the information changes from the submission of the MCO's proposal or the last report submission. The report must contain the following:

1. A list of all Affiliates.
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 Expenses in the FSR Report for services provided to the MCO by the Affiliate. The schedule should include financial terms

(such as pricing), a detailed description of the services to be provided, and an estimated aggregate amount that will be incurred by the MCO for each Affiliate's services during each Rate Period of the Contract.

Bonus and/or Incentive Payment Plan – If an MCO intends to include bonus or incentive payments as allowable administrative expenses, the MCO must furnish a written Bonus and/or Incentive Payments Plan to HHSC so it may determine whether such payments are Allowable Expenses in accordance with Cost Principles Document in the **Uniform Managed Care Manual.** The written plan must include a description of the MCO's criteria for establishing bonus and/or incentive payments, the methodology to calculate bonus and/or incentive payments, and the timing of bonus and/or incentive payments. The Bonus and/or Incentive Payment Plan and description must be submitted to HHSC for approval no later than 30 days after the Effective Date of the Contract and any Contract renewal. If the MCO substantively revises the Bonus and/or Incentive Payment Plan, the MCO must submit the revised plan to HHSC for prior review and approval.

Claims Lag Report – An MCO that is an HMO or EPP must submit a Claims Lag Report as a Contract year-to-date report. The report must be submitted quarterly by the last day of the month following the reporting period. The report must be submitted to HHSC in a format specified by HHSC, or in a format approved by HHSC. The report format is contained in the **Uniform Managed Care Manual** Chapter 5, Section 5.6.2. The report must at a minimum disclose the amount of incurred claims each month and the amount paid each month.

Form CMS-1513 - The MCO must file an original Form CMS-1513 during Readiness Review regarding the MCO'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 MCO must file quarterly and State Fiscal Year Financial-Statistical Reports (FSR) in the format, timeframe and per the instructions specified in the HHSC **Uniform Managed Care Manual (UMCM)**. The MCO must incorporate financial and statistical data of delegated networks (e.g., IPAs, Limited Provider Networks), if any, in its FSR Reports. Expenses reported in the FSRs must be reported in accordance with the Cost Principles For Expenses chapter in the

UMCM, Generally Accepted Accounting Principles (GAAP), and the Federal Acquisition Regulations (FAR). HHSC will post FSRs on the HHSC website. The FSR is subject to audit by HHSC and/or its designee.

Out-of-Network Utilization Reports – An MCO that is an HMO or EPP must file quarterly Out-of Network Utilization Reports in the format and timeframe specified in the **Uniform Managed Care Manual**. Quarterly reports are due 30 days after the end of each quarter.

Historically Underutilized Business (HUB) Reports – Upon contract award, the MCO must attend a post award meeting in Austin, Texas, at a time specified by HHSC, to discuss the development and submission of a Client Services HUB Subcontracting Plan for inclusion and the MCO's good faith efforts to notify HUBs of subcontracting opportunities. The MCO must maintain its HUB Subcontracting Plan and submit monthly reports documenting the MCO's HUB program efforts and accomplishments to the HHSC HUB Office. The report must include a narrative description of the MCO's program efforts and a financial report reflecting payments made to HUBs. The MCO must use the formats included in HHSC's **Uniform Managed Care Manual** for the HUB monthly reports. The MCO must comply with HHSC's standard Client Services HUB Subcontracting Plan requirements for all Subcontractors.

IBNR Plan - The MCO must furnish a written IBNR Plan to manage incurred-but-not-reported (IBNR) expenses, and a description of the method of insuring against insolvency, including information on all existing or proposed insurance policies. The Plan must include the methodology for estimating IBNR. The Plan and description must be submitted to HHSC no later than 60 days after the Effective Date of the Contract. Substantive changes to a MCO's IBNR plan and description must be submitted to HHSC no later than 30 days before the MCO implements changes to the IBNR Plan.

Medicaid Disproportionate Share Hospital (DSH) Reports – The MCO must file preliminary and final Medicaid DSH reports, required by HHSC to identify and reimburse Hospitals that qualify for Medicaid DSH funds. The preliminary and final DSH reports must include the data elements and be submitted in the form and format specified by HHSC in the **Uniform Managed Care Manual**. The

preliminary DSH reports are due on or before June 1 of the year following the state fiscal reporting year. The final DSH reports are due no later than July 15 of the year following the state fiscal reporting year.

TDI Examination Report – As applicable, the MCO must furnish a copy of any TDI Examination Report, including the financial, market conduct, target exam, quality of care components, and corrective action plans and responses, no later than 10 days after receipt of the final report from TDI.

TDI Filings –The MCO must furnish a copy of any TDI filings, including, without limitation, annual figures for controlled risk-based capital, and quarterly financial statements, both as applicable and required by TDI.

Registration Statement (also known as the "Form B") - If the MCO is a part of an insurance holding company system, the MCO must submit to HHSC a complete Form B, and all amendments to this form, and any other information filed by such insurer with the insurance regulatory authority of its domiciliary jurisdiction.

Section 1318 Financial Disclosure Report - The MCO must file an original CMS Public Health Service (PHS) Section 1318 Financial Disclosure Report during Readiness Review and an updated CMS PHS Section 1318 Financial Disclosure Report no later than 30 days after the end of each rate period and no later than 30 days after entering into, renewing, or terminating a relationship with an Affiliate.

Third Party Recovery (TPR) Reports - An MCO that is an HMO or EPP must file TPR Reports in accordance with the format developed by HHSC in the **Uniform Managed Care Manual**. HHSC will require the MCO to submit TPR reports no more often than quarterly. TRP reports must include total dollars recovered from third party payers for services to the MCO's Members, and the total dollars recovered through coordination of benefits, subrogation, and worker's compensation.

4.1.22 Management Information System Requirements

Section 4.1.22 modified by Version 1.1

The MCO must maintain a Management Information System (MIS) that supports all functions of the MCO's processes and procedures for the flow and use of MCO data. The MCO must have hardware, software, and a network and communications system with the capability and capacity to handle and operate all MIS subsystems for the following operational and administrative areas:

1. Enrollment/eligibility subsystem.
2. Provider subsystem.
3. Encounter/claims processing subsystem.
4. Financial subsystem.
5. Utilization/Quality Improvement subsystem.
6. Reporting subsystem.
7. Interface subsystem.
8. TPR subsystem.
9. Health Passport subsystem.
10. IMPACT subsystem (IMPACT is the DFPS system that will transmit to and receive data from the MCO).

The MIS must enable the MCO to meet the Contract requirements, including all applicable Texas and federal laws, rules, and regulations. The MIS must have the capacity and capability to capture and utilize various data elements required for MCO administration.

The MCO must have a system that can be adapted to changes in business practices or policies within the timeframes negotiated by the Parties. The MCO is expected to cover the cost of such systems modifications over the life of the Contract.

The MCO is required to participate in the HHSC Systems Work Group.

The MCO must provide HHSC prior written notice, generally at least ~~90~~ 180 days, of major systems changes and implementations, including any changes relating to Material Subcontractors, in accordance with the requirements of this Contract and the **General Terms and Conditions.** Refer

to **Attachment A, Article 12** and **Attachment B-5** for additional information regarding remedies and damages. Refer to **Attachment B-1, Section 3.4.7** and **Attachment B-1, Section 4.1.1.1** for additional information regarding HMO Readiness Reviews. Refer to **Attachment A, Section 4.09(c)** for information regarding Readiness Reviews of the MCO's Material Subcontractors.

The MCO must provide HHSC any updates to the MCO's organizational chart relating to MIS and the description of MIS responsibilities at least 30 days prior to the effective date of the change. The MCO must provide HHSC with the names of official points of contact for MIS issues on an ongoing basis.

If for any reason an MCO does not fully meet the MIS requirements, then the MCO 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 according to the severity of the deficiency including liquidated damages. The MCO's MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan. Refer to the **General Terms and Conditions** for additional information.

4.1.22.1 Encounter Data

Section 4.1.22.1 modified by Versions 1.1, 1.2, and 1.4

RFP Section 4.1.22.1. applies only to an MCO that is an HMO or EPP. The MCO must provide complete Encounter Data for all Covered Services, including Value-added Services. Encounter Data must follow the format and data elements in the Texas HIPAA-compliant 837 format. HHSC will specify the method of transmission, and the submission schedule, in the **Uniform Managed Care Manual**. Minimally, the MCO must submit monthly Encounter Data transmissions, and include all Encounter Data and Encounter Data adjustments processed by the MCO within the preceding month. Encounter Data quality validation must incorporate assessment standards developed jointly by the MCO and HHSC. The MCO must submit complete and accurate Encounter Data not later than the 30th calendar day after the last day of the month in which the claim was adjudicated. The MCO must make original records available for inspection by HHSC and its agents for validation purposes. The MCO must correct and return Encounter Data that do not meet quality standards within a time period specified by HHSC.

For reporting Encounters and Fee-for-Service claims to HHSC, the MCO must use the procedure codes, diagnosis codes, and other codes as directed by HHSC. Any exceptions will be considered on a code-by-code basis after HHSC receives written notice from the MCO requesting an exception. The MCO must also use the provider numbers as directed by HHSC for both Encounter Data and Fee-for-Service claims submissions, as applicable.

The MCO must report Texas Health Steps medical and dental checkups data in a manner required for the reports to courts of law, including the number and percent of Members who receive all of their Texas Health Steps medical and dental checkups when due.

4.1.22.2 MCO Deliverables related to MIS Requirements

At the beginning of each State Fiscal Year, the MCO 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.
5. Systems Quality Assurance Plan.

The MCO must submit such modifications to HHSC according to the format and schedule identified the HHSC **Uniform Managed Care Manual**.

4.1.22.3 System-wide Functions

The MCO's MIS system must include key business processing functions and/or features, which must apply across all subsystems as follows:

Section 4.1.22.3 modified by Version 1.2

1. Process electronic data transmission or media to add, delete or modify membership records with accurate begin and end dates.

2. For an MCO that is an HMO or EPP, track Covered Services received by Members through the system, and accurately and fully maintain those Covered Services as HIPAA-compliant Encounter Data transactions.
3. For an MCO that is an HMO or EPP, transmit or transfer Encounter Data transactions on electronic media in the HIPAA format to the contractor designated by HHSC to receive the Encounter Data.
4. Maintain a history of changes and adjustments and audit trails for current and retroactive data.
5. Maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure.
6. For an MCO that is an HMO or EPP, employ industry standard medical billing taxonomies (procedure codes, diagnosis codes) to describe services delivered and Encounter Data transactions produced.
7. For an MCO that is an HMO or EPP, accommodate the coordination of benefits.
8. For an MCO that is an HMO or EPP, produce standard Explanation of Benefits (EOBs).
9. For an MCO that is an HMO or EPP, pay financial transactions to providers in compliance with federal and state laws, rules and regulations.
10. Ensure that all financial transactions are auditable according to GAAP guidelines.
11. Relate and extract data elements to produce report formats (provided within the **Uniform Managed Care Manual**) or otherwise required by HHSC.
12. Ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS.
13. Maintain and cross-reference all Member-related information with the most current Medicaid Provider number.

4.1.22.4 Health Insurance Portability and Accountability Act (HIPAA) Compliance

Section 4.1.22.4 Modified by Version 1.2

The MCO's MIS system must comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA as amended or modified. The MCO must comply with HIPAA EDI requirements. MCO's enrollment files must be in the 834 HIPAA-compliant format. Eligibility inquiries must be in the 270/271 format and all claims and remittance

transactions in the 837/835 format. The MCO must provide its Members or their Medical Consenters with a privacy notice as required by HIPAA. The MCO must provide HHSC with a copy of its privacy notice for filing.

4.1.22.5 Claims Processing Requirements

Section 4.1.22.5 Modified by Versions 1.1 and 1.2

Refer to **Attachment C-2, Section 24** for additional information regarding Modifications to the Proposal.

This subsection applies only to an MCO that is an HMO or EPP. The MCO must process all provider claims and must pay all claims for Medically Necessary Covered Services that are filed within the timeframe specified by this Section. The MCO must administer an effective, accurate, and efficient claims payment process in compliance with state and federal laws, rules and regulations, and the Contract, including the claims processing procedures contained in the **Uniform Managed Care Manual**.

The MCO must maintain an automated claims processing system that registers the date a claim is received by the MCO, the detail of each claim transaction (or action) at the time the transaction occurs, and that has the capability to report each claim transaction by date and type to include interest payments. This information must be at claim and line detail level, maintained on line and in archived files, as appropriate, per contractual record retention requirements. All claims data must be easily sorted and produced in formats upon request by HHSC. All provider claims must be processed within 30 days from the date of claim receipt by the MCO. All provider claims that are Clean Claims must be adjudicated within 30 days from the date of claim receipt.

The MCO must offer its Providers the option of submitting and receiving claims information through electronic data interchange (EDI) that allows for automated processing and adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. Electronic claims must use HIPAA-compliant electronic formats.

The MCO is subject to remedies, including liquidated damages, if the MCO does not pay providers interest at an 18 percent annual rate, calculated daily for the full period in which the Clean Claim remains unadjudicated beyond the 30-day claims processing deadline. The MCO may negotiate

Provider contract terms that indicate that duplicate claims filed prior to the expiration of 31 days would not be subject to the 18 percent interest payment if not processed within 30 days.

The MCO must not pay any claim submitted by a provider excluded or suspended from the Medicare, Medicaid, or CHIP programs for Fraud and Abuse. The MCO must not pay any claim submitted by a provider that is on payment hold under the authority of HHSC or its authorized agent(s), or who has pending accounts receivable with HHSC.

The MCO is subject to remedies, including liquidated damages, if within 30 days of receipt, the MCO does not adjudicate to a paid or denied status 98 percent of all Clean Claims. The MCO is subject to remedies, including liquidated damages, if within 90 days of receipt, the MCO does not adjudicate to a paid or denied status 99 percent of all Clean Claims. Claims paid or denied deficient for additional information must be adjudicated paid or denied by the 30th day following the date the claim is pended or denied deficient, if reasonably requested information is not received prior to the expiration of 30 days (see the **Uniform Managed Care Manual)**.

The MCO must adjudicate all Appealed claims to a paid or denied status within 30 days of receipt of the appealed claim. The MCO is subject to remedies, including liquidated damages, if 98 percent of Appealed claims are not adjudicated to a paid or denied status within 30 days of receipt of the Appealed claim.

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

The MCO must send a remittance and status report or other remittance written communication that includes detailed information for each adjudicated, denied deficient and pended deficient claim to allow the Provider to easily identify the claim number, date of service, type of service, claim codes, Member's name, and Member ID number.

The MCO must finalize all claims, including Appealed claims, within 24 months of the date of service.

The MCO is subject to the requirements related to coordination of benefits for secondary payors in the Texas Insurance Code, §843.349 (e) and (f).

The MCO must inform all Network Providers about the information required to submit a claim at least 30 days prior to the Operational Start Date and as a provision within the MCO/Provider contract. The MCO must make available to providers claims coding and processing guidelines for the applicable provider type. Providers must receive 90 days notice prior to the MCO's implementation of changes to claims guidelines, unless HHSC requires a different notice period.

4.1.23 Fraud and Abuse

Section 4.1.23 modified by Versions 1.1, 1.2, and 1.3

The MCO is subject to all state and federal laws, rules and regulations relating to Fraud and Abuse in health care and the Medicaid programs. The MCO must cooperate and assist HHSC and any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected Fraud and Abuse. The MCO 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 MCO must provide all copies of records free of charge.

The MCO must submit a written Fraud and Abuse compliance plan to the Office of Inspector General (OIG) at HHSC for approval each year. The plan must be submitted 60 days prior to the start of the State fiscal year. (See RFP Section 3, Transition Phase Requirements, for requirements regarding timeframes for submitting the original plan.) If the MCO has not made any changes to its plan from the previous year, it may notify the HHSC OIG that: (1) no changes have been made to the previously-approved plan, (2) the plan will remain in place for the upcoming State Fiscal Year. The notification must be signed and certified by an officer or director of the MCO that is responsible

for carrying out the Fraud and Abuse compliance plan. Upon receipt of a written request from the HHSC OIG, the MCO must submit the complete Fraud and Abuse compliance plan. The MCO is subject to and must meet all requirements in Section 531.103 of the Texas Government Code, and Title 1 Texas Administrative Code (TAC), Part 15, Chapter 353, Subchapter F, Rule 353.501-353.505.

Additional Requirements

In accordance with Section 1902(a)(68) of the Social Security Act, Medicaid MCOs that receive or make annual Medicaid payments of at least $5 million must:

1. Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the MCO, which provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
2. Include as part of such written policies, detailed provisions regarding the MCO's policies and procedures for detecting and preventing fraud, waste, and abuse.

Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the MCO's policies and procedures for detecting and preventing fraud, waste, and abuse.

4.1.24 Reporting Requirements

The MCO must provide and must require its Subcontractors to provide:

Section 4.1.24 modified by Version 1.2

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 thereunder as reasonably requested by the HHSC.
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 the MCO to establish timeframe and formats reasonably acceptable to both parties.

3. The MCO's Chief Executive and Chief Financial Officers, or persons in equivalent positions, must certify that financial data, Encounter Data and other measurement data have been reviewed by the MCO and are true and accurate to the best of their knowledge after reasonable inquiry.

4.1.24.1 HEDIS, CAHPS and Other Statistical Performance Measures

The MCO must provide to HHSC or its designee all information necessary to analyze the MCO's provision of quality care to Members using measures to be determined by HHSC in consultation with the MCO. Such measures must be consistent with HEDIS or other externally based measures or measurement sets, and involve collection of information beyond that present in Encounter Data. Examples of measures that HHSC will use to evaluate performance of the MCO are found on the Performance Indicator Dashboard in the **Uniform Managed Care Manual**.

4.1.24.2 Reports

Section 4.1.24.2 modified by Versions 1.1, 1.2, 1.3, and 1.4

The MCO must provide the following reports, in addition to the Financial Reports described in **RFP Section 4.1.21** and those reporting requirements listed elsewhere in the Contract. The **HHSC Uniform Managed Care Manual** will include a list of all required reports, and a description of the format, content, file layout and submission deadlines for each report. HHSC also retains the option to require additional reports or to change the reporting frequency for any report(s).

(a) **Claims Summary Report** – For an MCO that is an HMO or EPP, the MCO must submit a quarterly Claims Summary Report to HHSC by claim type by the 30th day following the quarter unless otherwise specified. Claim Types include facility and/or professional services for Acute Care, Behavioral Health, Vision, and Dental. Within each claim type, claims data must be reported separately on the UB and CMS 1500 claim forms. Reporting specifications are found in Chapter 5, Section 5.6.1 of the **Uniform Managed Care Manual**.

(b) **Quality Assurance and Performance Improvement (QAPI) Program Annual Summary Report** - The MCO must submit a QAPI Program Annual Summary in a format and timeframe as specified in the **Uniform Managed Care Manual**.

(c) **Fraudulent Practices Report** - Utilizing the OIG fraud referral form, the MCO's assigned officer or director must report and refer all possible acts of Fraud or Abuse to the HHSC-OIG within 30 Business Days of receiving the reports of possible acts of Fraud or Abuse from the MCO'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; the Encounter Data submitted by the provider for the time period in question; and all supporting documentation obtained as the result of the investigation. This requirement applies to all reports of possible acts of Fraud and Abuse.

Additional reports required by the OIG relating to Fraud and Abuse are listed in the **HHSC Uniform Managed Care Manual**.

(d) **Summary Report of Member Complaints and Appeals** - The MCO must submit quarterly Member Complaints and Appeals reports. The MCO must include in its reports Complaints and Appeals submitted to the MCO or its Subcontracted risk groups (e.g., IPAs, Behavioral Health Organizations) and any other Subcontractor that provides Member services. The MCO must submit the Complaint and Appeals reports electronically on or before 45 days following the end of the state fiscal quarter, using the format specified by HHSC in the **HHSC Uniform Managed Care Manual**.

(e) **Summary Report of Provider Complaints -** The MCO must submit Provider Complaints reports on a quarterly basis. The MCO must include in its reports Complaints submitted by providers to the MCO or its subcontracted risk groups (e.g., IPAs, Behavioral Health Organizations) and any other Subcontractor that provides Provider services. The Complaint reports must be submitted electronically on or before 45 days following the end of the state

fiscal quarter, using the format specified by HHSC in the **HHSC Uniform Managed Care Manual**.

(f) **Report of Provider Terminations –** The MCO must submit, on a quarterly basis, a report of each Provider termination and the reason for the termination.

(g) **Hotline Reports -** The MCO must submit, on a quarterly basis, a status report for the Member Hotline, the Behavioral Health Services Hotline, the Nurse Hotline and the Provider Hotline in comparison with the performance standards in **RFP Sections 4.1.4.10, 4.1.5.6** and **4.1.18.4**. If the same toll-free number is used for more than one hotline, the MCO must report hotline call statistics separately for each hotline. The MCO shall submit such reports using a format to be prescribed by HHSC in the **Uniform Managed Care Manual**.

If the MCO is not meeting a hotline performance standard, HHSC may require the MCO to submit monthly Hotline performance reports and implement corrective actions until the hotline performance standards are met.

(h) **Medicaid Managed Care-Texas Health Steps Medical Checkups Reports (Frew 90-Day Reports) –**

The MCO must submit reports that identify:

(1) the total number of New Members under the age of 21 who were enrolled continuously for 90 days or more with the MCO;

(2) the number of New Members under the age of 21 who were enrolled continuously for 90 days or more with the MCO who get medical checkups within 90 days of enrollment into the MCO;

(3) the total number of Existing Members under the age of 21 who were enrolled at the beginning of the reporting year and continuously enrolled for 90 days or more with the MCO into the reporting year (excludes New Members reported in the same reporting year); and

(4) the number of Existing Members under the age of 21 who were enrolled at the beginning of the reporting year and continuously enrolled for 90 days or more with the

MCO into the reporting year (excludes New Members reported in the same reporting year) who got timely, age-appropriate medical checkups during the reporting year.

The MCO must also document and report those Members refusing to obtain the medical checkups. The documentation must include the reason the Member refused the checkup or the reason the checkup was not received. For purposes of the 90-Day Reports, "New Members" are Members who have not previously been enrolled at any time in the prior two years in the MCO.

The definitions, timeframe, format, and details of the report are contained and described in the **Uniform Managed Care Manual**.

(i) **Other -** The MCO must follow all applicable Joint Interface Plans (JIPs) and all required file submissions for HHSC's Administrative Services Contractor, EQRO and HHSC Medicaid Claims Administrator. The JIPs can be accessed through the **Uniform Managed Care Manual**.

(j) **Audit Reports –** The MCO must comply with the Uniform Managed Care Manual's requirements regarding notification and/or submission of audit reports.

(k) **BSP Report –** The MCO must submit a monthly Bariatric Supplemental Payment (BSP) Report that includes the data elements specified in the Uniform Managed Care Manual. The BSP Report must include only bariatric surgeries that meet all of the following requirements:

- unduplicated reports of bariatric surgeries;
- bariatric surgeries that the MCO has paid under the group of procedure codes defined as allowable for bariatric reimbursement, as designated in the "Texas Medicaid Providers Procedures Manual", including the Texas Medicaid Bulletins; and
- bariatric surgeries that were performed no longer than 210 days prior to the date HHSC receives the Report, or that were included in the Report within thirty days from the date of discharge from the Hospital for the stay related to the bariatric surgery, whichever is later. If

a medical service provider does not submit a claim to the MCO by the deadline described herein, the MCO may request and exception to include the claim in the BSP report. HHSC may, at its sole discretion, grant or deny the request.

(l) **Frew Quarterly Monitoring Report**

Each calendar year quarter, HHSC prepares a report for the court that addresses the status of the Consent Decree paragraphs of the *Frew vs. Hawkins* lawsuit. The MCO must prepare responses to questions posed by HHSC on the Frew Quarterly Monitoring Report template.

The timeframe, format, and details of the report are set forth in the **Uniform Managed Care Manual**.

(m) **Frew Health Care Provider Training Report**

Per the *Frew vs. Hawkins'* "Corrective Action Order: Health Care Provider Training," HHSC must compile a summary of the training health care providers receive throughout the year for the October Quarterly Monitoring Report for the court. The MCO must report to HHSC health care provider training conducted throughout the year to be included in this report.

The timeframe, format, and details of the report are contained and described in the **Uniform Managed Care Manual**.

4.1.25 Continuity of Care and Out-of-Network Providers

Section 4.1.25 Modified by Versions 1.1 and 1.2

Refer to **Attachment C-2, Section 27, Question f** for additional information regarding Modifications to the Proposal.

The MCO must ensure that the care of newly enrolled Members and Members who disenroll from the MCO is not disrupted or interrupted. The MCO must take special care to provide continuity of care to newly enrolled Members and Members who disenroll from the MCO whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if Medically Necessary Covered Services are disrupted or interrupted.

The MCO must make every effort to outreach to and recruit providers providing services to Members, including individual behavioral health providers providing services in RTCs.

The MCO 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 delivery, immediate postpartum care, and the follow-up postpartum checkup, even if the provider is Out-of-Network. If a Member wants to change her OB/GYN to one who is in the Network, she must be allowed to do so if the Provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

For an MCO that is an HMO or EPP, the MCO must pay a Member's existing Out-of-Network providers for Medically Necessary Covered Services until the Member's records, clinical information and care can be transferred to a Network Provider. Payment to Out-of-Network providers must be made within the time period required for Network Providers. The MCO must comply with Out-of-Network provider reimbursement rules as adopted by HHSC and found in 1 T.A.C. §353.4.

This Section does not extend the obligation of the MCO to reimburse the Member's existing Out-of-Network providers for ongoing care for more than 90 days after a Member enrolls in the MCO, or for more than nine months in the case of a Member who, at the time of enrollment in the MCO, has been diagnosed with and is receiving treatment for a terminal illness and remains enrolled in the MCO.

The MCO must provide or pay Out-of-Network providers who provide Medically Necessary Covered Services to Members who move out of the state through the end of the period for which capitation has been paid for the Member.

The MCO must provide Members with timely and adequate access to Out-of-Network Covered Services for as long as those services are necessary and are not available within the Network, in accordance with 42 C.F.R. §438.206(b)(4). The MCO will not be obligated to provide a Member

with access to Out-of-Network services if such Covered Services become available from a Network Provider.

The MCO must ensure that each Member, DFPS Staff, Caregiver or Medical Consenter has access to a second opinion regarding the use of any Medically Necessary Covered Service. A Member, DFPS Staff, Caregiver or Medical Consenter must be allowed access to a second opinion from a Network Provider or Out-of-Network provider if a Network Provider is not available, at no cost to the Member, in accordance with 42 C.F.R. §438.206(b)(3).

4.1.26 Provisions Related to Covered Services for Members

4.1.26.1 Emergency and Post-Stabilization Services

Section 4.1.26.1 modified by Version 1.2

Requirements in **RFP Section 4.1.26.**1 that relate to payment for services apply to an MCO that is an HMO or EPP. MCO Emergency Services and Post-Stabilization Care Services policies and procedures, Covered Services, claims adjudication methodology, and reimbursement performance must comply with all applicable state and federal laws, rules, and regulations including 42 C.F.R. §438.114 and Title 1, Texas Administrative Code, Chapter 353, Medicaid Managed Care. These requirements apply whether the provider is Network or Out-of-Network.

The MCO must pay for the professional, facility, and ancillary services that are related to the provision of Emergency Services needed to evaluate or stabilize an Emergency Medical Condition, and Emergency Behavioral Health Condition, and Post-Stabilization Care Services 24 hours a day, seven days a week, rendered by either the MCO's Network or Out-of-Network providers.

The MCO cannot require prior authorization as a condition for payment for Emergency Services. The MCO cannot limit what constitutes an Emergency Medical Condition or an Emergency Behavioral Health Condition on the basis of lists of diagnoses or symptoms. The MCO cannot refuse to cover Emergency Services based on the emergency room provider, Hospital, or fiscal agent not notifying the Member's PCP or the MCO of the Member's screening and treatment within ten calendar days of presentation for Emergency Services. The MCO may not hold the Member who has an Emergency Medical Condition or an Emergency Behavioral Health Condition liable for

payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member. The MCO must accept the attending emergency physician's or the treating provider's determination of when the Member is sufficiently stabilized for transfer or discharge.

Emergency Services must be provided in a Hospital-based emergency department that meets the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 C.F.R. §§489.20, 489.24 and 438.114(b)&(c)). The MCO must pay for the emergency medical screening examination, as required by 42 U.S.C. §1395dd. The MCO must reimburse for both the physician's services and the Hospital's Emergency Services, including the emergency room and its ancillary services.

When the medical screening examination determines that an Emergency Medical Condition or an Emergency Behavioral Health Condition exists, the MCO must pay for Emergency Services performed to stabilize the Member (Post-Stabilization Care Services). The emergency physician must document these services in the Member's medical record. The MCO must reimburse for both the physician's and Hospital's emergency stabilization services including the emergency room and its ancillary services.

- The MCO must cover and pay for Post-Stabilization Care Services in the amount, duration, and scope required by 42 C.F.R. §438.114(b)&(e) and 42 C.F.R. §422.113(c).

4.1.26.2 Family Planning - Specific Requirements

Section 4.1.26.2 modified by Versions 1.2 and 1.4

The MCO must require, through Provider contract provisions, that Members requesting contraceptive services or family planning services are also provided counseling and education about the family planning and family planning services available to Members. The MCO must develop outreach programs to increase community support for family planning and encourage Members to use available family planning services.

The MCO must ensure that Members and their Medical Consenters have the right to choose any Medicaid participating family planning provider, whether the provider chosen by the Member and their Medical Consenter is in or outside the Provider Network. The MCO must provide Members and

their Medical Consenters access to information about available providers of family planning services and the Member and their Medical Consenter's right to choose any Medicaid family planning provider. The MCO must provide access to confidential family planning services.

The MCO must provide at a minimum, the full scope of services available under the Texas Medicaid program for family planning services. The MCO will reimburse family planning agencies the Medicaid Fee-for Service amounts for family planning services, including Medically Necessary medications, contraceptives, and supplies and will reimburse Out-of-Network family planning providers in accordance with HHSC's administrative rules. The HMO cannot require prior authorization for family planning services whether rendered by a Network or Out-of-Network Provider.

The MCO must provide medically approved methods of contraception to Members, provided that the methods of contraception are Covered Services. Contraceptive methods must be accompanied by verbal and written instructions on their correct use. The MCO must establish mechanisms to ensure all medically approved methods of contraception are made available to the Member, either directly or by referral to a Subcontractor.

The MCO must develop, implement, monitor, and maintain standards, policies and procedures for providing information regarding family planning to Providers, Members, Caregivers, and Medical Consenters, specifically regarding state and federal laws governing Member confidentiality (including minors). Providers and family planning agencies cannot require parental consent for minors to receive family planning services. The MCO must require, through contractual provisions, that Subcontractors have mechanisms in place to ensure Member's (including minor's) confidentiality for family planning services.

4.1.26.3 Texas Health Steps (EPSDT) Medical and Dental

Section 4.1.26.3 modified by Versions 1.0, 1.1, 1.2, 1.3, and 1.4

Refer to **Attachment C-2, Section 7** for additional information regarding Modifications to the Proposal.

The MCO must develop effective methods to ensure that Members receive Texas Health Steps medical services through the month of their 21st birthday. Medical services must be provided within 21 days of enrollment or for newborn Members, within 14 days of enrollment. Texas Health Steps dental services must be provided to Members 6 months of age through the month of their twenty-first birthday. Members must receive Texas Health Steps dental services within 60 days of enrollment, when due and according to the Texas Health Steps periodicity schedule for children.

The MCO must arrange for Texas Health Steps services for all eligible Members except when a Member's Caregiver or Medical Consenter knowingly and voluntarily declines or refuses services after receiving sufficient information to make an informed decision.

For the purposes of this contract section only, enrollment means the effective date received on the Daily Eligibility file.

In addition, in compliance with Section 264.105(b) of the Family Code, the MCO must arrange for an assessment of each Member in conservatorship to determine if the Member has a developmental disability or mental retardation. The MCO may use the Texas Health Steps visits and other relevant screenings or assessments performed by the PCP to comply with this provision of the Family Code.

The MCO must ensure that Members, Caregivers and Medical Consenters are provided information and educational materials about the services available through the Texas Health Steps Program, and how and when they may obtain the services. The information should tell the Member, Caregiver and Medical Consenter how they can obtain medical and dental benefits, transportation services through HHSC's Medical Transportation Program, and advocacy assistance from the MCO.

The MCO will encourage Medicaid-enrolled pharmacies to also become Medicaid-enrolled durable medical equipment (DME) providers.

At least seventy-five percent (75%) of the MCO's network of PCPs must be enrolled as Texas Health Steps providers at all times. The MCO will implement an HHSC approved process by which it will systematically outreach contracted PCPs for enrollment and participation in the Texas Health

Steps program. The MCO must require PCPs who are not enrolled Texas Health Steps providers to refer Members to T Texas Health Steps providers for Texas Health Steps screenings. The MCO must also require non-PCP Texas Health Steps providers to notify the Members' PCP of the results of the Texas Health Steps exams, and refer Members to the PCP for follow-up services recommended as a result of the Texas Health Steps screening. HHSC will monitor the MCO's compliance with these requirements on a quarterly basis by comparing the MCO's PCP Provider list with Texas Health Steps listing of enrolled providers, in accordance with Performance Indicator Dashboard (see the **Uniform Managed Care Manual**).

The MCO must provide appropriate training to all Network Providers and Provider staff regarding the scope of benefits available and the Texas Health Steps Program. Training must include:

- Texas Health Steps benefits and training on how to use the mandatory Texas Health Steps forms.
- The periodicity schedule for Texas Health Steps medical and dental checkups and immunizations.
- The required elements of Texas Health Steps medical checkups.
- Providing or arranging for all required lab screening tests (including lead screening).
- Comprehensive Care Program (CCP) services available under the Texas Health Steps program to Members.
- Services available through Medical Transportation Program and Children and Pregnant Women Case Management Program and how to make referrals.

MCO must also educate and train Providers regarding the requirements imposed on HHSC and contracting HMOs under the Consent Decree and Corrective Action Orders entered in Frew v. Hawkins, et. al., Civil Action No. 3:93CV65, in the United States District Court for the Eastern District of Texas, Paris Division. Providers should be educated and trained to treat each Texas Health Steps visit as an opportunity for a comprehensive assessment of the Member.

The MCO will contact Members, Caregivers and Medical Consenters in the manner designated by HHSC to inform them to obtain Texas Health Steps services as soon as possible and of outreach opportunities. Each month, the MCO must retrieve from the HHSC Administrative Services Contractor Bulletin Board System a list of Members who are due and overdue Texas Health Steps services. Using these lists and its own internally generated list, the MCO will contact such Members, Caregivers and Medical Consenters to obtain the service as soon as possible. The MCO outreach staff must ensure that Members, Caregivers and Medical Consenters have access to the HHSC Medical Transportation Program. The MCO outreach staff must coordinate with the Texas Health Steps call center, agencies or staff for any other Texas Health Steps coordination needs.

The MCO must have mechanisms in place to ensure that all newborn Members have an initial newborn check-up before discharge from the Hospital in accordance with the Texas Health Steps periodicity schedule. The MCO must require Providers to send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section or to a laboratory approved by the department under Section 33.016 of the Health and Safety Code. Providers must include detailed identifying information for all screened newborn Members or mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.

All laboratory specimens collected as a required component of a Texas Health Steps check-up (see Medicaid Provider Procedures Manual for age-specific requirements), must be submitted to the DSHS Laboratory Services Section or to a laboratory approved by the department under Section 33.016 of the Health and Safety Code for analysis unless the Medicaid Provider Procedures Manual provides otherwise. The MCO must educate Providers about Texas Health Steps Program requirements for submitting laboratory tests to the DSHS Laboratory Services Section.

The MCO must make an effort to coordinate and cooperate with existing community and school-based health and education programs that offer services to school-aged children in a location that is both familiar and convenient to the Members. The MCO must educate Providers on the Immunization Standard Requirements set forth in Chapter 161, Health and Safety Code; the standards in the Advisory Committee on Immunization Practices (ACIP) Immunization Schedule and

the DSHS Periodicity Schedule for Medicaid Members. The MCO shall educate Providers that Members must be immunized during the Texas Health Steps checkup according to the DSHS routine immunization schedule. The MCO shall also educate Providers that the screening provider is responsible for administration of the immunization and should not refer children to Local Health Departments to receive immunizations.

The MCO must educate Providers about, and require Providers to comply with, the requirements of Chapter 161, Texas Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac), to include Medical Consenter consent on the Vaccine Information Statement.

An MCO must require all Texas Health Steps Providers to submit claims for services paid on the NSF 837 claim form or CMS 1500 claim form and use the HIPAA compliant code set required by HHSC.

HHSC or its designee will validate Encounter Data by comparing chart review data and Encounter Data for a random sample of Members. HHSC or its designee will conduct chart reviews to validate that all components of the Texas Health Steps checkups are performed when due and as reported, and that reported data are accurate and timely. Substantial deviation between reported and charted Encounter Data could result in the MCO and/or Network Providers being investigated for potential Fraud and Abuse infractions without notice to the MCO or the Provider.

4.1.26.3.1 Oral Evaluation and Fluoride Varnish

Section 4.1.26.3.1 added by Version 1.2

The MCO must educate Providers on the availability of the Oral Evaluation and Fluoride Varnish (OEVS) Medicaid benefit that can be rendered and billed by certified Texas Health Steps providers when performed on the same day as the Texas Health Steps medical check up. The Provider education must include information about how to assist a Member with referral to a dentist to establish a dental home.

4.1.26.4 Perinatal Services

Section 4.1.26.4 modified by Version 1.2

The MCO's perinatal health care services must ensure appropriate care is provided to Members and infant Members from the preconception period through the infant's first year of life. The MCO's perinatal health care system must comply with the requirements of the Texas Health and Safety Code, Chapter 32 (the Maternal and Infant Health Improvement Act) and administrative rules codified at 25 T.A.C. Chapter 37, Subchapter M.

The MCO must have a perinatal health care system in place that, at a minimum, provides the following services:

1. Pregnancy planning and perinatal health promotion and education for reproductive-age women.
2. Perinatal risk assessment of non-pregnant women, pregnant and postpartum women, and infants up to one year of age.
3. Access to appropriate levels of care based on risk assessment, including emergency care.
4. Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary.
5. Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems.
6. Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems.

The MCO must have a process to expedite scheduling a prenatal appointment for an obstetrical exam for a pregnant Member no later than two weeks after the MCO learns of her pregnancy.

The MCO must have procedures in place to contact and assist DFPS Staff, the Medical Consenter or the pregnant/delivering Member in selecting a PCP for her baby as soon as the baby is born.

The MCO must provide inpatient care and professional services relating to labor and delivery for its pregnant/delivering Members, and neonatal care for its newborn Members at the time of delivery

and for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated Caesarian delivery. For newborn Members with medical complications, Medically Necessary Covered Services include, but are not limited to, neonatal intensive care unit services.

For an MCO that is an HMO or EPP, the MCO must adjudicate provider claims for services provided to a newborn Member in accordance with HHSC's claims processing requirements using the proxy ID number or state-issued Medicaid ID number. The MCO cannot deny claims based on a Provider's non-use of state-issued Medicaid ID number for a newborn Member. The MCO must accept Provider claims for newborn services based on mother's name and/or Medicaid ID number with accommodations for multiple births, as specified by the MCO.

The MCO must notify providers involved in the care of pregnant/delivering women and newborns (including Out-of-Network providers and Hospitals) of the MCO's prior authorization requirements. The MCO cannot require a prior authorization for services provided to a pregnant/delivering Member or newborn Member for a medical condition that requires Emergency Services, regardless of when the emergency condition arises.

4.1.26.5 Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV)

Section 4.1.26.5 modified by Versions 1.1 and 1.2

The MCO must provide STD services that include STD/HIV prevention, screening, counseling, diagnosis, and treatment. The MCO is responsible for implementing procedures to ensure that Members have prompt access to appropriate services for STDs, including HIV. The MCO must allow Members access to STD services and HIV diagnosis services without prior authorization or referral by a PCP.

The MCO must comply with Texas Family Code § 32.003, relating to consent to treatment by a child. The MCO must provide all Covered Services required to form the basis for a diagnosis by the Provider as well as the STD/HIV treatment plan.

The MCO must make education available to Providers, Members, Caregivers and Medical Consenters, on the prevention, detection and effective treatment of STDs, including HIV.

The MCO must require Providers to report all confirmed cases of STDs, including HIV, to the local or regional health authority according to 25 T.A.C. §§97.131 - 97.134, using the required forms and procedures for reporting STDs. The MCO must require the Providers to coordinate with the HHSC regional health authority to ensure that Members with confirmed cases of syphilis, chancroid, gonorrhea, chlamydia and HIV receive risk reduction and partner elicitation/notification counseling, as appropriate.

The MCO must have established procedures to make Member records available to public health agencies with authority to conduct disease investigation, receive confidential Member information, and provide follow up activities.

The MCO must require that Providers have procedures in place to protect the confidentiality of Members provided STD/HIV services. These procedures must include, but are not limited to, the manner in which medical records are to be safeguarded, how employees are to protect medical information, and under what conditions information can be shared. The MCO must inform and require its Providers who provide STD/HIV services to comply with all state laws relating to communicable disease reporting requirements. The MCO must implement policies and procedures to monitor Provider compliance with confidentiality requirements.

The MCO must have policies and procedures in place regarding obtaining informed consent and counseling Members provided STD/HIV services. See also **RFP Attachment J** for the DFPS policy related to acquired immune deficiency syndrome (AIDS) and AIDS prevention.

4.1.26.6 Tuberculosis (TB)

Section 4.1.26.6 modified by Version 1.3

The MCO must provide Members, Caregivers, Medical Consenters, and Providers with education on the prevention, detection and effective treatment of tuberculosis (TB). The MCO must develop policies and procedures to ensure that all Members are screened for TB. The MCO must establish mechanisms to ensure all procedures required to screen Members for TB, and to form the basis for a diagnosis and proper prophylaxis and management of TB, are available to all Members, Caregivers and Medical Consenters, except services referenced in RFP Section 4.1.26.8 as Non-capitated Services. The MCO must consult with the local TB control program to ensure that all

services and treatments are in compliance with the guidelines recommended by the American Thoracic Society (ATS), the Centers for Disease Control and Prevention (CDC), and DSHS policies and standards.

The MCO must implement policies and procedures requiring Providers to report all confirmed or suspected cases of TB to the local TB control program within one Business Day of identification, using the most recent DSHS forms and procedures for reporting TB. The MCO must provide access to Member medical records to DSHS and the local TB control program for all confirmed and suspected TB cases upon request.

The MCO must coordinate with the local TB control program to ensure that all Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT). The MCO must require, through contract provisions, that Providers report to DSHS or the local TB control program any Member who is non-compliant, drug resistant, or who is or may be posing a public health threat. The MCO must cooperate with the local TB control program in enforcing the control measures and quarantine procedures contained in Chapter 81 of the Texas Health and Safety Code.

The MCO must have a mechanism for coordinating a post-discharge plan for follow-up DOT with the local TB program. The MCO must coordinate with the DSHS South Texas Health Care System 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.

4.1.26.7 Objection to Provide Certain Services

In accordance with 42 C.F.R. §438.102, the MCO may file an objection to providing, reimbursing for, or providing coverage of, a counseling or referral service for a Covered Service based on moral or religious grounds. The MCO must work with HHSC to develop a work plan to complete the necessary tasks and determine an appropriate date for implementation of the requested changes to the requirements related to Covered Services. The work plan will include timeframes for completing the necessary Contract and waiver amendments, adjustments to Capitation Rates, identification of the MCO and enrollment materials needing revision, and notifications to Members.

In order to meet the requirements of this section, the MCO must notify HHSC of grounds for and provide detail concerning its moral or religious objections and the specific services covered under the objection, no less than 120 days prior to the proposed effective date of the policy change.

4.1.26.8 Medicaid Non-capitated Services

Section 4.1.26.8 modified by Version 1.1

The following Texas Medicaid programs and services have been excluded from MCO Covered Services. Members are eligible to receive these Non-capitated services on a Fee-for-Service basis from Texas Medicaid providers. MCOs should refer to relevant chapters in the **Provider Procedures Manual** and the **Texas Medicaid Bulletins** for more information.

1. Early Childhood Intervention (ECI) Case Management.
2. DSHS Mental Health Targeted Case Management.
3. DSHS Case Management for Children and Pregnant Women.
4. DFPS Targeted Case Management.
5. Texas School Health and Related Services (SHARS).
6. DARS Blind Children's Vocational Discovery and Development Program.
7. Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation).
8. Medicaid Medical Transportation.
9. DADS hospice services (all Members are disenrolled from their health plan upon enrollment into hospice).
10. Audiology services and hearing aids for members through PACT (hearing screening services are provided through the Texas Health Steps Program and are capitated) (Program for Amplification for Children of Texas).
11. Personal Care Services for persons under age 21 are Non-capitated Services.

4.1.26.9 Referrals for Non-capitated Services

Although the MCO is not responsible for paying or reimbursing Non-capitated Services, the MCO is responsible for educating Members, Caregivers, Medical Consenters, and DFPS Staff about the availability of Non-capitated Services, and for providing appropriate referrals for Members,

Caregivers, and Medical Consenters to obtain or access these services. The MCO is responsible for informing Providers that bills for all Non-capitated Services must be submitted to HHSC's Claims Administrator for reimbursement.

4.1.27 Medicaid Significant Traditional Providers

Section 4.1.27 Modified by Versions 1.1 and 1.2

Refer to **Attachment C-2, Section 8** for additional information regarding Modifications to the Proposal.

The MCO must seek participation in its Network from all Significant Traditional Providers (STPs) listed in **RFP Attachment E**. The MCO must also seek participation in its Network from health care providers on contract or subcontract with DFPS. **RFP Attachment M-1** contains a list of DFPS residential providers. DFPS residential providers often have health care providers on contract to provide Medicaid services to the Target Population. These health care providers on contract with DFPS residential providers are considered STPs. **RFP Attachment M-2** contains a list of providers on contract with DFPS to provide evaluation and treatment services. The providers in **RFP Attachment M-2** are also considered STPs.

HHSC defines STPs as:

1. Health care providers on contract with DFPS residential providers.
2. Health care providers on contract with DFPS to provide evaluation and treatment services.

The MCO must provide all types of STPs above the opportunity to participate in its Network on an ongoing basis. Upon the request of a Member or their Caregiver to contract with a particular health care provider, the MCO must make best efforts to recruit that provider into the Network. However, the STP provider must:

1. Agree to accept the MCO's Provider reimbursement rate for the provider type
2. Meet the standard credentialing requirements of the MCO, 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.

The MCO is not obligated to retain STPs in the Provider Network that the MCO has determined to be non-compliant with requirements in the Provider agreement. The MCO must provide documentation on Providers terminated due to non-compliant, upon HHSC's request.

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

Section 4.1.28 modified by Versions 1.0, 1.1, and 1.2

The MCO must make reasonable efforts to include FQHCs and RHCs (freestanding and Hospital-based) in its Provider Network. An MCO that is an HMO or EPP must reimburse FQHCs and , RHCs, and municipal health departments' public clinics for Health Care Services provided outside of regular business hours, (defined under 1 Texas Administrative Code, Part 15, Chapter 353, Subchapter A, §353.2 (51), as time before 8:00 a.m. and after 5:00 p.m. Monday through Friday, weekends, and federal holidays,) at a rate that is equal to the allowable rate for those services as determined under §32.028, Texas Human Resources Code, if the Member does not have a referral from their PCP. Depending on the date of the claim, FQHCs or RHCs may receive a cost settlement from HHSC and must agree to accept initial payments from the MCO in an amount that is equal to or greater than the MCO's payment terms for other Providers providing the same or similar services.

1. **September 1, 2007 to September 1, 2008:** For claims accruing on or after September 1, 2007 but prior to September 1, 2008, The MCO is not required to pay full encounter rates to the FQHCs and RHCs. Therefore, HHSC cost settlements for FQHC's will continue to apply to all STAR Service Areas for this period of time.

2. **On or after September 1, 2008:** The MCO is required to pay the full encounter rates to RHCs for claims accruing on or after September 1, 2008; therefore, HHSC cost settlements will not apply to RHCs for this period of time. However, the MCO is not required to pay the full encounter rates to FQHCs for claims accruing on or after September 1, 2008; therefore, HHSC cost settlements will apply to FQHCs for this period of time.

The MCO must submit monthly FQHC and RHC encounter and payment reports to all contracted FQHCs and RHCs, and FQHCs and RHCs with which there have been encounters, not later than 21 days from the end of the month for which the report is submitted. The format will be developed by HHSC and provided in the **Uniform Managed Care Manual**. The FQHC and RHC must validate the encounter and payment information contained in the report(s). The MCO and the FQHC/RHC must both sign the report(s) after each party agrees that it accurately reflects encounters and payments for the month reported. The MCO must submit the signed FQHC and RHC encounter and payment reports to HHSC not later than 45 days from the end of the reported month. Encounter and payment reports will not be necessary for claims paid to RHCs on or after September 1, 2008, because the HMOs will pay full encounter rates to RHCs for this period of time.

4.1.29 Provider Complaints and Appeals

4.1.29.1 Provider Complaints

The MCO must develop, implement, and maintain a system for tracking and resolving all Provider Complaints. Within this process, the MCO must fully and completely respond to each Complaint and establish a tracking mechanism to document the status and final disposition of each Provider Complaint.

The MCO must resolve Provider Complaints within 30 days from the date the Complaint is received. The MCO is subject to remedies, including liquidated damages, if at least 98 percent of Provider Complaints are not resolved within 30 days of receipt of the Complaint by the HMO.

4.1.29.2 Appeal of Provider Claims

Section 4.1.29.2 modified by Version 1.2

RFP Section 4.1.29.2 applies only to an MCO that is an HMO or EPP. The MCO must develop, implement, and maintain a system for tracking and resolving all Provider Appeals related to claims payment. Within this process, the MCO must respond fully and completely to each provider's claims payment Appeal and establish a tracking mechanism to document the status and final disposition of each provider's claims payment Appeal.

The MCO must negotiate with third party physicians who are not Network Providers to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a Provider Appeal. The determination of the physician resolving the dispute must be binding on the MCO and the Provider. The physician resolving the dispute must hold the same specialty or a related specialty as the appealing Provider and cannot be part of the MCO's Network. HHSC reserves the right to amend this process to include an independent review process established by HHSC for final determination on these disputes.

4.1.30 Member Rights and Responsibilities

Section 4.1.30 modified by Version 1.2

In accordance with 42 C.F.R. §438.100, the MCO must maintain written policies and procedures for informing Members, DFPS Staff, and Medical Consenters of their rights and responsibilities, and right to a Medicaid Fair Hearing separate from the Appeals process. The MCO must notify Members, DFPS Staff, and Medical Consenters of their right to request a copy of these rights and responsibilities. The Member Handbook must include notification of Member, DFPS Staff, and Medical Consenter rights and responsibilities.

4.1.31 Member Complaint and Appeal System

Section 4.1.31 modified by Version 1.2

The MCO must develop, implement, and maintain a Member Complaint and Appeal system that complies with the requirements in applicable federal and state laws, rules and regulations, including 42 C.F.R. §431.200, 42 C.F.R. Part 438, Subpart F, "Grievance System," and the provisions of 1 T.A.C. Chapter 357 relating to Medicaid managed care organizations.

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, DFPS Staff, and Medical Consenters, and must be reviewed and approved in writing by HHSC or its designee. Providers and Caregivers who are not Medical Consenters may file a Complaint or an Appeal on behalf of a Member if authorized by the Medical Consenter. 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.

4.1.31.1 Member Complaint Process

Section 4.1.31.1 modified by Versions 1.2 and 1.3

The MCO must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting and resolving Complaints by Members, DFPS Staff, or Medical Consenters.

The MCO must resolve Complaints within 30 days from the date the Complaint is received. The MCO is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints are not resolved within 30 days of receipt of the Complaint by the MCO. Please see the **HHSC General Contract Terms & Conditions** and **Deliverables/Liquidated Damages Matrix**.

The Complaint procedure must be the same for all Members, DFPS Staff, and Medical Consenters. The Member, DFPS Staff, or Medical Consenter may file a Complaint either orally or in writing. The MCO must also inform Members, DFPS Staff, and Medical Consenters how to file a Complaint directly with HHSC, once the Member, DFPS Staff, or Medical Consenter has exhausted the MCO's Complaint process.

The MCO must designate an officer of the MCO who has primary responsibility for ensuring that Complaints are resolved in compliance with written policy and within the required timeframe. For purposes of this section, an "officer" of the MCO means a president, vice president, secretary, treasurer, or chairperson of the board for a corporation, the sole proprietor, the managing general partner of a partnership, or a person having similar executive authority in the organization.

The MCO must have a routine process to detect patterns of Complaints. Management, supervisory, and Quality Improvement staff must be involved in developing policies and procedures to address Complaints.

The MCO's Complaint procedures must be provided to Members, DFPS Staff, and Medical Consenters in writing and through oral interpretive services. A written description of the MCO's Complaint procedures must be available in Spanish and other prevalent non-English languages for Major Population Groups identified by HHSC, at no more than a 6th grade reading level. The MCO must include a written description of the Complaint process in the Member Handbook. The MCO must maintain 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 MCO's process must require that every Complaint received in person, by telephone, or in writing be acknowledged and recorded in a written record and logged with the following details:

- Date.
- Identification of the individual filing the Complaint.
- Identification of the individual recording the Complaint.
- Nature of the Complaint.
- Disposition of the Complaint (i.e., how the MCO resolved the Complaint).
- Corrective action required.
- Date resolved.

The MCO is prohibited from discriminating or taking punitive action against a Member, DFPS Staff, or Medical Consenter for making a Complaint or filing an Appeal.

The MCO will cooperate with HHSC or its designee to resolve all Member, DFPS Staff, or Medical Consenter Complaints. Such cooperation may include, but is not limited to, providing information or assistance to internal Complaint committees.

The MCO must provide designated Member Advocates to assist Members, DFPS Staff, and Medical Consenters in understanding and using the MCO's Complaint system as described in **RFP Section 4.1.31.** The MCO's Member Advocates must assist Members, DFPS Staff, and Medical Consenters in writing or filing a Complaint and monitoring the Complaint through the MCO's Complaint process until the issue is resolved.

4.1.31.2 Member Pre-Appeal Process

The MCO must develop, implement and maintain a Pre-Appeals process for tracking, resolving, and reporting disputes regarding the potential denial or limited authorization of a requested service, including the type or level of service, and the denial, in whole or in part, of payment for service. The

purpose of this process is to facilitate and expedite the resolution of disputes that may escalate to the point whereby the Member's receipt of services is delayed or impaired. The MCO should make consistent good-faith efforts to reach compromise and resolution, with the goal of resolving the majority of disagreements regarding potential denials or limited authorization of services before they become formal Member Appeals.

The Pre-Appeal Process agreed upon by HHSC, DFPS, and the MCO takes place when upon the review of an authorization request for Member services, Medical Management staff concludes there is either a) insufficient clinical or other information for a Covered Service to be authorized, or b) the available information does not meet the Medical Necessity criteria for the Covered Service. In this case, the MCO's Medical Management staff will contact the requesting Provider's office to determine if additional information is available. If additional information is available and, upon review of such information, the MCO determines that the Covered Service meets Medical Necessity criteria, it will approve the Covered Service within three (3) Business Days of receipt of the service authorization request. If additional information is not available, the request for services is transferred to the Medical Director, or his/her designee, for review.

The Medical Director, or his/her designee, will make at least two (2) attempts to schedule a peer-to-peer review to obtain additional clinical information and/or coordinate to provide acceptable alternative care options. The second attempt to contact the provider will be made no sooner than four (4) business hours after the first attempt. The Medical Director, or his/her designee, will consider any new information presented. In cases where all information relevant to the decision is available and the Covered Service meets Medical Necessity criteria, the requested services will be approved within fifteen (15) days from the date the additional information was requested. If, after all new information is reviewed, the Covered Service still does not meet Medical Necessity criteria, the Medical Management staff will request to obtain all available and necessary information relevant to the Pre-Appeal, by contacting the Member's Medical Consenter, Caregiver, and/or DFPS staff.

If any additional information is obtained and if the requested Covered Service meets Medical Necessity criteria, the MCO's Medical Management staff will approve the services requested within fifteen (15) days from the date it requested the additional information. If the resolution of the Pre-Appeal is to approve the request for a Covered Service, the MCO will give the affected health care provider(s) written notice of the Pre-Appeal resolution on the same day it gives notice to the Member's Medical Consenter. If no additional information is available or if the information provided does not meet Medical Necessity criteria for the Covered Service, the MCO will refer this information back to its Medical Director, or his/her designee, who will issue a final resolution to the Pre-Appeal within 48 hours of receiving the file from the Medical Management staff. The Medical Director, or his/her designee, may reverse a proposed denial, or deny the requested Covered Service with guidance for the provision of acceptable alternative care options. If the resolution of the Pre-Appeal approves the request for the Covered Service, the Medical Management staff will communicate the resolution verbally and in writing to the Medical Consenter for the Member. The MCO will give the affected health care provider(s) written notice of the Pre-Appeal resolution on the same day it gives notice to the Member's Medical Consenter.

4.1.31.3 Standard Member Appeal Process

Section 4.1.31.3 modified by Versions 1.2 and 1.3

The MCO must develop, implement and maintain an Appeal process by which a Member or his or her representative, Medical Consenter or DFPS Staff can request a review of the MCO's Action. This procedure must comply with the state and federal laws, rules and regulations, including 42 C.F.R.§ 431.200 and 42 C.F.R. Part 438, Subpart F, "Grievance System." The Appeal procedure must be the same for all Members, DFPS Staff, and Medical Consenters. When a Member, DFPS Staff, or Medical Consenter expresses orally or in writing any dissatisfaction or disagreement with an Action, the MCO must regard the expression of dissatisfaction as a request to Appeal an Action.

A Member, DFPS Staff, or Medical Consenter must file a request for an Appeal with the MCO within 30 days from receipt of the notice of the Action. The MCO is subject to remedies, including liquidated damages, if at least 98 percent of Appeals are not resolved within 30 days of receipt of the Appeal by the MCO. Please see the **HHSC General Contract Terms & Conditions and Deliverables/Liquidated Damages Matrix.** To ensure continuation of currently authorized services, however, the Member must file the Appeal on or before the later of 10 days following the

MCO's mailing of the notice of the Action, or the intended effective date of the proposed Action. The MCO must designate an officer who has primary responsibility for ensuring that Appeals are resolved in compliance with written policy and within the 30-day time limit.

The provisions of the Texas Insurance Code, Title 14, Chapter 4201, relating to a Member's right to Appeal an Adverse Determination made by the MCO or a Utilization Review agent to an independent review organization, do not apply to a Medicaid recipient. These provisions are pre-empted by Federal Fair Hearings requirements.

The MCO must have policies and procedures in place outlining the Medical Director's role in an Appeal of an Action. The Medical Director must have a significant role in monitoring, investigating and hearing Appeals. In accordance with 42 C.F.R.§ 438.406, the MCO's policies and procedures must require that individuals who make decisions on Appeals are not involved in any previous level of review or decision-making, and are health care professionals who have the appropriate clinical expertise in treating the Member's condition or disease.

The MCO must provide designated Member Advocates, as described in **RFP Section 4.1.31.10**, to assist Members, DFPS Staff, and Medical Consenters in understanding and using the Appeal process. The MCO's Member Advocates must assist Members, DFPS Staff, and Medical Consenters in writing or filing an Appeal and monitoring the Appeal through the MCO's Appeal process until the issue is resolved.

Requirements regarding the MCO's obligation to respond to each Member Appeal, and the timeframes associated with those responses, are identical to the requirements regarding Member Complaints in **RFP Section 4.1.31.1.**

During the Appeal process, the MCO must provide the Member, DFPS Staff, and Medical Consenter a reasonable opportunity to present evidence and any allegations of fact or law in person as well as in writing. The MCO must inform the Member, DFPS Staff, and Medical Consenter of the time available for providing this information and that, in the case of an expedited resolution, limited time will be available.

The MCO must provide the Member, DFPS Staff, and Medical Consenter an opportunity, before and during the Appeal process, to examine the Member's case file, including medical records and any other documents considered during the Appeal process. The MCO must include, as parties to the Appeal, the Member, DFPS Staff, and Medical Consenter, or the legal representative of a deceased Member's estate. The MCO must also seek information and participation from the Caregiver when appropriate.

In accordance with 42 C.F.R.§ 438.420, the MCO must continue 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:

- The Member, DFPS Staff, or Medical Consenter files the Appeal timely as defined in this Contract:
- The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- The Member, DFPS Staff, or Medical Consenter requests an extension of the benefits.

If, at the Member's, DFPS Staff, or Medical Consenter's request, the MCO continues or reinstates the Member's benefits while the Appeal is pending, the benefits must be continued until one of the following occurs:

1. The Member, DFPS Staff, or Medical Consenter withdraws the Appeal;
2. Ten days pass after the MCO mails the notice resolving the Appeal against the Member, unless the Member, DFPS Staff, or Medical Consenter, within the ten day timeframe, has requested a Fair Hearing with continuation of benefits until a Fair Hearing decision can be reached; or
3. A state Fair Hearing officer issues a hearing decision adverse to the Member or the time period or service limits of a previously authorized service have been met.

For an MCO that is an HMO or EPP, by execution of the Contract, the MCO agrees to waive its right under 42 C.F.R.§ 438.420(d), to recover costs from Members, HHSC, DFPS Staff, and Medical Consenters if the final resolution of the Appeal is adverse to the Member and upholds the MCO's Action.

For an MCO that is an HMO or EPP, if the MCO or state Fair Hearing Officer reverses a decision to deny authorization of services and the Member received the disputed services while the Appeal was pending, the MCO is responsible for the payment of services.

If the MCO or state Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires.

4.1.31.4 Expedited MCO Appeals

Section 4.1.31.4 modified by Version 1.2

In accordance with 42 C.F.R. §438.410, the MCO must establish and maintain an expedited review process for Appeals, when the MCO determines (for a request from a Member, DFPS Staff, or Medical Consenter) or the provider indicates (in making the request on the Member's behalf or supporting the Member's, DFPS Staff, or Medical Consenter's request) that taking the time for a standard resolution could seriously jeopardize the Member's life or health. The MCO must follow all Appeal requirements for standard Member Appeals as set forth in **RFP Section 4.1.5.9** and **RFP Section 4.1.5.10**, except where differences are specifically noted. The MCO must accept oral or written requests for Expedited Appeals.

Members, DFPS Staff, and Medical Consenters must exhaust the MCO's Expedited Appeal process before making a request for an expedited Fair Hearing. After the MCO receives the request for an Expedited Appeal, it must hear an approved request for a Member, DFPS Staff, or Medical Consenter to have an Expedited Appeal, and notify the Member, DFPS Staff, or Medical Consenter of the outcome of the Expedited Appeal within three Business Days, except that the MCO must complete investigation and resolution of an Appeal relating to an ongoing emergency or denial of continued hospitalization: (1) in accordance with the medical or dental immediacy of the case; and

(2) not later than one Business Day after receiving the Member's, DFPS Staff, or Medical Consenter'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, DFPS Staff, and Medical Consenter of the outcome of the Expedited Appeal may be extended up to 14 calendar days if the Member, DFPS Staff, or Medical Consenter requests an extension or the MCO shows (to the satisfaction of HHSC, upon HHSC's request) that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, the MCO must give the Member, DFPS Staff, and Medical Consenter written notice of the reason for delay if the Member, DFPS Staff, or Medical Consenter did not request the delay.

If the decision is adverse to the Member, the MCO must follow the procedures relating to the notice in **RFP Section 4.1.31.5**. The MCO is responsible for notifying Member, DFPS Staff, and Medical Consenter of the Member's right to access an expedited Fair Hearing from HHSC. The MCO will be responsible for providing documentation to HHSC and to the Member, DFPS Staff, and Medical Consenter, indicating how the decision was made, prior to HHSC's expedited Fair Hearing.

The MCO is prohibited from discriminating or taking punitive action against a Member, DFPS Staff, or Medical Consenter for requesting an Expedited Appeal. The MCO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a Member's, DFPS Staff's, or Medical Consenter's request.

If the MCO denies a request for expedited resolution of an Appeal, it must:

- Transfer the Appeal to the timeframe for standard resolution.
- Make a reasonable effort to give the Member, DFPS Staff, or Medical Consenter prompt oral notice of the denial, and follow up within two calendar days with a written notice.

4.1.31.5 Access to Fair Hearing for Members

Section 4.1.31.5 modified by Versions 1.1 and 1.2

The MCO must inform Members, DFPS Staff, and Medical Consenters that they have the right to access the Fair Hearing process at any time during the Appeals process provided by the MCO. In the case of an expedited Fair Hearing process, the MCO must inform the Member, DFPS Staff, or Medical Consenter that he or she must first exhaust the MCO's internal Expedited Appeal process prior to filing an Expedited Fair Hearing. The MCO must notify Members, and Medical Consenters that they may be represented by an authorized representative such as DFPS Staff, or a Medical Concenter in the Fair Hearing process.

If a Member requests a Fair Hearing, the MCO will complete the request for Fair Hearing, and submit the form via facsimile to the appropriate Fair Hearings office, within five (5) calendar days of the Member's request for a Fair Hearing.

Within five (5) calendar days of notification that the Fair Hearing is set, the MCO will prepare an evidence packet for submission to the HHSC Fair Hearings staff and send a copy of the packet to the Member. The evidence packet must comply with HHSC's Fair Hearings requirements.

4.1.31.6 Notices of Action and Disposition of Appeals for Members

Section 4.1.31.6 modified by Versions 1.1 and 1.2

The MCO must notify the Member, DFPS Staff, and Medical Consenter, in accordance with 1 T.A.C. Part 15, Chapter 357, whenever the MCO takes an Action. The notice must, at a minimum, include any information required by 1 T.A.C. Part 15, Chapter 357 that relates to an MCO's notice of Action and any information required by 42 C.F.R. §438.404, including but not limited to:

1. The dates, types and amount of service requested;
2. The Action the MCO has taken or intends to take.
3. The reasons for the Action. (If the Action taken is based upon a determination that the requested service is not medically necessary, the HMO must provide an explanation of the medical basis for the decision, application of policy or accepted standards of medical practice to the individuals medical circumstances, in it's notice to the Member.);

4. The Member's, DFPS Staff, and Medical Consenter's right to access the MCO's Appeal process.
5. The procedures by which the Member, DFPS Staff, and Medical Consenter may Appeal the MCO's Action.
6. The circumstances under which expedited resolution is available and how to request it.
7. The circumstances under which a Member may continue to receive benefits pending resolution of the Appeal and how to request that benefits be continued.
8. The date the Action will be taken.
9. A reference to the MCO policies and procedures supporting the MCO's Action.
10. An address where written requests may be sent and a toll-free number that the Member, DFPS Staff, and Medical Consenter can call to request the assistance of a Member representative, file an Appeal, or request a Fair Hearing.
11. An explanation that Members, DFPS Staff, and Medical Consenters may represent themselves, or be represented by a provider, legal counsel.
12. A statement that if the Member, DFPS Staff, and Medical Consenter wants a Fair Hearing on the Action, the Member, DFPS Staff, or Medical Consenter must make the request for a Fair Hearing within 90 days of the date on the notice or the right to request a hearing is waived.
13. A statement explaining that the MCO must make its decision within 30 days from the date the Appeal is received by the MCO, or three Business Days in the case of an Expedited Appeal.
14. A statement explaining that the hearing officer must make a final decision within 90 days from the date a Fair Hearing is requested.

4.1.31.7 Timeframe for Notice of Action

Section 4.1.31.7 modified by Version 1.2

In accordance with 42 C.F.R.§ 438.404(c), the MCO must mail a notice of Action within the following timeframes:

- For termination, suspension, or reduction of previously authorized Medicaid Covered Services, within the timeframes specified in 42 C.F.R.§§ 431.211, 431.213, and 431.214.
- For denial of payment, at the time of any Action affecting the claim (applicable to MCOs that are HMO or EPP only).
- For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R.§ 438.210(d)(1).

If the MCO extends the timeframe in accordance with 42 C.F.R. §438.210(d)(1), it must:

- Give the Member, DFPS Staff, and Medical Consenter written notice of the reason for the decision to extend the timeframe and inform the Member, DFPS Staff, and Medical Consenter of the right to file an Appeal if he or she disagrees with that decision.
- Issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.
- For service authorization decisions not reached within the timeframes specified in 42 C.F.R.§ 438.210(d) (which constitutes a denial and is thus an adverse Action), on the date that the timeframes expire.
- For expedited service authorization decisions, within the timeframes specified in 42 C.F.R. 438.210(d).

4.1.31.8 Notice of Disposition of Appeal

In accordance with 42 C.F.R.§ 438.408(e), the MCO must provide written notice of disposition of all Appeals including Expedited Appeals. The written resolution notice must include the results and date of the Appeal resolution. For decisions not wholly in the Member's favor, the notice must contain all of the following:

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. Any other information required by 1 T.A.C. Part 15, Chapter 357 that relates to a managed care organization's notice of disposition of an Appeal.

4.1.31.9 Timeframe for Notice of Resolution of Appeals

Section 4.1.31.9 modified by Version 1.2

In accordance with 42 C.F.R.§ 438.408, the MCO 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 MCO must make reasonable efforts to give the Member, DFPS Staff, and Medical Consenter 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 MCO denies a request for expedited resolution of an Appeal, the MCO must transfer the Appeal to the timeframe for standard resolution as provided in this Section, and make reasonable efforts to give the Member, DFPS Staff, or Medical Consenter prompt oral notice of the denial, and follow up within two calendar days with a written notice.

4.1.31.10 Member Advocates

Section 4.1.31.10 Modified by Versions 1.1, 1.2, and 1.3

The MCO must provide Member Advocates to assist Members, DFPS Staff, and Medical Consenters. Member Advocates may be Service Managers (or other MCO staff) as long as they meet Contract requirements for serving as Member Advocates. Member Advocates must be physically located within the State of Texas. Member Advocates must inform Members, DFPS Staff, and Medical Consenters of the following:

- Their rights and responsibilities.
- The Complaint process.
- The Appeal process.

- Covered Services available to them, including preventive services.
- Availability of and access to Non-capitated Services.

Member Advocates must assist Members, DFPS Staff, and Medical Consenters in writing Complaints and are responsible for monitoring the Complaint through the MCO's Complaint process.

Member Advocates are responsible for making recommendations to management on any changes needed to improve either the care provided or the way care is delivered. Member Advocates are also responsible for identifying and referring Members, DFPS Staff, and Medical Consenters to community resources available to meet Members' needs that are not available from the MCO as Covered Services.

4.1.32 Third-Party Liability and Recovery

Section 4.1.32 Modified by Version 1.2

This subsection applies only to an MCO that is an HMO or EPP. The MCO is responsible for establishing a plan and process for recovering costs for services that should have been paid through a third party in accordance with state and federal law and regulations. To recognize this requirement, Capitation Payments to the MCO are reduced by the projected amount of TPR that the MCO is expected to recover. Third-Party Recovery should be sought in the following instances only:

1. In cases of tort, the MCO will pay the claim and follow the established process for Third Party Recovery.
2. In cases where health care coverage was required of a biological parent by an order of the court, the MCO will cost avoid and deny the claim for other insurance ~~and~~ or, if the claim is already paid, pursue Third Party Recovery.

The MCO must provide required reports as stated in **RFP Section 4.1.21.1,** Financial Reporting Requirements.

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

The MCO shall provide a Member quarterly file, that contains the following information if available to the MCO: the Member name, address, claim submission address, group number, employer's mailing address, social security number, and date of birth for each subscriber or policyholder and each dependent of the subscriber or policyholder covered by the insurer. The file shall be used for the purpose of matching the HHSC Texas Medicaid eligibility file against the MCO Member file to identify Members for whom third party resources may be available and for whom information about potential third party resources may not have been known by the Medicaid Program.

4.1.33 Advance Directives

Section 4.1.33 modified by Versions 1.1 and 1.2

Federal and state law require MCOs and providers to maintain written policies and procedures for informing all Members 18 years of age and older about their rights to refuse, withhold or withdraw medical treatment and mental health treatment through advance directives (see Social Security Act §1902(a)(57) and §1903(m)(1)(A). Also see **RFP Attachment I**, DFPS Policy on Withdrawal of Life Support. The MCO's policies and procedures must include written notification to Members 18 years of age and older and comply with provisions contained in 42 C.F.R. § 489, Subpart I, relating to advance directives for all Hospitals, critical access Hospitals, skilled nursing facilities, home health agencies, providers of home health care, providers of personal care services and hospices, as well as the following state laws, rules and regulations:

1. A Member's right to self-determination in making health care decisions.
2. The Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:
    a) A Member's right to execute an advance written directive to physicians and family or surrogates, or to make a non-written directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition.
    b) A Member's right to make written and non-written out-of-Hospital do-not-resuscitate (DNR) orders.

c) A Member's right to execute a Medical Power of Attorney to appoint an agent to make health care decisions on the Member's behalf if the Member becomes incompetent.

3. The Declaration for Mental Health Treatment, Chapter 137, Texas Civil Practice and Remedies Code, which includes: a Member's right to execute a Declaration for Mental Health Treatment in a document making a declaration of preferences or instructions regarding mental health treatment.

The MCO must maintain written policies for Providers to follow regarding receiving and documenting consent from the DFPS individual authorized to provide medical consent prior to implementing a Member's advance directive. Those policies must include a clear and precise statement of limitation if the Provider cannot or will not implement a Member's advance directive.

The MCO cannot require a Member to execute or issue an advance directive as a condition of receiving Health Care Services. The MCO cannot discriminate against a Member based on whether or not the Member has executed or issued an advance directive.

The MCO's policies and procedures must require the MCO and Subcontractors to comply with the requirements of state and federal law and DPFS policies relating to advance directives. The MCO must provide education and training to employees and Members, Caregivers and Medical Consenters on issues concerning advance directives.

All materials provided to Members regarding advance directives must be written at a 7^{th} - 8^{th} 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 7^{th} - 8^{th} grade reading level because it is a reference to the law or is required to be included "as written" in the state or federal law.

The MCO must notify Members, Medical Consenters, DFPS staff, and Caregivers 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.

4.1.34 Performance Incentives and Disincentives

Section 4.1.34 modified by Version 1.1

This section describes performance incentives and disincentives related to HHSC's value-based purchasing approach. HHSC provides several financial and non-financial performance incentives and disincentives through this Contract. These incentives and disincentives are subject to change by HHSC over the course of the Contract Term. The methodologies required to implement these strategies will be refined by HHSC with input from the MCO. The MCO is prohibited from passing down financial disincentives and/or sanctions imposed on the MCO to health care providers, except on an individual basis and related to the individual provider's inadequate performance. For further information, the MCO should refer to the **General Terms and Conditions** and the **Uniform Managed Care Manual**.

4.1.34.1 Non-financial Incentives: Posted Performance Results

Section 4.1.34.1 modified by Version 1.1

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

4.1.34.2 Financial Incentives and Disincentives

4.1.34.2.1 Experience Rebate Reward

Section 4.1.34.2.1 modified by Version 1.2

RFP Section 4.1.34.2.1 applies only to an MCO that is an HMO or EPP. HHSC historically has required contracted HMOs to provide HHSC with an Experience Rebate (see the **General Contract Terms and Conditions, Article 10**) when there has been an aggregate excess of Revenues over Allowable Expenses. During the Contract Period, should the MCO experience an aggregate excess of Revenues over Allowable Expenses, HHSC will allow the MCO to retain that portion of the aggregate excess of Revenues over Allowable Expenses that is equal to or less than 2.5 percent of the total Revenue for the period should the MCO demonstrate superior performance on selected

performance indicators. The retention of 2.5 percent of Revenue exceeds the retention of 2.0 percent of Revenue that would otherwise be afforded to the MCO without demonstrated superior performance on these performance indicators. HHSC will develop the methodology for determining the level of performance necessary for the MCO to retain the additional 0.5 percent of Revenue after consultation with the MCO. The finalized methodology will be added to the **Uniform Managed Care Manual**.

HHSC will calculate whether the MCO is eligible for the Experience Rebate Reward prior to the first SFY Financial Statistical Report (FSR) filing.

HHSC anticipates that it will not implement the Experience Rebate Reward incentive for Rate Period 1 of the Contract. HHSC will invite MCO comments on potential approaches prior to implementation of the new performance-based Experience Rebate Reward.

4.1.34.2.2 Intentionally Left Blank

Section 4.1.34.2.2 modified by Version 1.1 and deleted by Version 1.3

4.1.34.3 Intentionally Left Blank

Section 4.1.34.3 modified by Versions 1.1 and 1.2, and deleted by version 1.3

4.1.34.4 Remedies and Liquidated Damages

All areas of responsibility and all requirements of the MCO in the Contract will be subject to performance evaluation by HHSC. Any and all responsibilities or requirements not fulfilled may have remedies, and HHSC may assess damages, including liquidated damages. Refer to **HHSC's General Contract Terms and Conditions** and **Deliverables/Liquidated Damages Matrix** for performance standards that carry liquidated damage values.

4.1.34.5 Additional Incentives and Disincentives

Section 4.1.35.5 added by Version 1.1

HHSC will evaluate all performance-based incentives and disincentive methodologies annually and in consultation from the MCO. HHSC may then modify the methodologies as needed, as funds

become available, or as mandated by court decree, statute, or rule in an effort to motivate, recognize, and reward the MCO for performance.

Information about the data collection period to be used, performance indicators selected or developed, or MCO ranking methodologies used for any specific time period will be found in the **HHSC Uniform Managed Care Manual**.

4.1.34.6 Frew Incentives and Disincentives

Section 4.1.35.6 added by Version 1.4

As required by the Frew vs. Hawkins Corrective Action Order: Managed Care, this Contract includes a system of incentives and disincentives associated with the Medicaid Managed Care Texas Health Steps Medical Checkups Reports. These incentives and disincentives apply to the MCO.

The incentives and disincentives and corresponding methodology are set forth in the Uniform Managed Care Manual.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Version 1.0	n/a	February 23, 2007	Initial version of Attachment B-1, RFP Section 5. Includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2008	Contract Amendment did not revise Attachment B-1, RFP Section 5 "Turnover Requirements"
Revision	1.2	September 1, 2008	Contract Amendment did not revise Attachment B-1, RFP Section 5 "Turnover Requirements"
Revision	1.3	June 1, 2009	Contract Amendment did not revise Attachment B-1, RFP Section 5 "Turnover Requirements"
Revision	1.4	September 1, 2009	Contract Amendment did not revise Attachment B-1, RFP Section 5 "Turnover Requirements"

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

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

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

5 TURNOVER REQUIREMENTS

5.1 Introduction

Turnover is defined as the activities the MCO must perform upon termination of the Contract, including the transition of Contract operations to HHSC or a subsequent contractor. During Turnover, the MCO must ensure that HHSC, Members and other stakeholders in the Model do not experience any adverse impact from the transfer of services.

5.2 Transfer of Data and Information

The MCO must transfer to HHSC or a subsequent contractor all data and information necessary to transition operations, including: data and reference tables; data entry software; 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 MCO's system(s) to the replacement system(s) of HHSC or a successor contractor, including a comprehensive data dictionary as defined by HHSC.
2. 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 MCO using its best efforts to ensure the efficient administration of the Model. 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 MCO.

5.3 Turnover Services

Six months prior to the end of the Initial Contract Period, including any extensions to such Contract Period, the MCO must propose a Turnover Plan. If HHSC terminates the Contract prior to the expiration of the Initial Contract Period, then HHSC may require the MCO 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 tasks. The Turnover Plan describes MCO'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 MCO during the transition to a subsequent health plan or provider;
2. Cooperation with HHSC and the subsequent health plan or provider in notifying Members of the transition , as requested and in the form required or approved by HHSC; and

3. Cooperation with HHSC and the subsequent health plan or provider in transferring information to the subsequent health plan or provider, 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 MCO's approach and schedule for the transfer of data and information, as described above.
2. The quality assurance process that the MCO will use to monitor Turnover activities.
3. The MCO's approach to training HHSC or a subsequent contractor's staff in the operation of its business processes.

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

5.4 Post-Turnover Services

Thirty (30) days following Turnover of operations, the MCO must provide HHSC with a Turnover results report documenting the completion and results of each step of the Turnover Plan. Turnover will not be considered complete until this document is approved by HHSC.

If the MCO does not provide the required data or information necessary for HHSC or the subsequent contractor to assume the operational activities successfully, the MCO agrees to reimburse HHSC for all reasonable costs and expenses, including, 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 23, 2007	Initial version of Attachment B-2, Covered Services. Includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2008	Contract Amendment did not revise Attachment B-2 Covered Services
Revision	1.2	September 1, 2008	Attachment B-2 has been modified to delete references to PIHP or ANHC. Attachment B-2 is modified to add additional covered services resulting from the Frew Settlement.
Revision	1.3	June 1, 2009	Contract Amendment did not revise Attachment B-2 Covered Services
Revision	1.4	September 1, 2009	All references to “check-ups” are changed to “checkups” Attachment B-2 is amended to remove “birthing center services” and add “Birthing services provided by a certified nurse midwife in a birthing center”; and to clarify age range for Oral evaluation and fluoride varnish in the Medical Home.

[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.

COVERED SERVICES

The following is a non-exhaustive, high-level listing of Services included in the Model.

Modified by Versions 1.2 and 1.4

The MCO will be responsible for providinga benefit package to Members that includes all Medically Necessary services covered under the traditional, fee-for-service Medicaid program except for Non-capitated Services listed in **Section 4.1.26.8** of the RFP. The MCO must coordinate care for Members for these Non-capitated Services so that Members have access to a full range of Medically Necessary Medicaid services. If the MCO is an HMO, EPP or ANHC, it may elect to offer additional Value-added Services.

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.)

The services listed in this Appendix are subject to modification based on Federal and State laws and regulations and Program policy updates.

Covered Services include:

- Ambulance services
- Attendant care services currently provided in Fee-for-Service through the Primary Home Care Program operated by the Department on Aging and Disability Services (DADS)
- Behavioral Health Services, including:
  - Inpatient and outpatient mental health services, including mental health rehabilitative services
  - Outpatient chemical dependency services
  - Detoxification services
  - Psychiatry services
- Birthing services provided by a certified nurse midwife in a birthing center
- Chiropractic services
- Dental services
  - Support of the First Dental Home strategic initiative for Texas Health Steps children 6 through 35 months of age.
- Dialysis
- Durable medical equipment and supplies
- Emergency Services
- Family planning services
- Home health care services
- Hospital services, including inpatient and outpatient
- Laboratory
- Medical checkups and Comprehensive Care Program Services through the Texas Health Steps Program (EPSDT)
  - Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical check up for children 6 months through 35 months of age.
- Optometry, glasses and contact lenses
- Prescription drugs and products (optional)
- Podiatry

- Prenatal care
- Primary care services
- Radiology, imaging, and X-rays
- Specialty physician services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	February 23, 2007	Initial version of Attachment B-3, Value-added Services. Includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2008	Attachment B-3 is modified to add a cross reference to Attachment C-2, Agreed Modifications to the Proposal.
Revision	1.2	September 1, 2008	Attachment B-3 is modified to change the operational start date in the template.
Revision	13	June 1, 2009	Attachment B-3 is modified to delete the cross reference to Attachment C-2, Agreed Modifications to the Proposal.
Revision	1.4	September 1, 2009	Contract amendment did not revise Attachment B-3, STAR Health Value Added Services

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

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

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

ATTACHMENT B-3: VALUE-ADDED SERVICES
September 1, 2009 – August 31, 2010

MCO: Superior HealthPlan Network

PROGRAM: Foster Care

SERVICE AREA(S): Statewide

Attachment B-3 Modified by Versions 1.1, 1.2, and 1.3

Value-added Services			
Value-added Service	**Description of Value-added Services and Members Eligible to Receive the Services**	**Limitations or Restrictions**	**Provider(s) responsible for providing this service**
Care Grants	Small grants to Members to pay for wrap-around services identified and included in the Health Care Service Plan. This benefit will be available to all Members as authorized and as funds are available.	$150,000 total for all care grants This benefit must be authorized by a Superior Network staff member as a part of the Health Care Service Plan.	Superior Network will utilize a variety of vendors to obtain these items.
Transportation	Transportation via bus, van or cab when Medical Transportation Program services are not readily available. This benefit will be available to all Members as authorized by Superior Network.	This benefit must be authorized by a Superior Network staff member.	Public and private transportation services.

ADDITIONAL INFORMATION:

1. Explain how and when Providers and Members will be notified about the availability of the value-added services to be provided.

Providers will be notified through the Provider Manual and during trainings sessions. Members will be notified through the Member Handbook, during orientations, or through Superior Network staff such as Service Managers and Service Coordinators. Periodically, Superior Network will also highlight these services in the Provider and Member Newsletters.

2. Describe how a Member may obtain or access the value-added services to be provided.

Members may access this service through a referral from a Provider, DFPS worker, Service Manager, Service Coordinator, CONNECTIONS Representative, Member Advocate, or Member Services Representative.

3. Describe how the MCO will identify the Value-added Service in administrative (encounter) data.

Through an administrative tracking system created by Superior Network.

4. By signing the Contract and/or Contract Amendment MCO certifies that it will provide the approved Value-added Services described herein from September 1, 2009 through August 31, 2010.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Version 1.0	n/a	February 23, 2007	Initial version of Attachment B-4, Performance Improvement Goals. Includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2008	Contract Amendment did not revise Attachment B-4 Performance Improvement Goals
Revision	1.2	September 1, 2008	Attachment B-4 is modified to reflect correct start date of SFY 2010.
Revision	1.3	June 1, 2009	Contract Amendment did not revise Attachment B-4 Performance Improvement Goals
Revision	1.4	September 1, 2009	Revised Attachment B-4, to add newly negotiated FY2010 Performance Improvement Goals.

Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions
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.
Brief description of the changes to the document made in the revision.

Texas Health and Human Services Commission
STAR Health Performance Improvement Goal Template
State Fiscal Year 2010
(September 1, 2009 – August 31, 2010)

Modified by Version 1.4

A. Health Plan Information	
Plan Name: Superior HealthPlan Network **HMO Program:** STAR Health **HMO Service Delivery Area:** Texas	
B. Overarching Goal	**C. Sub Goals:**
Goal 1: Improve Access to Primary Care Services for Members	▪ The percent of Primary Care Providers (PCPs), that provide services to members age 0-21, who maintain an open panel will increase by 5 percentage points by year-end. ▪ The percent of Members, ages 0-12, who have access to at least two Pediatricians with open panels within 30 miles will increase by 2 percentage points over baseline by year-end.
Goal 2: Improve Access to Behavioral Health Services for Members	▪ The percent of Members, ages 3-21, who have access to at least two outpatient behavioral health providers within 30 miles will increase by 4 percentage points over baseline by year-end. ▪ Decrease the percent of Member re-admissions that occur within 30 days of discharge from a facility following an inpatient hospitalization with a mental health diagnosis by 3 percentage points below the baseline.
Goal 3: Improve Quality/Access to Dental Services	▪ The percent of Members age 6 months to 21 years who have access to a general dentist within 30 miles will increase by 2 percentage points over baseline by year-end. ▪ The number of Members, ages 6 months to 21 years, receiving two unique preventative dental services during the reporting period will increase by 10 percentage points by year-end.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Version 1.0	n/a	February 23, 2007	Initial version of Attachment B-5, Deliverables/Liquidated Damages/Tailored Remedies Matrix. Includes all modifications negotiated by the Parties.
Revision	1.1	March 1, 2008	Contract Amendment did not revise Attachment B-5, Deliverables/Liquidated Damages/Tailored Remedies Matrix
Revision	1.2	September 1, 2008	Item 1 is modified to change date to reflect April 1, 2008 Operational start date. Item 9, Performance Standard Column is modified to add requirement to pay interest owed the provider on the same date that the claim is adjudicated. Item 10, Performance Standard Column is modified to add “by claim type” and change the amount to $5,000. Item 10, Measurement Assessment Column is modified to add “by claim type”. Item 11, Performance Standard Column is modified to add “by claim type”. Item 11, Measurement Assessment Column is modified to add “by claim type”. Item 15, Performance Standard Column is modified to change amount to $1,000. Item 18, General Requirement: Failure to Perform an Administrative Service is added. Item 19, General Requirement: Failure to Provide a Covered Service is added.
Revision	1.3	June 1, 2009	Items 9, 10, and 11 are modified to remove references to ANHC.

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.

			Item 20 RFP § 4.1.4.11 Provider Hotline is added. Item 21 RFP § 4.1.5.6 Nurse and Member Hotline Requirements is added. Item 22 RFP § 4.1.18.4 Behavioral Health Hotline Requirements is added.
Revision	1.4	September 1, 2009	Item 23 RFP §4.1.22.1 Encounter Data is added

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

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/Tailored Remedies Matrix

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
1	RFP § 3 Transition Phase Requirements RFP §4 Operations Phase Requirements and General Scope of Work Item 1 modified by Version 1.2	The MCO must be operational no later than the April 1, 2008 Operations Start Date. HHSC, or its agent, will determine when the MCO is considered to be operational based on the requirements in Section 3, Transition Phase Requirements and Section 4, Operations Phase Requirements and General Scope of Work.	Transition Period Operations Period	Each calendar day, or portion thereof, of non-compliance.	HHSC may assess up to $10,000 per calendar day, or portion thereof, for each day beyond the Operations Start date that the MCO is not operational until the day that the MCO is operational.
2	RFP § 3 Transition Phase Requirements 3.4.4 Systems Readiness Review Item 2 modified by Version 1.0	The MCO must submit to HHSC or to the designated Readiness Review Contractor the following plans for review at the onset of Readiness Review and no later than 10 Business Days following HHSC's written request: • Joint Interface Plan; • Disaster Recovery Plan; • Business Continuity Plan; • Risk Management Plan; and • Systems Quality Assurance Plan.	Transition Period	Each calendar day or portion thereof of non-compliance, per report.	HHSC may assess up to $1,000 per calendar day or portion thereof per deliverable that is late, inaccurate or incomplete.

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
3	RFP § 3 Transition Phase Requirements 3.4.5 Operations Readiness (9) Uniform Managed Care Manual	Final versions of the Provider Directory must be submitted to the Enrollment Broker no later than 90 calendar days prior to the Operational Start Date.	Transition Period	Each calendar day, or portion thereof, of non-compliance.	HHSC may assess up to $1,000 per calendar day, or portion thereof, for each day that the directory is late, inaccurate, or incomplete.
4	RFP § 4 Operational Phase Requirements and Scope of Work 4.1.21.1 Financial Reporting Requirements 4.1.24.2 Reports Uniform Managed Care Manual	All reports and deliverables as specified in Section 4, Operational Phase Requirements and Scope of Work, must be submitted according to the timeframes and requirements stated in the Contract (including all attachments), and HHSC's Uniform Managed Care Manual. (Specific Reports or deliverables listed separately in this matrix are subject to the specified liquidated damages.)	Transition Period Operations Period Turnover Period	Each calendar day, or portion thereof, of non-compliance.	HHSC may assess up to $250 per calendar day, or portion thereof, per report/deliverable that is late, inaccurate, or incomplete.
5	RFP § 4 Operational Phase Requirements and Scope of Work 4.1.21.1 Financial Reporting Requirements Uniform Managed Care Manual	Financial Statistical Report (FSR**)**: The MCO must file quarterly FSRs and annual SFY FSRs. Quarterly reports are due no later than 30 days after the conclusion of each State Fiscal Quarter (SFQ). The first annual SFY FSR report is due no later than 120 days after the end of the State Fiscal Year, and the subsequent annual reports are	Operations Period Turnover Period	Per calendar day, or portion thereof, of non-compliance.	HHSC may assess up to $1,000 per calendar day, or portion thereof, per FSR that is late, inaccurate, or incomplete.

Item 3 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
		due no later than 365 days after the end of the State Fiscal Year.			
6	RFP § 4 Operational Phase Requirements and Scope of Work 4.1.21.1 Financial Reporting Requirements Uniform Managed Care Manual	Medicaid Disproportionate Share Hospital (DSH) Reports: The MCO must submit, on an annual basis, preliminary and final DSH Reports. The preliminary report is due no later than June 1 of the year following the SFY, and the final report is due no later than July 15 of the year following the SFY**.**	Operations Period Turnover Period	Per calendar day, or portion thereof, of non-compliance.	HHSC may assess up to $1,000 per calendar day, or portion thereof, per report that is late, incorrect, inaccurate, or incomplete.
7	RFP § 4 Operational Phase Requirements and Scope of Work 4.1.22. Management Information System Requirements Uniform Managed Care Manual	The MCO's MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan.	Operations Period Turnover Period	Per calendar day, or portion thereof, of non-compliance.	HHSC may assess up to $5,000 per calendar day, or portion thereof, that the system is not operational after the 72-hour timeframe has passed.
8	RFP§ 3 Transition Phase Requirement 3.4.3.1 Systems Testing and Transfer of Data 3.4.4.1 Demonstration and Assessment of Systems	After the Operational Start Date, the MCO's MIS system must meet all requirements in Sections 3, Transition Phase Requirements and Section 4, Operational Phase Requirements and Scope of Work.	Operations Period Turnover Period	Per calendar day, or portion thereof, of non-compliance.	HHSC may assess up to $5,000 per calendar day, or portion thereof, for 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.

#	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
	Readiness 3.4.6 Assurance of Systems and Operational Readiness RFP § 4 Operational Phase Requirements and Scope of Work 4.1.12 Health Passport 4.1.22 Management Information System Requirements Uniform Managed Care Manual				
9	RFP § 4 Operational Phase Requirements and Scope of Work 4.1.22.5 Claims Processing Requirements Uniform Managed Care Manual Item 9 modified by Versions 1.2 and 1.3	The MCO must adjudicate all provider Clean Claims within 30 days of receipt. The MCO must pay providers interest at an 18% per annum rate, calculated daily for the full period in which the Clean Claim remains unadjudicated beyond the 30-day claims processing deadline. Interest owed the provider must be paid on the same date that the claim is adjudicated.	Operations Period Turnover Period	Per incident of non-compliance.	HHSC may assess up to $1,000 per claim, if the HMO or EPP fails to timely pay interest.
10	RFP § 4 Operational	The HMO or EPP must comply	Operations	Per quarterly reporting	HHSC may assess liquidated

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
	Phase Requirements and Scope of Work 4.1.22.5 Claims Processing Requirements Uniform Managed Care Manual Item 10 modified by Versions 1.2 and 1.3	with the aggregate claims processing requirements and standards as described in Section 4.1.22.5 and the Uniform Managed Care Manual.	Period Turnover Period	period, per claim type.	damages of up to $5,000 for the first quarter that the MCO's Claims Performance percentages by claim type fall below the performance standards. HHSC may assess up to $25,000 per quarter for each additional quarter that the Claims Performance percentages by claim type fall below the performance standards.
11	RFP § 4 Operational Phase Requirements and Scope of Work 4.1.24.2 Reports Claims Summary Report Uniform Managed Care Manual Item 11 modified by Versions 1.2 and 1.3	All Claims Summary Report: The HMO or EPP must submit quarterly, noncumulative-Claims Summary Reports to HHSC by claim type no later than 30 days after each quarterly reporting period.	Operations Period Turnover Period	Per calendar day, or portion thereof, of non-compliance, per claim type.	HHSC may assess up to $1,000 per calendar day, or portion thereof, per report is late, inaccurate, or incomplete.
12	RFP § 4 Operational Phase Requirements and Scope of Work 4.1.31.1 Member Complaint Process	The MCO must resolve at least 98% of Member Complaints within 30 calendar days, from the date the Complaint is received by the MCO.	Operations Period Turnover Period	Per reporting period.	HHSC may assess up to $250 per reporting period the MCO fails to meet the Member Complaint resolution performance standard.
13	RFP § 4 Operational Phase Requirements and	The MCO must resolve at least 98% of Member Appeals within 30	Operations Period	Per reporting period.	HHSC may assess up to $500 per quarterly reporting period if the

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
	Scope of Work 4.1.31.3 Standard Member Appeal Process	calendar days from the date the Appeal is filed with the MCO.	Turnover Period		MCO fails to meet the Member Appeals resolution performance standard.
14	RFP §5 Turnover Requirements 5.2 Transfer of Data and Information 5.3 Turnover Services	The MCO must transfer to HHSC, or a subsequent contractor, all data and information necessary to transition operations by the date included in the HHSC-approved Turnover Plan.	Operations Period Turnover Period	Per incident of non-compliance.	HHSC may assess up to $10,000 per calendar day, or portion thereof, that the data is late, inaccurate, or incomplete.
15	RFP §5 Turnover Requirements 5.3 Turnover Services Item 15 modified by Version 1.2	Six months prior to the end of the Initial Contract Period, including any extensions to such Period, the MCO must propose a Turnover Plan. If HHSC terminates the Contract prior to the expiration of the Initial Contract Period, then HHSC may require the MCO to propose the Turnover Plan sooner than six months prior to the termination date.	Operations Period	Each calendar day, or portion thereof, of non-compliance.	HHSC may assess up to $1,000 per calendar day, or portion thereof, that the Turnover Plan is late, inaccurate, or incomplete.
16	RFP §5 Turnover Requirements 5.4 Post-Turnover Services	The MCO must provide HHSC with a Turnover Results report documenting the completion and results of each step of the Turnover Plan 30 days after the	Turnover Period	Each calendar day, or portion thereof, of non-compliance.	HHSC may assess up to $250 per calendar day, or portion thereof, that the report is late, inaccurate, or incomplete.

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
		Turnover of Operations.			
17	General Terms and Conditions Article 4 Section 4.09 Subcontractors	The MCO must notify HHSC in writing within 3 business days upon 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 Period Operations Period Turnover Period	Each calendar day, or portion thereof, of non-compliance.	HHSC may assess up to $5,000 per calendar day, or portion thereof, of non-compliance.
18	General Requirement: Failure to Perform an Administrative Service General Terms and Conditions, RFP §§ 1, 2, 3, 4, and 5 Item 18 Added by Version 1.12	The HMO fails to timely perform an HMO 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.	Ongoing	Each incident of non-compliance per HMO Program and SA.	HHSC may assess up to $5,000.00 per calendar day for each incident of non-compliance per HMO Program and SA.
19	General Requirement: Failure to Provide a Covered Service General Terms and Conditions, Item 19 Added by Version 1.2	The HMO fails to timely provide a HMO Covered Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, such failure results in	Ongoing	Each calendar day of non-compliance	HHSC may assess up to $ 7,500.00 per day for each incident of non-compliance.

erived 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 §§ 1, 2, 3, 4, and 5	actual harm to a Member or places a Member at risk of imminent harm.			
20	RFP § 4.1.4.11 Provider Hotline Item 20 Added by Version 1.3	A: The MCO must operate a toll-free telephone line for Provider inquiries from 8 a.m. to 5 p.m. local time for all areas of the state, Monday through Friday, except for state-approved holidays. B: The MCO must ensure that the Provider Hotline meets the following minimum performance requirements: 1. Ninety-nine percent 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 call abandonment rate is seven percent or less. C. Average hold time is 2 minutes or less.	Operations Period Turnover Period	A. Each incident of non-compliance B. Per month, each percentage point below the standard for 1 and 2, each percentage point above standard for 3 C. Per month, for each 30 second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time.	HHSC may assess: A. Up to $100.00 for each hour or portion thereof that appropriately staffed toll-free lines are not operational. If the MCO's failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the MCO fails to implement its Disaster Recovery Plan. B. Up to $100.00 for each percentage point for each standard that the MCO fails to meet the requirements for a monthly reporting period for any MCO operated toll-free lines. C. Up to $100.00 for each 30 second time increment, or portion thereof, by which the MCO's average hold time exceeds the maximum acceptable hold time.
21	RFP § 4.1.5.6 Nurse and Member Hotline	A: The MCO must operate a toll-free Nurse Hotline that Providers,	Operations Period	A. Per hotline, each incident of non-	HHSC may assess: A. Per hotline, up to $100.00 for

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
	Requirements Item 21 Added by Version 1.3	Members, DFPS Staff, Caregivers, and Medical Consenters can call 24 hours a day, seven days a week. In addition, the MCO must operate a toll-free Member Hotline that Members, DFPS Staff, Caregivers and Medical Consenters can call 24 hours a day, seven (7) days a week. B: The MCO must ensure that the Nurse and Member Hotlines meet the following minimum performance requirements: 1. At least 99 percent of calls are answered by the fourth ring or an automated call pickup system. 2. At least 80 percent of calls must be answered by toll-free line staff within 30 seconds. 3. The call abandonment rate is seven percent or less. C. Average hold time is 2 minutes or less.	Turnover Period	compliance B. Per hotline, per month, each percentage point below the standard for 1 and 2, each percentage point above standard for 3 C. Per month, for each 30 second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time.	each hour or portion thereof that appropriately staffed toll-free lines are not operational. If the MCO's failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the MCO fails to implement its Disaster Recovery Plan. B. Per hotline, up to $100.00 for each percentage point for each standard that the MCO fails to meet the requirements for a monthly reporting period for any MCO operated toll-free lines. C. Up to $100.00 for each 30 second time increment, or portion thereof, by which the MCO's average hold time exceeds the maximum acceptable hold time.
22	RFP § 4.1.18.4 Behavioral Health Hotline Requirements Item 22 Added by Version 1.3	A: The MCO must have a Behavioral Health Services Hotline, answered by a live voice, staffed by trained personnel and	Operations Period, Turnover	A. Per hotline, each incident of non-compliance	HHSC may assess: A. Per hotline, up to $100.00 for each hour or portion thereof that

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
	Item 22 Added by Version 1.3	available 24 hours per day, 7 days a week, toll-free throughout the state which addresses routine and crisis Behavioral Health calls. B: The MCO must ensure that the Behavioral Health Services Hotline meets the following minimum performance requirements: 1. At least 99 percent of calls are answered by the fourth ring or an automated call pickup system. 2. At least 80 percent of calls must be answered by toll-free line staff within 30 seconds. 3. The call abandonment rate is seven percent or less. C. Average hold time is 2 minutes or less.	Period	B. Per hotline, per month, each percentage point below the standard for 1 and 2, each percentage point above standard for 3 C. Per month, for each 30 second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time.	appropriately staffed toll-free lines are not operational. If the MCO's failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the MCO fails to implement its Disaster Recovery Plan. B. Per hotline, up to $100.00 for each percentage point for each standard that the MCO fails to meet the requirements for a monthly reporting period for any MCO operated toll-free lines. C. Up to $100.00 for each 30 second time increment, or portion thereof, by which the MCO's average hold time exceeds the maximum acceptable hold time.
23	RFP §4.1.22.1 Encounter Data Item 23 Added by Version 1.4	The MCO must submit Encounter Data transmissions and include all Encounter Data and Encounter Data adjustments processed by the MCO on a monthly basis, not later than the 30th day after the last day of the month in which the claim(s) are adjudicated. Additionally, the Quarterly	Measured Quarterly during Operations Period	Per incident of non-compliance	HHSC may assess up to $2,500 per Quarter if the MCO fails to submit monthly encounter data. HHSC may assess up to $5,000 per Quarter for each additional Quarter that the MCO fails to submit monthly Encounter Data. Additionally, HHSC may assess

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
		Encounter Reconciliation Report (which reconciles the year-to-date paid claims reported in the Financial Statistical Report (FSR) to the appropriate paid dollars reported in the Texas Encounter Data (TED) Warehouse) must include no more than a 2% variance (i.e., no less than a 98% match).			up to $2,500 per Quarter if the MCO falls below the 98% match standard. HHSC may assess up to $5,000 per Quarter for each additional Quarter that the MCO falls below the 98% match 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.