

## **Texas Dual Eligible Integrated Care Demonstration Project Summary of Changes to the Three-Way Contract**

The three-way contract was re-executed on August 1, 2017 with the following changes:

- Added a two-year extension to the contract, for a new demonstration end date of December 31, 2020, and updated applicable provisions throughout to reflect the extension (e.g., savings percentages and quality withhold measures for Demonstration Years 4 and 5).
- Made revisions throughout to reflect the new Medicaid managed care regulations, such as updating citations, adding in definitions of new terms, and aligning appeal and grievance procedures.
- Performed general clean-up, made technical changes to streamline provisions, and added updates to align with Texas Medicaid program requirements. For example:
  - Revised the definition of third-party insurance to more clearly articulate what constitutes comprehensive health care coverage (see 1.168).
  - Added a requirement that Medicare-Medicaid Plans (MMPs) must provide CMS and the state with secure access rights to all provider and enrollee access points (such as portals and call systems) for monitoring purposes (see 2.1.5.10).
  - Added a requirement that MMPs must have a process in place to monitor an enrollee's claims history to ensure that authorized services are delivered (see 2.4.1.1.3).
  - Revised the language regarding reimbursement of out of network providers of emergency/urgent services in order to more accurately reflect Medicare Advantage policy (see 2.6.5.4.1 and 2.6.5.4.2).
  - Clarified expectations for initiating community-based LTSS services following the determination that an enrollee is eligible for such services (2.7.1.12.8).
  - Added a reference to the state's new Quality Incentive Payment Program for nursing facilities, which MMPs will be required to participate in upon CMS approval (see 2.7.4.6.3).
  - Added a section regarding Attendant Reimbursement, which requires that MMPs participate in the state's Attendant Care Enhancement Program as directed by the Texas legislature (see 2.7.4.8).
  - Revised the language regarding written notice of termination of an enrollee's provider from the MMP's network in order to align with Texas administrative code and Medicare Advantage policy (see 2.7.5.4, 2.7.5.4.1, and 2.7.5.4.2).
  - Added a requirement regarding abuse, neglect, and exploitation (ANE) training as directed by the Texas legislature (see 2.7.6.6.17).
  - Added clarification regarding the permissibility of marketing calls to current enrollees, consistent with the Medicare Marketing Guidelines (see 2.15.1.16).
  - Added information about Liquidated Damages that may be assessed if the MMPs do not timely resolve appeals (see 2.12.3.2.3) or accurately report encounters to the state (see 2.18.1.7.1).
  - Added information about Medical Loss Ratio reporting (see 4.3.1.7.1 and 4.3.1.7.1.1) and the Admin Cap calculation (see 4.3.7.2.3.1).
  - Added a reference to existing policy regarding using alternative quality withhold measures if an MMP is unable to report standard quality withhold measures in a given year (see 4.4.5.6.3).
  - Clarified the approach to be taken regarding all outstanding demonstration-specific payments in the event of MMP termination (see 4.7.3.2.1).
  - Added information about new ANE reporting requirements and scope/jurisdiction requirements as directed by the Texas legislature (see 5.1.14.3 and 5.1.14.4).