Contract

Between

United States Department of Health and Human Services

Centers for Medicare & Medicaid Services

In Partnership with

Texas Health and Human Services Commission

and

<Entity>

Issued:

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This Contract, made on December 15, 2015 is between the United States Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the State of Texas, acting by and through the Health and Human Services Commission (HHSC), and <Entity> (the STAR+PLUS MMP). The STAR+PLUS MMP's principal place of business is <Principal Place of Business>.

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title XIX, Title XI, and Title XXI of the Social Security Act;

WHEREAS, Section 1115A of the Social Security Act provides CMS the authority to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals under such titles, including allowing states to test and evaluate fully integrating care for dual eligible individuals in the State;

WHEREAS, HHSC is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq., and Chapter 533, Texas Government Code designed to pay for medical, behavioral health, and long term services and supports (LTSS) for eligible beneficiaries;

WHEREAS, the STAR+PLUS MMP is in the business of providing or arranging for health-related services, and CMS and HHSC desire to purchase such services from the STAR+PLUS MMP;

WHEREAS, the STAR+PLUS MMP agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and State laws and regulations;

WHEREAS, this Contract replaces in its entirety, the Contract entered into by CMS, HHSC, and <Entity> (the STAR+PLUS MMP) executed November 14, 2014.

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the Parties agree as follows:

Section 1. **Definition of Terms**

1.1. **Abuse –** Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid or Medicare Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includesEnrollee practices that result in unnecessary cost to the Medicaid or Medicare Program.

1.2. **Abuse, Neglect, or Exploitation (ANE) –** As defined in 40 Tex. Admin. Code, Chapter 705 (for Adult Protective Services in-home Investigations) and 40 Tex. Admin. Code Chapter 711 (for Adult Protective Services provider investigations and DADS investigations).

1.3. **Adjusted Revenue** – All Revenue received by the STAR+PLUS MMP pursuant to this Contract, minus the Part D Component. See "Revenue" for more information.

1.4. **Administrative Expense Cap (Admin Cap)** – The Admin Cap is a calculated maximum amount of administrative expense dollars that can be deducted from Revenues for purposes of determining income subject to the Experience Rebate. While administrative expenses may be limited by the Admin Cap to determine Experience Rebates, all valid Allowable Expenses will continue to be reported on the Financial Statistical Reports (FSRs). Thus, the Admin Cap does not impact FSR reporting, but may impact any associated Experience Rebate calculation. Note that the Admin Cap under this Contract will be separate and apart from the Admin Cap calculated for contracts under other programs with HHSC. It will not be part of the "consolidated basis" of reporting utilized in other HHSC contracts.

1.5. **Adverse Action** – (i) The denial or limited authorization of a service authorization request, including the type or level of service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the failure to provide services in a timely manner; (iv) or the denial in whole or in part of a payment for a Covered Service for an Enrollee; (v) the failure by the STAR+PLUS MMP to render a decision within the required timeframes; or (vi) solely with respect to a MMP that is the only contractor serving a rural area, the denial of an Enrollee's request to obtain services outside of the Service Area.

1.6. **Affiliate** – Any individual or entity that meets any of the following criteria:

- 1.6.1 Any entity in which the STAR+PLUS MMP owns or holds more than a 5% interest (either directly, or through one or more intermediaries);
- 1.6.2 Any parent entity or subsidiary entity of the STAR+PLUS MMP, regardless of the organizational structure of the entity;
- 1.6.3 Any entity that has a common parent with the STAR+PLUS MMP (either directly, or through one or more intermediaries);
- 1.6.4 Any entity that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the STAR+PLUS MMP; or

1.6.5 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.

1.7. **Allowable Expenses –** All expenses related to the provision of Covered Services for Enrollees that are incurred during the State Fiscal Year, are not reimbursable or recovered from another source, and that conform to requirements of HHSC's Cost Principles, as referenced in this Contract. However, specifically for the purposes of the demonstration, certain HHSC-specified Flexible Benefits will also be allowable as expenses under this contract.The determination of the allowability of expenses reported on the Financial Statistical Report (FSR) is subject to routine audit by HHSC or its agents.

1.8. **Alternative Format –** Provision of Enrollee information in a format that takes into consideration the special needs of those who, for example, are visually impaired or have limited reading proficiency. Examples of Alternative Formats include Braille, large font, audio tape, video tape, and information read aloud to Enrollee.

1.9. **Appeal –** An Enrollee's request for review of an Adverse Action taken by a STAR+PLUS MMP related to items or services. In accordance with 42 C.F.R. § 438.400, a Medicaid-based Appeal is defined as a request for review of an Adverse Action, as defined in this Section. An Appeal is an Enrollee's challenge to the Adverse Actions regarding services, benefits, and reimbursement provided by the STAR+PLUS MMP or its Providers.

1.10. **Batch Processing** – A billing technique that uses a single program loading to process many individual jobs, tasks, or requests for service. Specifically in managed care, batch billing is a technique that allows Providers to send billing information all at once in a "batch" rather than in separate individual transactions.

1.11. **Behavioral Health Inpatient Services** – Behavioral Health Services provided in a hospital setting to include medical/surgical/psychiatric and chemical dependency services.

1.12. **Behavioral Health Outpatient Services** – Behavioral Health Services that are provided in the home or community setting to include medical/surgical/psychiatric and chemical dependency service and to Enrollees who are able to return home after care without an overnight stay in a hospital or other inpatient facility.

1.13. **Behavioral Health Services –** Services for the treatment of mental, emotional or chemical dependency disorders.

1.14. **Care Management –** A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services (both Medicare and Medicaid) required to meet an Enrollee's needs across the continuum of care. It is characterized by advocacy, communication, and resource management to promote quality, cost effectiveness, and positive outcomes.

1.15. **Capitated Financial Alignment Model ("the Demonstration") –** A model where a State, CMS, and a health plan enter into a three-way Contract, and the plan receives a prospective blended Capitation Payment to provide comprehensive, coordinated care.

1.16. **Capitation Payment –** The aggregate payment CMS and the State make periodically to a STAR+PLUS MMP on behalf of all of the Enrollees enrolled under this Contract for the provision of services within this Demonstration, regardless of whether a specific Enrollees receives services during the period covered by the payment. Except as provided in this Contract, any and all costs incurred by the STAR+PLUS MMP in excess of a Capitation Payment shall be born in full by the STAR+PLUS MMP.

1.17. **Capitation Rate –** The amount per person per month (reflecting coverage of Medicare Parts A & B services, Medicare Part D services, and Medicaid services, pursuant to Appendix A of this Contract) including: 1) the application of risk adjustment methodologies as described in Section 4.2.5; and 2) any payment adjustments as a result of the reconciliation described in Section 4.7.

1.18. **Carved-Out Service(s) –** The subset of Medicaid and Medicare Covered Services for which the STAR+PLUS MMP will not be responsible under this Contract. Refer to Appendix A for the list of Carved-Out Services. Also referred to as "Non-Capitated Services."

1.19. **Centers for Medicare & Medicaid Services (CMS) –** The federal agency under the US Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

1.20. **Claim –** An itemized statement of services rendered by health care Providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the applicable payment form.

1.21. **Clean Claim –** A Claim submitted by a physician or Provider for health care services rendered to an Enrollee, with the data necessary for the STAR+PLUS MMP or subcontracted Claims processor to adjudicate and accurately report the Claim. A Clean Claim other than a Nursing Facility Services Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate Claim type encounter guides as follows:

1.21.1 837 Professional Combined Implementation Guide;
1.21.2 837 Institutional Combined Implementation Guide;
1.21.3 837 Professional Companion Guide;
1.21.4 837 Institutional Companion Guide; or

1.21.5 National Council for Prescription Drug Programs (NCPDP) Companion Guide.

The STAR+PLUS MMP may not require a physician or Provider to submit documentation that conflicts with the requirements of 28 T.A.C., Chapter 21, Subchapters C and T. Claims submitted by a Nursing Facility must meet DADS' criteria for Clean Claims submission as described in the Uniform Managed Care Manual Chapter 2.3, "Nursing Facility Claims Manual."

1.22. **CMS –** See Centers for Medicare & Medicaid Services (CMS).

1.23. **Cognitive Rehabilitation Therapy** – An Home and Community Based Services (HCBS) STAR+PLUS Waiver service that assists an Enrollee in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the Enrollee to compensate for the lost cognitive functions. Cognitive Rehabilitation Therapy may be provided when an appropriate professional assesses the Enrollee and determines it is medically necessary. Cognitive Rehabilitation Therapy it is provided in accordance with the plan of care developed by the assessor, and includes reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.

1.24. **Community First Choice (CFC)** – Personal Assistance Services; acquisition, maintenance and enhancement of skills; emergency response services; and support management provided in a community setting for eligible Enrollees who have received a Level of Care (LOC) determination from an HHSC-authorized entity.

1.25. **Community-Based Long Term Services and Supports (LTSS) –** Services provided to Enrollees in their home or other community-based settings necessary to provide assistance with activities of daily living to allow the Enrollee to remain in the most integrated setting possible. Community-Based LTSS includes services available to all Enrollees, which include personal assistance services (PAS) and day activity and health services (DAHS), as well as those services available only to Enrollees who qualify for HCBS STAR+PLUS waiver services.

1.26. **Competent Interpreter** - A person who is proficient in both English and the other language being used, has had orientation or training in the ethics of interpreting, including accuracy and impartiality in interpretation.

1.27. **Complaint –** see Grievance.

1.28. **Comprehensive Health Risk Assessment –** An assessment used to confirm the appropriate risk stratification level for the Enrollee and as the basis for developing the Plan of Care. Comprehensive Health Risk Assessment domains will include, but not be limited to, physical and behavioral health, social needs, functional status, wellness and prevention domains, caregiver status and capabilities, as well as the Enrollees' preferences, strengths, and goals.

1.29. **Confidential Information –** Any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) consisting of: (1) confidential beneficiary information, including Health Insurance Portability and Accountability Act (HIPAA) 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; CMS, and (5) information utilized, developed, received, or maintained by CMS, HHSC, the STAR+PLUS MMP, or participating State agencies for the purpose of fulfilling a duty or obligation under this Contract and that has not been disclosed publicly.

1.30. **Consumer Assessment of Healthcare Providers and Systems (CAHPS) –** Enrollee survey tools developed and maintained by the Agency for Healthcare Research and Quality to support and promote the assessment of consumers' experiences with health care.

1.31. **Consumer-Directed Services (CDS) Options –** The Enrollee or his/her Legally Authorized Representative (LAR) is the employer of and retains control over the hiring, management, and termination of an individual providing personal assistance or respite. There are three (3) options available to Enrollees desiring to self-direct the delivery of:

1.31.1 Primary Home Care (PHC) (which is available to all Enrollees), and

1.31.2 Personal Attendant Services (PAS); in-home or out-of-home respite; nursing; physical therapy (PT); occupational therapy (OT); and/or speech/language therapy (SLT) for (which are available to Enrollees in the HCBS STAR+PLUS Waiver).

These three (3) options are: 1) Consumer-Directed; 2) Service Related; and 3) Agency.

1.32. **Continuity of Care –** Care provided to an Enrollee by the same Provider to ensure that the delivery of care to the Enrollee remains stable, and services are consistent and unduplicated.

1.33. **Contract –** The participation agreement that CMS and HHSC have with a STAR+PLUS MMP, for the terms and conditions pursuant to which a STAR+PLUS MMP may participate in this Demonstration.

1.34. **Contract Management Team (CMT) –** A group of CMS and HHSC representatives responsible for overseeing the Contract management functions outlined in Section 2 and 5 of this Contract.

1.35. **Contract Effective Date** – The date this Contract is signed by the parties.

1.36. **Contract Operational Start Date –** The first date on which any Enrollment into a STAR+PLUS MMP is effective.

1.37. **Cost Sharing –** Co-payments paid by the Enrollee to a pharmacy, physician office, or as otherwise may be appropriate, in order to receive Medicare Part D health care services.

1.38. **Covered Services –** Health care services the STAR+PLUS MMP must arrange to provide to Enrollees, including all services required by the Contract and state and federal law.

1.39. **Credentialing –** 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.

1.40. **Critical Event or Incident -** An event or incident that may harm, or create the potential for harm to, an individual. Critical events or incidents include:

1.40.1 Abuse, Neglect, or Exploitation

1.40.2 the unauthorized use of restraint, seclusion, or restrictive interventions;

1.40.3 serious injuries that require medical intervention or result in hospitalization;

1.40.4 criminal victimization;

1.40.5 unexplained death;

1.40.6 medication errors; and

1.40.7 other incidents or events that involve harm or risk of harm to an Enrollee.

1.41. **Cultural Competency –** 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.

1.42. **DADS –** Texas Department of Aging and Disability Services or its successor agency.

1.43. **Day Activity and Health Services (DAHS) –** Daytime services for Enrollees residing in the community in order to provide an alternative to placement in nursing facilities or other institutions. Services may include but are not limited to nursing and personal care, noon meal and snacks, transportation, and social, educational and recreational activities at no cost to the Enrollee.

1.44. **Delivery System Reform Incentive Payment (DSRIP):** Incentive payments available for projects under the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. Projects eligible for incentive payments must come from the DSRIP menu, be approved by HHSC and CMS, and have corresponding metrics and milestones.

1.45. **Discharge –** A formal release of an Enrollee from an Inpatient Hospital Stay. Movement or Transfer from one acute care hospital or long term care hospital/facility and readmission to another within twenty-four (24) hours for continued treatment is not a Discharge under this Contract.

1.46. **Disease Management –** A system of coordinated health care interventions and communications for populations with conditions in which Enrollee self-care efforts are significant.

1.47. **Disability –** A physical or mental impairment that substantially limits one or more of an Enrollee's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working.

1.48. **DSHS –** Texas Department of State Health Services.

1.49. **EDI –** Electronic data interchange.

1.50. **Electronic Visit Verification (EVV)** – The electronic verification and documentation of visit data, such as the date and time the Provider begins and ends the delivery of services, the attendant, the recipient, and the location of services provided.

1.51. **Eligible Beneficiary –** An individual who is eligible to enroll in the Demonstration but has not yet done so. This includes individuals who are entitled to or enrolled in Medicare Part A and B, eligible to enroll in Part D, are receiving full Medicaid benefits, have no other Third Party Health Insurance, and who meet all other Demonstration eligibility criteria. In other materials including the CFR, such an individual is sometimes referred to as a "potential enrollee."

1.52. **Encounter –** Covered Service or group of Covered Services delivered by a Provider to an Enrollee during a visit between the Enrollee and Provider.

1.53. **Encounter Data** – Data elements from fee-for-service (FFS) or Capitated Services Claims that are submitted by the STAR+PLUS MMP in accordance with the required format for STAR+PLUS MMPs.

1.54. **Emergency Medical Condition –** A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including but not limited to severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (1) that there is inadequate time to effect a safe Transfer to another hospital before delivery, or (2) that Transfer may pose a threat to the health or safety of the woman or the unborn child.

1.55. **Emergency Services –** Covered inpatient and outpatient services furnished by a Provider qualified to furnish such services under the Contract and that are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including Post-Stabilization Care Services.

1.56. **Employee Misconduct Registry:** A registry of persons who have been confirmed to have committed acts of abuse, neglect, or exploitation. The purpose of the **Employee Misconduct Registry** is to ensure that unlicensed personnel who commit acts of abuse, neglect, exploitation, misappropriation, or misconduct against residents and consumers are denied employment in certain facilities and agencies. The following is a non-exhaustive list of facilities and agencies are required to check the **Employee Misconduct Registry** prior to hiring an unlicensed employee:

1.56.1 Nursing facilities;

1.56.2 Assisted living (personal care) facilities;

1.56.3 Adult foster care (Type C) facilities;

1.56.4 Adult day care facilities;

1.56.5 Hospices; and

1.56.6 Home and community support services agencies (HCSSAs).

1.57. **Employment Assistance** – Assistance provided as an HCBS STAR+PLUS Waiver service to an Enrollee to help the Enrollee locate paid employment in the community. Employment assistance includes:

1.57.1 Identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;

1.57.2 Locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements; and

1.57.3 Contacting a prospective employer on behalf of an individual and negotiating the individual's employment.

Employment Assistance is not available to Enrollees receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. For any Enrollee receiving one of those waiver services, the STAR+PLUS MMP must document that the Employment Assistance service is not available to the Enrollee in the Enrollee's record.

1.58. **Enrollee –** Any Eligible Beneficiary who is enrolled with a STAR+PLUS MMP, including the duration of any month in which their eligibility for the Demonstration ends. See also "Medicare-Medicaid Enrollee."

1.59. **Enrollment –** The processes by which an Eligible Beneficiary is enrolled into the STAR+PLUS MMP.

1.60. **Enrollee Medical Record –** Documentation containing medical history, including information relevant to maintaining and promoting each Enrollee's general health and well-being, as well as any clinical information concerning illnesses and chronic medical conditions.

1.61. **Expedited Appeal –** The accelerated process by which a STAR+PLUS MMP must respond to an Appeal by an Enrollee if a decision by a STAR+PLUS MMP may jeopardize life, health, or ability to attain, maintain, or regain maximum function.

1.62. **Experience Rebate –** The portion of the STAR+PLUS MMP's Net Income Before Taxes, if any, which is returned to HHSC in accordance with requirements in this Contract. The Experience Rebate calculation under this Contract will be separate and apart from the Experience Rebate calculation done for other contracts with HHSC. This Experience Rebate will not be included in the "consolidated basis" of other HHSC contracts. For the purposes of calculating the Experience Rebate under this Contract, Medicare Part D premium revenues, along with associated Medicare Part D costs, will be excluded. Costs under the Experience Rebate calculation are subject to the Admin Cap and the Reinsurance Cap.

1.63. **External Appeal –** An Appeal, subsequent to the STAR+PLUS MMP Appeal decision, to the Fair Hearing process for Medicaid-based Adverse Actions or the Medicare process for Medicare-based Adverse Actions.

1.64. **External Quality Review Organization (EQRO)** – An independent entity that contracts with the State and evaluates the access, timeliness, and quality of care delivered by the STAR+PLUS MMP to their Enrollees.

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

1.66. **Federally-Qualified Health Center (FQHC) –** An entity that satisfies the criteria set forth in 42 U.S.C. § 1396d(l)(2)(B) that is enrolled as a Provider in the Texas Medicaid program.

1.67. **Financial Management Service Agency (FMSA) –** An organization that assists the Enrollee and/or his/her legally authorized representative (LAR) in hiring or retaining HCBS service Providers in accordance with qualifications and other requirements. The FMSA enters into service agreements with each of the Enrollee's service Providers before issuing payment. A FMSA is not responsible for providing case management services to the Enrollee. The FMSA must obtain employer-agent status and perform all responsibilities as required by the Internal Revenue Service and other appropriate government agencies.

1.68. **Financial Statistical Report (FSR) –** A report designed by HHSC, and submitted to HHSC by the STAR+PLUS MMP in accordance with Contract requirements. The FSR is a form of modified income statement, subject to audit, and contains revenue, cost, and other data, as defined by the HHSC Cost Principles and the FSR Instructions, which are incorporated into this Contract. Not all incurred expenses may be included in the FSR. The FSR will include revenue, cost, and other data broken out for Demonstration Enrollees separate from individuals served by other Texas Medicaid programs. [Note that the present STAR+PLUS FSR template will be modified to reflect changes in line items to better reflect both Medicaid and Medicare items.] The FSR is based on a State Fiscal Year basis. The FSR under this Contract will have its own separate STAR+PLUS MMP administrative expenses, which will not be consolidated with the administrative expenses of other programs under contract with HHSC.

1.69. **First Tier, Downstream, or Related Entity –** An individual or entity that enters into a written arrangement with the STAR+PLUS MMP, acceptable to CMS and HHSC, to provide administrative or health care services of the STAR+PLUS MMP under this Contract. Specifically:

1.69.1 **First Tier Entity** – Any party that enters into an acceptable written arrangement with a STAR+PLUS MMP to provide administrative services or health care services for an Enrollee.

1.69.2 **Downstream Entity** – Any party that enters into an acceptable written arrangement below the level of the arrangement between a STAR+PLUS MMP and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.

1.69.3 **Related Entity** – Any entity that is related to the STAR+PLUS MMP by common ownership or control and (1) performs some of the STAR+PLUS MMP's management functions under contract or delegation; (2) furnishes services to Enrollees under an oral or written agreement; or (3) leases real property or sells materials to the STAR+PLUS MMP at a cost of more than $2,500 during a contract period.

1.70. **Flexible Benefits –** Additional services for coverage beyond Covered Services, which may be actual health care services or benefits that HHSC and CMS determine will promote healthy lifestyles and improve health outcomes among Enrollees. These benefits may include weight loss, smoking cessation, or other programs approved by HHSC and CMS. Temporary phones, cell phones, additional transportation benefits, and extra home health services may be Flexible Benefits, if approved by HHSC and CMS. Neither best practice approaches to delivering Covered Services nor rewards and incentives defined at 42 C.F.R.§422.134 are considered Flexible Benefits. Flexible Benefits provided by an MMP are for purposes of attracting or keeping Enrollees, or to promote health in a manner that may save other health-related expenses, or for other purposes as may be determined by the STAR+PLUS MMP. Any services or benefits that are approved as Flexible Benefits are deemed to be Allowable Costs under this Contract.

1.71. **Fraud –** 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.

1.72. **Full Dual Eligible or Full Medicaid Benefits –** Individuals age 21 or older who receive Medicare Part A, B, and D and full Medicaid benefits through the STAR+PLUS program. This includes individuals receiving full Medicaid benefits as a result of their "Medical Assistance Only (MAO)."

1.73. **Functionally Necessary Covered Services** – Community-Based LTSS provided to assist STAR+PLUS MMP Enrollees with activities of daily living based on a functional assessment of the Enrollee's activities of daily living and instrumental activities of daily living and a determination of the amount and scope of supplemental supports necessary for the STAR+PLUS MMP Enrollee to remain independent and/or live in the most integrated setting possible.

1.74. **Grievance –** Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the STAR+PLUS MMP's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. A grievance is filed and decided at the STAR+PLUS MMP level. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Enrollee's rights as provided for in Appendix B of this Contract). Also called a "Complaint."

1.75. **Health and Human Services Commission** (**HHSC) –** 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.

1.76. **Health Outcomes Survey (HOS) –** Enrollee survey used by CMS to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

1.77. **Healthcare Effectiveness Data and Information Set (HEDIS) –** Tool developed and maintained by the National Committee for Quality Assurance (NCQA) that is used by health plans to measure performance on dimensions of care and service in order to maintain or improve quality.

1.78. **Health Plan Management System (HPMS) –** The system that supports Contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, plan benefit packages, formularies, and other information via HPMS.

1.79. **HHSC Administrative Services Contractor** – An entity performing administrative services functions, including Enrollment functions, for the STAR+PLUS MMP.

1.80. **HHSC Cost Principles** – Principles establishing the allowability or unallowability of administrative expenses, reinsurance expenses, subcontract expenses, Affiliate assessments and costs, and other expenses relative to the STAR+PLUS MMP Financial Statistical Reports (FSRs), as outlined in the Uniform Managed Care Manual.

1.81. **Home and Community-Based Services (HCBS) STAR+PLUS Waiver –** The Texas HHSC program under the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) section 1115(a) demonstration that provides HCBS to aged and disabled Medicaid beneficiaries as cost-effective alternatives to institutional care in nursing homes. Enrollees who qualify for the HCBS STAR+PLUS Waiver are eligible to receive the HCBS component of the Texas Health Care Transformation and Quality Improvement Program (THTQIP) section 1115(a) demonstration. Covered waiver services include: personal assistance services (PAS) (including CDS Options; in-home or out-of-home respite services; nursing services (in home); emergency response services; home delivered meals; minor home modifications; adaptive aids and medical equipment; dental health services; financial management services; support consultation; medical supplies not otherwise available under the Texas Medicaid State Plan or THTQIP section 1115(a) demonstration; physical, occupational, and speech therapy; adult foster care; assisted living; transition assistance services; Cognitive Rehabilitation Therapy; Supported Employment; and Employment Assistance.

1.82. **Home and Community Support Services Agency or (HCSSA) –** The entity licensed to provide home health, hospice, or personal assistance services (PAS) provided to individuals in their own home or independent living environment as prescribed by a physician or individualized service plan (ISP). Each HCSS must provide Enrollees with a Plan of Care that includes specific services the agency agrees to perform and that the Enrollee agrees to receive. The agencies are licensed and monitored by DADS.

1.83. **Hospital –** 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.

1.84. **Individual Service Plan (ISP)** – A person-centered plan developed for Enrollees eligible for HCBS STAR+PLUS Waiver services by the Service Coordinator and incorporated into the Enrollee's Plan of Care. Service planning includes: 1) determining the Enrollee needs; 2) determining service levels; 3) maintaining costs and cost ceilings; 4) regularly reviewing services; and 5) obtaining approval for planned services from the Enrollee and the Service Coordinator. For Enrollees seeking or needing the HCBS STAR+PLUS Waiver services, the STAR+PLUS MMP must use the medical necessity/level of care (MN/LOC) assessment instrument, as amended or modified, to assess Enrollees and to supply current medical information for medical necessity determinations. For each Enrollee receiving HCBS STAR+PLUS Waiver services, the STAR+PLUS MMP must also complete the ISP form. The ISP is established for a one-year period. After the initial ISP is established, the ISP must be completed on an annual basis and the end date or expiration date does not change, regardless of mid-year updates. Both of these forms (MN/LOC assessment instrument and ISP form) must be completed annually at reassessment.

1.85. **Inpatient Hospital Stay** – At least a twenty-four (24)-hour stay in a facility licensed to provide Hospital care.

1.86. **Legally Authorized Representative (LAR)** - The Enrollee's representative defined by State or federal law, including Tex. Occ. Code § 151.002(6), Tex. Health & Safety Code § 166.164, and Tex. Estates Code Ch. 752.

1.87. **Linguistic Access –** 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.

1.88. **List of Excluded Individuals and Entities (LEIE) –** When the Office of Inspector General (OIG) excludes a Provider from participation in federally funded health care programs; it enters information about the Provider into the LEIE, a database that houses information about all excluded Providers. This information includes the Provider's name, address, Provider type, and the basis of the exclusion. The LEIE is available to search or download on the OIG Web site and is updated monthly. To protect sensitive information, the downloadable information does not include unique identifiers such as Social Security numbers (SSN), Employer Identification numbers (EIN), or National Provider Identifiers (NPI).

1.89. **Local Health Department –** A Local Health Department established pursuant to Health and Safety Code §121.031.

1.90. **Local Mental Health Authority (LMHA) –** Defined in Texas Health and Safety Code §531.002(10).

1.91. **Major Systems Change –** A new version of an existing software platform often identified by a new software version number or conversion to an entirely new software platform.

1.92. **Marketing, Outreach, and Member Materials –** Any informational materials targeted to Enrollees that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260.

1.93. **Material Subcontract/Material Subcontractor** - For the purposes of this Contract, Material Subcontractors are a type of First Tier, Downstream, and Related Entity. A Material Subcontract is any contract, subcontract, or agreement between the STAR+PLUS MMP and another entity that meets any of the following criteria:

1.93.1 The other entity is an Affiliate of the STAR+PLUS MMP;

1.93.2 The subcontract is considered by HHSC to be for a key type of service or function, including:

- Administrative Services (including but not limited to third party administrator, Network administration, and Claims processing);
- Delegated Networks (including but not limited to behavioral health, dental, pharmacy, and vision);
- Management services (including management agreements with parent)
- Reinsurance;
- Disease Management;
- Pharmacy benefit management (PBM) or pharmacy administrative services; or
- Call lines (including nurse and medical consultation); or

1.93.3 Any other subcontract that exceeds, or is reasonably expected to exceed, the lesser of:

- $500,000 per year, or,
- 1% of the STAR+PLUS MMP's annual revenues under this Contract.

Any subcontracts between the STAR+PLUS MMP and a single entity that are split into separate agreements by time period or service area, etc., will be consolidated for the purpose of this definition.

For the purposes of this Agreement, Material Subcontracts do not include contracts with any non-Affiliates for any of the following, regardless of the value of the contract: utilities (e.g., water, electricity, telephone, Internet, trash), mail/shipping, office space, maintenance, security, or computer hardware.

1.94. **Medicaid –** 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.

1.95. **Medicaid Waiver –** Generally, a waiver of existing law authorized under Section 1115(a), 1115A, or 1915 of the Social Security Act.

1.96. **Medical Home –** The meaning assigned to a patient-centered Medical Home in Texas Government Code § 533.0029(a).

1.97. **Medically Necessary Services –** Services must be provided in a way that provides all protections to covered individuals provided by Medicare and Texas Medicaid. (per Medicare) Services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. §1395; (per HHSC) Has meaning assigned in Texas Administrative Code (T.A.C.) Section 353.2.

1.98. **Medicare –** Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional Providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

1.99. **Medicare Waiver –** Generally, a waiver of existing law authorized under Section 1115A of the Social Security Act.

1.100. **Medicare-Medicaid Coordination Office (MMCO) –** Formally the Federal Coordinated Health Care Office, established by section 2602 of the Patient Protection and Affordable Care Act (the ACA).

1.101. **Medicare-Medicaid Enrollees –** Individuals who are entitled to or enrolled in Medicare Part A and B, eligible to enroll in Part D, receive full benefits under the Texas Medicaid State Plan, and otherwise meet eligibility criteria for the Demonstration. See also "Enrollee."

1.102. **Medicare-Medicaid Plan (MMP) –** The general term for managed care plans contracted with CMS and Texas to participate in the Capitated Financial Alignment Demonstration. These are referred to as STAR+PLUS MMPs in Texas and in this Contract.

1.103. **Medicare Advantage –** The Medicare managed care options that are authorized under Part C of Title XVIII of the Social Security Act and as specified at Part C and implementing regulations at 42 C.F.R. Part§ 422.

1.104. **Member Materials –** Materials designed to communicate STAR+PLUS MMP plan benefits, policies, processes and/or Enrollee rights to Enrollees. This includes pre-Enrollment, post-Enrollment, and operational materials.

1.105. **Member Month** – The period in which one Enrollee is enrolled with the STAR+PLUS MMP during any given month. The total Member Months for each month of a year comprise the annual Member Months.

1.106. **Mental Health Rehabilitative Services** – Age-appropriate services determined by HHSC and federally-approved protocol as medically necessary to reduce an Enrollee's Disability resulting from severe mental illness, and to restore the Enrollee to his or her best possible functioning level in the community. Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help an Enrollee achieve a rehabilitation goal as defined in the Enrollee's rehabilitation plan.

1.107. **Mental Health Targeted Case Management –** Services designed to assist Enrollees with gaining access to needed medical, social, educational, and other services and supports. Enrollees are eligible to receive these services based on a standardized Strengths Assessment (ANSA).

1.108. **Net Income Before Taxes** – An aggregate excess of Revenues over Allowable Expenses. Also called "Pre-Tax Income." For purposes of the Experience Rebate, the calculation of Net Income Before Taxes will exclude Medicare Part D, both in terms of premium revenues and associated costs.

1.109. **Network (or Provider Network) –** All Providers that have a Contract with the STAR+PLUS MMP , or any First Tier, Downstream, or Related Entity, for the delivery of Covered Services to the STAR+PLUS MMP 's Enrollees under the Contract.

1.110. **Non-Capitated Services** – Medicaid services identified in Section 2.4.2.

1.111. **Nurse Aide Registry** – Texas maintains a registry of all nurse aides who are certified to provide services in nursing facilities and skilled nursing facilities licensed by the Texas Department of Aging and Disability Services (DADS). The NAR includes information about confirmed findings of abuse, neglect, or misappropriation. The following is a non-exhaustive list of facilities and agencies are required to check the NAR prior to hiring an unlicensed employee or a nurse aide:

1.111.1 nursing facilities;

1.111.2 assisted living (personal care) facilities;

1.111.3 adult foster care (Type C) facilities;

1.111.4 adult day care facilities;

1.111.5 hospices; and

1.111.6 home and community support services agencies (HCSSAs).

1.112. **Nursing Facility –** An entity or institution that provides organized and structured nursing care and services, and is subject to licensure under Texas Health and Safety Code, Chapter 242, as defined in 40 T.A.C. § 19.101 and 1 T.A.C. § 358.103. (Also called nursing home or skilled nursing facility).

1.113. **Nursing Facility Cost Ceiling –** The annualized cost of serving an Enrollee in a Nursing Facility. A per diem cost is established for each Medicaid Nursing Facility resident based on the level of care needed. This level of care and associated resource allocation is referred to as the Resource Utilization Group (RUG) level. The per diem cost is annualized to achieve the Nursing Facility ceiling.

1.114. **Nursing Facility Level of Care –** The determination that the level of care (LOC) required to adequately serve a STAR+PLUS MMP Enrollee is at or above the level of care provided by a Nursing Facility.

1.115. **Nursing Facility Unit Rate –** The type of services included in the DADS daily rate for Nursing Facility Providers, such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The Nursing Facility Unit Rate also includes applicable Nursing Facility rate enhancements and professional and general liability insurance. This Nursing Facility Unit Rate excludes Nursing Facility add-on services, defined as services that are provided in the nursing facility, but are not included in the Nursing Facility Unit Rate, including but not limited to emergency dental services, physician-ordered rehabilitative services, customized power wheel chairs, and augmentative communication devices.

1.116. **Opt-Out –** A process by which an Enrollee can choose not to participate in the Demonstration.

1.117. **Outpatient Hospital Services –** Diagnostic, therapeutic, and rehabilitative services that are provided to Enrollees in an organized medical facility, for less than a twenty-four (24) hour period, by or under the direction of a physician.

1.118. **Out-of-Network Provider –** A Provider not affiliated or contracted with the STAR+PLUS MMP.

1.119. **Passive Enrollment –** An Enrollment process through which an Eligible Beneficiary is enrolled by the state (or its vendor) into a STAR+PLUS MMP, when not affirmatively electing one, following a minimum sixty (60)-day advance notification that identifies the STAR+PLUS MMP the state has selected and the opportunity to select a different plan, make another Enrollment decision, or decline Enrollment into a STAR+PLUS MMP and Opt-Out of the Demonstration prior to the effective date of coverage.

1.120. **Personal Assistance Services (PAS) –** Assistance with activities of daily living and household chores necessary to maintain clean and safe home environments in community settings. Services may include protective supervision and help performing health-related tasks delegated by a registered nurse.

1.121. **Plan of Care –** A person-centered care plan that addresses acute care and LTSS for Enrollees. The plan is developed by the STAR+PLUS MMP Service Coordinator with the Enrollee, his/her family and caregiver supports, as appropriate, and Providers. The Plan of Care will contain the Enrollee's health history; a summary of current, short-term, and long-term health and social needs, concerns, and goals; and a list of required services, their frequency, and a description of who will provide such services. For Enrollees eligible for HCBS, the Enrollee's ISP is incorporated into the Plan of Care.

1.122. **Post-Stabilization Care Services –** Covered Services, related to an Emergency Medical Condition that are provided after a Enrollee is Stabilized in order to maintain the Stabilized condition, or, for an Enrollee, 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 Enrollee's condition.

1.123. **Preadmission Screening and Resident Review (PASRR) –** A federally mandated program applied to all individuals seeking admission to a Medicaid-certified Nursing Facility. PASRR helps ensure that individuals are not inappropriately placed in nursing homes for long-term care and requires that all applicants to a Medicaid-certified Nursing Facility: (1) be evaluated for mental illness, intellectual Disability, or both; (2) be offered the most appropriate setting for their needs (in the community, a Nursing Facility, or acute care settings); and (3) receive the services they need in those settings.

1.123.1 PASRR Level I Screening -has the meaning assigned in 40 T.A.C. § 17.102(16).
1.123.2 PASRR Level II Evaluation -has the meaning assigned in 40 T.A.C. § 17.102(24).
1.123.3 PASRR Specialized Services - has the meaning assigned in 40 T.A.C. § 17.102(33).

1.124. **Prevalent Languages –** When five (5) percent of the STAR+PLUS MMP's enrolled population is non-English speaking and speaks a common language other than English.

1.125. **Primary Care Provider (PCP) –** A Provider who has agreed with the STAR+PLUS MMP to provide a Medical Home to Enrollees and who is responsible for providing initial and primary care to Enrollees, maintaining the continuity of care, and initiating referral for services.

1.126. **Primary Home Care (PHC) –** Assistance with activities of daily living and household chores necessary to maintain clean and safe home environments in community settings.

1.127. **Privacy –** Requirements established in the Privacy Act of 1974, Health Insurance Portability and Accountability Act (HIPAA) of 1996, and implementing regulations, Medicaid regulations, including 42 C.F.R. §§ 431.300 through 431.307, as well as relevant Texas privacy laws.

1.128. **Program of All-Inclusive Care for the Elderly (PACE) –** A capitated benefit for frail elderly authorized by the Balanced Budget Act 1997 (BBA) that features a comprehensive service delivery system an integrated Medicare and Medicaid financing. PACE is a three-way partnership between the Federal Government, a State, and the PACE organization.

1.129. **Provider (or Network Provider) –** An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and First Tier, Downstream, or Related Entities , that has a Provider Contract with the STAR+PLUS MMP for the delivery of Covered Services to the STAR+PLUS MMP's Enrollees.

1.130. **Provider Contract –** A contract entered into by a Provider and the STAR+PLUS MMP or a First Tier, Downstream or Related Entity for Covered Services. Also called "Network Provider Agreement."

1.131. **Provider Materials** – All written materials produced or authorized by the STAR+PLUS MMP or its First Tier, Downstream, and Related Entities concerning the STAR+PLUS MMP that are distributed to Providers. Provider Materials include the STAR+PLUS MMP's Provider Manual, training materials regarding STAR+PLUS MMP requirements, and mass communications directed to all or a large group of Network Providers (email or fax "blasts"). Provider Materials do not include written correspondence between the STAR+PLUS MMP or its First Tier, Downstream, and Related Entities and a Provider regarding individual business matters.

1.132. **Provider Preventable Condition –** A Hospital acquired condition or a condition occurring in any health care setting that has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines, has a negative consequence for the beneficiary, and is auditable.

1.133. **Public Health Entity** – A HHSC Public Health Region, a Local Health Department, or a Hospital district.

1.134. **Quality Improvement Organization (QIO) –** As set forth in Section 1152 of the Social Security Act and 42 C.F.R. Part 476, an organization under contract with CMS to perform utilization and quality control peer review in the Medicare program or an organization designated as QIO-like by CMS. The QIO or QIO-like entity provides quality assurance and utilization review.

1.135. **Rate Cell** – A distinct group of Enrollees identified by age, age range, gender, type of program, eligibility category, or other criteria established by HHSC or CMS for which a Capitation Rate has been determined.

1.136. **Readiness Review –** Prior to entering into a three-way Contract with HHSC and CMS, the STAR+PLUS MMP will undergo a Readiness Review. The Readiness Review will evaluate the STAR+PLUS MMP's ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process Claims and Enrollment information, accept and transition new Enrollees, and provide adequate access, including physical and linguistic accessibility, to all Medicare- and Medicaid-covered medically necessary services. CMS and HHSC will use the results to inform their decision of whether the STAR+PLUS MMP is ready to participate in the Demonstration. At a minimum, each Readiness Review will include a desk review and a site visit to the STAR+PLUS MMP's headquarters.

1.137. **Revenue** – All Revenue received by the STAR+PLUS MMP pursuant to this Contract, including retroactive adjustments made by HHSC or CMS. Revenue includes any funds earned on Medicaid or Medicare managed care funds such as investment income and earned interest. Revenue excludes any reinsurance recoveries, which shall be shown as a contra-cost, or reported offset to reinsurance expense. With respect to any reinsurance, revenues are reported at gross, and are not netted for any reinsurance premiums paid. Revenues *do* include any upfront withhold due to quality or other incentives, as well as any retrospective recoupment by HHSC due to such provisions (in other words, reported Revenues will not be reduced due to any actual or potential payment reductions due to these measures). (See also the Uniform Managed Care Manual's "Cost Principles for Expenses.")

1.138. **Rewards and Incentives** – Positive incentives that HHSC determine will promote healthy lifestyles and improve health outcomes among Enrollees. STAR+ PLUS MMPs have flexibility to provide rewards and incentives to current members consistent with the required Marketing Guidelines and all relevant CMS sub regulatory guidance. Any Rewards and Incentives that the STAR+PLUS MMP elects to provide must be provided at no cost to HHSC or CMS. The costs of Rewards and Incentives are not reportable as Allowable Expenses (either medical or administrative), and therefore are not factored into the rate setting process. In addition, the STAR+ PLUS MMP must not pass on the cost of the Rewards and Incentives to Enrollees or Providers.

1.138.1 The STAR+ PLUS MMP will be given the opportunity to add or enhance Rewards and Incentives twice per State Fiscal Year, with changes to be effective September 1 and March 1. The STAR+PLUS MMP will also be given the opportunity to delete or reduce Rewards and Incentives once per State Fiscal Year, with changes to be effective September 1. The STAR+PLUS MMP's request to add, enhance, delete, or reduce Rewards and Incentives must be submitted to HHSC by April 1 of each year to be effective September 1 for the following contract period. The STAR+PLUS MMP cannot reduce or delete any Rewards and Incentives until September 1 of the next State Fiscal Year. A second request to add or enhance Rewards and Incentives must be submitted to HHSC by October 1 each year to be effective March 1. When the STAR+PLUS MMP requests deletion of a Rewards and Incentives, the STAR+PLUS MMP must include information regarding the processes by which the STAR+PLUS

MMP will notify Enrollees and revise materials. The STAR+PLUS MMP must use HHSC's template for submitting the proposed Rewards and Incentives (See Uniformed Managed Care Manual Chapter 4.10).

1.139. **Rural Health Clinic (RHC) –** An entity that meets all of the requirements for designation as a RHC under 1861(aa)(1) of the Social Security Act and is approved for participation in the Texas Medicaid Program.

1.140. **Severe and Persistent Mental Illness (SPMI) –** A diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) accompanied by impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder, or impaired emotional or behavioral functioning that interferes substantially with the Enrollee's capacity to remain in the community without supportive treatment or services.

1.141. **Service Area –** The specific geographic area of Texas designated in the CMS HPMS, and as referenced in Appendix H, for which the STAR+PLUS MMP agrees to provide Covered Services to all Enrollees who select or are passively enrolled with the STAR+PLUS MMP.

1.142. **Service Authorization** – A request for Covered Services consistent with 42 CFR § 431.201.

1.143. **Service Coordination –** A specialized Care Management service that is performed by a Service Coordinator that includes but is not limited to: 1) identification of needs, including physical and behavioral health services, and LTSS, 2) development of and necessary updates to a Plan of Care to address those identified needs; 3) assistance to ensure timely and a coordinated access to an array of Providers and Covered Services; 4) attention to addressing unique, person-centered needs of Enrollees; 5) coordination of Covered Services with Non-Capitated Services, as necessary and appropriate; and 6) includes, for Enrollees who have been determined STAR+PLUS HCBS eligible, the development of an ISP with the Enrollee, family members, and Provider(s), as well as authorization of HCBS services.

1.144. **Service Coordination Team –** Led by a Service Coordinator and ensures the integration of the Enrollee's medical, behavioral health, substance use, LTSS, and social needs. The Service Coordination Team includes the Enrollee's PCP, regardless of whether the PCP is in the STAR+PLUS MMP's network during the transition period. The Service Coordination Team coordinates all Covered Services and any applicable Non-Capitated Services. The Service Coordination Team is person-centered, built on the Enrollee's specific preferences and needs, and delivers services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

1.145. **Service Coordinator –** The person with primary responsibility for providing Service Coordination and Care Management to STAR+PLUS MMP Enrollees. The Service Coordinator leads the Service Coordination Team and actively collaborates with the Enrollee's specialty care Providers, including behavioral health and LTSS service Providers, as appropriate.

1.146. **Significant Traditional Provider (STP) –** Acute care, LTSS, and pharmacy Providers in a county that provide a significant level of care to Eligible Beneficiaries, as identified by HHSC.

1.147. **Solvency –** Standards for requirements on cash flow, net worth, cash reserves, working capital requirements, insolvency protection and reserves established and monitored by the Texas Department of Insurance (TDI) and agreed to by CMS.

1.148. **Special Health Care Needs –** Characteristics of an Enrollee who:

1.148.1 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

1.148.2 Requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel.

1.149. **Stabilized –** As defined in 42 C.F.R. § 489.24(b), means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the Discharge, Transfer, or admission of the Enrollee from a Hospital or, in the case of a pregnant woman who is having contractions, that the woman has delivered the child and the placenta.

1.150. **STAR+PLUS –** The State of Texas Access Reform (STAR) Plus Medicaid managed care program in which HHSC contracts with managed care organizations to provide, arrange, and coordinate preventive, primary, acute, and LTSS services. Those eligible for the STAR+PLUS program include adult persons with Disabilities and persons age 65 and over who qualify for Medicaid through the Supplemental Security Income (SSI) program or the Medical Assistance Only program or who meet the functional and income eligibility requirements for STAR+PLUS HCBS Waiver and meet program rules for income and asset levels.

1.151. **STAR+PLUS MCO –** A managed care organization (MCO) contracted by the state to offer Covered Services under the STAR+PLUS program.

1.152. **STAR+PLUS MMP –** See Medicare-Medicaid Plan (MMP).

1.153. **State –** The State of Texas.

1.154. **State Fiscal Year –** A 12-month period beginning on September 1 and ending on August 31 the following year.

1.155. **Substance Use Disorder (SUD)** – Substance use disorder includes substance abuse and dependence as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

1.156. **Supported Employment** – Assistance provided as an HCBS STAR+PLUS Waiver service, in order to sustain competitive employment, to an Enrollee who, because of a Disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which Enrollees without disabilities are employed. Supported Employment includes employment adaptations, supervision, and training related to an Enrollee's assessed needs. Individuals receiving supported employment earn at least minimum wage (if not self-employed). Supported Employment is not available to Enrollees receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. For any Enrollee receiving one of those waiver services, the STAR+PLUS MMP must document that the Employment Assistance service is not available to the Enrollee in the Enrollee's record.

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

1.158. **T.A.C. –** Texas Administrative Code.

1.159. **TDD –** Telecommunication device for the deaf. It is interchangeable with the term Teletype machine or TTY.

1.160. **Texas Department of Insurance (TDI) –** Regulates certain aspects of the business of insurance in the State of Texas (Tex. Ins. Code 31.002).

1.161. **Texas Health Care Transformation and Quality Improvement Program (THTQIP) –** Section 1115(a) demonstration program under which the STAR+PLUS program operates.

1.162. **Texas Medicaid Provider Procedures Manual –** 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 as needed.

1.163. **Texas Promoting Independence –** The Promoting Independence (PI) initiative is Texas's response to *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999), which requires states to provide community-based services for persons with Disabilities who would otherwise be entitled to institutional services when:

1.163.1 The state's treatment professionals determine that such placement is appropriate;

1.163.2 The affected persons do not oppose such treatment; and

1.163.3 The placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state supported Disability services.

1.164. **Third Party Health Insurance** – Other health coverage, including private insurance and non-Medicare/Medicaid public insurance, such as insurance through the Veterans Administration, retiree Insurance and Medigap (Medicare Supplemental Insurance) Insurance.

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

1.166. **Third Party Recovery (TPR)** –The recovery of payments on behalf of an Enrollee by HHSC, CMS or the STAR+PLUS MMP from an individual or entity with the legal responsibility to pay for the Covered Services.

1.167. **Transfer –** The movement of the Enrollee from one Acute Care Hospital or Long Term Care Hospital/facility and readmission to another Acute Care Hospital or Long Term Care Hospital/facility within twenty-four (24) hours for continued treatment.

1.168. **Uniform Managed Care Manual (UMCM) –** The manual published by or on behalf of HHSC that contains policies and procedures required of all managed care organizations participating in the HHSC programs (available here: https://www.hhsc.state.tx.us/medicaid/managed-care/umcm/).

1.169. **Urgent Care –** Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a Hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Medical Condition.

1.170. **Utilization Management –** The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

1.171. **Waste –** Practices that are not cost-efficient.

Section 2. **STAR+PLUS MMP Responsibilities**

2.1. General

2.1.1. General Responsibilities

2.1.1.1. Through the Financial Alignment initiative's capitated model, CMS and HHSC will work in partnership to offer Eligible Beneficiaries the option of enrolling in a STAR+PLUS MMP, which consists of a comprehensive network of health and social service Providers. The STAR+PLUS MMP will deliver and coordinate all components of Covered Services for Enrollees.

2.1.2. STAR+PLUS MMP Requirements for State Operations

2.1.2.1. Licensure, Certification, or Approval

2.1.2.1.1. STAR+PLUS MMPs must be licensed by the Texas Department of Insurance (TDI) as health maintenance organizations 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. The STAR+PLUS MMP shall obtain and retain at all times during the period of this Contract a valid license and Service Area certification or approval issued with the TDI and comply with all applicable terms and conditions of the Texas Insurance Code, and any and all other applicable laws of the State of Texas, as amended. The STAR+PLUS MMP must receive TDI licensure, certification or approval (as applicable) for all zip codes in the awarded Service Areas before the Contract Operational Start Date.

2.1.2.2. Accreditation

2.1.2.2.1. If the STAR+PLUS MMP is accredited by or seeks accreditation from the National Committee for Quality Assurance (NCQA) or another accreditation entity, the STAR+PLUS MMP must report to HHSC any deficiencies noted by the accreditation entity for the STAR+PLUS MMP's Medicare and/or Medicaid product lines within thirty (30) calendar days of being notified of the deficiencies, or on the earliest date permitted by the accreditation entity, whichever is earliest.

2.1.2.3. Mergers and Acquisitions – If the STAR+PLUS MMP is accredited through the NCQA, in addition to the requirements at 42 C.F.R. § 422 Subpart L, the STAR+PLUS MMP must adhere to the NCQA notification requirements with regards to mergers and acquisitions and must notify HHSC and CMS of any action by NCQA that is prompted by a merger or acquisition (including, but not limited to change in accreditation status, loss of accreditation, etc.).

2.1.3. Compliance

2.1.3.1. The STAR+PLUS MMP must, to the satisfaction of CMS and HHSC:

2.1.3.1.1. Comply with all provisions set forth in this Contract;

2.1.3.1.2. Comply with all applicable provisions of federal and state laws, regulations, guidance, waivers, Demonstration terms and conditions, policies and guidelines, and any court-ordered consent decrees, settlement agreements, or other court orders that govern the performance of the Contract, including the implementation of a compliance plan. The STAR+PLUS MMP must comply with the Medicare Advantage and Medicaid requirements in Part C of Title XVIII, and 42 C.F.R. Parts 422, 423, and 438, except to the extent that waivers of these requirements are provided in the memorandum of understanding (MOU) signed by CMS and HHSC for this initiative or in this Contract.

2.1.3.1.3. Comply with Other Laws. No obligation imposed herein on the STAR+PLUS MMP shall relieve the STAR+PLUS MMP of any other obligation imposed by law or regulation, including, but not limited to those imposed by:

2.1.3.1.3.1. Titles XIX and XXI of the Social Security Act;

2.1.3.1.3.2. Chapters 62 and 63, Texas Health and Safety Code;

2.1.3.1.3.3. Chapters 531 and 533, Texas Government Code;

2.1.3.1.3.4. 42 C.F.R. Parts 417, 455, and 457, as applicable;

2.1.3.1.3.5. 45 C.F.R. Parts 74 and 92;

2.1.3.1.3.6. 48 C.F.R. Part 31, and 2 C.F.R. Part 200, or OMB Circular A-122, based on whether the entity is for-profit or nonprofit;

2.1.3.1.3.7. 1 T.A.C. Part 15, Chapters 361, 370, 371, 391, and 392;

2.1.3.1.3.8. Texas Human Resources Code Chapters 32 and 36;

2.1.3.1.3.9. Texas Penal Code Chapter 35A (Medicaid Fraud);

2.1.3.1.3.10. 1 T.A.C. Chapter 353;

2.1.3.1.3.11. 1 T.A.C. Chapter 354, Subchapters B, J, and F, with the exception of the following provisions in Subchapter F: 1 T.A.C. §354.183, §354.1867, §354.1873, and Division 6, "Pharmacy Claims; and §354.1877:

2.1.3.1.3.12. 1 T.A.C. Chapter 354, Subchapters I and K, as applicable;

2.1.3.1.3.13. The Patient Protection and Affordable Care Act (ACA; Public Law 111-148);

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

2.1.3.1.3.15. The Immigration and Nationality Act (8 U.S.C § 1101 et seq.) and all subsequent immigration laws and amendments;

2.1.3.1.3.16. All state and federal tax laws, employment laws, regulatory requirements, and licensing provisions,

2.1.3.1.3.17. The federal Balanced Budget Act of 1997 (Public Law 105-33),

2.1.3.1.3.18. Regulations promulgated by HHSC or CMS, and

2.1.3.1.3.19. Texas Human Resources Code § 48.051, related to STAR+PLUS MMP, First Tier, Downstream, and Related Entity, and Provider requirements for reporting suspicions or allegations of ANE.

2.1.3.1.4. Comply with all aspects of the joint Readiness Review.

2.1.3.2. HHSC and CMS shall report to the appropriate agency any information it receives that indicates a violation of a law or regulation.

2.1.3.3. HHSC or CMS will inform the STAR+PLUS MMP and each other of any such report unless the appropriate agency to which HHSC or CMS has reported requests that HHSC or CMS not inform the STAR+PLUS MMP.

2.1.4. Program Integrity

2.1.4.1.1. The STAR+PLUS MMP will adopt and implement an effective compliance program that applies to its operations consistent with 42 C.F.R § 420, et seq, 42 C.F.R. § 422.503, and 42 C.F.R. §§ 438.600-610, 42 C.F.R. § 455.200 et. seq. The compliance program must, at a minimum, include written policies, procedures, and standards of conduct that:

2.1.4.1.2. Articulate the STAR+PLUS MMP 's commitment to comply with all applicable federal and state standards, including:

2.1.4.1.2.1. Fraud detection and investigation;

2.1.4.1.2.2. Procedures to guard against Fraud, Waste, and Abuse;

2.1.4.1.2.3. Prohibitions on certain relationships as required by 42 C.F.R. § 438.610;

2.1.4.1.2.4. Obligation to suspend payments to Providers;

2.1.4.1.2.5. Disclosure of ownership and control of STAR+PLUS MMP;

2.1.4.1.2.6. Disclosure of business transactions;

2.1.4.1.2.7. Disclosure of information on persons convicted of health care crimes; and

2.1.4.1.2.8. Reporting Adverse Actions taken for Fraud, Waste, Abuse, or quality.

2.1.4.1.3. Describe compliance expectations as embodied in the STAR+PLUS MMP's standards of conduct;

2.1.4.1.4. Implement the operation of the compliance program;

2.1.4.1.5. Provide guidance to employees and others on dealing with potential compliance issues;

2.1.4.1.6. Identify how to communicate compliance issues to appropriate compliance personnel;

2.1.4.1.7. Describe how potential compliance issues are investigated and resolved by the STAR+PLUS MMP; and

2.1.4.1.8. Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

2.1.4.2. The STAR+PLUS MMP must designate one primary and one secondary contact person for all HHSC OIG records requests. HHSC OIG records requests will be sent to the designated contact person(s) in writing via email, fax, or regular mail, and will provide the specifics of the information being requested. The STAR+PLUS MMP will respond to the appropriate HHSC OIG staff Enrollee within the timeframe designated in the request. If the STAR+PLUS MMP is unable to provide all of the requested information with in the designated timeframe, an extension may be granted and must be request in writing (email) by the STAR+PLUS MMP no less than two business days prior to the due date. When a request for data is provided to the STAR+PLUS MMP, the STAR+PLUS MMP's response must include data for all data fields, as available. If any data field is left blank, an explanation must accompany the response. The data must be provided in the order and format requested. The STAR+PLUS MMP must not include any additional data fields in its response. All requested information must be accompanied by a notarized business records affidavit unless indicated otherwise in HHSC OIG's record request.

2.1.4.3. The STAR+PLUS MMP must submit a written Fraud and Abuse compliance plan to the HHSC OIG for approval each year. The Fraud, Waste, and Abuse compliance plan must be submitted ninety (90) days prior to the start of the State Fiscal Year.

2.1.4.4. The STAR+PLUS MMP is subject to and must meet all requirements in Section 531.113 of the Texas Government Code, Section 533.012 of the Texas Government Code, Title 1 Texas Administrative Code (TAC), Part 15, Chapter 353, Subchapter F, Rule 353.501-353.505, and Title 1 TAC, Part 15, Chapter 370, Subchapter F, Rule 370.501-370.505 as well as all applicable State and federal lows. Additionally, the STAR+PLUS MMP must require all employees who process Medicaid Claims, including First Tier, Downstream, and Related Entities , to attend annual training as provided by HHSC per Texas Government Code § 531.105. Failure to comply with any requirement outlined in this Section subjects the STAR+PLUS MMP to enforcement pursuant to 1 TAC Chapter 371 Subchapter G in addition to any other legal remedy.

2.1.4.5. The STAR+PLUS MMP must refer suspected cases of Network Provider, Out-of-Network Provider, or Enrollee Fraud, Abuse, or Waste to the Texas Office of Inspector General (OIG) as well as CMS as required by Section 2.1.5.

2.1.4.6. The STAR+PLUS MMPs shall contract with EVV Vendors who use a system to verify attendant care services, and other services as identified by UMCM Chapter 8.7. STAR+PLUS MMPs must contract with EVV Vendors for the provision of EVV services in a manner consistent with the UMCM. The STAR+PLUS MMPs may not pass EVV transaction costs to Network Providers.

2.1.5. Fraud, Waste, and Abuse

2.1.5.1. A STAR+PLUS MMP is subject to all state and federal laws and regulations relating to Fraud, Waste, and Abuse in health care and the Medicaid and Medicare programs. The STAR+PLUS MMP must cooperate and assist CMS, the HHSC Office of Inspector General (OIG), and any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected Fraud, Waste, or Abuse. In order to facilitate cooperation with (OIG), the STAR+PLUS MMP must have staff available for Special Investigative Unit (SIU) either in-house or by contract with

another entity, to investigate possible acts of fraud, waste, or abuse for all services provided under the Contract, including those that the STAR+PLUS MMP subcontracts to outside entities.

2.1.5.1.1. The STAR+PLUS MMP's SIU does not have to be physically located in Texas but must be adequately staffed to handle Texas volume. The SIU must have adequate staff and resources apportioned at the levels and experience sufficient to effectively work Texas cases based on objective criteria considering, but not necessarily limited to, the STAR+PLUS MMP's total Enrollee population, claims processes, risk exposure, current caseload, and other duties as described in 1 Tex. Admin. Code §§ 353.501-353.505, and 1 Tex. Admin. Code §§ 370.501-370.505.

2.1.5.1.2. The STAR+PLUS MMP must submit a written Fraud and Abuse compliance plan to OIG for approval each year. The Fraud and Abuse compliance plan must be submitted ninety (90) days prior to the start of the SFY. If the STAR+PLUS MMP has not made any changes to its Fraud and Abuse compliance plan from the previous year, it may notify OIG that: (1) no changes have been made to the previously-approved Fraud and Abuse compliance plan and (2) the Fraud and Abuse compliance plan will remain in place for the upcoming SFY. The notification must be signed and certified by an officer or director of the STAR+PLUS MMP that is responsible for carrying out the Fraud and Abuse compliance plan. Upon receipt of a written request from OIG, the STAR_PLUS MMP must submit the complete Fraud and Abuse compliance plan.

2.1.5.2. The STAR+PLUS MMP must allow access to all premises and provide originals or copies of all records and information requested free of charge to the HHSC OIG, 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, the Office of the Attorney General, the Texas Department of Insurance (TDI), or other units of state government

2.1.5.3. The most common requests will include:

2.1.5.3.1. 1099 data and other financial information – three (3) business days.

2.1.5.3.2. Claims data for sampling – five (5) business days.

2.1.5.3.3. Urgent Claims data requests – three (3) business days (with OIG manager's approval).

2.1.5.3.4. Provider education information – ten (10) business days.

2.1.5.3.5. Files associated with an HMO conducted investigation – fifteen (15) business days.

2.1.5.3.6. Other time-sensitive requests – as needed.

2.1.5.4. The STAR+PLUS MMP is subject to and must meet all requirements in Texas Government Code § 531.113, Texas Government Code § 533.012, 1 Tex. Admin. Code §§ 353.501-353.505, and 1 Tex. Admin. Code §§ 370.501-370.505 as well as all laws specified in the Contract. Additionally, the STAR+PLUS MMP must require all employees who process Medicaid Claims, including First Tier, Downstream, and Related Entities, to attend annual training as provided by HHSC per Texas Government Code § 531.105. The STAR+PLUS MMP must perform pre-payment review for identified providers as directed by OIG. Failure to comply with any requirement of this Section subjects the STAR+PLUS MMP to enforcement pursuant to 1 T.A.C. Chapter 371 Subchapter G in addition to any other legal remedy. 42 C.F.R. § 455.23 requires the State Medicaid agency to suspend all Medicaid payments to a Provider after the agency determines there is a credible allegation of Fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or suspend payment only in part. In Texas, HHSC OIG is responsible for evaluating allegations of Fraud and imposing payment suspensions when appropriate. The rules governing payment suspensions based upon pending investigations of credible allegations of Fraud apply to STAR+PLUS MMPs. Capitation payments may be included in a suspension when an individual Network Provider is under investigation based upon credible allegations of Fraud, depending on the allegations at issue.

2.1.5.5. The STAR+PLUS MMP must cooperate with HHSC OIG when HHSC OIG imposes payment suspensions or lifts a payment hold. When HHSC OIG sends notice that payments to a Provider have been suspended, the STAR+PLUS MMP must also suspend payments to the Provider within one (1) business day. When notice of a payment hold or a paymant hold lift is

received, the STAR+PLUS MMP must respond to the notice within three (3) business days and inform HHSC OIG of action taken.

2.1.5.6. The STAR+PLUS MMP must follow the requirements set forth in a settlement agreement involving a STAR+PLUS MMP's Provider and HHSC OIG. The STAR+PLUS MMP must withhold the designated percentage of funds to be paid toward an identified overpayment. Upon HHSC OIG request, the STAR+PLUS MMP must forward the held funds to HHSC OIG, Attn: Sanctions Division, along with an itemized spreadsheet detailing the Provider's Claims paid so that the Claims data can be reconciled with the monthly Remittance & Status statements. The STAR+PLUS MMP must also report all of the following information to HHSC OIG after it suspends payments to the Provider: date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, outcome of any appeals, amount of payments held, and, if applicable, the good cause rationale for not suspending payment (for example, the Provider is not enrolled in the STAR+PLUS MMP's network) or imposing a partial payment suspension. If the STAR+PLUS MMP does not suspend payments to the Provider, or if the STAR+PLUS MMP does not correctly report the amount of adjudicated payments on hold,, HHSC may impose contractual or other remedies. The STAR+PLUS MMP must report the fully adjudicated hold amount on the monthly open case list report required by UMCM Chapter 5.5 and provide this information to HHSC OIG upon request.

2.1.5.7. For payment suspensions initiated by the STAR+PLUS MMP, the STAR+PLUS MMP must report the following information to HHSC OIG: the nature of the suspected Fraud, basis for the suspension, date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, outcome of any appeals, the amount of payments held, and, if applicable, the good cause rationale for imposing a partial payment suspension.

2.1.5.8. STAR+PLUS MMPs must maintain all documents and Claims data on Providers who are under HHSC OIG investigation or any internal investigations that are referred to HHSC OIG for recoupment. The STAR+PLUS MMP's failure to comply with requirements in this Section and all state and federal laws and regulations relating to Fraud, Waste, and Abuse in healthcare and the Medicaid and Medicare programs are subject to

administrative enforcement by HHSC OIG as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G.

2.1.5.9. Additional Requirements for STAR+PLUS MMPs: In accordance with Section 1902(a)(68) of the Social Security Act, STAR+PLUS MMPs and their First Tier, Downstream, and Related Entities that receive or make annual Medicaid payments of at least $5 million must:

2.1.5.9.1. Establish written policies for all employees, managers, officers, and agents of the STAR+PLUS MMP or First Tier, Downstream, and Related Entities. The policies must provide detailed information about the False Claims Act, administrative remedies for false Claims and statements, any state laws about civil or criminal penalties for false Claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A);

2.1.5.9.2. Include as part of such written policies detailed provisions regarding the STAR+PLUS MMP's or First Tier, Downstream, and Related Entities' policies and procedures for detecting and preventing Fraud, Waste, and Abuse; and

2.1.5.9.3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the STAR+PLUS MMP's or First Tier, Downstream, and Related Entities' policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

2.2. Contract Readiness Review and STAR+PLUS MMP Management Requirements

2.2.1. Contract Readiness Review Requirements

2.2.1.1. CMS and HHSC, or their designee, will conduct a Readiness Review of each STAR+PLUS MMP, which must be completed successfully, as determined by CMS and HHSC, prior to the Contract Operational Start Date.

2.2.1.2. CMS and HHSC Readiness Review Responsibilities

2.2.1.2.1. CMS and HHSC or their designees will conduct a Readiness Review of each STAR+PLUS MMP that will include, at a minimum, one on-site review. This review shall be completed prior to marketing to and Enrollment of Eligible Beneficiaries into the STAR+PLUS MMP. CMS and HHSC or their designees will conduct the Readiness Review to verify the STAR+PLUS MMP's assurances that the STAR+PLUS MMP is ready and able to meet its obligations under the Contract.

2.2.1.2.2. The scope of the Readiness Review will include a review of the following elements:

2.2.1.2.2.1. Network Provider composition and access, in accordance with Section 2.7;

2.2.1.2.2.2. Staffing, including key personnel and functions directly impacting Enrollees (e.g., adequacy of Member Services staffing, in accordance with Section 2.2.2;

2.2.1.2.2.3. Capabilities of First Tier, Downstream or Related Entities, in accordance with Appendix C;

2.2.1.2.2.4. Care management capabilities, in accordance with Section 2.5;

2.2.1.2.2.5. Member Services capability (materials, processes and infrastructure, e.g., call center capabilities), in accordance with Sections 2.8, 2.9, and 2.15;

2.2.1.2.2.6. Comprehensiveness of quality management/quality improvement and Utilization Management (UM) strategies, in accordance with Section 2.14.5;

2.2.1.2.2.7. Internal Grievance and Appeal policies and procedures, in accordance with Sections 2.11 and 2.12;

2.2.1.2.2.8. Fraud, Waste, and Abuse and program integrity policies and procedures, in accordance with Section 2.1.4;

2.2.1.2.2.9. Financial solvency, in accordance with Section 2.16;

2.2.1.2.2.10. Information systems, including Claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with Section 2.18, including IT testing and security assurances.

2.2.1.2.3. No individual shall be enrolled into the STAR+PLUS MMP unless and until CMS and HHSC determine that the STAR+PLUS MMP is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

2.2.1.2.4. CMS and HHSC or their designee will identify to the STAR+PLUS MMP all areas where a STAR+PLUS MMP is not ready and able to meet its obligations under the Contract and provide an opportunity for the STAR+PLUS MMP to remedy all deficiencies prior to the Contract Operational Start Date.

2.2.1.2.5. CMS or HHSC may, at its discretion, postpone the Contract Operational Start Date for the STAR+PLUS MMP that fails to satisfy any or all Readiness Review requirements. If, for any reason, the STAR+PLUS MMP does not fully satisfy CMS or HHSC that it is ready and able to perform its obligations under the Contract prior to the Contract Operational Start Date, and CMS or HHSC do not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then CMS or HHSC may terminate the Contract.

2.2.1.3. STAR+PLUS MMP Readiness Review Responsibilities

2.2.1.3.1. The STAR+PLUS MMP must demonstrate to CMS and HHSC's satisfaction that the STAR+PLUS MMP is ready and able to meet all Contract requirements identified in the Readiness Review prior to the Contract Operational Start Date, and prior to the STAR+PLUS MMP engaging in marketing of its Demonstration product.

2.2.2. STAR+PLUS MMP Administration & Management

2.2.2.1. Qualifications, retention and replacement of STAR+PLUS MMP employees.

2.2.2.1.1. The STAR+PLUS MMP agrees to maintain the organizational and administrative capacity and capabilities to carry out all duties and responsibilities under this Contract. The personnel the STAR+PLUS MMP assigns to perform the duties and responsibilities under this Contract will be properly trained and qualified for the functions they are to perform. The STAR+PLUS MMP shall establish and maintain the interdepartmental structures and processes to support the operation and management of its Demonstration line of business in a manner that fosters integration of physical health, behavioral health, and community-based and facility-based LTSS service provisions. The STAR+PLUS MMP shall describe the interdepartmental structures and processes to support the operation and management of its Demonstration line of business.

2.2.2.1.2. Notwithstanding transfer or turnover of personnel, the STAR+PLUS MMP remains obligated to perform all duties and responsibilities under this Contract without degradation and in accordance with the terms of this Contract.

2.2.2.2. Support and replacement of key personnel.

2.2.2.2.1. The STAR+PLUS MMP 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 STAR+PLUS MMP 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 STAR+PLUS MMP must maintain the overall level of expertise, experience, and skill reflected in the key STAR+PLUS MMP personnel job descriptions and qualifications.

2.2.2.2.2. On an annual basis, and on an ad hoc basis when changes occur or as directed by HHSC or CMS, the STAR+PLUS MMP shall submit to the Contract Management Team (CMT) an overall organizational chart that includes key personnel and other senior managers.

2.2.2.2.3. If any Demonstration-specific services and activities are provided by a First Tier, Downstream, or Related Entity, the STAR+PLUS MMP shall submit the organizational chart of the First Tier, Downstream, or Related Entity that clearly demonstrates the relationship with the First Tier, Downstream, or Related Entity and the STAR+PLUS MMP's oversight of the First Tier, Downstream, or Related Entity.

2.2.2.3. Notification of replacement of key personnel

2.2.2.3.1. The STAR+PLUS MMP must notify the CMT within fifteen (15) business days of any change in key personnel as designated in Section 2.2.2.4. 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 STAR+PLUS MMP in writing. Upon receipt of HHSC's notice, HHSC and STAR+PLUS MMP will attempt to resolve HHSC's concerns on a mutually agreeable basis.

2.2.2.4. Key Personnel – The STAR+PLUS MMP must designate key management and technical personnel who will be assigned to the Contract.

2.2.2.4.1. Executive Director – The STAR+PLUS MMP must employ a qualified individual to serve as the Executive Director (also referred to as "CEO – Senior Official for Contracting") for all its HHSC Program(s), including the STAR+PLUS MMP.

2.2.2.4.1.1. Such Executive Director must be employed full-time by the STAR+PLUS MMP, be primarily dedicated to HHSC Program(s), and must hold a senior executive or management position in the STAR+PLUS MMP's organization, except that the STAR+PLUS MMP may propose an alternate structure for the Executive Director position, subject to HHSC's prior written approval.

2.2.2.4.1.2. The Executive Director must be authorized and empowered to represent the STAR+PLUS MMP regarding all matters pertaining to the Contract prior to such representation. The Executive Director must act as liaison between the STAR+PLUS MMP, HHSC, and CMS and must have responsibilities that include, but are not limited to, the following:

2.2.2.4.1.2.1. Ensure the STAR+PLUS MMP's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

2.2.2.4.1.2.2. Receive and respond to all inquiries and requests made by CMS, HHSC, or both in timeframes and formats specified by CMS and HHSC;

2.2.2.4.1.2.3. Acting as an ADA compliance director and/or point of contact for reasonable accommodations,

2.2.2.4.1.2.4. Represent the STAR+PLUS MMP at the HHSC or CMS meetings;

2.2.2.4.1.2.5. Coordinate requests and activities among the STAR+PLUS MMP, all First Tier, Downstream, and Related Entities, CMS, and HHSC;

2.2.2.4.1.2.6. Make best efforts to promptly resolve any issues related to the Contract identified either by the STAR+PLUS MMP, CMS, or HHSC;

2.2.2.4.1.2.7. Meet with the CMT at the time and place requested by the CMT if either CMS or HHSC or both determine that the STAR+PLUS MMP is not in compliance with the requirements of the Contract; and

2.2.2.4.1.2.8. Attend and participate in regular HHSC Regional Advisory Committees (RACs) for managed care (the Executive Director may designate alternative key personnel to attend a RAC if the Executive Director is unable to attend).

2.2.2.4.2. Medical Director – The STAR+PLUS MMP must have a qualified individual to serve as the Medical Director for its STAR+PLUS MMP Program.

2.2.2.4.2.1. The Medical Director must be currently licensed in Texas under the Texas Medical Board as an M.D. or D.O. with no restrictions or other licensure limitations. The Medical Director must comply with the requirements of 28 TAC §11.1606 and all applicable federal and state statutes and regulations.

2.2.2.4.2.2. The Medical Director, or his or her designee, must be reasonably available 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 Enrollees, including after regular business hours.

2.2.2.4.2.3. The Medical Director, or his or her designee, must be authorized and empowered to represent the STAR+PLUS MMP regarding clinical issues, Utilization Review and quality of care inquiries. The Medical Director, or his or her designee, must exercise independent medical judgment in all decisions relating to medical necessity. The STAR+PLUS MMP 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.

2.2.2.4.2.4. For purposes of this section, the Medical Director's designee must be:

2.2.2.4.2.4.1. A physician that meets the qualifications for a Medical Director; or

2.2.2.4.2.4.1. For prior authorization determinations for outpatient pharmacy benefits, a Texas-licensed pharmacist working under the direction of the Medical Director and meeting the Medicare Part D requirements in 42 CFR 423.562(a)(5), provided such delegation is included in the STAR+PLUS MMP TDI-approved utilization review plan. This requirement applies only to Medicaid covered drugs. Prior authorization determinations for Part D-covered drugs are governed by Appendix D.

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

2.2.2.4.3. Compliance Officer

2.2.2.4.3.1. The STAR+PLUS MMP Compliance Officer shall fulfill the requirements under 42 C.F.R. §§ 422.503(b)(4)(vi)(B), 423.504(b)(4)(vi)(B), and 438.608(b)(2).

2.2.2.4.4. In addition, key personnel are those with management responsibility or principal technical responsibility for the following functional areas for the STAR+PLUS MMP:

2.2.2.4.4.1. Member Services;

2.2.2.4.4.2. Management Information Systems (also referred to as “System Contact”);

2.2.2.4.4.3. Claims Processing (also referred to as “MA Claims Processing Contact for Public Website”);

2.2.2.4.4.4. Provider Network Development and Management;

2.2.2.4.4.5. Benefit Administration and Utilization and Care Management (also referred to as “Utilization Management Contact”);

2.2.2.4.4.6. Quality Improvement (also referred to as “Quality Contact”);

2.2.2.4.4.7. Behavioral Health Services;

2.2.2.4.4.8. Financial Functions (also referred to as "Financial Reporting Contact");

2.2.2.4.4.9. Reporting (also referred to as "MMP Reporting Requirements Contact"); and

2.2.2.4.4.10. Management positions for STAR+PLUS MMP Service Coordinators for STAR+PLUS MMP.

2.2.2.4.1. If the CMT is concerned that any of the key personnel are not performing the responsibilities, including but not limited to, those provided for in the person's position, the CMT shall inform the STAR+PLUS MMP of this concern. The STAR+PLUS MMP shall investigate said concerns promptly, take any actions the STAR+PLUS MMP reasonably determines necessary to ensure full compliance with the terms of this Contract, and notify the CMT of such actions. If the STAR+PLUS MMP's actions fail to ensure full compliance with the terms of this Contract, as determined by the CMT, the provisions in Sections 5.3.13, 5.3.14, 5.3.15, 5.3.16, and 5.3.17 may be invoked by the CMT.

2.3. Eligibility and Enrollment Responsibilities

2.3.1. Eligibility Determinations

2.3.1.1. CMS and HHSC shall have sole responsibility for determining the eligibility of an Enrollee for Medicare- and Medicaid-funded services. CMS and HHSC or their designees shall have sole responsibility for determining Enrollment in the STAR+PLUS MMP's plan.

2.3.1.2. CMS and the State will utilize an independent third party entity to facilitate all Enrollment into the STAR+PLUS MMPs.

2.3.1.3. All Enrollment and Disenrollment transactions, including Enrollments from one STAR+PLUS MMP to a different STAR+PLUS MMP, will be processed through the Administrative Services Contractor except those transactions related to non-Demonstration plans participating in Medicare Advantage.

2.3.1.4. STAR+PLUS MMP Enrollments, including Enrollment from one STAR+PLUS MMP to a different STAR+PLUS MMP,

and Opt-Outs shall become effective on the same day for both Medicare and Medicaid.

2.3.1.5. For those who lose Medicaid eligibility during the month, coverage and federal financial participation (FFP) will continue through the end of that month.

2.3.1.6. In addition to the groups listed in the MOU between Texas and CMS signed May 23, 2014, individuals with Third Party Health Insurance will be ineligible for Enrollment in a STAR+PLUS MMP.

2.3.2. General Enrollment

2.3.2.1. HHSC will begin opt-in Enrollment prior to the initiation of Passive Enrollment. During this opt-in Enrollment period, Eligible Beneficiaries may choose to enroll into a particular STAR+PLUS MMP. Eligible Beneficiaries who do not select an STAR+PLUS MMP or who do not Opt-Out- of the Demonstration will be assigned to a STAR+PLUS MMP during Passive Enrollment.

2.3.2.2. The first effective Enrollment date for this initial opt-in period is scheduled for no earlier than March 1, 2015.

2.3.2.3. Beneficiary-elected Enrollments are effective the first day of the month following the month in which the beneficiary is eligible, or the first day of the month following the initial receipt of a beneficiary's request to enroll, as long as the request to enroll is received before the cutoff date.

2.3.2.4. Requests to opt-in, which includes Enrollment or change from one STAR+PLUS MMP and enroll into a different STAR+PLUS MMP, will be accepted through the 12th of the month for an effective date of coverage the first calendar day of the next month. Enrollment requests received after the 12th of the month will be effective the first calendar day of the second month following initial receipt of the request.

2.3.3. Passive Enrollment

2.3.3.1. HHSC may conduct Passive Enrollment during the term of the Contract to assign Eligible Beneficiaries who do not select a STAR+PLUS MMP, Opt-Out or disenroll from the Demonstration. Eligible beneficiaries who have Third Party Health Insurance will not be passively enrolled in the Demonstration.

2.3.3.2. Passive Enrollment is effective no sooner than sixty (60) calendar days after beneficiary notification of plan selection and the right to select a different STAR+PLUS MMP or with the option to opt out until the last day of the month prior to the Enrollment effective date.

2.3.3.3. For the first six (6) months of this Demonstration, CMS and the State will monitor each STAR+PLUS MMPs' ability to serve Enrollees enrolled through opt-in and Passive Enrollments.

2.3.3.4. Dependent on each STAR+PLUS MMP's capacity, as determined by its ability to manage the opt-in Enrollments and the prior month's Passive Enrollments (once applicable), the State will passively enroll a number of beneficiaries into the STAR+PLUS MMP that takes into consideration the number of opt-in Enrollments and the Opt-Out rate for each STAR+PLUS MMP. Furthermore:

2.3.3.4.1. In Harris County, the Passive Enrollment phase-in will occur over a period of at least six (6) months and will not exceed five thousand (5,000) beneficiaries per month per STAR+PLUS MMP; and

2.3.3.4.2. In the remaining Demonstration counties as outlined in Appendix H, the Passive Enrollment phase-in will occur over a period of at least six (6) months and will not exceed three thousand (3,000) beneficiaries per month per STAR+PLUS MMP per county.

2.3.3.5. HHSC and CMS must agree to any changes to the Enrollment effective dates. CMS will provide identifying information to HHSC about Eligible Beneficiaries prior to the effective date of each phase of Passive Enrollment.

2.3.3.6. HHSC will apply an intelligent methodology to assign Eligible Beneficiaries to a STAR+PLUS MMP, which will include at minimum:

2.3.3.6.1. Previous managed care Enrollment, including current STAR+PLUS MCO or Medicare Advantage. Enrollees may be passively enrolled from their current STAR+PLUS MCO or Medicare Advantage plan to the same organization's STAR+PLUS MMP;

2.3.3.6.2. Existing and historic Provider relationships;

2.3.3.6.3. CMS and HHSC may stop Passive Enrollment to a STAR+PLUS MMP if the STAR+PLUS MMP does not meet reporting requirements necessary to maintain Passive Enrollment as set forth by CMS and HHSC.

2.3.3.7. Enrollment Transactions

2.3.3.7.1. Enrollments and Disenrollments will be processed through HHSC or its Administrative Services Contractor consistent with the Enrollment effective date requirements set forth in the Medicare-Medicaid Enrollment and Disenrollment Guidance. HHSC or its Administrative Services Contractor will then submit Passive Enrollment transactions sixty (60) calendar days in advance of the effective date, to the CMS Medicare Advantage Prescription Drug (MARx) Enrollment system directly or via a third-party CMS designates to receive such transactions, and HHSC or its Administrative Services Contractor will receive notification on the next Daily Transaction Reply Report. The STAR+PLUS MMP will then receive Enrollment transactions from HHSC or its Administrative Services Contractor. The STAR+PLUS MMP will also use the third-party CMS designates to submit additional Enrollment-related information to MARx, and receive files from CMS on a daily basis.

2.3.3.7.2. The STAR+PLUS MMP must have a mechanism for receiving timely information about all Enrollments in the STAR+PLUS MMP, including the effective Enrollment date, from CMS and HHSC systems on a daily basis.

2.3.3.7.3. The STAR+PLUS MMP shall accept for Enrollment all Eligible Beneficiaries, as described in Section 3.1.2.2. The STAR+PLUS MMP shall accept for Enrollment all Eligible Beneficiaries identified by CMS and HHSC at any time without regard to income status, physical or mental condition, age, gender, sexual orientation, religion, creed, race, color, physical or mental Disability, national origin, ancestry, pre-existing conditions, expected health status, or need for health care services.

2.3.3.7.4. Upon instruction by HHSC and CMS, the Administrative Services Contractor may not enroll new Enrollees within six (6) months of the end date of the Demonstration, unless the Demonstration is renewed or extended.

2.3.3.7.5. HHSC and CMS will monitor Enrollments, including Passive Enrollments, and Disenrollments to and from all STAR+PLUS MMPs and may make adjustments to the volume and spacing of Passive Enrollment phases based on the capacity of the STAR+PLUS MMP, and of STAR+PLUS MMPs in aggregate, to accept projected Passive Enrollments. Adjustments to the volume of Passive Enrollment based on the capacity of the STAR+PLUS MMP will be subject to any capacity determinations, including but not limited to, those documented in the CMS and HHSC final Readiness Review report and ongoing monitoring by CMS and HHSC.

2.3.3.7.6. The STAR+PLUS MMP must cover continuation of services to Enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until Discharge.

2.3.4. Enrollment Notices

2.3.4.1. The State will provide Eligible Beneficiaries with notice of the option to select a STAR+PLUS MMP at least sixty (60) days prior to the effective date of Passive Enrollment and will accept Opt-Out requests through the last day of the month prior to the effective date of Enrollment and at any time during the Demonstration period on a monthly basis. The notice will:

2.3.4.1.1. Explain the Enrollee's options, including the option to Opt-Out of or disenroll from the Demonstration.

2.3.4.1.2. Include the name of the STAR+PLUS MMP in which the Eligible Beneficiary will be enrolled unless he/she selects another STAR+PLUS MMP or chooses to Opt-Out of the Demonstration; and

2.3.4.1.3. A list of Flexible Benefits offered by each STAR+PLUS MMP.

2.3.4.2. No later than thirty (30) days prior to the Enrollment effective dates, the State will provide a second notice to Eligible Beneficiaries who have not made an active choice to either

select a STAR+PLUS MMP or Opt-Out of the Demonstration. In addition to requirements in section 2.3.4.1, the notice will:

2.3.4.2.1. Include the name of the STAR+PLUS MMP in which the Eligible Beneficiary will be enrolled unless he/she selects another STAR+PLUS MMP or chooses to Opt-Out of the Demonstration.

2.3.4.3. The State will proceed with Passive Enrollment into the identified STAR+PLUS MMP for Eligible Beneficiaries who do not make a different choice, with an effective date of the first day of the referenced month.

2.3.5. Disenrollment

2.3.5.1. **Voluntary Disenrollment**: The STAR+PLUS MMP shall have a mechanism for receiving timely information about all Disenrollments from the STAR+PLUS MMP, including the effective date of Disenrollment, from CMS and HHSC or its Administrative Services Contractor. All Disenrollment-related transactions will be performed by HHSC or the Administrative Services Contractor consistent with the enrollment effective date requirements set forth in the Medicare-Medicaid Enrollment and Disenrollment Guidance. Enrollees can elect to disenroll from the STAR+PLUS MMP or the Demonstration at any time and enroll in another STAR+PLUS MMP, a STAR+PLUS MCO, a Medicare Advantage plan, PACE; or may elect to receive services through Medicare fee-for-service (FFS) and a prescription drug plan and to receive Medicaid services in accordance with the Texas State Plan and any waiver programs (if eligible). Disenrollments received by HHSC or its Administrative Services Contractor, or by CMS or its contractor, either orally or in writing, by the last calendar day of the month will be effective on the first calendar day of the following month.

2.3.5.1.1. The STAR+PLUS MMP may not request Disenrollment on behalf of an Enrollee, except as outlined in Section 40.3 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.

2.3.5.1.2. The STAR+PLUS MMP shall be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of Disenrollment.

2.3.5.2. Requests to disenroll from a STAR+PLUS MMP or Opt-Out of the Demonstration will be accepted at any point after an individual's initial Enrollment occurs and are effective on the first day of the month following receipt of request.

2.3.5.3. Any time an individual requests to Opt-Out of Passive Enrollment or disenrolls from the Demonstration, the State or the Administrative Services Contractor will send a letter confirming the Opt-Out and disenrollment effective date in addition to providing information on the Medicaid benefits available to the beneficiary once they have opted out or disenrolled, and contact information to receive more information about Medicare benefits.

2.3.5.4. The STAR+PLUS MMP shall be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of Disenrollment.

2.3.5.5. The STAR+PLUS MMP shall not interfere with the Enrollee's right to disenroll through threat, intimidation, pressure, or otherwise.

2.3.5.6. The STAR+PLUS MMP shall not request the Disenrollment of any Enrollee due to an adverse change in the Enrollee's health status or because of the Enrollee's utilization of treatment plan, medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. The STAR+PLUS MMP, however, may submit a written request, accompanied by supporting documentation, to the Contract Management Team (CMT) to disenroll an Enrollee, for cause, for the following reason:

2.3.5.6.1. The Enrollee's continued Enrollment seriously impairs the STAR+PLUS MMP's ability to furnish services to either this Enrollee or other Enrollees, provided the Enrollee's behavior is determined to be unrelated to an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

2.3.5.7. **Required Involuntary Disenrollments.** Texas and CMS shall terminate an Enrollee's Enrollment in the STAR+PLUS MMP upon the occurrence of any of the conditions enumerated in Section 40.2 of the most current Medicare-Medicaid Plan Enrollment and Disenrollment Guidance or upon the

occurrence of any of the conditions described in this section. Except for the CMT's role in reviewing documentation related to an Enrollee's residence outside the Service Area or alleged material misrepresentation of information regarding third-party reimbursement coverage, as described in this section, the CMT shall not be responsible for processing Disenrollments under this section. Further, nothing in this section alters the obligations of the parties for administering Disenrollment transactions described elsewhere in this Contract.

2.3.5.7.1. If the STAR+PLUS MMP becomes aware of any conditions enumerated in Sections 40.2 of the most current Medicare-Medicaid Plan Enrollment and Disenrollment Guidance that would prompt termination of coverage, STAR+PLUS MMP shall notify the HHSC Administrative Services Contractor of any individual who is no longer eligible to remain enrolled in the Demonstration per CMS Enrollment guidance, in order for the HHSC Administrative Services Contractor to disenroll the Enrollee.

2.3.5.7.2. The STAR+PLUS MMP shall notify HHSC when an Enrollee has private or Third Party Health Insurance coverage with the STAR+PLUS MMP or any other carrier:

2.3.5.7.2.1. Within fifteen (15) business days when an Enrollee is verified as having Third Party Health Insurance with the STAR+PLUS MMP, as defined herein.

2.3.5.7.2.2. Within fifteen (15) business days of the date when the STAR+PLUS MMP becomes aware that an Enrollee has any health care insurance coverage with any other insurance carrier. The STAR+PLUS MMP is not responsible for the determination of Third Party Health Insurance.

2.3.5.7.3. Any Enrollee with Third Party Health Insurance will be disenrolled from the STAR+PLUS MMP.

2.3.5.7.4. The Enrollment of any Enrollee under this Contract shall be terminated if the Enrollee becomes ineligible for Enrollment due to a change in eligibility status. When an Enrollee's Enrollment is terminated for eligibility, the termination shall be effective:

2.3.5.7.4.1. The first day of the month following the month in which the eligibility is lost or person determined to be out of the Service Area.

2.3.5.7.5. Upon the Enrollee's death. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month in which the Enrollee dies. Termination may be retroactive to this date.

2.3.5.7.6. When an Enrollee remains out of the Service Area or for whom residence in the Service Area cannot be confirmed for more than six (6) consecutive months.

2.3.5.7.7. When CMS or HHSC is made aware that an Enrollee is incarcerated in a county jail, Texas Department of Corrections facility, or Federal penal institution. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month during which the Enrollee was incarcerated.

2.3.5.7.8. The termination or expiration of this Contract terminates coverage for all Enrollees with the STAR+PLUS MMPs. Termination will take effect at 11:59 p.m. on the last day of the month in which this Contract terminates or expires, unless otherwise agreed to, in writing, by the Parties.

2.3.5.7.9. When the CMT approves a request based on information sent from any party to the Demonstration showing that an Enrollee has materially misrepresented information regarding third-party reimbursement coverage according to Section 40.2.6 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.

2.3.5.7.10. If an Enrollee is to be disenrolled at the request of the STAR+PLUS MMP under the provisions of this Section, the STAR+PLUS MMP must first provide documentation satisfactory to the CMT that the Enrollee meets one of the disenrollment criteria as outlined in the MOU or Section 2.3.5.7.. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which the CMT determines that the Enrollee no longer resides in the Service Area. Termination may be retroactive if requested by the Enrollee and if HHSC and CMS are able to determine the month in which the Enrollee moved from the Service Area.

2.3.5.8. Discretionary Involuntary Disenrollment: 42 C.F.R. § 422.74 and Sections 40.3 and 40.4 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance provide instructions to STAR+PLUS MMPs on discretionary involuntary disenrollment. This Contract and other guidance provides procedural and substantive requirements the STAR+PLUS MMP, HHSC, and CMS must follow prior to involuntarily disenrolling an Enrollee. If all of the procedural requirements are met, HHSC and CMS will decide whether to approve or deny each request for involuntary disenrollment based on an assessment of whether the particular facts associated with each request satisfy the substantive evidentiary requirements.

2.3.5.8.1. Bases for Discretionary Involuntary Disenrollment

2.3.5.8.1.1. Disruptive conduct: When the Enrollee engages in conduct or behavior that seriously impairs the STAR+PLUS MMP's ability to furnish Covered Items and Services to either this Enrollee or other Enrollees and provided the STAR+PLUS MMP made and documented reasonable efforts to resolve the problems presented by the Enrollee.

2.3.5.8.1.2. Procedural requirements:

2.3.5.8.1.2.1. The STAR+PLUS MMP's request must be in writing and include all of the supporting documentation outlined in the evidentiary requirements.

2.3.5.8.1.2.2. The process requires three (3) written notices. The STAR+PLUS MMP must include in the request submitted to HHSC and CMS evidence that the first two (2) have already been sent to the Enrollee. The notices are:

2.3.5.8.1.2.2. 1. Advance notice to inform the Enrollee that the consequences of continued disruptive behavior will be disenrollment. The advance notice must include a clear and thorough explanation of the disruptive conduct and its impact on the STAR+PLUS MMP's ability to provide services, examples of the types of reasonable accommodations the STAR+PLUS MMP has already offered, the grievance procedures, and an explanation of the availability of other accommodations. If the disruptive behavior ceases after the Enrollee receives notice and then later resumes, the STAR+PLUS MMP must begin the process again. This includes sending another advance notice.

2.3.5.8.1.2.2. 2. Notice of intent to request the State and CMS' permission to disenroll the Enrollee; and

2.3.5.8.1.2.2. 3. A planned action notice advising that CMS and the State have approved the STAR+PLUS MMP's request. This notice is not a procedural prerequisite for approval and should not be sent under any circumstances prior to the receipt of express written approval and a disenrollment transaction from CMS and HHSC.

2.3.5.8.1.2.3. The STAR+PLUS MMP must provide information about the Enrollee, including age, diagnosis, mental status, functional status, a description of his or her social support systems, and any other relevant information;

2.3.5.8.1.2.4. The submission must include statements from providers describing their experiences with the Enrollee (or refusal in writing, to provide such statements); and

2.3.5.8.1.2.5. Any information provided by the Enrollee. The Enrollee can provide any information he/she wishes.

2.3.5.8.1.2.6. If the STAR+PLUS MMP is requesting the ability to decline future Enrollments for this individual, the STAR+PLUS MMP must include this request explicitly in the submission.

2.3.5.8.1.2.7. Prior to approval, the complete request must be reviewed by HHSC and CMS including representatives from the Center for Medicare and must include staff with appropriate clinical or medical expertise.

2.3.5.8.2. Evidentiary standards; At a minimum, the supporting documentation must demonstrate the following to the satisfaction of both HHSC and CMS staff with appropriate clinical or medical expertise:

2.3.5.8.2.1. The Enrollee is presently engaging in a pattern of disruptive conduct that is seriously impairing the STAR+PLUS MMP's ability to furnish Covered Items and Services to the Enrollee and/or other Enrollees.

2.3.5.8.2.2. The STAR+PLUS MMP took reasonable efforts to address the disruptive conduct including at a minimum:

2.3.5.8.2.2.1. A documented effort to understand and address the Enrollee's underlying interests and needs reflected in his/her disruptive conduct and provide reasonable accommodations as defined by the Americans with Disabilities Act including those for individuals with mental and/or cognitive conditions. An accommodation is reasonable if it is efficacious in providing equal access to services and proportional to costs. HHSC and CMS will determine whether the reasonable accommodations offered are sufficient.

2.3.5.8.2.2.2. A documented provision of information to the Enrollee of his or her right to use the STAR+PLUS MMP Grievance procedures.

2.3.5.8.2.3. The STAR+PLUS MMP provided the Enrollee with a reasonable opportunity to cure his/her disruptive conduct.

2.3.5.8.2.4. The STAR+PLUS MMP must provide evidence that the Enrollee's behavior is not related to the use, or lack of use, of medical services.

2.3.5.8.2.5. The STAR+PLUS MMP may also provide evidence of other extenuating circumstances that demonstrate the Enrollee's disruptive conduct;

2.3.5.8.3. Limitations: The STAR+PLUS MMP shall not seek to terminate Enrollment because of any of the following:

2.3.5.8.3.1. The Enrollee's uncooperative or disruptive behavior resulting from such Enrollee's special needs unless treating providers explicitly document their belief that there are no reasonable accommodations the STAR+PLUS MMP could provide that would address the disruptive conduct.

2.3.5.8.3.2. The Enrollee exercises the option to make treatment decisions with which the STAR+PLUS MMP or any health care professionals associated with the STAR+PLUS MMP disagree, including the option of declining treatment and/or diagnostic testing.

2.3.5.8.3.3. An adverse change in an Enrollee's health status or because of the Enrollee's utilization of Covered Items and Services.

2.3.5.8.3.4. The Enrollee's mental capacity is, has, or may become diminished.

2.3.5.8.4. Fraud or abuse: When the Enrollee provides fraudulent information on an Enrollment form or the Enrollee willfully misuses or permits another person to misuse the Enrollee's ID card.

2.3.5.8.4.1. The STAR+PLUS MMP may submit a request that an Enrollee be involuntarily disenrolled if an Enrollee knowingly provides, on the election form, fraudulent information that materially affects the individual's eligibility to enroll in the STAR+PLUS MMP's plan; or if the Enrollee intentionally permits others to use his or her Enrollment card to obtain services under the STAR+PLUS MMP's plan.

2.3.5.8.4.2. Prior to submission, the STAR+PLUS MMP must have and provide to CMS/HHSC credible evidence substantiating the allegation that the Enrollee knowingly provided fraudulent information or intentionally permitted others to use his or her card.

2.3.5.8.4.3. The STAR+PLUS MMP must immediately notify the CMT so that the enrollment broker and the HHS Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse.

2.3.5.8.4.4. The STAR+PLUS MMP must provide notice to the Enrollee prior to submission of the request outlining the intent to request disenrollment with an explanation of the basis of the STAR+PLUS MMP's decision and information on the Enrollee's access to Grievance procedures and a fair hearing.

2.3.6. Initial Enrollee Contact

2.3.6.1. Within thirty (30) days of enrollment, the STAR+PLUS MMP shall assist the Enrollee in choosing a Network PCP when the Enrollee's current PCP is not in Network and refuses to become a Network Provider or enter into a single-case Out-of-Network agreement where applicable (see Section 2.6.5.4).

2.3.6.1.1. The Enrollee must choose a new PCP by the end of the ninety (90)-day continuity of care period or after the Plan of Care is developed. If the Enrollee has not chosen an in-network PCP by that time, the STAR+PLUS MMP shall choose one for the Enrollee.

2.3.6.2. The STAR+PLUS MMP shall make available to the family of Enrollees, caregivers, and LARs, as appropriate, any Enrollment materials upon request and with consent of the Enrollee.

2.3.6.3. The STAR+PLUS MMP shall provide non-written information in a format such as telephone calls, home visits, video screenings, or group presentations to Enrollees for whom written materials are not appropriate.

2.3.6.4. The STAR+PLUS MMP must notify its Enrollees:

2.3.6.4.1. That translations of written information are available in Prevalent Languages, as provided for in the Medicare-Medicaid marketing guidance;

2.3.6.4.2. That oral interpretation services are available free of charge for any language spoken by Enrollees and Eligible Beneficiaries;

2.3.6.4.3. How Enrollees can access oral interpretation services;

2.3.6.4.4. How Enrollees can access non-written materials described in Section 2.3.6.3; and

2.3.6.5. The STAR+PLUS MMP shall ensure that all Member Materials, such as the Member Handbook, are comprehensive yet written to comply with readability requirements. For the purposes of this Contract, no program information document shall be used unless it is at or below a 6th grade reading level. The document must set forth the Flesch score and certify compliance with this standard. These requirements shall not apply to language that is mandated by federal or state laws, regulations or agencies. Additionally, the STAR+PLUS MMP shall ensure that written Member Materials are available in Alternative Formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited, consistent with 42 C.F.R. § 438.10(d)(1)(ii).

2.3.6.6. The STAR+PLUS MMP must make available handbooks in languages other than English when five (5) percent of the STAR+PLUS MMP's enrolled population is non-English speaking and speaks a common language. The populations will be assessed by Demonstration Service Areas and will only affect handbooks distributed in the affected Service Area.

2.4. Covered Services

2.4.1. General

2.4.1.1. The STAR+PLUS MMP must authorize, arrange, and coordinate the provision of all Covered Services for its Enrollees. (See Covered Services in Appendix A.) Covered Services must be available to all Enrollees, as authorized by the STAR+PLUS MMP and as determined Medically Necessary pursuant to Appendix A, A.1. Covered Services will be managed and coordinated by the STAR+PLUS MMP

through the Service Coordination Team (see Section 2.5.2). STAR+PLUS MMP must also provide Functionally Necessary Covered Services to all Enrollees beginning on the Enrollee's date of Enrollment. The STAR+PLUS MMP must not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any Enrollee.

2.4.1.1.1. The STAR+PLUS MMP must provide full coverage for Medically Necessary Covered Services to all Enrollees and, for STAR+PLUS Enrollees, Functionally Necessary Covered Services, without regard to the Enrollee's:

2.4.1.1.1.1. Previous coverage, if any, or the reason for termination of such coverage;

2.4.1.1.1.2. Health status;

2.4.1.1.1.3. Confinement in a health care facility; and

2.4.1.1.1.4. Any other reason.

2.4.1.1.2. The STAR+PLUS MMP must not practice discriminatory selection, or encourage segregation among the total group of eligible Enrollees by excluding, seeking to exclude, or otherwise discriminating against any group or class of individuals.

2.4.1.2. Flexible Benefits – The STAR+PLUS MMP will have discretion to use the capitated payment to offer Flexible Benefits, as specified in the Enrollee's Plan of Care, as appropriate to address the Enrollee's needs. The STAR+PLUS MMP must offer Flexible Benefits to all Enrollees in a Service Area as appropriate. Flexible Benefits are health-related services as approved by CMS and HHSC on an annual basis and shall be listed on the HHSC and on the STAR+PLUS MMPs' websites. Any Flexible Benefit that a STAR+PLUS MMP elects to provide must be provided at no additional cost to CMS or HHSC or the Enrollee. In addition, the STAR+PLUS MMP must not pass on the cost of the Flexible Benefit to Enrollees or Providers. The STAR+PLUS MMP may offer discounts on non-covered benefits to Enrollees, provided that the STAR+PLUS MMP complies with Texas Insurance Code § 1451.155 and § 1451.2065. The STAR+PLUS MMP must ensure that Providers do not charge Enrollees for any other Cost Sharing for Flexible Benefits (including copayments or deductibles).

2.4.1.3. Under the Demonstration, skilled nursing level of care may be provided in a long term care facility without a preceding acute care inpatient stay for Enrollees, when the provision of this level of care is clinically appropriate and can avert the need for an inpatient stay.

2.4.1.4. The STAR+PLUS MMP must provide the full range of Covered Services. STAR+PLUS MMPs are responsible for providing all services and benefits available to beneficiaries of the Medicaid or Medicare fee-for-service programs to the STAR+PLUS MMP's Enrollees, with the exception of Non-Capitated Services (Section 2.4.2). If either Medicare or Texas Medicaid provides more expansive services than the other program does for a particular condition, type of illness, or diagnosis, the STAR+PLUS MMP must provide the most expansive set of services required by either program. The STAR+PLUS MMP may not limit or deny services to Enrollees based on Medicare or Texas Medicaid providing a more limited range of services than the other program. In addition to all Medicare Parts A, B, and D, and Medicaid State Plan services, the STAR+PLUS MMPs will be required to provide services as defined in the approved THTQIP section 1115(a) demonstration. STAR+PLUS MMPs must also provide services and benefits that would otherwise be covered by Texas Medicaid, or when the Texas Medicaid benefit is more expansive than the Medicare benefit, according to the limits described in the most recent Texas Medicaid Provider Procedures Manual and any updates to the Manual. Covered Services are subject to change due to changes in federal and state law; changes in Medicare or Medicaid program policy; and changes in medical practice, clinical protocols, or and technology.

2.4.1.5. The STAR+PLUS MMP must also provide Medically Necessary services that are available to those in the HCBS STAR+PLUS Waiver.

2.4.1.5.1. The Enrollee must meet the MN/LOC criteria and the cost of the services in the ISP cannot exceed 202% of cost of providing the same services in a Nursing Facility.

2.4.1.5.2. The STAR+PLUS MMP must be able to demonstrate that that Enrollee has a minimum of one unmet need for at least one STAR+PLUS HCBS waiver service before the services in the ISP may be authorized by the State.

2.4.1.6. NorthSTAR - In order to provide Enrollees with access to fully integrated services through the STAR+PLUS MMPs, Enrollees in Dallas County will not access behavioral health services through the NorthSTAR program. Enrollees who choose to Opt-Out or disenroll from the Demonstration will continue to have access to NorthSTAR services.

2.4.1.7. In lieu of services - On a case-by-case basis, a STAR+PLUS MMP may offer additional benefits that are outside the scope of services to individual Enrollees. Case-by-case services may be based on medical necessity, functional necessity, cost-effectiveness, the preferences and goals of the Enrollee or the Enrollee's family, and the potential for improving the Enrollee's health status. These services and benefits cannot increase the cost borne or capitation rates paid during any current contract term or in any subsequent contract term and cannot violate any other state or federal rule or regulation.

2.4.2. Excluded Services

2.4.2.1. Although the STAR+PLUS MMP is not responsible for paying or reimbursing for Non-Capitated Services, the STAR+PLUS MMPs is responsible for educating Enrollees about the availability of Non-Capitated Services, and for providing appropriate referrals for Enrollees to obtain or access these services. The STAR+PLUS MMP may offer discounts on non-covered benefits to Enrollees, provided that the STAR+PLUS MMP complies with Texas Insurance Code § 1451.155 and § 1451.2065.

2.4.2.2. The STAR+PLUS MMP is responsible for informing Providers that bills for all Non-Capitated Services must be submitted to HHSC's Claims administrator or other appropriate entity for reimbursement.

2.4.2.3. Consistent with Appendix A, A.5, the following services have been excluded from STAR+PLUS MMP Covered Services. Enrollees are eligible to receive these Non-Capitated Services as described below:

2.4.2.3.1. Medical Transportation Program;

2.4.2.3.2. Medicare and Medicaid Hospice benefits; and

2.4.2.3.3. Preadmission Screening and Resident Review (PASRR).

2.4.3. Requirements for Specific Covered Services

2.4.3.1. Mental Health Rehabilitative Services and Mental Health Targeted Case Management Services.

2.4.3.1.1. For Enrollees with severe and persistent mental illness (SPMI) and severe emotional disturbance (SED), Mental Health Rehabilitative Services and Mental Health Targeted Case Management must be available to eligible Enrollees. The STAR+PLUS MMP must maintain a qualified Network of entities, such as Local Mental Health Authorities (LMHAs) and multi-specialty groups, that employ providers of these services.

2.4.3.1.2. Mental Health Rehabilitative Services include training and services that help the Enrollee maintain independence in the home and community, such as the following.

2.4.3.1.2.1. Medication training and support – Curriculum-based training and guidance that serves as an initial orientation for the Enrollee in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community.

2.4.3.1.2.2. Psychosocial rehabilitative services – social, educational, vocational, behavioral, or cognitive interventions to improve the Enrollee's potential for social relationships, occupational or educational achievement, and living skills development.

2.4.3.1.2.3. Skills training and development – skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers.

2.4.3.1.2.4. Crisis intervention – intensive community-based one-to-one service provided to Enrollees who require services in order to control acute symptoms that place the Enrollee at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting.

2.4.3.1.2.5. Day program for acute needs – short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms of prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting.

2.4.3.1.3. The STAR+PLUS MMP must provide Mental Health Rehabilitative Services and Mental Health Targeted Case Management in accordance with UMCM Chapter 15, including the use of the DSHS Resiliency and Recovery Utilization Management Guidelines (RRUMG). The STAR+PLUS MMP must also ensure that a Provider review an Enrollee's plan of care for Mental Health Rehabilitative Services in accordance with the RRUMG to determine whether a change in the Enrollee's condition or needs warrants a reassessment or change in service. If the Enrollee's condition warrants a change in service, the provider must submit a new plan of care to the STAR+PLUS MMP for authorization. Additionally, the STAR+PLUS MMP must ensure that providers of Mental Health Rehabilitative Services and Mental Health Targeted Case Management use, and are trained and certified to use, the Adult Needs and Strengths Assessment (ANSA) tools for assessing an Enrollee's needs.

2.4.3.2. Community First Choice (CFC)

2.4.3.2.1. CFC provides Community-Based LTSS to eligible Enrollees who are elderly and to individuals with physical or cognitive disabilities as an alternative to living in an institution. To be eligible for CFC services, an Enrolleemust meet income and resource requirements for Medicaid under the state plan and receive a determination from HHSC that the Enrollee meets LOC requirements for Nursing Facility care, an intermediate care facility, or an institution for mental diseases. The STAR+PLUS MMP must make available to STAR+PLUS MMP Enrollees who meet these eligibility requirements the array of services allowable under CFC.

2.4.3.2.2. Community First Choice Eligibility

2.4.3.2.2.1. Recipients of CFC services must meet level of care criteria for participation and must have a plan of care at initial determination of eligibility. Enrollees needing services provided through CFC must be tested for eligibility before those services are provided through other STAR+PLUS MMP Community-Based LTSS.

2.4.3.2.3. For Enrollees Who Are Elderly or have Physical Disabilities

2.4.3.2.3.1. To be eligible for the CFC services, the Enrollee must be eligible for Medicaid, with the exception of Enrollees who receive Medicaid as a result of being a HCBS STAR+PLUS waiver recipient under the 217-Like Group provision, and meet MN/LOC.

2.4.3.2.3.2. The STAR+PLUS MMP must complete the Community Medical Necessity and Level of Care Assessment Instrument for MN/LOC determination, and submit the form to HHSC's Administrative Services Contractor. The STAR+PLUS MMP is also responsible for completing the assessment documentation, and preparing a service plan identifying the needed CFC services, as well as any additional services the Enrollee may benefit from, including the HCBS STAR+PLUS waiver. The STAR+PLUS MMP must complete these activities within the timeframe specified by HHSC in the STAR+PLUS Handbook.

2.4.3.2.4. For Enrollees with an Intellectual or Developmental Disability

2.4.3.2.4.1. To be eligible for CFC services, the Enrollee must be eligible for Medicaid and meet an institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF-IID). The STAR+PLUS MMP must review and consider the assessment and service plan completed by the Local Intellectual and Developmental Disability Authority (LIDDA) when determining eligibility and finalizing the service plan. The STAR+PLUS MMP must complete these activities within the timeframe specified by HHSC in the STAR+PLUS Handbook.

2.4.3.2.5. For Enrollees with Severe and Persistent Mental Illness or Severe Emotional Disturbance

2.4.3.2.5.1. To be eligible for the CFC services, the Enrollee must be eligible for Medicaid, under age 21 or over age 65, and meet an IMD level of care, which is determined by CANS or ANSA LOC 4.

2.4.3.2.5.2. The STAR+PLUS MMP must coordinate with a Provider of mental health rehabilitation and Mental Health Targeted Case Management to determine whether the Enrollee meets an IMD level of care. The STAR+PLUS MMP is also responsible for preparing a functional assessment and a service plan identifying the needed CFC services, as well as any additional services the Enrollee may benefit from, including the HCBS STAR+PLUS waiver. The STAR+PLUS MMP must complete these activities within the timeframe specified by HHSC in the STAR+PLUS Handbook.

2.4.3.2.6. CFC Eligibility

2.4.3.2.6.1. The STAR+PLUS MMP will notify the Enrollee of the eligibility determination, which will be based on results of the assessments. If the Enrollee is eligible for CFC services, the STAR+PLUS MMP will notify the Enrollee of the effective date of eligibility. If the Enrollee is not eligible for CFC services, the STAR+PLUS MMP or the Department of Aging and Disability Services (DADS) will provide the Enrollee information on the right to Appeal the determination, including access to HHSC's Fair Hearing process. The STAR+PLUS MMP and DADS is responsible for preparing any requested documentation regarding its assessments and service plans and attending the Fair Hearing, if applicable.

2.4.3.2.7. CFC Annual Reassessment

2.4.3.2.7.1. The STAR+PLUS MMP is responsible for tracking the renewal dates to ensure all Enrollee reassessment activities are completed. Before the end date of the annual Community Medical Necessary and Level of Care Assessment; before the end of the 12th month after the previous assessment was completed for Enrollees with intellectual or developmental disabilities; or Enrollees with severe and persistent mental illness or severe emotional disturbance, the STAR+PLUS MMP must initiate an annual reassessment to determine and validate continued eligibility for CFC services for each Enrollee receiving these services. As part of the assessment, the STAR+PLUS MMP must inform the Enrollee about Consumer Directed Services options. The STAR+PLUS MMP will be expected to complete the same activities for each annual reassessment as required for the initial eligibility determination.

2.5. Care Delivery Model

2.5.1. General

2.5.1.1. The STAR+PLUS MMP shall provide Service Coordination to all Enrollees to ensure effective integration and coordination between the Medical Home and other Providers and services and to coordinate the full range of medical and social supports, as needed.

2.5.1.2. The STAR+PLUS MMP must provide written notice to all Enrollees that includes:

2.5.1.2.1. A description of Service Coordination; and

2.5.1.2.2. The STAR+PLUS MMP's Service Coordination Hotline.

2.5.1.3. The STAR+PLUS MMP must notify all Enrollees receiving Service Coordination of:

2.5.1.3.1. The name of their Service Coordinator;

2.5.1.3.2. The phone number to reach their Service Coordinator;

2.5.1.3.3. The minimum number of contacts they will receive every year; and

2.5.1.3.4. The types of contacts they will receive.

2.5.1.4. The STAR+PLUS MMP must have a systematic process for generating or receiving referrals and sharing confidential medical, treatment, and planning information across Providers.

2.5.2. Service Coordination Team

2.5.2.1. For each Enrollee, STAR+PLUS MMPs will support a Service Coordination Team, led by a Service Coordinator to ensure the integration of the Enrollee's medical, behavioral health, substance use treatment, LTSS, and social needs. Every Enrollee shall have access to and input in the development of their own Service Coordination Team.

2.5.2.2. The team will be person-centered, built on the Enrollee's specific preferences and needs, as identified in the Comprehensive Health Risk Assessment and outlined in the Plan of Care, and deliver services with transparency, individualization, respect, linguistic and cultural competence, dignity, and accountability.

2.5.2.3. STAR+PLUS MMP staff who are members of the team must participate in approved training on the person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles, along with other required training, as specified by the State. This training will include ADA/*Olmstead* requirements. The STAR+PLUS MMP must offer similar trainings to additional members of the team as appropriate and document any refusals.

2.5.3. Service Coordination Team Members

2.5.3.1. The Service Coordination Team must be comprised, first and foremost, of the Enrollee and/or his/her LAR. The Enrollee shall be encouraged to identify individuals that he/she would like to participate on the team. Enrollees must be assured choice of all Providers, including the Service Coordinator and others, that will participate in their Service Coordination Team.

2.5.3.2. Enrollees must have a single, identified person as their assigned Service Coordinator and the STAR+PLUS MMP must notify Enrollees within five (5) business days of the name and phone number of their new Service Coordinator, if

their Service Coordinator changes. The STAR+PLUS MMP must also post the new Service Coordinator's information on the provider web portal, described in Section 2.17.3.3, within the same time period. The STAR+PLUS MMP must make its best efforts to provide the Enrollee with Service Coordination information in a format that is accessible to the Enrollee.

2.5.3.3. The team must be led by the Service Coordinator and must also include the Enrollee's PCP.

2.5.3.4. Other members of the team must have the following expertise or access within the STAR+PLUS MMP to identified subject matter experts in the following areas: behavioral health, including outpatient services and mental health rehabilitative services; substance abuse; local resources (e.g., basic needs like housing, food, utility assistance); LTSS; Durable Medical Equipment (DME); end of life/advanced illness services; acute care; preventive care; cultural competency based on National Standards for Culturally and Linguistically Appropriate Services (CLAS); pharmacology; nutrition; Texas Promoting Independence strategies; Consumer-Directed Services options; person-centered planning; employment assistance and supported employment; and PASRR requirements. These other team members may include as appropriate or by request of the Enrollee:

2.5.3.4.1. Other Providers; and

2.5.3.4.2. Other individuals, including the Enrollee's caregiver.

2.5.3.5. Service Coordinators must also actively collaborate with the Enrollee's specialty care Providers, including behavioral health and LTSS service Providers, as appropriate.

2.5.4. Service Coordination Team Responsibilities

2.5.4.1. The Service Coordination Team shall:

2.5.4.1.1. Have an overarching philosophy of independent living, self-determination, and community integration;

2.5.4.1.2. Provide dedicated toll-free Service Coordination Hotline numbers;

2.5.4.1.3. Be available for all Enrollees. If the Enrollee refuses Service Coordination, the STAR+PLUS MMP should document the refusal in the Enrollee's case file;

2.5.4.1.4. Have two levels of Service Coordination for all Enrollees, with level 1 being those stratified as high risk, and level 2 as moderate or lower risk;

2.5.4.1.5. Work with the Enrollee's PCP to coordinate all Covered Services and any applicable Non-Capitated Services. In order to integrate the Enrollee's care while remaining informed of the Enrollee's needs and condition, the Service Coordinator must actively involve the Enrollee'sspecialty care Providers, including Providers of Behavioral Health Services and Non-Capitated Services;

2.5.4.1.6. Participate, as appropriate, in Comprehensive Health Risk Assessments and reassessments;

2.5.4.1.7. Maintain frequent contact with the Enrollee through various methods, including, but not limited to, face-to-face visits, email, and telephone options, as appropriate to the Enrollee's needs and risk-level. In addition,

2.5.4.1.7.1. The Service Coordinator must ensure that all Enrollees stratified to level 1 must receive a minimum of two (2) in-person Service Coordination contacts annually and those stratified to level 2 receive a minimum of one (1) in-person and one (1) telephonic Service Coordination contact annually, or as specified in the HCBS STAR+PLUS Waiver if more frequent and applicable.

2.5.4.1.7.2. At a minimum, level 1 Enrollees in a Nursing Facility must receive quarterly face-to-face visits, including Nursing Facility care planning meetings or other interdisciplinary team meetings. The STAR+PLUS MMP must maintain and make available upon request documentation verifying the occurrence of required face-to-face Service Coordination visits, which may include participation in care planning or other interdisciplinary team meetings. All other community based level 1 Enrollees must receive a minimum of two (2) face-to-face Service Coordination contacts annually.

2.5.4.1.7.3. Enrollees with SPMI must receive one telephonic Service Coordination contact annually in addition to the minimum of two face-to-face service coordination contacts for level 1.

2.5.4.1.8. Develop, maintain, and monitor a Plan of Care (see Section 2.6.3) with the Enrollee and/or Enrollee's LARs, if any, and with all the appropriate team members, including the Enrollee;

2.5.4.1.9. Assist in the implementation and monitoring of the Plan of Care;

2.5.4.1.10. Coordinate, consult with, and advise acute, specialty, LTSS, and Behavioral Health Service Providers about Plans of Care and clinically appropriate interventions on an ongoing basis;

2.5.4.1.11. Promote independent functioning of the Enrollee and providing services in the most appropriate, most integrated community environment;

2.5.4.1.12. Document and comply with advance directives about the Enrollee's wishes for future treatment and health care decisions;

2.5.4.1.13. Maintain the Enrollee Medical Record, including but not limited to appropriate and timely entries about the care provided, diagnoses determined, medications prescribed, and treatment plans developed and designate the physical location of the record for each Enrollee;

2.5.4.1.14. Communicate with other team members regarding the medical, functional, and psychosocial condition of Enrollees;

2.5.4.1.15. Communicate with the Enrollee and the Enrollee's family members and caregiver(s), if any, in accordance with the Enrollee's preferences, about the Enrollee's medical, social, and psychological needs at least as frequently as outlined in Section 2.5.4.1.7;

2.5.4.1.16. Document changes in the Enrollees' condition(s) in the Enrollee's Medical Record consistent with documentation polices established by the STAR+PLUS MMP;

2.5.4.1.17. Ensure that team members who are completing Service Coordination activities are operating within their professional scope of practice, appropriate for responding to and meeting the Enrollee's needs, and complying with the State's licensure/credentialing requirements;

2.5.4.1.18. Support Providers in Medical Homes and assist in assuring integration of services and coordination of care across the spectrum of the healthcare system;

2.5.4.1.19. Provide Enrollee health education on complex clinical conditions and wellness programs;

2.5.4.1.20. Provide medication management;

2.5.4.1.21. Provide Discharge planning, transition care, and other education programs to Network Providers regarding all available long-term care settings and options. The STAR+PLUS MMP must have a protocol for quickly assessing the needs of Enrollees Discharged from a Hospital, Nursing Facility, or other care or treatment facility, including inpatient psychiatric facilities;

2.5.4.1.22. Work with the Enrollee's PCP, the Hospital, or Nursing Facility Discharge planner(s), the attending physician, the Enrollee, and the Enrollee's family and/or caregivers to assess and plan for the Enrollee's Discharge. Upon discharge from an inpatient psychiatric facility, Service Coordinators must contact the Enrollee within twenty-four (24) hours. When LTSS are needed, the team must ensure that the Enrollee's Discharge plan includes arrangements for receiving community-based care whenever possible. The team must ensure that the Enrollee, the Enrollee's family, and the Enrollee's PCP are all well informed of all service options available to meet the Enrollee's needs in the community;

2.5.4.1.23. Assure that referrals result in timely appointments and assist Enrollees in setting up appointments with Providers, as outlined in Section 2.7.1.12;

2.5.4.1.24. Assure that the Enrollees receive needed Covered Services, reasonable accommodations, and social services;

2.5.4.1.25. Develop strong working relationships between Service Coordinators and Providers;

2.5.4.1.26. Provide evidence-based Enrollee education programs, including health education on complex clinical conditions and wellness principles;

2.5.4.1.27. Coordinate Enrollee transportation, as needed;

2.5.4.1.28. Continuously monitor Enrollees' functional and health status;

2.5.4.1.29. Make the following supports available:

2.5.4.1.29.1. A toll-free Service Coordination Hotline for all of the Enrollee's questions;

2.5.4.1.29.2. Communication and education regarding available Covered Services and community resources; and

2.5.4.1.29.3. Assistance developing self-management skills to effectively access and use services.

2.5.4.1.30. Inform Enrollees of the Consumer-Directed Services options at initial and regular Service Coordination contacts; and

2.5.4.1.31. Cooperate with, collaborate with, and facilitate Enrollees' access to the Ombudsman.

2.5.5. Service Coordinators

2.5.5.1. Service Coordinator Qualifications

2.5.5.1.1. STAR+PLUS MMPs must employ as Service Coordinators persons experienced in meeting the needs of people with disabilities, old and young, and vulnerable populations who have chronic or complex conditions, including multiple chronic conditions.

2.5.5.1.2. A Service Coordinator for a level 1 Enrollee must be a registered nurse (RN) or nurse practitioner (NP). Licensed vocational nurses (LVNs) employed as Service Coordinators before March 1, 2013 will be allowed to continue in that role.

2.5.5.1.3. A Service Coordinator for a level 2 Enrollee must have an undergraduate or graduate degree in social work or a related field or be an LVN, RN, NP, or physician's assistant (PA); or have a minimum of a high school diploma or GED, and direct experience with the aged, blind, or disabled (ABD)/SSI population in three of the last five years prior to beginning in the role of Service Coordinator.

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

2.5.5.2. Service Coordinator Training

2.5.5.2.1. Service Coordinators must possess knowledge of the principles of most integrated residential and work settings, including federal and state requirements.

2.5.5.2.2. Service Coordinators must complete sixteen (16) hours of Service Coordination training every two (2) years. The STAR+PLUS MMP must administer the training, which must include:

2.5.5.2.2.1. Information related to the population served;

2.5.5.2.2.2. How to assess Enrollees' medical, behavioral health, and social needs and concerns;

2.5.5.2.2.3. How to assess and provide information to Enrollees related to Employment Assistance and Supported Employment;

2.5.5.2.2.4. How to provide Mental Health Targeted Case Management for Enrollees receiving Mental Health Rehabilitative Services;

2.5.5.2.2.5. PASRR requirements:

2.5.5.2.2.6. Person-directed planning;

2.5.5.2.2.7. Consumer-Directed Service Options;

2.5.5.2.2.8. Refresher of available local and statewide resources;

2.5.5.2.2.9. Respect for cultural, spiritual, racial, and ethnic beliefs of others; and

2.5.5.2.2.10. Identifying and reporting Critical Events or Incidents such as ANE and educating Enrollees regarding protections.

2.5.5.2.3. Service Coordinators working with Enrollees receiving home and Community-Based LTSS, including CFC and HCBS services, an HHSC-approved training on Person-Centered Practices and Person-Centered Plan Facilitation to meet federal requirements on person-centered planning for home and Community-Based LTSS. As part of continuing education, Service Coordinators must also complete by March 1, 2017, (or within two (2) years of hire date for Service Coordinators hired after March 1, 2015) a comprehensive training on Person-Centered Practices and Person-Centered Plan Facilitation using a certified trainer or an HHSC-approved curriculum. This training is in addition to current Service Coordinator training requirements.

2.5.5.3. Service Coordinator Assignments and Change Requests

2.5.5.3.1. The STAR+PLUS MMP shall assign to every Enrollee a Service Coordinator with the appropriate experience and qualifications based on a Enrollee's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers).

2.5.5.3.2. The STAR+PLUS MMP must have a process to ensure that an Enrollee and/or his/her caregiver is able to request a change in his or her Service Coordinator at any time.

2.5.5.3.2.1. All Enrollees within a Nursing Facility must have the same assigned Service Coordinator, unless a change is requested by the Enrollee. The STAR+PLUS MMP must regularly report to the CMT the number of Enrollees who request to change their Service Coordinator, including Enrollees within a Nursing Facility.

2.5.5.4. Service Coordinator Responsibilities

2.5.5.4.1. The Service Coordinator must be responsible for working with the Enrollee or his or her LAR, the PCP and other Providers to develop a seamless package of care in which primary, acute, LTSS, behavioral health, and substance abuse treatment, and social service needs are met through a single, understandable, rational person-centered Plan of Care.

2.5.5.4.2. The STAR+PLUS MMP must empower its Service Coordinators to authorize the provision and delivery of Covered Services, including Community LTSS.

2.5.5.4.3. The Service Coordinator must be responsible for maintaining a centralized record related to Enrollee contacts, assessments, and service authorizations. The STAR+PLUS MMP must ensure that the organization of and documentation included in the centralized Enrollee record meets all applicable professional standards ensuring confidentiality of Enrollee records, referrals, and documentation of information.

2.5.5.4.4. The Service Coordinator must coordinate with the DADS Section 811 Project Rental Assistance (PRA) Program point of contact on an ongoing basis for Enrollees with disabilities exiting a Nursing Facility and receiving services from the Section 811 PRA program.

2.5.6. Referrals to Community Organizations

2.5.6.1. The STAR+PLUS MMP must provide information about and referral to community organizations that may not be providing Covered Services, but are otherwise important to the health and wellbeing of Enrollees. These organizations include, but are not limited to:

2.5.6.1.1. State/federal agencies (e.g., those agencies with jurisdiction over aging, public health, substance abuse, mental health, intellectual or developmental disabilities, rehabilitation, income support, nutritional assistance, family support agencies, etc.);

2.5.6.1.2. Social service agencies (e.g., area agencies on aging, residential support agencies, independent living centers, supported employment agencies, etc.);

2.5.6.1.3. City and county agencies (e.g., welfare departments, housing programs, etc.);

2.5.6.1.4. Civic and religious organizations; and

2.5.6.1.5. Consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning, etc.).

2.5.7. Health Promotion and Wellness Activities

2.5.7.1. The STAR+PLUS MMP must, at a minimum, develop and implement health education initiatives that educate Enrollees about:

2.5.7.1.1. How the STAR+PLUS MMP operates, including the role of the Service Coordination Team and PCP;

2.5.7.1.2. Covered Services, limitations, and any Flexible Benefits offered by the STAR+PLUS MMP;

2.5.7.1.3. Copayment responsibilities;

2.5.7.1.4. The value of screening and preventive care; and

2.5.7.1.5. How to obtain Covered Services, including:

2.5.7.1.5.1. Emergency Services;

2.5.7.1.5.2. OB/GYN and specialty care;

2.5.7.1.5.3. Behavioral Health Services;

2.5.7.1.5.4. Disease Management programs;

2.5.7.1.5.5. Service Coordination, treatment for pregnant women, Enrollees with Special Health Care Needs, Nursing Facility residents, and other special populations;

2.5.7.1.5.6. Screening and preventive services;

2.5.7.1.5.7. Suicide prevention services;

2.5.7.1.5.8. Health education related to Obesity;

2.5.7.1.5.9. A 72-hour supply of emergency, Medicaid prescriptions from Network pharmacies when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical prior authorization;

2.5.7.1.5.10. Nursing Facility Services;

2.5.7.1.5.11. Discharge planning, transitional care, housing aid, and other education programs on all available long term care settings including community settings for Nursing Facility residents;

2.5.7.1.5.12. Medical Transportation Program services; and

2.5.7.1.5.13. CFC services.

2.5.7.2. The STAR+PLUS MMP must provide a range of general health promotion, prevention, and wellness information and activities for Enrollees in formats that meet the needs of all Enrollees. The STAR+PLUS MMP may cooperatively conduct health education classes with one (1) or more of the other contracted STAR+PLUS MMPs in the Service Area. The STAR+PLUS MMP must work with its Providers to integrate health education, wellness, and prevention training into each Enrollee's Plan of Care.

2.5.7.3. Per Texas Health and Safety Code §48.052(c), STAR+PLUS MMPs may use certified Community Health Workers to conduct outreach and Enrollee education activities.

2.6. Enrollee Stratification, Assessments, and Plans of Care

2.6.1. Risk Stratification

2.6.1.1. The STAR+PLUS MMP will develop and implement a risk stratification process that uses a combination of predictive-modeling software, assessment tools, referrals, administrative Claims data, and other sources of information as appropriate that will consider Enrollees' physical and behavioral health, substance use, and LTSS needs.

2.6.1.2. The STAR+PLUS MMP will stratify Enrollees into two (2) risk levels, with level 1 the highest risk and level 2 moderate and lower risk Enrollees.

2.6.1.2.1. These levels of stratification should be based on:

2.6.1.2.1.1. Level 1 Enrollees: Highest level of risk/utilization includes HCBS STAR+PLUS Waiver, Nursing Facility (except for nursing facility Enrollees listed under Level 3), individuals with SPMI, and other Enrollees with complex medical needs.

2.6.1.2.1.2. Level 2 Enrollees: Lower level of risk/utilization includes Enrollees receiving LTSS for personal assistance services or day activity and health services (PAS and DAHSand Enrollees with non-SPMI behavioral health issues.

2.6.2. Comprehensive Health Risk Assessments

2.6.2.1. The STAR+PLUS MMP must make its best efforts to conduct and encourage each Enrollee to be an active participant in, a timely Comprehensive Health Risk Assessment of medical, behavioral health, community-based or facility-based LTSS, and social needs.

2.6.2.1.1. An Enrollee may choose to decline an assessment. Should that occur, the STAR+PLUS MMP will not continue to contact the Enrollee for an assessment unless a new assessment is needed as indicated in Section 2.6.2.8.

2.6.2.1.2. In some instances, Enrollees are not reachable through the contact information provided by HHSC or CMS. To comply with Sections 2.6.2.1, 2.6.3, and 2.6.2.8, the STAR+PLUS MMP must:

2.6.2.1.2.1. Document its attempts to reach Enrollees and the modes of communication attempted.

2.6.2.1.2.2. Attempt to reach the Enrollee at least five (5) times within the first ninety (90) days of enrollment. Attempts must be on different days of the week and at different times during the day, including times outside of standard work hours.

2.6.2.1.3. The STAR+PLUS MMP shall use community resources where possible to identify and engage Enrollees.

2.6.2.2. Comprehensive Health Risk Assessment domains will include, but not be limited to, the following: physical and behavioral health, social needs, functional status, wellness and prevention domains, caregiver status and capabilities, health and safety, as well as the Enrollees' preferences, strengths, and goals.

2.6.2.3. Assessment Instrument – The STAR+PLUS MMP must have and use functional assessment instruments to identify Enrollees with significant health problems, Enrollees requiring immediate attention, and Enrollees who need or are at risk of needing LTSS. The STAR+PLUS MMP, a First Tier, Downstream, or Related Entity, including a Provider, may complete assessment instruments, but the STAR+PLUS MMP remains responsible for the data recorded. The Comprehensive Health Risk Assessment is performed using state-approved assessment tools. Specifically:

2.6.2.3.1. The STAR+PLUS MMP must use the state-required assessment instrument, to assess an Enrollee's need for Functionally Necessary PAS. The STAR+PLUS MMP may adapt the form to reflect the STAR+PLUS MMP's name or distribution instructions, but the elements must be the same and instructions for completion must be followed without amendment.

2.6.2.3.2. The state-required assessment instrument must be completed if a need for or a change in PAS is warranted at the initial contact, at the annual reassessment, and anytime an Enrollee requests the services or requests a change in services. The state required assessment instrument must also be completed at any time the STAR+PLUS MMP determines the Enrollee requires the services or requires a change in the PAS that are authorized.

2.6.2.3.3. For Enrollees and potential Enrollee seeking or needing HCBS STAR+PLUS Waiver services, the STAR+PLUS MMP must use the MN/LOC assessment instrument, as amended or modified, to assess Enrollees and to supply current medical information for Medical Necessity determinations.

2.6.2.3.4. The STAR+PLUS MMP must also complete the ISP form, including all addendums, for each Enrollee receiving HCBS STAR+PLUS Waiver services. The ISP is established for a one (1)-year period, after which it expires. After the initial ISP is established, the ISP must be completed on an annual basis and the expiration date does not change regardless of any mid-year updates.

2.6.2.3.5. These state-required assessment instruments and forms (MN/LOC assessment instrument, Functionally Necessary PAS instrument, and ISP form and addendums) must be completed annually at reassessment. The STAR+PLUS MMP is responsible for tracking the expiration dates of the ISP to ensure all Enrollee reassessment activities have been completed and posted on the Long-Term Care (LTC) online portal prior to the expiration date.

2.6.2.3.6. The STAR+PLUS MMP cannot submit its MN/LOC assessment instrument earlier than one hundred twenty (120) days prior to the expiration date of the ISP. An MN/LOC assessment determination will expire one hundred twenty (120) days after it is approved by the HHSC Claims administrator if HCBS STAR+PLUS Waiver services have not begun. The STAR+PLUS MMP cannot submit a renewal of the MN/LOC assessment earlier than ninety (90) days prior to the expiration date of the ISP. The renewal will expire ninety (90) days after it is approved by the HHSC Claims administrator.

2.6.2.4. Relevant and comprehensive data sources, including the Enrollee, Providers, and family/caregivers, as appropriate, shall be used by the STAR+PLUS MMP. Results of the assessment will be used to confirm the appropriate risk stratification level for the Enrollee and as the basis for developing the Plan of Care.

2.6.2.5. Initial Comprehensive Health Risk Assessments and annual reassessments will be completed in person for Enrollees

stratified to level 1. Initial Comprehensive Health Risk Assessments and annual reassessments may be completed telephonically for Enrollees assigned to level 2 unless an in-person assessment is requested by the Enrollee, caregiver, or Provider.

2.6.2.6. Assessments will be completed by qualified, trained health professionals who possess a professional scope of practice, licensure, and/or credentials appropriate for responding to and managing the Enrollee's needs.

2.6.2.7. The STAR+PLUS MMP will use the results of the Comprehensive Health Risk Assessment to confirm the appropriate acuity or risk stratification level for the Enrollee and as the basis for developing the integrated, Person-Centered Plan of Care.

2.6.2.8. Timing of Comprehensive Health Risk Assessments and Reassessments –

2.6.2.8.1. All Enrollees will receive a Comprehensive Health Risk Assessment to be completed no later than ninety (90) days after the individual's Enrollment in the STAR+PLUS MMP.

2.6.2.8.2. The STAR+PLUS MMP must ensure that a reassessment and/or a Plan of Care update are performed:

2.6.2.8.2.1. As warranted by the Enrollee's condition but at least every twelve (12) months after the initial Comprehensive Health Risk Assessment completion date;

2.6.2.8.2.2. When there is a change in the Enrollee's health status or needs;

2.6.2.8.2.3. When there is a significant health care event;

2.6.2.8.2.4. When the Enrollee's health and safety are deemed to be at risk;

2.6.2.8.2.5. As requested by the Enrollee, his/her caregiver, and/or his/her Provider; and

2.6.2.8.2.6. As requested by a member of the Service Coordination Team who observes a change that requires further investigation.

2.6.2.8.3. The STAR+PLUS MMP shall notify PCPs of Enrollment of any new Enrollee who has not completed a Comprehensive Health Risk Assessment within the time period set forth above and whom the STAR+PLUS MMP has been unable to contact. The STAR+PLUS MMP shall encourage PCPs to conduct outreach to these Enrollees and to schedule visits.

2.6.2.9. Eligibility for HCBS STAR+PLUS Waiver Services

2.6.2.9.1. As part of the Comprehensive Health Risk Assessment, the STAR+PLUS MMP will also conduct an assessment to determine eligibility for HCBS STAR+PLUS waiver services if the Enrollee has an unmet need for at least one waiver service or if requested by the Enrollee.

2.6.2.9.2. The STAR+PLUS MMP must also provide medically necessary services that are available to those in the HCBS STAR+PLUS waiver to those Enrollees who meet the additional Medicaid Waiver eligibility requirements criteria, as described in the THTQIP section 1115(a) demonstration. The State provides an enhanced array of services to beneficiaries who would otherwise qualify for Nursing Facility care through a HCBS waiver. The Enrollee must meet MN/LOC criteria and the cost of the services in the ISP cannot exceed 202% of cost of providing the same services in a Nursing Facility. The STAR+PLUS MMP must be able to demonstrate that that Enrollee has a minimum of one unmet need for at least one HCBS STAR+PLUS Waiver service before the services in the ISP may be authorized by the State.

2.6.2.9.3. Enrollees can request to be tested for eligibility into the HCBS STAR+PLUS Waiver. The STAR+PLUS MMP can also initiate HCBS STAR+PLUS Waiver eligibility testing on a Enrollee if the STAR+PLUS MMP determines that the Enrollee would benefit from the HCBS STAR+PLUS Waiver services.

2.6.2.9.4. The STAR+PLUS MMP is responsible for completing the assessment documentation, and preparing a HCBS STAR+PLUS ISP for identifying the needed HCBS STAR+PLUS Waiver services. The ISP is submitted to the State to ensure that the total cost does not exceed the 202% limit. The STAR+PLUS MMP must complete these activities within forty-five (45) days of receiving the State's authorization form for eligibility testing.

2.6.2.9.5. The STAR+PLUS MMP must complete the Community MN/LOC assessment instrument for MN/LOC determination, and submit the form to HHSC's Administrative Services Contractor.

2.6.2.9.6. If the STAR+PLUS MMP determines the Enrollee's cost of care will exceed the 202% limit, the STAR+PLUS MMP will submit the individual service planning documents to HHSC utilization management review (UMR). The UMR may request a clinical review of the case to consider the use of State general Revenue funds to cover costs over the 202% allowance, as per HHSC's policy and procedures related to use of general revenue for HCBS STAR+PLUS Waiver participants.

2.6.2.9.7. If HHSC approves the use of state general revenue funds, the STAR+PLUS MMP will be allowed to provide waiver services as per the ISP, and non-waiver services (services in excess of the 202% allowance) utilizing State General Revenue Funds. Non-waiver services are not Medicaid Allowable Expenses, and may not be reported as such on the FSRs. The STAR+PLUS MMP will submit reports documenting expenses for non-waiver services in an HHSC-approved format. HHSC will reimburse the STAR+PLUS MMP for such expenses in excess of the 202% allowance.

2.6.3. Plan of Care

2.6.3.1. Following the Comprehensive Health Risk Assessment (as described in Section 2.6.2), the STAR+PLUS MMP shall assign a Service Coordinator who works with the Enrollee, his/her family supports, Providers, and other Service Coordination Team members to develop a comprehensive, person-centered, written Plan of Care for each Enrollee.

2.6.3.2. Every Enrollee must have an Plan of Care, unless the Enrollee refuses and such refusal is documented.

2.6.3.3. For all Enrollees, the STAR+PLUS MMP must ensure that the Plan of Care is in place within ninety (90) days of Enrollment, or upon receipt of all necessary eligibility information from the State, whichever is later.

2.6.3.4. The STAR+PLUS MMP shall utilize information gathered during the risk stratification process in order to update the Plan of Care.

2.6.3.5. The Plan of Care must:

2.6.3.5.1. Contain the Enrollee's health history; a summary of current, short-term, and long-term health and social needs, concerns, and goals; and a list of required services, their frequency, and a description of who or what entity will provide such services.

2.6.3.5.2. Include, as applicable and consistent with Enrollee preferences, coordination with the Enrollee's family and community support systems, including independent living centers, area agencies on aging, and local authorities, as applicable.

2.6.3.5.3. Be agreed to and signed by the Enrollee or the Enrollee's LAR to indicate agreement with the Plan of Care. The Enrollee maintains all Appeal rights if the Plan of Care is signed.

2.6.3.5.4. Allow for financial management services and promote self-determination and may include information about accessing services outside of Covered Services, such as affordable, integrated housing;

2.6.3.5.5. Include opportunities for input from the Enrollee, his/her LAR, and the Service Coordination Team during the development, implementation, and ongoing assessment of ICP; and

2.6.3.5.6. Include a risk assessment that identifies and evaluates risks associated with the Enrollee's care.

2.6.3.6. Plan of Care Expiration date

2.6.3.6.1. The STAR+PLUS MMP is required to conduct an annual reassessment for each Enrollee and update the Plan of Care prior to the expiration date. All services under the current Plan of Care would continue in the event of expiration.

2.6.3.7. Plan of Care Monitoring

2.6.3.7.1. Continuous monitoring of the Plan of Care will occur, and any gaps in services will be addressed in an integrated manner by the STAR+PLUS MMP, including any necessary revisions to the Plan of Care.

2.6.3.8. Individual Service Plan (ISP)

2.6.3.8.1. If an Enrollee is found to be eligible for HCBS STAR+PLUS Waiver services as a result of the HCBS assessment described in Section 2.6.2.3.3above, the Service Coordinator will work with the Enrollee to develop an Individual Service Plan (ISP).

2.6.3.8.2. The ISP will be incorporated into the Enrollee's overall Plan of Care.

2.6.3.8.3. After the initial ISP is established, the ISP must be completed on an annual basis and the end date or expiration date does not change.

2.6.3.8.4. Prior to the expiration date of the ISP, the STAR+PLUS MMP must initiate an annual reassessment to determine and validate continued eligibility for HCBS STAR+PLUS Waiver services for each Enrollee receiving these services and update the ISP. All services under the current ISP would continue in the event of expiration.

2.6.3.8.5. As part of the assessment, the STAR+PLUS MMP must inform the Enrollee about Consumer - Directed Services Options.

2.6.3.8.6. The STAR+PLUS MMP will be expected to complete the same activities for each annual reassessment as required for the initial eligibility determination.

2.6.4. Consumer-Directed Services

2.6.4.1. STAR+PLUS MMPs will support Enrollees in directing their own care services and Plan of Care development.

2.6.4.2. Enrollees may have the opportunity to direct their own services, including both employer and budget authority. Enrollees will choose a financial management service agency (FMSA) to assist with these activities.

2.6.4.3. There are three options available to Enrollees desiring to self-direct the delivery of Primary Home Care (PHC) (which is available to all Enrollees) ; Personal Assistance Services or acquisition, maintenance and enhancement of skills in CFC; PAS; in-home or out-of-home respite; nursing; physical therapy (PT); occupational therapy (OT); and/or speech/language therapy (SLT) for (which are available to Enrollees in the HCBS STAR+PLUS Waivers). These three options are: 1) Consumer-Directed; 2) Service Related; and 3) Agency, described in more detail below in section 2.6.4.8. The STAR+PLUS MMP must provide information concerning the three options to all Enrollees who:

2.6.4.3.1. Meet the functional requirements for PHC services and the requirements for PAS (the functional criteria for these services are described in the Community MN/LOC assessment instrument);

2.6.4.3.2. Are eligible for in-home or out-of-home respite services in the HCBS STAR+PLUS Waiver;

2.6.4.3.3. Are eligible for nursing, PT, OT and/or SLT in the HCBS STAR+PLUS Waiver; and

2.6.4.3.4. Are eligible for PAS or acquisition, maintenance and enhancement of skills under CFC.

2.6.4.4. In addition to providing information concerning the three options, the STAR+PLUS MMP must provide Enrollee orientation in the option selected by the Enrollee at any time when an Enrollee receiving PHC, PAS, respite, nursing, physical therapy (PT); occupational therapy (OT); and/or speech/language therapy (SLT), or CFC services requests the information; and

2.6.4.5. The STAR+PLUS MMP must contract with Providers who are able to offer PHC/PAS in-home or out-of-home respite, nursing, PT, OT, and/or SLT, or Community First Choice services, and must also educate/train the Network Providers regarding the three options for self-directed care. Network Providers must meet licensure/certification requirements.

2.6.4.6. In all three options, the Service Coordinator and the Enrollee work together in developing the ISP.

2.6.4.7. A more comprehensive description of Consumer-Directed Services is found in the STAR+PLUS Handbook, Section

8000 (available at
http://www.dads.state.tx.us/handbooks/sph/index.htm

2.6.4.8. Consumer Directed Service Options

2.6.4.8.1. Consumer-Directed Option Model

2.6.4.8.1.1. In the Consumer-Directed Option Model, the Enrollee or the Enrollee's LAR is the employer of record and retains control over the hiring, management, and termination of an individual providing PHC/PAS in-home or out-of-home respite; nursing, PT, OT, and/or SLT; or CFC services. The Enrollee is responsible for assuring that the employee meets the requirements for PHC/PAS; in-home or out-of-home respite; nursing, PT, OT, and/or SLT; or CFC services, including the criminal history check. The Enrollee uses a FMSA to handle the employer-related administrative functions such as payroll, substitute (back-up), and filing tax-related reports of PHC/PAS; in-home or out-of-home respite; nursing, PT, OT, and/or SLT; or CFC services.

2.6.4.8.2. Service Related Option Model

2.6.4.8.2.1. In the Service Related Option Model, the Enrollee or the Enrollee's LAR is actively involved in choosing their personal attendant, respite Provider, nurse, physical therapist, occupational therapist and/or speech/language therapist, or CFC services but is not the employer of record.

2.6.4.8.2.2. The Home and Community Support Services agency (HCSSA) in the STAR+PLUS MMP Provider Network is the employer of record for the personal attendant employee and respite Provider. In this model, the Enrollee selects the personal attendant and/or respite Provider from the HCSSA's personal attendant employees. The personal attendant's/respite Provider's schedule is set up based on the Enrollee input, and the Enrollee manages the PHC/PAS, in-home or out-of-home respite. The Enrollee retains the right to supervise and train the personal attendant. The Enrollee may request a different personal attendant and the HCSSA would be expected to honor the request as long as the new attendant is a Network Provider. The HCSSA establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of PHC/PAS and/or in-home or out-of-home respite. In this model, the Enrollee selects the nurse, physical therapist, occupational therapist, and/or speech/language therapist from the STAR+PLUS MMP's Provider Network. The nurse, physical therapist, occupational therapist, and/or speech/language therapist's schedule is set up based on the Enrollee's input, and the Enrollee manages the nursing, PT, OT, and/or SLT services. The Enrollee retains the right to supervise and train the nurse, physical therapist, occupational therapist, and/or speech/language therapist. The Enrollee may request a different nurse, physical therapist, occupational therapist, and/or speech/language therapist and the STAR+PLUS MMP must honor the request as long as the nurse, physical therapist, occupational therapist, and/or speech/language therapist is a Network Provider. The STAR+PLUS MMP establishes the payment rate, benefits, and

provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of nursing, PT, OT, and/or SLT services.

2.6.4.8.3. Agency Model

2.6.4.8.3.1. In the Agency Model, the STAR+PLUS MMP contracts with a Home and Community Support Services agency (HCSSA) or a certified Home and Community-based Services or Texas Home Living Agency for the delivery of services. The HCSSA is the employer of record for the personal attendant, respite Provider, nurse, physical therapist, occupational therapist, and speech language therapist. The HCSSA establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of PHC/PAS and/or in-home or out-of home respite, or CFC services.

2.6.5. Continuity of Care

2.6.5.1. Service Transitions

2.6.5.1.1. The STAR+PLUS MMP must ensure that the care of new Enrollees is not disrupted or interrupted.

2.6.5.1.2. Any preexisting Plan of Care and/or ISP will remain in place until the STAR+PLUS MMP conducts an initial Comprehensive Health Risk Assessment and contacts the Enrollee and/or the Enrollee's LAR and coordinates updates to the Enrollee's Plan of Care. The STAR+PLUS MMP must perform an initial Comprehensive Health Risk Assessment within ninety (90) days of an individual's Enrollment in the STAR+PLUS MMP.

2.6.5.1.3. The STAR+PLUS MMP must ensure continuity of care for new Enrollees 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.

2.6.5.1.4. The STAR+PLUS MMP allows Enrollees receiving any services at the time of Enrollment to maintain their current Providers, including with Providers who are not part of the STAR+PLUS MMP's network, and service authorizations, including drugs, for at least up to ninety (90) days after the Enrollee's Enrollment effective date or until the Plan of Care and/or ISP are updated and agreed to by the Enrollee, whichever is earlier, except as otherwise described in this section. The Plan of Care and/or ISP should be agreed to and signed by the Enrollee or the Enrollee's LAR to indicate agreement with the plan. The STAR+PLUS MMP must continue to provide Covered Services as indicated in the Enrollee's existing Plan of Care and/or ISP until the Enrollee signs the new Plan of Care. Exceptions to the ninety (90) day continuity of care period shall be made for the following circumstances:

2.6.5.1.4.1. The STAR+PLUS MMP is required to ensure that all Enrollees who are receiving LTSS, including Nursing Facility services, at the time of Enrollment into the Demonstration receive continued authorization of those services for up to six (6) months after initial Enrollment into the Demonstration or until the Comprehensive Health Risk Assessment has been completed and the Enrollee has signed the Plan of Care;

2.6.5.1.4.2. For all Enrollees who, at the time of Enrollment in the STAR+PLUS MMP, have been diagnosed with and are receiving treatment for a terminal illness and remain enrolled in the Demonstration, in which case the STAR+PLUS MMP shall ensure continued access to Covered Services for nine (9) months from the time of Enrollment or until the Comprehensive Health Risk Assessment has been completed and the Enrollee has signed the Plan of Care.

2.6.5.1.4.3. At any time, an Enrollee may access a 72-hour emergency supply of Medicaid-only covered drugs in accordance with the requirements in Section 2.8.3.10.

2.6.5.1.5. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 C.F.R. §§ 438.404, and 422.568, which articulates the Enrollee's right to file an Appeal (either expedited, if warranted, or standard), the right to have authorized service continue pending the Appeal, and the right to a Fair Hearing if the STAR+PLUS MMP renders an adverse determination (either in whole or in part) on the Appeal.

2.6.5.1.6. Transition Plan – The STAR+PLUS MMP must provide a transition plan for all Enrollees newly enrolled in the STAR+PLUS MMP. HHSC or the previous STAR+PLUS MCO or MMP and/or Medicare Advantage plan operated by the same parent organization as a STAR+PLUS MCO in which the Enrollee was previously enrolled will provide the new STAR+PLUS MMP with information such as detailed Plans of Care and names of current Providers, for Enrollees already receiving Covered Services at the time of Enrollment in the STAR+PLUS MMP. The STAR+PLUS MMP's transition planning process must include the following:

2.6.5.1.6.1. Review of existing Plans of Care and/or ISPs;

2.6.5.1.6.2. Preparation of a transition plan that ensures continuous care under the Enrollee's existing Plan of Care during the transfer into the STAR+PLUS MMP's Network while the STAR+PLUS MMP conducts an appropriate assessment and development of a new Plan of Care, if needed;

2.6.5.1.6.3. Upon receipt of notification that durable medical equipment or supplies had been ordered prior to Enrollment but have not been received by the time of Enrollment, coordination and follow-through to ensure that the Enrollee receives the necessary supportive equipment and supplies without undue delay; and

2.6.5.1.6.4. Payment to the existing Provider of service under the existing authorization for the continuity of care period applicable to the Covered Service authorized, until the STAR+PLUS MMP has completed the assessment and updated the Plan of Care and issued new authorizations.

2.6.5.1.7. Except as provided below, the STAR+PLUS MMP must review any existing Plan of Care and develop a transition plan within thirty (30) days of receiving notice of the Enrollee's Enrollment. For all existing Plans of Care received prior to the Operational Start Date, the STAR+PLUS MMP will have additional time to complete this process, not-to-exceed one hundred twenty (120) days after the Enrollee's Enrollment.

2.6.5.1.8. The transition plan will remain in place until the STAR+PLUS MMP contacts the Enrollee or the Enrollee's LAR, conducts the Comprehensive Health Risk Assessment, and coordinates modifications to the Enrollee's current Plan of Care. The STAR+PLUS MMP must ensure that the existing services continue and that there are no breaks in services.

2.6.5.1.9. The transition plan itself must include:

2.6.5.1.9.1. The Enrollee's health history;

2.6.5.1.9.2. Summary of current medical, behavioral health, and social needs and concerns;

2.6.5.1.9.3. Short-term and long term needs, preferences, and goals; and

2.6.5.1.9.4. A list of services required, their frequency, and a description of who or what entity will provide these services.

2.6.5.1.10. The transition plan may include information for services outside the scope of Covered Services such as how to access affordable, integrated housing.

2.6.5.1.11. The STAR+PLUS MMP must ensure that the Enrollee or the Enrollee's LAR is involved in the assessment process and fully informed about options, is included in the development of the transition plan, and is in agreement with the transition plan when completed.

2.6.5.1.12. During the first six (6) months of the Enrollment phase-in period, HHSC or the STAR+PLUS MCO in which the Enrollee was previously enrolled will provide the STAR+PLUS MMP with files identifying Enrollees receiving Community-Based LTSS. The STAR+PLUS MMP is required to work with CMS, HHSC, its Administrative Services Contractor, and DADS to ensure that all necessary authorizations are in place within the STAR+PLUS MMP's system(s) for the continuation of Community-based LTSS and prior authorized acute care services.

2.6.5.2. Drug Transitions

2.6.5.2.1. Any non-Part D drugs will follow the service transitions requirements articulated in Section 2.6.5.1.

2.6.5.2.2. The STAR+PLUS MMP must provide an appropriate transition process for Enrollees who are prescribed Medicare Part D drugs that are not on its formulary (including drugs that are on the STAR+PLUS MMP's formulary but require prior authorization or step therapy under the STAR+PLUS MMP's utilization management rules). This transition process must be consistent with the requirements at 42 C.F.R. § 423.120(b)(3).

2.6.5.2.3. The drug transition requirement does not apply to drugs not covered by Medicare Part D or Texas Medicaid, even if the Enrollee has a prior authorization for such drug upon enrollment into the STAR+PLUS MMP.

2.6.5.3. Out-of-Network Provider Transitions

2.6.5.3.1. The STAR+PLUS MMP must allow pregnant Enrollees past the 24th week of pregnancy to remain under the care of the Enrollee's current OB/GYN through the Enrollee's postpartum checkup, even if the Provider is Out-of-Network. If an Enrollee 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.

2.6.5.3.2. The STAR+PLUS MMP must pay an Enrollee's existing Out-of-Network Providers for Medically Necessary Covered Services until the Enrollee's records, clinical information and care can be transferred to a Network Provider, or until such time as the Enrollee is no longer enrolled in that STAR+PLUS MMP, whichever is shorter. Payment to Out-of-Network Providers must be made within the time period required for Network Providers. The STAR+PLUS MMP must comply with Out-of-Network Provider reimbursement rules as described in Section 2.6.5.4.

2.6.5.3.3. Except as provided in this Contract and for pregnant Enrollees who are past the 24th week of pregnancy, this Contract does not extend the obligation of the STAR+PLUS MMP to reimburse the Enrollee's existing Out-of-Network Providers for ongoing care for:

2.6.5.3.3.1. More than ninety (90) days after an Enrollee enrolls in the STAR+PLUS MMP;

2.6.5.3.3.2. More than six (6) months for Enrollees receiving LTSS at the time of Enrollment; or

2.6.5.3.3.3. For more than nine (9) months in the case of an Enrollee who, at the time of Enrollment in the STAR+PLUS MMP, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled in the STAR+PLUS MMP.

2.6.5.3.4. The STAR+PLUS MMP's obligation to reimburse the Enrollee's existing Out-of-Network Provider for services provided to a pregnant Enrollee past the 24th week of pregnancy extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six (6) weeks of delivery.

2.6.5.3.5. If an Enrollee moves out of a Service Area, the STAR+PLUS MMP must provide or pay Out-of-Network Providers in the new Service Area who provide Medically Necessary Covered Services to Enrollees through the end of the period for which the STAR+PLUS MMP received a Capitation Payment for the Enrollee.

2.6.5.3.6. If Covered Services are not available within the STAR+PLUS MMP's Network, the STAR+PLUS MMP must provide Enrollees with timely and adequate access to Out-of-Network services for as long as those services are necessary and not available in the Network, in accordance with 42 C.F.R. § 438.206(b)(4). Unless an exception applies under this Contract, the STAR+PLUS MMP will not be obligated to provide an Enrollee with access to Out-of-Network services if such services become available from a Network Provider.

2.6.5.4. Out-of-Network Payment Rules

2.6.5.4.1. The STAR+PLUS MMP must reimburse an Out-of-Network Provider of emergent or Urgent Care, as defined by 42 C.F.R. § 424.101 and 42 C.F.R. § 405.400 respectively, at the amounts that the Provider could collect for that service if the beneficiary were enrolled in Original Medicare, or, if a lesser amount, the Provider's charge for that service. The Original Medicare reimbursement amounts for section 1861(u) Providers do not include payments under 42 C.F.R. §§ 412.105(g) and 413.76. For services for which Medicaid is the primary payor, the STAR+PLUS MMP must reimburse an Out-of-Network Provider of emergent or Urgent Care consistent with 1 T.A.C. § 353.4. Enrollees maintain balance billing protections.

2.6.5.4.2. For items and services that are part of the traditional Medicare benefit package, the STAR+PLUS MMP will be required to pay Out-of-Network Providers at least the lesser of the Providers' charges or the amount that the Provider could collect for that service if the beneficiary were enrolled in Original Medicare (less any payments under 42 C.F.R. 412.105(g) and 413.76 for section 1861(u) Providers), regardless of the setting and type of care for authorized Out-of-Network services. For services for which Medicaid is the primary payor, the STAR+PLUS MMP must comply with Out-of-Network Provider reimbursement in accordance with 42 CFR § 438.206(b)(5) and 1 T.A.C. § 353.4 for services for which Medicaid is the primary payor. Enrollees maintain balance billing protections.

2.6.5.4.3. If an Enrollee is receiving any item or service that would not otherwise be covered by the STAR+PLUS MMP at an in-Network level after the continuity of care period, the STAR+PLUS MMP must notify the Enrollee prior to the end of the continuity of care period, according to the requirements at 42 C.F.R. § 438.404 and 42 C.F.R. § 422.568.

2.6.5.4.3.1. The Enrollee shall be entitled to all Appeal rights, including aid pending Appeal, if applicable, as outlined in Section 2.12 of this Contract.

2.6.5.4.3.1. The STAR+PLUS MMP must ensure that each Enrollee has access to a second opinion regarding the use of any Medically Necessary Covered Service. An Enrollee 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 Enrollee, in accordance with 42 C.F.R. § 438.206(b)(3).

2.6.5.4.4. Out-of-Network Specialty Providers – It is understood that in some instances Enrollees will require specialty care not available from a Network Provider and that the STAR+PLUS MMP will arrange that such services be provided by an Out-of-Network Provider. In such event, STAR+PLUS MMP will promptly attempt to negotiate a single case agreement with an Out-of-Network Provider to treat the Enrollee until a qualified Network Provider is available. The STAR+PLUS MMP shall make best efforts to have any Out-of-Network Provider billing for services be enrolled in the Medicare Program or Texas Medicaid Program, as appropriate and in the same manner as Network Providers under Section 2.7.4, prior to paying a Claim.

2.6.5.5. Transferring Plans of Care

2.6.5.5.1. The STAR+PLUS MMP must be able to accept and honor established Plans of Care provided on paper or electronically transferred from FFS or prior managed care plans when Enrollees transition with Plans of Care in place as outlined in Section 2.6.5.1.6; and

2.6.5.5.2. The STAR+PLUS MMP must be able to ensure timely transfer of Plans of Care to other STAR+PLUS MMPs or other plans when an Enrollee is disenrolling from the STAR+PLUS MMP.

2.6.6. Span of Coverage Rules

2.6.6.1. Inpatient Hospital – Payment for Enrollees in an inpatient hospital will follow the same rule for STAR+PLUS MMPs as per the Medicare Managed Care Manual, Chapter 8, Section 120, “Special Rules for Coverage that Begins or Ends During an Inpatient Hospital Stay.”

2.6.6.2. CDTF – The following table describes payment responsibility for enrollment changes that occur during a stay in a residential SUDtreatment facility or residential detoxification for SUD treatment facility (collectively, chemical dependency treatment facility (CDTF)), beginning on the Enrollee's Effective Date of coverage with the new STAR+PLUS MMP.

2.6.6.2.1. Enrollees also can move to Medicaid FFS during a CDTF stay under the limited circumstances following an Involuntary Disenrollment.

Table 2-1 Payment Responsibility for CDTF during Transition

	Scenario	CDTF Charge	All Other Covered Services
1	Enrollee prospectively moves from Medicaid FFS to STAR+PLUS MMP	New STAR+PLUS MMP	New STAR+PLUS MMP
2	Enrollee moves from STAR+PLUS MMP to other Texas Medicaid MCO	Former STAR+PLUS MMP	New MCO
3	Enrollee moves from STAR+PLUS MMP to Medicaid FFS (Involuntary Disenrollment)	Former STAR+PLUS MMP	Medicaid FFS
4	Enrollee moves from other Texas Medicaid MCO to STAR+PLUS MMP	Former MCO	New STAR+PLUS MMP
5	Enrollee moves between STAR+PLUS MMPs	Former STAR+PLUS MMP	New STAR+PLUS MMP

2.6.6.2.2. The responsible party will pay the CDTF charge until the earlier of: (1) date of Discharge from the CDTF, or (2) loss of eligibility. The New MCO may evaluate for medical necessity of the CDTF stay prior to the end of the authorized services period. For Enrollees who move from STAR+PLUS MMP into Star Health, the date of Discharge from the CDTF includes extended stay days, as described in the Texas Medicaid Provider Procedures Manual.

2.6.6.3. Skilled Nursing Facility Services – Payment for skilled nursing facility (SNF) stays for Enrollees who change Enrollment is treated differently than for inpatient hospital stays. The SNF payment is split by the day, according to the Medicare Claims Processing Manual, Chapter 6, Section 90:

2.6.6.3.1. SNFs follow the requirements of the agreement they have with the STAR+PLUS MMP. In cases where the Enrollee may have enrolled or disenrolled from the STAR+PLUS MMP during the billing period, the SNF will split the bill and send the STAR+PLUS MMP's portion to it and the remaining portion to the new Medicare Advantage plan or Medicare Administrative Contractor for Original Medicare.

2.6.6.4. Nursing Facility Services – The following table describes payment responsibility for enrollment changes that occur during a Nursing Facility stay, beginning on the Enrollee's Effective Date of coverage with the new MCO.

Table 2-2 Payment Responsibility for Nursing Facility during Transition

	Scenario	Nursing Facility Charge	All Other Covered Services
1	Enrollee moves from Medicaid FFS to STAR+PLUS MMP	New STAR+PLUS MMP	New STAR+PLUS MMP
2	Enrollee moves from other Texas Medicaid MCO to STAR+PLUS MMP	New STAR+PLUS MMP	New STAR+PLUS MMP
3	Enrollee moves between	New STAR+PLUS	New STAR+PLUS

	Scenario	Nursing Facility Charge	All Other Covered Services
	STAR+PLUS MMPs	MMP	MMP

2.6.6.5. Custom DME and Augmentative Device - The following table describes payment responsibility for enrollment changes that occur when a prior authorization exists for custom DME, before the delivery of the product.

Table 2-3 Payment Responsibility for Custom DME and Augmentative Device

	Scenario	Custom DME	All Other Covered Services
1	Enrollee moves between STAR+PLUS MMPs	Former STAR+PLUS MMP	New STAR+PLUS MMP
2	Enrollee moves from FFS to STAR+PLUS MMP	New STAR+PLUS MMP	New STAR+PLUS MMP

2.6.6.6. Home Modification -The following table describes payment responsibility for enrollment changes that occur during a minor home modification service provided to an HCBS STAR+PLUS Waiver Enrollee, before completion of the modification.

Table 2-4 Payment Responsibility for Home Modification

	Scenario	Minor Home Modification	All Other Covered Services
1	Enrollee moves between STAR+PLUS MMPs	Former STAR+PLUS MMP	New STAR+PLUS MMP

2.7. Provider Network

2.7.1. Network Adequacy

2.7.1.1. The STAR+PLUS MMP must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including the appropriate range of preventive, primary, specialty, behavioral health, and all other services required in 42 C.F.R. §§ 422.112, 423.120, and 438.206, and under this Contract (see Covered Services in Appendix A).

2.7.1.2. The STAR+PLUS MMP must demonstrate annually that its Medicare Provider Network meets the standards in 2.7.1.2.1 and 2.7.1.2.2 and must demonstrate quarterly that its Medicaid Provider Network meets the standards in 2.7.1.2.3:

2.7.1.2.1. Medicare's time, distance, and minimum number standards for medical Providers and facilities, updated annually on the CMS website (http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html) Medicare's time, distance, and minimum number standards for pharmacy Providers, as required in Appendix D, Article II, Section I and 42 C.F.R. § 423.120;

2.7.1.2.2. HHSC standards for services for which Medicaid is the traditional primary payor, including behavioral health, substance abuse services, and LTSS. For each Provider type, the STAR+PLUS MMP must provide access to at least ninety (90) percent of Enrollees in each Service Area within the prescribed distance standard for each State Fiscal Quarter; and

2.7.1.2.3. The stricter of the applicable standards in Section 2.7.1.2 for services for which Medicare and Medicaid overlap (including, but not limited to, Home Health, Durable Medical Equipment and skilled therapies, but excluding Part D).

2.7.1.3. STAR+PLUS MMPs are required to develop and maintain Provider Networks adequate to deliver all Covered Services, with an emphasis on the special needs of individuals with chronic conditions and physicial and mental disabilities. Each STAR+PLUS MMP Provider Network must provide convenient and timely access to care. In addition to meeting Medicare Advantage minimum network requirements, the STAR+PLUS MMP must meet the following network adequacy standards:

2.7.1.3.1. Other LTSS Providers: STAR+PLUS MMPs must ensure that Enrollees have access to at least one LTSS Provider of each service type required by HHSC in the network within seventy-five (75) miles of the Enrollee's residence.

2.7.1.3.2. Behavioral Health Providers: STAR+PLUS MMPs must ensure that Enrollees have access to the following types of Behavioral Health Service Providers within seventy-five (75) miles of the Enrollee's residence: psychologists and other Behavioral Health Service Providers who are qualified to provide Covered Services as outlined in Appendix A.

2.7.1.4. Providers must not be under sanction or exclusion from the Medicaid and Medicare programs and must have a valid National Provider Identifier (NPI) or Atypical Provider Identifier (API).

2.7.1.5. The STAR+PLUS MMP may enroll out-of-state Providers in its Medicaid Networks in accordance with 1 TAC § 352.17. For Medicaid covered drugs, pharmacies must be an enrolled Medicaid Provider. .

2.7.1.6. The STAR+PLUS MMP may enroll out-of-state diagnostic laboratories in its Medicaid Networks under the circumstances described in Texas Government Code § 531.066.

2.7.1.7. The STAR+PLUS MMP must ensure its Providers and First Tier, Downstream, and Related Entities meet all current and future state and federal eligibility criteria, reporting

requirements, and any other applicable rules and/or regulations related to this Contract.

2.7.1.8. Each STAR+PLUS MMP's Provider Network must be responsive to the linguistic, cultural, and other unique needs of any minority, older, disabled, or other special needs populations served by the STAR+PLUS MMP. This includes the capacity to communicate with Enrollees in languages other than English, when necessary, as well as with those who require sign language interpreting.

2.7.1.9. The STAR+PLUS MMP must notify the CMT of any significant Provider Network changes immediately, but no later than five (5) days after becoming aware of an issue, including a change in the STAR+PLUS MMP's Provider Network that renders the STAR+PLUS MMP unable to provide one or more Covered Services within the access to care standards set forth in this section, with the goal of providing notice to the CMT at least sixty (60) days prior to the effective date of any such change.

2.7.1.10. HHSC and CMS will monitor access to care and the prevalence of needs indicated through Enrollee assessments, and, based on those findings, may require that the STAR+PLUS MMP initiate further Provider Network expansion over the course of the Demonstration.

2.7.1.11. The STAR+PLUS MMP ensures that Enrollees have access to the most current and accurate information on Network Providers by updating its online Provider directory and search functionality on a timely basis, as outlined in Section 2.15.5. This information includes Provider compliance with the ADA in terms of physical and communications accessibility for Enrollees who are blind or deaf as well as other reasonable accommodations.

2.7.1.12. Appointment Wait Times – Through its Provider Network composition and management, the STAR+PLUS MMP must ensure that the following standards are met. In all cases below, "day" is defined as a calendar day, and the standards are measured from the date of presentation or request, whichever occurs first:

2.7.1.12.1. Emergency Services must be provided upon Enrollee presentation at the service delivery site, including at non-network and out-of-area facilities;

2.7.1.12.2. Urgent care, including urgent specialty care, must be provided within twenty-four (24) hours;

2.7.1.12.3. Routine primary care must be provided within fourteen (14) days;

2.7.1.12.4. Initial outpatient behavioral health visits must be provided within fourteen (14) days;

2.7.1.12.5. PCPs must make referrals for specialty care on a timely basis, based on the urgency of the Enrollee's medical condition, but no later than thirty (30) days;

2.7.1.12.6. Pre-natal care must be provided within fourteen (14) days, except for high-risk pregnancies or new Enrollee s in the third trimester, for whom an appointment must be offered within five (5) days, or immediately, if an emergency exists;

2.7.1.12.7. Preventive health services for adults must be offered within ninety (90) days; and

2.7.1.12.8. Community-Based LTSS for Non-HCBS STAR+PLUS Waiver Enrollees must be initiated within seven (7) days from the date the STAR+PLUS MMP authorizes services unless the referring Provider or Enrollee states otherwise.

2.7.2. Network Provider Requirements

2.7.2.1. The STAR+PLUS MMP must enter into written Provider Contracts with properly credentialed Providers as described in Section 2.7.3.7.

2.7.2.1.1. The STAR+PLUS MMP shall assure that all Network Providers that provide Medicare Covered Services are enrolled as Medicare Providers in order to submit Claims for reimbursement or otherwise participate in the Medicare Program.

2.7.2.1.2. The STAR+PLUS MMP shall assure that all Network Providers, including out-of-State Network Providers, that provide Medicaid Covered Services, are enrolled in the Texas Medicaid Program, if such Enrollment is required by HHSC's rules or policy in order to submit Claims for reimbursement or otherwise participate in the Texas Medicaid Program.

2.7.2.1.3. STAR+PLUS MMPs utilizing Out-of-Network Providers to render services to their Enrollees must not exceed the utilization standards established in 1 T.A.C. §353.4. HHSC may modify this requirement for STAR+PLUS MMPs that demonstrate good cause for noncompliance, as set forth in §353.4(e)(3).

2.7.2.2. All Network Providers must serve the target population.

2.7.2.3. All Providers' physical sites must be accessible to all Enrollees, including Enrollees with disabilities, as must all Providers that deliver services in the Enrollees' locations.

2.7.2.4. The STAR+PLUS MMP shall ensure that its Network Providers are responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of any minority, homeless population, Enrollees with disabilities (both congenital and acquired disabilities), or other special population served by the STAR+PLUS MMP. This responsiveness includes the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those with a vision or hearing impairment.

2.7.2.5. The STAR+PLUS MMP shall ensure that, to the extent that such capacity exists within the STAR+PLUS MMP's Service Area, all Network Providers understand and comply with their obligations under state or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations.

2.7.2.6. The STAR+PLUS MMP shall ensure that Network Providers and interpreters/translators are available for those within the STAR+PLUS MMP's Service Area who are deaf, or vision- or hearing-impaired.

2.7.2.7. The STAR+PLUS MMP shall ensure that its Network Providers have a strong understanding of Disability, recovery, and resilience cultures and LTSS.

2.7.2.8. The STAR+PLUS MMP shall make best efforts to promote full and equal business opportunities for businesses in state contracting in accordance with the goals specified in the State of Texas Disparity Study. HHSC encourages the use of Historically Underutilized Business (HUBs) through race, ethnic and gender-neutral means. HHSC has adopted administrative rules relating to HUBs, and a policy on the

Utilization of HUBs, Title 1, Part 15, Chapter 392, Subchapter J.

2.7.2.9. Inpatient Hospital and Medical Services – The STAR+PLUS MMP must ensure access to acute care hospitals and specialty hospitals in the STAR+PLUS MMP's Network. Covered Services provided by such Hospitals must be available and accessible twenty-four (24) hours per day, seven (7) days per week. The STAR+PLUS MMP must enter into a Provider Contract with any willing state hospital that meets the STAR+PLUS MMP's credentialing requirements and agrees to the STAR+PLUS MMP's contract rates and terms.

2.7.2.10. Nursing Facility Services – PCPs associated with Nursing Facilities must have admitting privileges to Network Hospitals.

2.7.2.11. Behavioral Health Services – The STAR +PLUS MMP must maintain a Behavioral Health Services Provider Network that includes psychiatrists, psychologists, and other Behavioral Health Service Providers.

2.7.2.12. Women's Health Services – The STAR+PLUS MMP shall ensure that the Provider Network provides all female Enrollees with direct access to a women's health specialist, including an obstetrician or gynecologist, within the Provider Network for Covered Services necessary to provide women's routine and preventive health care services. This shall include contracting with, and offering to female Enrollees, women's health specialists as PCPs.

2.7.2.13. The STAR+PLUS MMP must seek participation in the Provider Network from the following types of entities that may serve American Indian and Alaskan Natives:

2.7.2.13.1. Health clinics operated by a federally-recognized tribe in the Service Area;

2.7.2.13.2. Federally Qualified Health Centers (FQHC) operated by a federally-recognized tribe in the Service Area; and

2.7.2.13.3. Urban Indian organizations in the Service Area.

2.7.2.14. Significant Traditional Providers (STPs) – Medicaid STPs are defined in 1 Tex. Admin. Code § 353.2. In the first three (3) operational years of the Demonstration, the STAR+PLUS MMP must offer Provider Contracts to the following STPs:

2.7.2.14.1. Nursing facilities – Nursing facilities that are licensed, certified, and have a valid DADS contract on September 1, 2013, will be included on the STP list. If any willing Nursing Facility Provider is not on the STP list but will agree to the STAR+PLUS MMP's contract rates and terms, the STAR+PLUS MMP must also enter into a Provider Contract with that Provider if the Nursing Facility is licensed, Medicaid-certified, and has a valid DADS contract. Any willing Nursing Facility Provider includes Nursing Facility STPs who have gone through a change in ownership after September 1, 2013, and new Nursing Facility Providers.

2.7.2.14.2. Community First Choice (CFC) – Providers will be included on the STP list who have a valid certification or license (as applicable) and who are:

2.7.2.14.2.1. Home and community support services agencies licensed under the Texas Health and Safety Code Chapter 142 that are contracted with DADS to provide services under the Community Living Assistance and Support Services (CLASS) or Deaf Blind Multiple Disabilities (DBMD) waiver programs; or

2.7.2.14.2.2. Providers exempted from licensing under Texas Health and Safety Code 142.003(a)(19) and are contracted with DADS to provide services under the Home and Commutniy-based Services (HCS) or Texas Home Living (TxHmL) waiver programs.

2.7.2.14.3. Local Mental Health Authorities (LMHAs) and behavioral health providers providing Targeted Case Management and Mental Health Rehabilitative Services.

2.7.2.14.4. The STP must:

2.7.2.14.4.1. Agree to accept the STAR+PLUS MMP's Provider reimbursement rate for the Provider type; and

2.7.2.14.4.2. Meet the standard credentialing requirements of the STAR+PLUS MMP, provided that lack of board certification or accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) may not be the sole grounds for exclusion from the Provider Network.

2.7.2.14.5. The STAR+PLUS MMP may terminate a Provider Contract with an STP after demonstrating, to the satisfaction of HHSC, good cause for the termination. Good cause may include evidence of Provider Fraud, Waste, or Abuse.

2.7.3. Provider Contracting

2.7.3.1. General

2.7.3.1.1. The STAR+PLUS MMP must contract only with qualified or licensed Providers who continually meet federal and state requirements, as applicable, and the qualifications contained in Appendix C.

2.7.3.1.2. The STAR+PLUS MMP must resubmit the model/template Provider Contracts any time it makes substantive modifications to such agreements. HHSC and CMS retain the right to reject or require changes to any Provider Contract that does not comply with STAR+PLUS MMP requirements or this Contract.

2.7.3.1.3. If the STAR+PLUS MMP declines to include individuals or groups of Providers in its Provider Network, the STAR+PLUS MMP must give the affected Providers written notice of the reason for its decision.

2.7.3.1.4. The STAR+PLUS MMP must make any policies affecting claims adjudication and claims coding and processing guidelines available to Providers for the applicable provider type. Providers must receive ninety (90) day's notice prior to the STAR+PLUS MMP's implementation of changes to these claims policies and guidelines.

2.7.3.1.5. The STAR+PLUS MMP must notify the CMT within five (5) days after termination of (1) a PCP contract that impacts more than ten (10%) percent of its Enrollees or (2) any Provider contract that impacts more than ten (10%) percent of its Network for a Provider type by Service Area and program. The STAR+PLUS MMP must also notify the CMT of Provider terminations in accordance with UMCM Chapter 5.4.1.1, "Provider Termination Report." Additionally, unless prohibited or limited by applicable law and consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice of termination of a contracted Provider or pharmacy at least thirty (30) calendar days before when practicable but no later than fifteen (15) days after the termination effective date to all Enrollees who regularly use the Provider or pharmacy's services; if a contract termination involves a primary care professional, all Enrollees who are patients of that primary care professional must be notified.

2.7.3.2. Excluded Providers

2.7.3.2.1. The STAR+PLUS MMP may not contract with, or otherwise pay for any items or services furnished, directed or prescribed by, a Provider that has been excluded from participation in federal health care programs by the OIG of the U.S. Department of Health and Human Services under either Section 1128 or Section 1128A of the Social Security Act, and implementing regulations at 42 C.F.R. Part 1001 et. seq., or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 C.F.R. §1001.1801 and §1001.1901.

2.7.3.2.2. The STAR+PLUS MMP shall, at a minimum, check the OIG List of Excluded Individuals Entities (LEIE), Medicare Exclusion Database (MED), and the System for Awards Management (SAM) (the successor to the Excluded Parties List System (EPLS)) for its Providers at least monthly, before contracting with the Provider, and at the time of a Provider's credentialing and recredentialing.

2.7.3.2.3. If a Provider is terminated or suspended from the HHSC Medicaid Program, Medicare, or another state's Medicaid program or is the subject of a State or federal licensing action, the STAR+PLUS MMP shall terminate, suspend, or decline a Provider from its Provider Network as appropriate.

2.7.3.2.4. Upon notice from HHSC or CMS, the STAR+PLUS MMP shall not authorize any Providers who are terminated or suspended from participation in the Texas Medicaid Program, Medicare, or from another state's Medicaid program, to treat Enrollees and shall deny payment to such Providers for services provided.

2.7.3.2.5. The STAR+PLUS MMP shall notify CMS and HHSC, via the CMT, when it terminates, suspends, or declines a Provider from its Provider Network because of Fraud, integrity, or quality.

2.7.3.2.6. The STAR+PLUS MMP shall notify CMS and HHSC on a quarterly basis when a Provider fails credentialing or re-credentialing because of a program integrity or Adverse Action reason, and shall provide related and relevant information to CMS and HHSC as required by CMS, HHSC, or state or federal laws, rules, or regulations.

2.7.3.3. Primary Care Providers – For purposes of establishing the Provider Network, a PCP must be one of the following:

2.7.3.3.1. A physician who is:

2.7.3.3.1.1. Licensed by the State of Texas;

2.7.3.3.1.2. In good standing with the Medicare and Medicaid programs; and either

2.7.3.3.1.2.1. Specialized in family practice, internal medicine, general practice, OB/GYN, or geriatrics; or

2.7.3.3.1.2.2. Specialists who perform primary care functions, including but not limited to FQHCs, rural health clinics, health departments, and other similar community clinics.

2.7.3.3.2. A registered nurse or nurse practitioner who is licensed by the State of Texas; or

2.7.3.3.3. A physician assistant who is licensed by the State of Texas.

2.7.3.4. Behavioral Health Service Providers

2.7.3.4.1. In addition to those requirements described above, the STAR+PLUS MMP shall comply with the requirements of 42 C.F.R. § 438.214 regarding selection, retention and exclusion of Behavioral Health Care Providers. The STAR+PLUS MMP shall have an adequate Network of behavioral health and substance abuse Providers to meet the needs of the population, including their community mental health rehabilitative service needs. Examples of these types of Providers include, but are not limited to, psychiatrists, clinical psychologists, licensed clinical social workers, outpatient substance abuse treatment Providers, and residential substance abuse treatment Providers for pregnant women, etc.

2.7.3.4.2. To ensure accessibility and availability of qualified Providers to all Enrollees in the Service Area, the Provider Network must include Behavioral Health Service Providers with experience serving special populations among the STAR+PLUS MMP's enrolled population, including, as applicable persons with disabilities, the elderly, and cultural or linguistic minorities.

2.7.3.5. Indian Health Care Providers

2.7.3.5.1. The STAR+PLUS MMP shall offer Indian Enrollees the option to choose an Indian health care Provider as a PCP if the STAR+PLUS MMP has an Indian PCP in its Network that has capacity to provide such services; in addition, the STAR + PLUS MMP shall permit any Indian who is enrolled in a non-Indian MMP and eligible to receive services from a participating I/T/U provider to choose to receive covered services from that I/T/U provider.

2.7.3.5.2. The STAR+PLUS MMP shall demonstrate that it has sufficient access to Indian health care Providers to ensure access to Covered Services for Indian Enrollees;

2.7.3.5.3. The STAR+PLUS MMP shall pay both Network and Out-of-Network Indian health care Providers who provide Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the HHSC FFS rate for the same service or, in the absence of a negotiated rate, an amount not less than the amount that the STAR+PLUS MMP would pay for the Covered Service provided by a non-Indian health care Provider;

2.7.3.5.4. The STAR+PLUS MMP shall make prompt payment to Indian health care Providers; and

2.7.3.5.5. The STAR+PLUS MMP shall pay Out-of-Network Indian health care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the STAR+PLUS MMP would pay to a Network FQHC that is not an Indian health care Provider.

2.7.3.5.6. The STAR+PLUS MMP may restrict enrollment of Indians in the same manner as Indian health programs restrict delivery of services to Indians.

2.7.3.6. Non-Allowed Terms of Provider Contracts

2.7.3.6.1. The STAR+PLUS MMP shall not require as a condition of participation/contracting with Providers in their STAR+PLUS MMP Network to also participate in the STAR+PLUS MMP's other lines of business (e.g., commercial managed care network). However, this provision would not preclude a STAR+PLUS MMP from requiring their commercial network Providers to participate in their STAR+PLUS MMP Provider Network.

2.7.3.6.2. The STAR+PLUS MMP is prohibited from requiring a Provider or Provider group to enter into an exclusive contracting arrangement with the STAR+PLUS MMP as a condition for Network participation.

2.7.3.6.3. The STAR+PLUS MMP shall not require as a condition of participation/contracting with Providers in the network a Provider's terms of panel participation with other STAR+PLUS MMPs.

2.7.3.6.4. The STAR+PLUS MMP shall not include in its Provider Contracts any provision that directly or indirectly prohibits, through incentives or other means, limits, or discourages Network Providers from participating as Network or non-network Providers in any Provider Network other than the STAR+PLUS MMP's Provider Network(s).

2.7.3.6.5. The STAR+PLUS MMP shall not establish selection policies and procedures for Providers that discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

2.7.3.7. Provider Credentialing, Board Certification, and Licensure

2.7.3.7.1. The STAR+PLUS MMP shall implement written policies and procedures that comply with the requirements of 42 C.F.R. § 422.504(i)(4)(iv) and § 438.214(b) regarding the selection, retention and exclusion of Providers, credentialing and recredentialing requirements and nondiscrimination, and meet, at a minimum, the requirements in this section.

2.7.3.7.2. At least once every three years, the STAR+PLUS MMP must review and approve the credentials of all participating licensed and unlicensed Providers who participate in the STAR+PLUS MMP's Network. The STAR+PLUS MMP may subcontract with another entity to which it delegates credentialing activities if the delegated credentialing is maintained in accordance with the National Committee for Quality Assurance (NCQA) delegated credentialing requirements and any comparable requirements defined by HHSC. The STAR+PLUS MMP must report this information annually to HHSC through the Quality Assessment and Performance Improvement (QAPI) Program process using the form found in UMCM Chapter 5.7.1.

2.7.3.7.3. At a minimum, the scope and structure of a STAR+PLUS MMP's credentialing and re-credentialing processes must be consistent with recognized industry standards, such as those provided by NCQA and relevant state and federal regulations including 28 TAC §§ 11.1902 and 11.1402(c), relating to Provider credentialing and notice. STAR+PLUS MMPs must also comply with 42 C.F.R. § 438.12 and 42 C.F.R. § 438.214(b).

2.7.3.7.4. The STAR+PLUS MMPs must use state-identified credentialing criteria for Nursing Facilities and may only contract with a Nursing Facility with a valid certification, license, and contract with DADS. The STAR+PLUS MMP may not discriminate against the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. Additionally, if the STAR+PLUS MMP declines to include individual or groups of Providers in its Network, it must give the affected Providers written notice of the reasons for its decision.

2.7.3.7.5. The re-credentialing process must take into consideration Provider performance data including Enrollee Complaints and Appeals, quality of care, and utilization management.

2.7.3.7.6. STAR+PLUS MMPs must comply with the requirements of Texas Insurance Code Chapter 1452, Subchapters C, D, and E, regarding expedited credentialing and payment of physicians, as applicable, who have joined established medical groups or professional practices that are already contracted with the STAR+PLUS MMP. Additionally, the STAR+PLUS MMP must comply with the Subchapters' hold harmless requirements for Enrollees.

2.7.3.7.7. The STAR+PLUS MMP must complete the credentialing process for a new Provider, and its Claim systems must be able to recognize the Provider as a Network Provider no later than ninety (90) calendar days after receipt of a complete application. If an application does not include required information, the STAR+PLUS MMP must provide the Provider written notice of all missing information no later than five (5) business days after receipt.

2.7.3.7.8. Additionally, if a Provider qualifies for expedited credentialing, the STAR+PLUS MMP's Claims system must be able to process Claims from the Provider as if the Provider was a Network Provider no later than thirty (30) calendar days after receipt of a complete application, even if the STAR+PLUS MMP has not yet completed the credentialing process.

2.7.3.7.9. The STAR+PLUS MMP shall ensure that no credentialed Provider engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 C.F.R. Part 80, 45 C.F.R. Part 84, and 45 C.F.R. Part 90;

2.7.3.7.10. The STAR+PLUS MMP shall obtain disclosures from all Network Providers and applicants in accordance with 42 C.F.R. 455 Subpart B and 42 C.F.R.§ 1002.3, including but not limited to obtaining such information through Provider enrollment forms and credentialing and recredentialing packages, and maintain such disclosed information in a manner which can be periodically searched by the STAR+PLUS MMP for exclusions and provided to HHSC in accordance with this Contract, including this Section, and relevant state and federal laws and regulations.

2.7.3.7.11. Board Certification Requirements

2.7.3.7.11.1. The STAR+PLUS MMP shall maintain a policy that encourages participation of board certified PCPs and specialty physicians in the Provider Network.

2.7.3.7.11.2. The STAR+PLUS MMP must make information on the percentage of board-certified PCPs in the Provider Network and the percentage of board-certified specialty Providers, by specialty, available upon request.

2.7.3.7.12. HCBS STAR+PLUS Waiver Services Licensure and Certification Requirements

2.7.3.7.12.1. Employment Assistance and Supported Employment – The Provider of Employment Assistance and Supported Employment services must meet all of the criteria in one of these three (3) options:

2.7.3.7.12.1.1. Option 1: A bachelor's degree in rehabilitation, business, marketing, or a related human services field; and one (1) year of documented experience providing Employment Assistance and Supported Employment services to people with disabilities in a professional or personal setting.

2.7.3.7.12.1.2. Option 2: An associate's degree in rehabilitation, business, marketing, or a related human services field; and two (2) years of documented experience providing Employment Assistance and Supported Employment services to people with disabilities in a professional or personal setting.

2.7.3.7.12.1.3. Option 3: A high school diploma or GED; and three (3) years of documented experience providing Employment Assistance and Supported Employment services to people with disabilities in a professional or personal setting.

2.7.3.7.12.2. Assisted Living – The Assisted Living Provider must be licensed by the DADS Long Term Care Regulatory Division in accordance with 40 T.A.C., Part 1, Chapter 92. The type of licensure determines what services may be provided.

2.7.3.7.12.3. Emergency Response Services – The Provider must be licensed by the Texas Department of State Health Services as a Personal Emergency Response Services Agency under 25 T.A.C., Part 1, Chapter 140, Subchapter B.

2.7.3.7.12.4. Nursing Services – The Provider must be a licensed registered nurse by the Texas Board of Nursing under 22 T.A.C., Part 11, Chapter 217. The registered nurse must comply with the requirements for delivery of nursing services, which include requirements such as compliance with the Texas Nurse Practice Act and delegation of nursing tasks. The licensed vocational nurse must practice under the supervision of a registered nurse, licensed to practice in the state.

2.7.3.7.12.5. Cognitive Rehabilitative Therapy – Psychologists must be licensed under Texas Occupations Code Chapter 501. Speech and language pathologists must be licensed under Texas Occupations Code Chapter 401. Occupational Therapist must be licensed under Texas Occupations Code Chapter 454.

2.7.3.7.12.6. Adult Foster Care – Adult foster care homes must meet the minimum standards described in the STAR+PLUS Handbook, Section 7100. Adult foster care homes serving four (4) or more participants must be licensed by DADS under 40 T.A.C. Chapter 92.

2.7.3.7.12.7. Dental – Providers must be licensed by the Texas State Board of Dental Examiners as a Dentist under 22 T.A.C., Part 5, Chapter 101.

2.7.3.7.12.8. Respite Care – Providers must be licensed by DADS as a Home and Community Support Services Agency (HCSSA) under 40 T.A.C., Part 1, Chapter 97.

2.7.3.7.12.9. Home Delivered Meals – Providers must comply with requirement of 40 T.A.C., Part 1, Chapter 55 for providing home delivered meal services, which include requirements such as dietary requirements, food temperature, delivery times, and training of volunteers and others who deliver meals.

2.7.3.7.12.10. Physical Therapy (PT) Services – Providers must be licensed Physical Therapists through the Texas Board of Physical Therapy Examiners, Chapter 453 of the Texas Occupations Code.

2.7.3.7.12.11. Occupational Therapy (OT) Services – Providers must be licensed Occupational Therapists through the Texas Board of Occupational Therapy Examiners, Chapter 454 of the Texas Occupations Code.

2.7.3.7.12.12. Speech, Hearing and Language Therapy – Providers must be licensed Speech Therapists through the Texas Department of State Health Services.

2.7.3.7.12.13. Financial Management Services –Providers must complete DADS' required training. Current FMSAs contracted by DADS are assumed to have completed the training.

2.7.3.7.12.14. Support Consultation – Providers must be certified by DADS.

2.7.3.7.12.15. Transition Assistance Services (TAS) – The Provider must comply with the requirements for delivery of TAS, which include requirements such as allowable purchases, cost limits, and timeframes for delivery. TAS Providers must demonstrate knowledge of, and experience in, successfully serving individuals who require HCBS.

2.7.3.7.12.16. Minor Home Modifications – No licensure or certification requirements.

2.7.3.7.12.17. Adaptive Aids and Medical Equipment – No licensure or certification requirements.

2.7.3.7.12.18. Medical Supplies – No licensure or certification requirements.

2.7.3.7.12.19. Community First Choice (CFC) – At a minimum, Providers must meet all of the following state licensure and certification requirements for providing the following services:

2.7.3.7.12.19.1. CFC Services - with the exception of Emergency Response Service (CFC) – The Provider must be licensed by DADS as a Home and Community Support Services Agency (HCSSA) or certified as a HCBS or Texas Home Living agency. The level of licensure required depends on the type of service delivered. For PAS (CFC), the agency may have only the PAS level of licensure.

2.7.3.7.12.19.2. Emergency Response (CFC) – The Provider must be licensed 1) By the Public Security Bureau of the Texas Department of Public Safety as an alarm systems company; or 2) By the Texas Department of State Health Services as a personal emergency response system provider.

2.7.3.7.12.20. Support Consultation (CFC) – The Provider must meet all qualifications defined in 40 T.A.C. § 41.601, Support Consultation Services.

2.7.3.7.13. LTSS Provider Credentialing Requirements. Before contracting with unlicensed LTSS Providers or LTSS Providers not certified by a State HHS Agency, the STAR+PLUS MMP must ensure that the Provider:

2.7.3.7.13.1. Has not been convicted of a crime listed in Texas Health and Safety Code § 250.006;

2.7.3.7.13.2. Is not listed as "unemployable" in the Employee Misconduct Registry or the Nurse Aide Registry maintained by DADS by searching or ensuring a search of such registries is conducted, before hire and annually thereafter;

2.7.3.7.13.3. Is not listed on the HHS-OIG Exclusion or HHSC-OIG Exclusion Search websites as excluded from participation in any federal or State health care program by searching or ensuring a search of such registries is conducted, before hire and at least monthly thereafter;

2.7.3.7.13.4. Is knowledgeable of acts that constitute ANE of an Enrollee;

2.7.3.7.13.5. Is instructed on and understands how to report ANE;

2.7.3.7.13.6. Adheres to applicable State laws if providing transportation; and

2.7.3.7.13.7. Is not a spouse of, legally responsible person for, or employment supervisor of the Enrollee who receives the service, except as allowed in the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver.

2.7.3.8. Provider Shared Risk and Savings Arrangements

2.7.3.8.1. Except as otherwise specified in Sections 2.7.4.5 and 2.7.4.6, by July 1, 2015, the STAR+PLUS MMP shall have a minimum of one (1) Provider Contracts in effect to pay Network Providers, including but not limited to organizations functioning as Medicare Shared Savings Program ACOs, through a shared savings or other arrangement as an alternative to FFS.

2.7.3.8.2. The STAR+PLUS MMPs will be required to report to the CMT on its use of such Provider Contracts throughout the Demonstration.

2.7.4. Provider Payment and Reimbursement

2.7.4.1. The STAR+PLUS MMP must pay for all medically necessary and Functionally Necessary Covered Services provided to Enrollees. The STAR+PLUS MMP's Provider Contract must include a complete description of the payment methodology or amount, as described in Uniform Managed Care Manual Chapter 8.1.

2.7.4.1.1. The STAR+PLUS MMP must ensure Claims payment is timely and accurate as described in Section 5.1.9. The STAR+PLUS MMP must require tax identification numbers from all participating Providers. The STAR+PLUS MMP is required to do back-up withholding from all payments to Providers who fail to give tax identification numbers or who give incorrect numbers.

2.7.4.1.2. Provider payments must comply with all applicable state and federal laws, rules, and regulations, including Section 1903 of the Social Security Act and the following sections of the Patient Protection and Affordable Care Act (ACA) and, upon implementation, corresponding federal regulations:

2.7.4.1.2.1. Section 2702 of the ACA, entitled "Payment Adjustment for Health Care-Acquired Conditions;" and

2.7.4.1.2.2. Section 6505 of the ACA, entitled "Prohibition on Payments to Institutions or Entities Located Outside of the United States."

2.7.4.1.2.3. Tex. Ins. Code § 1458.051 and with reimbursement and fee schedule requirements in Tex. Ins. Code § 1451.451 and 1458.101–102.

2.7.4.2. As required by Texas Government Code § 533.005(a)(25), the STAR+PLUS MMP cannot implement across-the-board Provider reimbursement rate reductions for Medicaid benefits covered under the State Plan and/or section 1115(a) demonstration unless: (1) it receives HHSC's prior approval, or (2) the reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by HHSC. For purposes of this requirement an across-the-board rate reduction is a reduction that applies to all similarly-situated Providers or types of Providers. The STAR+PLUS MMP must submit a written request for an across-the-board rate reduction to HHSC, if the reduction is not based on a change in the Medicaid fee schedule or cost containment initiative implemented by HHSC. The STAR+PLUS MMP must submit the request at least ninety (90) days prior to the planned effective date of the reduction, and provide a copy to HHSC. If HHSC does not issue a written statement of disapproval within 45 days of receipt, then the STAR+PLUS MMP may move forward with the reduction on the planned effective date.

2.7.4.3. The STAR+PLUS MMP must give Providers at least thirty (30) days notice of changes to the STAR+PLUS MMP's fee schedule, excluding changes derived from changes to the Medicaid fee schedule, before implementing the change. If the STAR+PLUS MMP fee schedule is derived from the Medicaid fee schedule, the STAR+PLUS MMP must implement fee schedule changes no later than sixty (60) days after the Medicaid fee schedule change, and any retroactive claim adjustments must be completed within sixty (60) days after HHSC retroactively adjusts the Medicaid fee schedule.

2.7.4.4. The STAR+PLUS MMP ensures that it will enter into a contract with any willing nursing facility that agrees to the STAR+PLUS MMP's contract terms.

2.7.4.5. FQHC Reimbursements

2.7.4.5.1. The STAR+PLUS MMP shall ensure that payments to FQHCs for Covered Services to Enrollees are no less than the sum of:

2.7.4.5.1.1. The level and amount of payment that the plan would make for such services if the services had been furnished by an entity providing similar services that was not a FQHC, and

2.7.4.5.1.2. The amount, if any, that Texas Medicaid would have paid as coinsurance if the Enrollee were in FFS.

2.7.4.6. Nursing Facility Reimbursements

2.7.4.6.1. The STAR+PLUS MMP must ensure that Network Nursing Facility providers are paid Nursing Facility Unit Rates at or above the minimum rates established by HHSC for the dates of service. HHSC will post this information on the HHSC website at http://www.hhsc.state.tx.us/rad/rate-packets.shtml. If HHSC makes a retroactive rate adjustment to a Nursing Facility Unit Rate, the STAR+PLUS MMP must retroactively adjust payment to a Nursing Facility no later than thirty (30) days after receipt of HHSC notification. Also, STAR+PLUS MMPs must comply with 1 Tex. Admin. Code § 353.608, regarding minimum payment amounts for qualified nursing facilities, and must educate Nursing Facility Providers about eligibility and claims filing deadlines for receipt of these minimum payment amounts. Further, the STAR+PLUS MMP must provide a list of Network Nursing Facilities upon HHSC's request and must withhold payments to a Nursing Facility in accordance with 1 Tex. Admin. Code § 355.101. The STAR+PLUS MMP must pay Clean Claims, as defined in the Texas Gov't. Code § 533.00251(a)(2), no later than ten (10) calendar days after submission of the Clean Claim. The STAR+PLUS MMP must use the Initial and Daily Service Authorization System (SAS) Provider and rate data in the adjudication of Nursing Facility claims for Unit Rate and Medicare Coinsurance.

2.7.4.6.2. The STAR+PLUS MMP shall have a mechanism for passing through quality incentive payments from HHSC to Nursing Facilities.

2.7.4.7. Non-Payment and Reporting of Provider Preventable Conditions

2.7.4.7.1. The STAR+PLUS MMP agrees to take such action as is necessary in order for HHSC to comply with and implement all federal and state laws, regulations, policy guidance, and Texas policies and procedures relating to the identification, reporting, and non-payment of Provider Preventable Conditions, as defined in 42 U.S.C. 1396b-1 and regulations promulgated thereunder.

2.7.4.7.2. As a condition of payment, the STAR+PLUS MMP shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law, including but not limited to 42 C.F.R. §§ 434.6(a)(12), 438.6(f)(2), and 447.26, and guidance and be consistent with HHSC policies, procedures, and guidance on Provider Preventable Conditions.

2.7.4.7.3. The STAR+PLUS MMP's policies and procedures shall also be consistent with the following:

2.7.4.7.3.1. The STAR+PLUS MMP shall not pay a Provider for a Provider Preventable Condition.

2.7.4.7.3.2. The STAR+PLUS MMP shall require, as a condition of payment from the STAR+PLUS MMP, that all Providers comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the STAR+PLUS MMP and/or HHSC.

2.7.4.7.3.3. STAR+PLUS MMPs must identify Present on Admission (POA) indicators as required in the Uniform Managed Care Manual Chapter 2.0, and STAR+PLUS MMPs must reduce or deny payments for Provider Preventable Condition that were not POA using a methodology approved by HHSC in the Uniform Managed Care Manual. This includes any hospital-acquired conditions or health care acquired conditions identified in the Texas Medicaid Provider Procedures Manual.

2.7.4.7.3.4. The STAR+PLUS MMP shall not impose any reduction in payment for a Provider-Preventable Condition when the condition defined as a Provider-Preventable Condition for a particular Enrollee existed prior to the Provider's initiation of treatment for that Enrollee.

2.7.4.7.3.5. A STAR+PLUS MMP may limit reductions in Provider payments to the extent that the following apply:

2.7.4.7.3.5.1. The identified Provider-Preventable Condition would otherwise result in an increase in payment;

2.7.4.7.3.5.2. The STAR+PLUS MMP can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider-Preventable Condition;

2.7.4.7.3.6. The STAR+PLUS MMP shall ensure that its non-payment for Provider-Preventable Conditions does not prevent Enrollee access to services;

2.7.4.7.3.7. As directed by HHSC, and in consultation with CMS, the STAR+PLUS MMP shall develop and implement a process for ensuring non-payment or recovery of payment for preventable hospital readmissions; and

2.7.4.7.3.8. The STAR+PLUS MMP shall report all identified Provider-Preventable Conditions in a form and format specified by HHSC within seven (7) calendar days from the occurrence.

2.7.5. Network Management

2.7.5.1. The STAR+PLUS MMP shall develop and implement a strategy to manage the Provider Network with a focus on access to services for Enrollees, quality, consistent practice patterns, recovery and resilience, independent living philosophy, cultural competence, integration and cost effectiveness.

2.7.5.2. Provider Profiling. The STAR+PLUS MMP must conduct PCP and other Provider profiling activities at least annually. As part of its QAPI Program, the STAR+PLUS MMP must describe the methodology it uses to identify which and how many Providers to profile and to identify measures to use for profiling such Providers. Provider profiling activities must include, without limitation:

2.7.5.2.1. Developing PCP and Provider-specific reports that include a multi-dimensional assessment of a PCP or Provider's performance using clinical, administrative, and Enrollee satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;

2.7.5.2.1. Establishing PCP, Provider, group, Service Area or regional benchmarks for areas profiled, where applicable, including STAR+PLUS MMP-specific benchmarks; and

2.7.5.2.2. Providing feedback to individual PCPs and Providers regarding the results of their performance and the overall performance of the Provider Network.

2.7.5.3. For Network Management, the STAR+PLUS MMP must:

2.7.5.3.1. Use the results of its Provider profiling activities to identify areas of improvement for individual PCPs and Providers, and/or groups of Providers;

2.7.5.3.2. Establish Provider-specific quality improvement goals for priority areas in which a Provider or Providers do not meet established STAR+PLUS MMP standards or improvement goals;

2.7.5.3.3. Develop and implement incentives, which may include financial and non-financial incentives, to motivate Providers to improve performance on profiled measures; and

2.7.5.3.4. At least annually, measure and report to HHSC on the Provider Network and individual Providers' progress, or lack of progress, towards such improvement goals.

2.7.5.4. STAR+PLUS MMP shall make a good faith effort to give written notice of termination of a Provider at least thirty (30) calendar days before the termination effective date when practicable, consistent with 42 C.F.R. § 422.111(e), but in no event later than fifteeen (15) days following such termination, to each Enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated Provider. The STAR+PLUS MMP shall also assist Enrollees in transitioning to a new Provider, when a Provider's contract is terminated. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or LTSS, the STAR+PLUS MMP shall ensure that there is no disruption in services provided to the Enrollee.

2.7.5.4.1. The STAR+PLUS MMP must send notice to:

2.7.5.4.1.1. All Enrollees in a PCP's panel, and

2.7.5.4.1.2. All Enrollees who have had two or more visits with the Network Provider for home-based or office-based care in the past twelve (12) months.

2.7.5.5. The STAR+PLUS MMP shall not limit or prohibit Provider-based marketing activities or Provider affiliation information addressed by §§ 70.11.1 and 70.11.2 of the Medicare Marketing Guidelines. The STAR+PLUS MMP shall not prohibit a Provider from informing Enrollees of the Provider's affiliation or change in affiliation.

2.7.5.6. The STAR+PLUS MMP shall establish and conduct an ongoing process for enrolling in their Provider Network qualified Providers in order to maintain an adequate Network according to Medicare and Medicaid access standards.

2.7.5.7. The STAR+PLUS MMP shall maintain a protocol that shall facilitate communication to and from Providers and the STAR+PLUS MMP, and which shall include, but not be

limited to, a Provider newsletter and periodic Provider meetings;

2.7.5.8. Except as otherwise required or authorized by CMS, HHSC, or by operation of law, the STAR+PLUS MMP ensures that Providers receive ninety (90) days advance notice of policy and procedure changes and maintain a process to provide education and training for Providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect; and

2.7.5.9. The STAR+PLUS MMP shall perform an annual review to assure that the health care professionals under contract with the First Tier, Downstream, or Related Entities are qualified to perform the services covered under this contract. The STAR+PLUS MMP must have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a Provider's license.

2.7.5.10. The STAR+PLUS MMP shall require its Providers to fully comply with federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare, Medicaid, and/or CHIP programs, as described in 42 C.F.R. § 455.

2.7.5.11. The STAR+PLUS MMP shall collect sufficient information from Providers to assess compliance with the ADA. As necessary to serve Enrollees, Provider locations where Enrollees receive services shall be ADA compliant. In addition, the STAR+PLUS MMP shall include within its Network Provider locations that are able to accommodate the unique needs of Enrollees.

2.7.6. Provider Education and Training

2.7.6.1. Prior to any Enrollment of Enrollees under this Contract and thereafter, the STAR+PLUS MMP shall conduct Network Provider education regarding the STAR+PLUS MMP's policies and procedures as well as the Demonstration.

2.7.6.2. The STAR+PLUS MMP must educate its Provider Network about its responsibilities for the integration and coordination of Covered Services.

2.7.6.3. The STAR+PLUS MMP must inform its Provider Network about its service delivery model and Covered Services,

Flexible Benefits, Non-Capitated Services and policies, procedures, and any modifications to these items.

2.7.6.4. The STAR+PLUS MMP must inform its Provider Network about its policies and procedures, especially regarding Network and Out-of-Network referrals.

2.7.6.5. The STAR+PLUS MMP must inform its Provider Network about QAPI program and the Provider's role in such a program.

2.7.6.6. The STAR+PLUS MMP must ensure that all Network Providers receive proper education and training regarding the Demonstration to comply with this Contract and all applicable federal and state requirements. The training must be completed within thirty (30) days of placing a newly contracted Provider on active status. The STAR+PLUS MMP must maintain and make available upon request Enrollment or attendance rosters dated and signed by each attendee, or other written evidence of training of each Provider and his or her staff. The STAR+PLUS MMP must establish ongoing Provider training that includes the following issues:

2.7.6.6.1. Eligibility standards, eligibility verification, and benefits; and

2.7.6.6.2. The role of HHSC (or its Administrative Services Contractor) regarding Enrollment and disenrollment;

2.7.6.6.3. ADA compliance, accessibility, and accommodations;

2.7.6.6.4. The rights and responsibilities pertaining to:

2.7.6.6.4.1. Grievance and Appeals procedures and timelines; and

2.7.6.6.4.2. Procedures for identifying, preventing and reporting Fraud, Waste, ANE, and other Critical Events or Incidents;

2.7.6.6.5. Covered Services and the Provider's responsibilities for providing and coordinating these services. Special emphasis must be placed on areas that vary from commercial coverage rules (e.g., therapies and DME/medical supplies), pharmacy services and processes, including information regarding outpatient drug benefits, the STAR+PLUS MMP's formulary, prior authorization processes, and seventy-two (72) hour emergency supplies of non-Part D prescription drugs. The STAR+PLUS MMP should also place special emphasis on Mental Health Rehabilitative Services and the availability of Mental Health Targeted Case Management for qualified Enrollees, and the processes for making referrals and coordination with Services;

2.7.6.6.6. Medical Transportation Program services such as rides to services by bus, taxi, van, airfare, etc., gas money, mileage reimbursement, and meals and lodging when away from home;

2.7.6.6.7. Enrollee Cost Sharing obligations, benefit limitations, Flexible Benefits, and prohibitions on balance-billing Enrollees for Covered Services;

2.7.6.6.8. The role of the STAR+PLUS MMP Service Coordinators;

2.7.6.6.9. Information on Discharge planning, transitional care, and other educational programs related to long-term care settings;

2.7.6.6.10. The importance of updating contact information to ensure accurate Provider Directories and the Medicaid Online Provider Lookup; practices for these services and whom to contact at the STAR+PLUS MMP for assistance with this process;

2.7.6.6.11. What Network Providers need to know in and how to find Medicaid and Medicare manuals, memoranda, and other related documents;

2.7.6.6.12. PCP training on identification of and coordination of LTSS and Behavioral Health services;

2.7.6.6.13. Cultural Competency and Disability literacy, including, but not limited to the following information:

2.7.6.6.13.1. Various types of chronic conditions prevalent within the target population;

2.7.6.6.13.2. Awareness of personal prejudices;

2.7.6.6.13.3. Legal obligations to comply with the ADA requirements;

2.7.6.6.13.4. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs;

2.7.6.6.13.5. Types of barriers encountered by the target population;

2.7.6.6.13.6. Training on person-centered planning and self-determination, the social model of Disability, the independent living philosophy, and the recovery model;

2.7.6.6.13.7. Use of evidence-based practices and specific levels of quality outcomes; and

2.7.6.6.13.8. Working with Enrollees with mental health diagnoses, including crisis prevention and treatment.

2.7.6.6.13.9. Cultural Competency Training based on National Standards for CLAS.

2.7.6.6.13.9.1. The STAR+PLUS MMP shall educate Providers through a variety of means including, but not limited to, Provider alerts or similar written issuances, about their legal obligations under state and federal law to communicate with Enrollees and Eligible Beneficiaries with limited English proficiency, including the provision of interpreter services, and the resources available to help Providers comply with those obligations. All such written communications shall be subject to review at the CMT's discretion.

2.7.6.6.14. Person-centered planning processes taking into consideration the specific needs of subpopulations of Enrollees;

2.7.6.6.15. Administrative issues such as Claims filing and billing instructions that comply with the Demonstration encounter data submission requirements (including the processes regarding claims appeals and recoupments); and,

2.7.6.6.16. Marketing practice guidelines and the responsibility of the Provider when representing the STAR+PLUS MMP. Specifically:

2.7.6.6.16.1. Provider Materials must comply with state and federal laws.HHSC must approve the STAR+PLUS MMP's Provider Manual and all substantive revisions. The STAR+PLUS MMP must submit, for review, all other Provider Materials relating to the STAR+PLUS MMP prior to to publication or distribution . If HHSC has not responded to the STAR+PLUS MMP's request for review within fifteen (15) business days, the STAR+PLUS MMP may use the submitted materials provided the STAR+PLUS MMPfirst notifies HHSC of its intended use.

2.7.6.6.16.2. The STAR+PLUS MMP must submit Provider materials for review and approval to the state using the following e-mail address: Dual_Demo_Pilot@hhsc.state.tx.us and must include the following in the email submission: Material File Name; Material ID; Target Audience; Service Area; Purpose/Intended Use.

2.7.6.6.16.3. The CMT reserves the right to require discontinuation or correction of any Provider Materials that are not in compliance with state and federal laws or the Contract's requirements including those previously approved by HHSC.

2.7.6.7. LTSS Provider Training – In addition to the above training for all Providers, the STAR+PLUS MMP must train all Nursing Facility Providers and/or Community Long-term Services and Supports Providers, as appropriate, regarding:

2.7.6.7.1. Covered Services and the Provider's responsibilities for providing services to Enrollees and billing the STAR+PLUS MMP for the services. The STAR+PLUS MMP must place special emphasis on Nursing Facility Services and requirements, policies, and procedures that vary from FFS and commercial coverage rules, including payment policies and procedures.

2.7.6.7.2. The transition period of up to six months for the continuation of Nursing Facility services for Enrollees receiving those services at the time of Enrollment including Provider billing practices for these services and who to contact at the STAR+PLUS MMP for assistance with this process; and

2.7.6.7.3. Processes for making referrals and coordinating Services.

2.7.7. Provider Advisory Groups

2.7.7.1. The STAR+PLUS MMP must establish and conduct quarterly meetings with Network Providers.

2.7.7.2. Membership in the Provider Advisory Group(s) must include, at a minimum, acute, Community-Based LTSS , and pharmacy Providers.

2.7.7.3. The STAR+PLUS MMP must maintain a record of Provider Advisory Group meetings, including agendas and minutes, for at least three years.

2.7.8. Provider Relations

2.7.8.1. The STAR+PLUS MMP must maintain a Provider relations presence and be available to meet with Providers in each Service Area.

2.7.8.2. The STAR+PLUS MMPs must assign a Provider Relations Specialist to each Network Nursing Facility.

2.7.8.3. The assigned Provider Relations Specialist may be assigned to more than one Nursing Facility in a Service Area.

2.7.8.4. The specialist must be proficient in Nursing Facility billing and able to resolve Provider billing and payment inquiries. The STAR+PLUS MMP must notify the Nursing Facility within ten (10) days of any change to the assigned Provider Relations Specialist.

2.7.9. Provider Manual

2.7.9.1. The STAR+PLUS MMP must prepare and issue Provider Manual(s) to all Network Providers, including any necessary specialty manuals (e.g., behavioral health, Nursing Facility Services). The Provider Manual shall be a comprehensive online reference tool for the Provider and staff regarding, but not limited to, administrative, prior authorization, and referral processes, Claims and Encounter Data submission processes, and plan benefits. The Provider Manual shall also address topics such as clinical practice guidelines, availability and access standards, Care Management programs and Enrollee rights, including Enrollees rights not to be balanced billed. The STAR+PLUS MMP must include in the Provider Manual a provision explaining that the STAR+PLUS MMP may not limit a Provider's communication with Enrollees as provided in Section 2.7.5.5.

2.7.9.2. For newly contracted Providers, the STAR+PLUS MMP must issue or provide access to copies of the Provider Manual(s) no later than five (5) business days after inclusion in the Network.

2.7.9.3. The Provider Manual, and any substantive revisions to the Provider Manual must be approved by the CMT, prior to publication and distribution to Providers.

2.7.10. Provider Subcontracting Requirements

2.7.10.1. The STAR+PLUS MMP remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the STAR+PLUS MMP subcontracts for performance of any Contract responsibility. The STAR+PLUS MMP shall require each First Tier, Downstream, or Related Entity to meet all terms and requirements of the Contract that are applicable to such First Tier, Downstream, or Related Entity. No subcontract will operate to relieve the STAR+PLUS MMP of its legal responsibilities under the Contract.

2.7.10.2. The STAR+PLUS MMP is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream, and Related Entities. First Tier, Downstream, and Related Entities are required to meet the same federal and state financial and program reporting requirements as the STAR+PLUS MMP. The STAR+PLUS MMP is required to evaluate any potential First Tier, Downstream, and Related Entity prior to delegation, pursuant to 42 C.F.R. § 438.230.

Additional information about subcontracting requirements is contained in Appendix C.

2.7.10.3. The STAR+PLUS MMP must establish contracts and other written agreements between the STAR+PLUS MMP and First Tier, Downstream, and Related Entities for Covered Services not delivered directly by the STAR+PLUS MMP or its employees.

2.7.11. Challenge Survey

2.7.11.1. The STAR+PLUS MMP is required to design, develop, and implement a mandatory challenge survey to verify Provider information and monitor adherence to Provider requirements. The STAR+PLUS MMP must design the survey so that on a periodic, randomized basis, a Provider's input is required before accessing the STAR+PLUS MMP Provider portal functionalities. At a minimum, the challenge survey must include verification of the following elements:

2.7.11.1.1. Provider Name;

2.7.11.1.2. Address;

2.7.11.1.3. Phone Number;

2.7.11.1.4. Office Hours;

2.7.11.1.5. Days of Operation;

2.7.11.1.6. Practice Limitations;

2.7.11.1.7. Languages Spoken;

2.7.11.1.8. Provider Type / Provider Specialty;

2.7.11.1.9. Length of time a patient must wait between scheduling an appointment and receiving treatment; and

2.7.11.1.10. Accepting new patients (PCPs only).

2.7.11.2. The STAR+PLUS MMP must collect, analyze, and submit survey results as specified in UMCM Chapter 5.4.1.10, "Provider Network Examination."

2.8. Enrollee Access to Services

2.8.1. General

2.8.1.1. The STAR+PLUS MMP must authorize, arrange, coordinate, and ensure the provision of all Medically Necessary Covered Services for Enrollees, as specified in Section 2.4 and Appendix A, in accordance with the requirements of the Contract. Services shall be available twenty-four (24) hours a day, seven (7) days a week when Medically Necessary.

2.8.1.2. The STAR+PLUS MMP must offer adequate choice and availability of primary, specialty, acute care, behavioral health, and LTSS Providers that meet CMS and HHSC standards as provided for in Section 2.7;

2.8.1.3. The STAR+PLUS MMP must at all times cover the appropriate level of service for all Emergency Services and non-Emergency Services in an appropriate setting;

2.8.1.4. All urgent and symptomatic office visits must be available to Enrollees within twenty-four (24) hours. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention;

2.8.1.5. All nonsymptomatic office visits must be available to Enrollees within thirty (30) calendar days;

2.8.1.6. Network Providers shall offer hours of operation that are no less than the hours of operation offered to individuals who are not Enrollees.

2.8.1.7. The STAR+PLUS MMP must reasonably accommodate persons and shall ensure that the programs and services are as accessible (including physical and geographic access) to an individual with disabilities as they are to an individual without disabilities. The STAR+PLUS MMP and its Network Providers must comply with the American with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees. The STAR+PLUS MMP shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all Covered Services from the STAR+PLUS MMP by:

2.8.1.7.1. Providing flexibility in scheduling to accommodate the needs of the Enrollees;

2.8.1.7.2. Providing interpreters or translators for Enrollees who are Deaf and hard of hearing and those who do not speak English;

2.8.1.7.3. Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to:

2.8.1.7.3.1. Providing large print (at least 16-point font) versions of all written materials to individuals with visual impairments;

2.8.1.7.3.2. Ensuring that all written materials are available in formats compatible with optical recognition software;

2.8.1.7.3.3. Reading notices and other written materials to individuals upon request;

2.8.1.7.3.4. Assisting individuals in filling out forms over the telephone;

2.8.1.7.3.5. Ensuring effective communication to and from individuals with disabilities through email, telephone, personal assistance, and other electronic means;

2.8.1.7.3.6. Providing TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the Deaf;

2.8.1.7.3.7. Providing individualized forms of assistance;

2.8.1.7.3.8. Ensuring safe and appropriate physical access to buildings, services, parking, and equipment; and

2.8.1.7.3.9. Demonstrating compliance with the ADA by conducting an independent survey or site review of facilities for both physical and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies.

2.8.1.8. When the Food and Drug Administration (FDA) determines a drug to be unsafe, the STAR+PLUS MMP shall remove it from the formulary immediately. The STAR+PLUS MMP must make a good faith effort to give written notification of removal of this drug from the formulary and the reason for its removal as soon as possible after the removal, to each Enrollee with a current or previous prescription for the drug.

2.8.1.9. If the STAR+PLUS MMP's network is unable to provide Medically Necessary Services covered under the Contract to a particular Enrollee, the STAR+PLUS MMP must adequately and timely cover these services Out-of-Network for the Enrollee, for as long as the STAR+PLUS MMP is unable to provide them, according to Section 2.6.5.3.6. The STAR+PLUS MMP must ensure that the cost to the Enrollee is no greater than it would be if the services were furnished within the network.

2.8.2. Services Not Subject to Prior Approval

2.8.2.1. The STAR+PLUS MMP will assure coverage of Emergency Medical Conditions and Urgent Care services. Additionally, the STAR+PLUS MMP must not require prior approval for the following services:

2.8.2.1.1. Any services for Emergency Conditions as defined in 42 C.F.R § 422.113(b)(1) and § 438.114(a) (which includes emergency Behavioral Health Service);

2.8.2.1.2. Urgent Care sought outside of the Service Area;

2.8.2.1.3. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical Provider is unavailable or inaccessible;

2.8.2.1.4. Family planning services;

2.8.2.1.5. Out-of-area renal dialysis services;

2.8.2.1.6. Any Behavioral Health Services Network Provider without a referral from the Enrollee's PCP.

2.8.2.1.7. Network ophthalmologist or therapeutic optometrist to provide eye health care services, other than surgery; and

2.8.2.1.8. Sexually Transmitted Disease (STD) services that include STD/HIV prevention, screening, counseling, diagnosis, and treatment. The STAR+PLUS MMP is responsible for implementing procedures to ensure that Enrollees have prompt access to appropriate services for STDs, including HIV. The STAR+PLUS MMP must allow Enrollees access to STD services and HIV diagnosis services without prior authorization or referral by a PCP.

2.8.2.2. The STAR+PLUS MMP must have a mechanism in place to allow Enrollees with Special Health Care Needs to have direct access to a specialist as appropriate for the Enrollee's condition and identified needs, such as a standing referral to a specialty Provider.

2.8.3. Authorization of Services

2.8.3.1. The STAR+PLUS MMP shall authorize services as in accordance with 42 C.F.R. § 438.210.

2.8.3.2. For the processing of requests for initial and continuing authorizations of Covered Services, the STAR+PLUS MMP and any First Tier, Downstream, and Related Entities shall:

2.8.3.2.1. Have in place and follow written policies and procedures, including:

2.8.3.2.1.1. Procedures to allow Enrollees to initiate requests for provision of services; and

2.8.3.2.1.2. Mechanisms to ensure the consistent application of review criteria for authorization decisions.

2.8.3.2.2. Consult with the requesting Provider when appropriate.

2.8.3.3. The STAR+PLUS MMP shall ensure that the Medical Director and a Behavioral Health Service Provider are available twenty-four (24) hours a day for timely authorization of Medically Necessary services, including, if necessary, the Transfer of the

Enrollee who presented to an emergency department with an Emergency Medical Condition that has been Stabilized.

2.8.3.4. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral Health services denials must be rendered by board-certified or board-eligible psychiatrists or by a clinician licensed with the same or similar specialty as the Behavioral Health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist or psychiatrist .

2.8.3.5. The STAR+PLUS MMP shall assure that all Behavioral Health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). STAR+PLUS MMP must comply with the requirements for demonstrating parity for both Cost Sharing (co-payments) and treatment limitations between mental health and SUD and medical/surgical inpatient, outpatient, and pharmacy benefits.

2.8.3.6. The STAR+PLUS MMP must notify the requesting Provider, either orally or in writing, and give the Enrollee written notice of any decision by the STAR+PLUS MMP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Section 5.1, and must:

2.8.3.6.1. Be produced in a manner, format, and language that can be easily understood;

2.8.3.6.2. Be made available in Prevalent Languages, upon request; and

2.8.3.6.3. Include information, in the most commonly used languages about how to request translation services and Alternative Formats.

2.8.3.7. The STAR+PLUS MMP must provide notice of authorization decisions that meet the timing requirements set forth in 42 C.F.R. § 438.404 and as follows:

2.8.3.7.1. For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than three (3) business days after receipt of the request for service.

2.8.3.7.2. For expedited service authorization decisions, including for concurrent hospitalization decisions, where the Provider indicates or the STAR+PLUS MMP determines that following the standard timeframe in Section 2.8.3.7 could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the STAR+PLUS MMP must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than one (1) business day after receipt of the request for service.

2.8.3.7.3. For Post-Stabilization or life-threatening conditions, provide notice within one (1) hour, except that for Emergency Medical Conditions and Emergency Behavioral Health Conditions, the STAR+PLUS MMP must not require prior authorization.

2.8.3.8. Behavioral Health Service Authorization Policies and Procedures

2.8.3.8.1. The STAR+PLUS MMP shall:

2.8.3.8.1.1. Review and update annually and submit for CMT approval, at a minimum, its Behavioral Health Services authorization policies and procedures.

2.8.3.8.1.2. Review and update annually, at a minimum, the behavioral health clinical criteria and other clinical protocols that the STAR+PLUS MMP may develop and utilize in its clinical case reviews and care management activities. Submit any modifications to the CMT annually for review and approval. In its review and update process, the STAR+PLUS MMP shall consult with clinical experts either within its own clinical and medical staff or medical consultants outside of the STAR+PLUS MMP's organization, who are familiar with standards and practices of mental health and substance use treatment in Texas. STAR+PLUS MMP shall ensure that clinical criteria are based on current research, relevant quality standards and evidence-based models of care.

2.8.3.8.1.3. Develop and maintain Behavioral Health Inpatient Services authorization policies and procedures, which shall, at a minimum, contain the following requirements:

2.8.3.8.1.3.1. If prior authorization is required for any Behavioral Health Inpatient Services admission for acute care, assure the availability of such prior authorization twenty-four (24) hours a day, seven (7) days a week; access to a reviewer and response to a request for authorization is within established timeliness standards aligned with the level of urgency of the request, ensuring the safety of an Enrollee at all times;

2.8.3.8.1.3.2. A plan and a system in place to direct Enrollees to the least restrictive environment and the least intensive yet the most clinically appropriate service to safely and adequately treat the Enrollee;

2.8.3.8.1.3.3. A process to render an authorization and communicate the authorized length of stay to the Enrollee, facility, and attending physician for all Behavioral Health admissions in accordance with the timelines described in Section 2.8.3.7 and that assures all Behavioral Health authorization requirements and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8);

2.8.3.8.1.3.4. Processes to ensure safe placement for Enrollees who require Behavioral Health Inpatient Services when no inpatient beds are available, including methods and places of care to be utilized while Enrollee is awaiting an inpatient bed and to avoid delay of onset of treatment to minimize risk to Enrollee;

2.8.3.8.1.3.5. A system to provide concurrent clinical reviews for continued stay in Behavioral Health Inpatient Services. STAR+PLUS MMP to monitor Medical Necessity for the clinical need for continued stay, and progress toward and achievement of Behavioral Health Inpatient Services treatment goals and objectives;

2.8.3.8.1.3.6. Verification and authorization of all adjustments to Behavioral Health Inpatient Services treatment plans based on updated clinical reports of Enrollee's status and response to existing treatment plan; and

2.8.3.8.1.3.7. Processes to ensure that treatment and Discharge needs are addressed at the time of initial authorization and concurrent review, and that treatment planning includes coordination with the PCP and other service Providers, such as community-based mental health services Providers, as appropriate;

2.8.3.8.1.4. Develop and maintain Behavioral Health Outpatient Services policies and procedures which shall include, but are not limited to, the following:

2.8.3.8.1.4.1. Policies and procedures to authorize Behavioral Health Outpatient Services for initial and ongoing requests for outpatient care;

2.8.3.8.1.4.2. Policies and procedures to authorize Behavioral Health Outpatient Services based upon Behavioral Health Clinical Criteria, based on current research, relevant quality standards and evidence-based models of care; and,

2.8.3.8.1.4.3. Review and update annually, at a minimum, and submit for HHSC approval its Behavioral Health Outpatient Services policies and procedures.

2.8.3.8.1.5. The STAR+PLUS MMP will ensure that when Enrollees are receiving Behavioral Health Services from the LMHA, the STAR+PLUS MMP is using utilization management (UM) guidelines that are consistent with §422.202 as well as those prescribed for use by LMHA, which are published at: http://www.dshs.state.tx.us/MHSA/UMGUIDELINES/.

2.8.3.8.1.6. The STAR+PLUS MMP must maintain an Enrollee education process to help Enrollees know where and how to obtain Behavioral Health Services.

2.8.3.8.1.7. The STAR+PLUS MMP must permit Enrollees to self-refer to any Network Behavioral Health Services Provider without a referral from the Enrollee's PCP. The STAR+PLUS MMP s' policies and procedures, including its Provider Manual, must include written policies and procedures for allowing such self-referral to Behavioral Health Services.

2.8.3.8.1.8. The STAR+PLUS MMP must permit Enrollees to participate in the selection of the appropriate Behavioral Health Service Providers, and must provide the Enrollee with information on accessible Network Providers with relevant experience.

2.8.3.9. Authorization of LTSS

2.8.3.9.1. The STAR+PLUS MMP must develop an authorization process for the LTSS listed in Appendix A.

2.8.3.9.2. The STAR+PLUS MMP must ensure that Enrollees needing Community-Based LTSS are identified, and that services are referred and authorized in a timely manner. The STAR+PLUS MMP must ensure that Providers of Community-Based LTSS are licensed or certified to deliver the services they provide.

2.8.3.9.3. Community-Based LTSS may be necessary as a preventive service to avoid more expensive hospitalizations, emergency room visits, or institutionalization. Community-Based LTSS should also be made available to Enrollees to assure maintenance of the highest level of functioning possible in the least restrictive setting. Community-Based LTSS to assist with the activities of daily living must be considered as important as needs related to a medical condition. STAR+PLUS MMPs must provide both Medically Necessary and Functionally Necessary Covered Services to Enrollees accessing Community-Based LTSS.

2.8.3.9.3.1. Community-Based LTSS available to all Enrollees include PAS and DAHS. Licensure and Certification Requirements for these services are outlined below. The STAR+PLUS MMP must contract with Providers of PAS and DAHS to ensure access to these services for all Enrollees. At a minimum, these Providers must meet all of the following state licensure and certification requirements for providing the services in Appendix A of this Contract:

2.8.3.9.3.1.1. PAS: The Provider must be licensed by DADS as a Home and Community Support Services Agency (HCSSA). The level of licensure required depends on the type of service delivered. NOTE: For Personal Assistance Services, the agency may have only the PAS level of licensure.

2.8.3.9.3.1.2. DAHS: The Provider must be licensed by the DADS Regulatory Division as an adult day care Provider. To provide DAHS, the Provider must provide the range of services required for DAHS.

2.8.3.9.4. The STAR+PLUS MMP must provide HCBS STAR+PLUS Waiver services to qualified Enrollees, as outlined in Section 2.6.2.9.

2.8.3.10. 72-Hour Emergency Supply of Medicaid Prescription Drugs

2.8.3.10.1. If a prescription for Medicaid-only covered drugs cannot be filled when presented to the pharmacist due to a prior authorization requirement and the prescriber's office cannot be reached, then the STAR+PLUS MMP must instruct the pharmacy to dispense a 72-hour emergency supply of the prescription. The pharmacy is not required to dispense a 72-hour supply if the dispensing pharmacist determines that taking the prescribed medication would jeopardize the Enrollee's health or safety, and he or she has made good faith efforts to contact the prescriber. The pharmacy may fill consecutive 72-hour supplies if the prescriber's office remains unavailable. The STAR+PLUS MMP must reimburse the pharmacy for dispensing the temporary supply of medication.

2.8.4. Utilization Management

2.8.4.1. The STAR+PLUS MMP's Utilization Management (UM) programs shall comply with CMS requirements and timeframes for historically Medicare-paid services in addition to the requirements for historically Medicaid-paid services.

2.8.4.2. The STAR+PLUS MMP must have a written UM program description which includes procedures to evaluate medical necessity, criteria used, information source, the process used to review and approve or deny the provision of medical and long-term care services, the method for periodically reviewing and amending the UM clinical review criteria, and the staff position functionally responsible for the day-to-day management of the UM function.

2.8.4.3. The STAR+PLUS MMP's UM program must consult with the requesting Provider when appropriate. The program shall demonstrate that Enrollees have equitable access to care across

the network and that UM decisions are made in a fair, impartial, and consistent manner that serves the best interests of the Enrollees. The program shall reflect the standards for utilization management from the most current NCQA standards when applicable.

2.8.4.4. If the STAR+PLUS MMP delegates responsibilities for UM to a First Tier, Downstream, or Related Entity, the contract must have a mechanism in place to ensure that these standards are met by the First Tier, Downstream, or Related Entity. The UM plan shall be submitted annually to HHSC and upon revision.

2.8.4.5. The STAR+PLUS MMP shall assume responsibility for all Covered Services authorized by HHSC, CMS, or a previous managed care plan, which are rendered after the Enrollment effective date.

2.8.4.6. The STAR+PLUS MMP must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating Provider as appropriate in making UM determinations. When making UM determinations, the STAR+PLUS MMP must comply with the requirements of 42 C.F.R. § 456.111 (Hospitals) and 42 C.F.R. § 456.211 (Mental Hospitals), as applicable.

2.8.4.7. The STAR+PLUS MMP's UM program must include written policies and procedures to ensure:

2.8.4.7.1. Consistent application of review criteria that are compatible with Enrollees' needs and situations;

2.8.4.7.2. Determinations to deny or limit services are made by physicians under the direction of the Medical Director;

2.8.4.7.3. At the STAR+PLUS MMP's discretion, pharmacy prior authorization determinations may be made by pharmacists, subject to the limitations described in Section 2.2.2.4.2, "Medical Director." This requirement applies only to Medicaid covered drugs;

2.8.4.7.4. Appropriate personnel are available to respond to utilization review inquiries 8:00 a.m. to 5:00 p.m. local time, Monday through Friday, with a telephone system capable of accepting utilization review inquiries after normal business hours. The STAR+PLUS MMP must respond to calls within one (1) business day;

2.8.4.7.5. Confidentiality of clinical information; and

2.8.4.7.6. Compensation to individuals or entities conducting UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services as required by 42 C.F.R. § 438.210(e), and quality is not adversely impacted by financial and reimbursement-related processes and decisions.

2.8.4.8. For STAR+PLUS MMPs with preauthorization or concurrent review programs, qualified medical professionals must supervise preauthorization and concurrent review decisions.

2.8.4.9. The STAR+PLUS MMP's UM program must include policies and procedures to:

2.8.4.9.1. Routinely assess the effectiveness and the efficiency of the UM program;

2.8.4.9.2. Evaluate the appropriate use of medical technologies, including medical procedures, drugs and devices;

2.8.4.9.3. Target areas of suspected inappropriate service utilization;

2.8.4.9.4. Detect over- and under-utilization;

2.8.4.9.5. Routinely generate Provider profiles regarding utilization patterns and compliance with utilization review criteria and policies;

2.8.4.9.6. Compare Enrollee and Provider utilization with norms for comparable individuals;

2.8.4.9.7. Routinely monitor inpatient admissions, emergency room use, ancillary, and out-of-area services;

2.8.4.9.8. Ensure that when Enrollees are receiving Behavioral Health Services from the Local Mental Health Authority, the STAR+PLUS MMP is using the same UM guidelines as those prescribed for use by Local Mental Health Authorities which are published at: http://www.dshs.state.tx.us/MHSA/UMGUIDELINES/; and

2.8.4.9.9. Refer suspected cases of Network Provider, Out-of-Network Provider, or Enrollee Fraud, Abuse, or Waste, or Abuse to the [Texas] Office of Inspector General (OIG).

2.8.5. Services for Specific Populations

2.8.5.1. As appropriate, the STAR+PLUS MMP shall coordinate with social service agencies (e.g., local departments of health and social services) and refer Enrollees to the following programs, to include, but not be limited to:

2.8.5.1.1. Entering into a subcontract for Covered Services with Public Health Entities. Possible Covered Services that could be provided by Public Health Entities include, but are not limited to, the following services:

2.8.5.1.1.1. STD services;

2.8.5.1.1.2. Confidential HIV testing;

2.8.5.1.1.3. Immunizations;

2.8.5.1.1.4. Tuberculosis (TB) care;

2.8.5.1.1.5. Family planning services; and

2.8.5.1.1.6. Prenatal services.

2.8.5.1.2. If the STAR+PLUS MMP is unable to enter into a contract with Public Health Entities, the STAR+PLUS MMP must document efforts to contract with Public Health Entities, and make such documentation available to HHSC upon request.

2.8.5.1.3. Contracts with Public Health Entities must specify the scope of responsibilities of each party, the methodology and agreements regarding billing and reimbursements, reporting responsibilities, Enrollee and Provider educational responsibilities, and the methodology and agreements regarding sharing of confidential medical record information between the Public Health Entity and the STAR+PLUS MMP or PCP.

2.8.5.1.4. The STAR+PLUS MMP must:

2.8.5.1.4.1. Identify and train Service Coordinators to assist PCPs in efficiently referring Enrollees to the public health Providers, specialists, and health-related service Providers either within or outside the STAR+PLUS MMP's Network; and

2.8.5.1.4.2. Inform Enrollees that confidential healthcare information will be provided to the PCP, and educate Enrollees on how to better utilize their PCPs, public health Providers, emergency departments, specialists, and health-related service Providers.

2.8.5.1.5. The STAR+PLUS MMP must coordinate with Public Health Entities in its Service Area(s) regarding the provision of essential public Health Care Services. The STAR+PLUS MMP must also meet the following requirements:

2.8.5.1.5.1. Report to Public Health Entities regarding communicable diseases and/or diseases that are preventable by immunization as defined by state law;

2.8.5.1.5.2. Notify the local Public Health Entity of communicable disease outbreaks involving Enrollees; and

2.8.5.1.5.3. Educate Enrollees and Providers regarding Women, Infants, and Children (WIC) services available to Enrollees.

2.8.5.1.6. In addition, the STAR+PLUS MMP must make a good faith effort to establish an effective working relationship with all state and local Public Health Entities in its Service Area(s) to identify issues and promote initiatives addressing public health concerns.

2.8.5.1.7. The STAR+PLUS MMP must coordinate with other Texas HHS programs in each Service Area regarding the provision of essential public Health Care Services. In addition to the requirements listed above or otherwise required under state law or the Contract, the STAR+PLUS MMP must meet the following requirements:

2.8.5.1.7.1. Work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac Registry;

2.8.5.1.7.2. Educate Providers and Enrollees about services available through the Department of State Health Services (DSHS) Case Management for Children and Pregnant Women program;

2.8.5.1.7.3. Coordinate with the Case Management for Children and Pregnant Women program for health care needs that are identified and referred to the STAR+PLUS MMP;

2.8.5.1.7.4. Participate, to the extent practicable, in the community-based coalitions with the Medicaid-funded case management programs in the Department of Assistive and Rehabilitative Services (DARS), DADS, and DSHS;

2.8.5.1.7.5. Cooperate with activities required of state and local public health authorities necessary to conduct the annual population and community based needs assessment;

2.8.5.1.7.6. Report all blood lead results;

2.8.5.1.7.7. Coordinate care protocols for working with Dental Contractors, as well as protocols for reciprocal referral and communication of data and clinical information regarding the Enrollee's Medically Necessary dental Covered Services; and

2.8.5.1.7.8. Develop a coordination plan to share with local entities regarding Enrollees identified as requiring special needs or assistance during a disaster.

2.8.5.2. The STAR+PLUS MMP shall arrange and coordinate the delivery of preventive health care services including, but not limited to, cancer screenings and appropriate follow-up treatment to Enrollees, other screenings or services as specified in guidelines set by CMS and/or HHSC or, where there are no guidelines, in accordance with nationally accepted standards of practice.

2.8.5.3. The STAR+PLUS MMP shall provide systems and mechanisms, including the Provider portal described at Section 2.17.3.3, designed to make Enrollees' medical history and

treatment information available, within applicable legal limitations, at the various sites where the same Enrollee may be seen for care, especially for Enrollees identified as homeless. While establishing a fully integrated delivery system, the STAR+PLUS MMP shall respect the privacy of Enrollees. The STAR+PLUS MMP shall comply with Section 5.2 regarding compliance with laws and regulations relating to confidentiality and privacy.

2.8.6. Emergency and Post-Stabilization Care Coverage

2.8.6.1. STAR+PLUS MMP policy and procedures, Covered Services, Claims adjudication methodology, and reimbursement performance for Emergency Services must comply with all applicable state and federal laws, rules, and regulations including 42 C.F.R. §438.114, whether the Provider is in-Network or Out-of-Network. STAR+PLUS MMP policies and procedures must be consistent with the prudent layperson definition of an Emergency Medical Condition and the Claims adjudication processes required under the Contract and 42 C.F.R. § 438.114

2.8.6.2. The STAR+PLUS MMP cannot require prior authorization as a condition for payment for an Emergency Medical Condition, an Emergency Behavioral Health Condition, or labor and delivery. The STAR+PLUS MMP cannot limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. The STAR+PLUS MMP cannot refuse to cover Emergency Services based on the emergency room Provider, Hospital, or fiscal agent not notifying the Enrollee's PCP or the STAR+PLUS MMP of the Enrollee's screening and treatment within 10 calendar days of presentation for Emergency Services. The STAR+PLUS MMP may not hold the Enrollee who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The STAR+PLUS MMP must accept the emergency physician or Provider's determination of when the Enrollee is sufficiently Stabilized for Transfer or Discharge.

2.8.6.3. The STAR+PLUS MMP's Provider network must ensure access to 24-hour Emergency Services for all Enrollees, whether they reside in institutions or in the community. The STAR+PLUS MMP must cover and pay for any services obtained for Emergency Medical Conditions in accordance with 42 C.F.R. § 438.114(c).

2.8.6.4. The STAR+PLUS MMP shall cover and pay for professional, facility, and ancillary services provided in a Hospital emergency department that are Medically Necessary to perform the medical screening examination and stabilization of an Enrollee presenting with an Emergency Medical Condition or an Emergency Behavioral Health Condition, regardless of whether the Provider that furnishes the services has a contract with the STAR+PLUS MMP. The STAR+PLUS MMP shall pay a non-contracted Provider of Emergency and Post-stabilization Care an amount equal to or, if the STAR+PLUS MMP can negotiate a lower payment, less than the amount allowed under Medicare's FFS rate, less any payments for indirect costs of medical education and direct costs of graduate medical education. The STAR+PLUS MMP shall ensure that the Enrollee is not billed for the difference, if any, between such rate and the Out-of-Network Provider's charges.

2.8.6.4.1. Payment must be issued within sixty (60) calendar days after the Claim has been submitted. The STAR+PLUS MMP must ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the network.

2.8.6.5. The STAR+PLUS MMP shall:

2.8.6.5.1. Have a process established to notify the PCP or Service Coordination Team (or the designated covering physician) of an Emergency Condition within one business day after the STAR+PLUS MMP is notified by the Provider.

2.8.6.5.2. Have a process to notify the PCP or Service Coordination Team of required Urgent Care within one business day of the STAR+PLUS MMP being notified.

2.8.6.5.3. Record summary information about Emergency Medical Conditions and Urgent Care services in the Enrollee Medical Record no more than eighteen (18) hours after the PCP or Service Coordination Team is notified, and a full report of the services provided within two (2) business days.

2.8.6.6. The STAR+PLUS MMP shall not deny payment for treatment for an Emergency Medical Condition, pursuant to 42 C.F.R § 438.114.

2.8.6.7. The STAR+PLUS MMP shall not deny payment for treatment of an Emergency Medical Condition if a representative of the STAR+PLUS MMP instructed the Enrollee to seek Emergency Services.

2.8.6.7.1. STAR+PLUS MMP may not deny payment for treatment obtained when an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R § 438.114(a) of the definition of Emergency Medical Condition.

2.8.6.8. The STAR+PLUS MMP shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

2.8.6.9. The STAR+PLUS MMP shall require Providers to notify the Enrollee's PCP of an Enrollee's screening and treatment, but may not refuse to cover Emergency Services based on their failure to do so.

2.8.6.10. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

2.8.6.11. The attending emergency physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently Stabilized for Transfer or Discharge. That determination is binding on the STAR+PLUS MMP if such Transfer or Discharge order:

2.8.6.11.1. Is consistent with generally accepted principles of professional medical practice; and

2.8.6.11.2. Is a Covered Service under the Contract.

2.8.6.12. The STAR+PLUS MMP shall cover and pay for post-stabilization Care Services in accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c).

2.8.6.13. STAR+PLUS MMP shall cover Post-Stabilization Services provided by a Provider in any of the following situations:

2.8.6.13.1. If the STAR+PLUS MMP authorized such services;

2.8.6.13.2. If such services were administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to the STAR+PLUS MMP for authorization of further Post-Stabilization Services; or

2.8.6.13.3. The STAR+PLUS MMP does not respond to a request to authorize further Post-Stabilization Services within one (1) hour, the STAR+PLUS MMP could not be contacted, or the STAR+PLUS MMP and the treating Provider cannot reach an agreement concerning the Enrollee's care and a Provider is unavailable for a consultation, in which case the treating Provider must be permitted to continue the care of the Enrollee until a Provider is reached and either concurs with the treating Provider's plan of care or assumes responsibility for the Enrollee's care.

2.8.7. Emergency Medical Treatment and Labor Act (EMTALA)

2.8.7.1. The STAR+PLUS MMP and Providers shall comply with EMTALA, which, in part, requires:

2.8.7.1.1. Qualified hospital medical personnel to provide appropriate medical screening examinations to any individual who "comes to the emergency department," as defined in 42 C.F.R.§ 489.24(b);

2.8.7.1.2. As applicable, to provide individuals stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, appropriate Transfers.

2.8.7.1.3. The STAR+PLUS MMP must pay for the emergency medical screening examination, as required by 42 U.S.C. §1395dd. The STAR+PLUS MMP must reimburse for both the physician's services and the Hospital's Emergency Services, including the emergency room and its ancillary services.

2.8.7.1.4. When the medical screening examination determines that an Emergency Medical Condition exists, the STAR+PLUS MMP must pay for Emergency Services performed to stabilize the Enrollee. The emergency physician must document these services in the Enrollee Medical Record. The STAR+PLUS MMP must reimburse for both the physician's and Hospital's emergency stabilization services including the emergency room and its ancillary services.

2.8.7.1.5. The STAR+PLUS MMP's contracts with its Providers must clearly state the Provider's EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.

2.8.8. Cultural Competency Plan

2.8.8.1. The STAR+PLUS MMP must have a comprehensive written Cultural Competency plan describing how it will ensure culturally competent services, and provide Linguistic Access and Disability-related access to information, facilities, and services. The Cultural Competency plan must adhere to the following: Title VI of the Civil Rights Act guidelines and the provision of auxiliary aids and services, in compliance with the Americans with Disabilities Act, Title III, Department of Justice Regulation 36.303, 42 C.F.R. § 438.10(f)(6)(i), and 1 Tex. Admin. § 353.411.

2.8.8.2. The Cultural Competency plan must describe how the individuals and systems within the STAR+PLUS MMP will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each. During the operations phase, the STAR+PLUS MMP must submit modifications and amendments to the Cultural Competency plan to HHSC no later than thirty (30) days prior to implementation of a change. The STAR+PLUS MMP must also make the Cultural Competency plan available to its Network Providers. HHSC may require the STAR+PLUS MMP to update the plan to incorporate new or amended requirements based on HHSC guidance. In that event, the STAR+PLUS MMP has sixty (60) days to submit the updated plan to HHSC.

2.8.9. Linguistic Competency

2.8.9.1. The STAR+PLUS MMP must demonstrate linguistic competency in its dealing, both written and verbal, with Enrollees and must understand that linguistic differences between the Provider and the Enrollee cannot be permitted to present barriers to access and quality health care and demonstrate the ability to provide quality health care across a variety of cultures.

2.8.9.2. As required by 1 Tex. Admin. Code § 353.411, the STAR+PLUS MMP must arrange and pay for Competent

Interpreter services for Enrollees to ensure effective communication regarding treatment, medical history, or health condition. The STAR+PLUS MMP must maintain policies and procedures outlining the manner in which Enrollees can access Competent Interpreter services (including when the Enrollee is in a Provider's office or accessing emergency services).

2.8.10. Access for Enrollees with Disabilities

2.8.10.1. The STAR+PLUS MMP and its Providers must comply with the ADA (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees.

2.8.10.2. The STAR+PLUS MMP and its Providers can demonstrate compliance with the ADA by conducting an independent survey/site review of facilities for both physical and programmatic accessibility.

2.8.10.3. Physical and telephone access to services must be made available for individuals with disabilities and fully comply with the ADA.

2.8.10.4. The STAR+PLUS MMP must reasonably accommodate persons with disabilities and ensure that physical and communication barriers do not inhibit individuals with disabilities from obtaining services from the STAR+PLUS MMP.

2.8.10.5. The STAR+PLUS MMP must have policies and procedures in place demonstrating a commitment to accommodating the physical access and flexible scheduling needs of Enrollees, in compliance with the ADA. This includes the use of TTY/TDD devices for the Deaf and hard of hearing, qualified American Sign Language (ASL) interpreters, and alternative, cognitively accessible communication, such as written materials in simple, clear language at or below 6th grade reading level, and individualized guidance from customer service representatives to ensure materials are understood, for persons with cognitive limitations.

2.8.11. Toll-free Fax Line for Service Authorizations

2.8.11.1. The STAR+PLUS MMP must provide access to a toll-free fax line where Providers may send requests for authorization of services and any supplemental information related to service authorization.

2.9. STAR+PLUS MMP Hotlines

2.9.1. Enrollee Services Hotline

2.9.1.1. Customer service representatives

2.9.1.1.1. The STAR+PLUS MMP must employ customer service representatives trained to answer Enrollee inquiries and concerns from Enrollees and Eligible Beneficiaries, consistent with the requirements of 42 CFR§§ 422.111(h) and 423.128(d).

2.9.1.1.2. Customer service representatives must be trained to answer inquiries and concerns from Enrollees and prospective Enrollees;

2.9.1.1.3. Customer service representatives must be trained in the use of TTY, Video Relay services, remote interpreting services, how to provide accessible PDF materials, and other Alternative Formats;

2.9.1.1.4. Customer service representatives must be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including ASL, or through an alternative language device, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays, telephone translation services, and other services for deaf and hard of hearing Enrollees free-of-charge;

2.9.1.1.5. Customer service representatives must inform callers that interpreter services are free;

2.9.1.1.6. Customer service representatives must be knowledgeable about Texas Medicaid, Medicare, and the terms of the Contract, including the Covered Services listed in Appendix A, including Flexible Benefits;

2.9.1.1.7. Customer service representatives must be available to discuss and provide assistance with resolving Enrollee Grievances;

2.9.1.1.8. Customer service representatives must have access to the STAR+PLUS MMP's Enrollee database and an electronic Provider and Pharmacy Directory.

2.9.1.1.9. Customer service representatives must be trained in Cultural Competancy and demonstrate sensitivity to the Enrollee's culture, including Disability culture and the independent living philosophy;

2.9.1.1.10. Customer service representatives must provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their Disability to the STAR+PLUS MMP;

2.9.1.1.11. Customer service representatives must maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives; and

2.9.1.1.12. The STAR+PLUS MMP must ensure that customer service representatives make available to Enrollees and Eligible Beneficiaries, upon request, information concerning the following:

2.9.1.1.12.1. The identity, locations, qualifications, and availability of Providers;

2.9.1.1.12.2. Enrollees' rights and responsibilities;

2.9.1.1.12.3. The procedures available to an Enrollee and Provider(s) to challenge or Appeal the failure of the STAR+PLUS MMP to provide a Covered Service and to Appeal any Adverse Actions (denials);

2.9.1.1.12.4. How to access oral interpretation services and written materials in Prevalent Languages and Alternative Formats;

2.9.1.1.12.5. Information on all Covered Services, Flexible Benefits, and other available services or resources (e.g., State agency services) either directly or through referral or authorization;

2.9.1.1.12.6. The procedures for an Enrollee to change plans or to Opt-Out of the Demonstration;

2.9.1.1.12.7. Additional information that may be required by Enrollees and Potential Enrollees to understand the requirements and benefits of the STAR+PLUS MMP;

2.9.1.1.13. Customer service representatives must be:

2.9.1.1.13.1. Able to answer non-technical questions about the role of the PCP, as applicable;

2.9.1.1.13.2. Able to answer non-clinical questions about referrals or the process for receiving authorization for procedures or services;

2.9.1.1.13.3. Knowledgeable about Fraud, Abuse, and Waste and the requirements to report any conduct that, if substantiated, may constitute Fraud, Abuse, or Waste;

2.9.1.1.13.4. Trained regarding the process used to confirm the status of persons with Special Health Care Needs;

2.9.1.1.13.5. Able to answer non-clinical questions about accessing Non-Capitated Services;

2.9.1.1.13.6. Trained regarding the emergency prescription process and what steps to take to immediately address problems when pharmacies do not provide a seventy-two (72) hour supply of emergency non-Part D drugs and DME processes for obtaining services and how to address common problems;

2.9.1.1.13.7. Able to help Enrollees access the HHSC's Office of the Ombudsman, HHSC's Administrative Services Contractor, and 1-800-Medicare; and

2.9.1.1.13.8. Knowledgeable about how to identify and report a Critical Event or Incident such as Abuse, Neglect, or Exploitation (ANE) to the State related to LTSS delivered in the STAR+PLUS MMP program.

2.9.1.2. Enrollee Services Hotline Responsiveness

2.9.1.2.1. The STAR+PLUS MMP must operate a call center during normal business hours seven (7) days a week, consistent with the required Marketing Guidelines and the Medicare-Medicaid marketing guidance.

2.9.1.2.2. Customer service representatives must be available Monday through Friday, during normal business hours, consistent with the required Marketing Guidelines and the Medicare-Medicaid marketing guidance. The STAR+PLUS MMP may use alternative call center technologies on Saturdays, Sundays, all federal holidays except New Year's Day, and state holidays. The state-approved holiday schedule is updated annually and can be found at http://sao.hr.state.tx.us/compensation/holidays.html.

2.9.1.2.3. A toll-free TTY number or state relay service must be provided.

2.9.1.2.4. The STAR+PLUS MMP must process all incoming Enrollee correspondence and telephone inquiries in a timely and responsive manner.

2.9.1.2.5. The STAR+PLUS MMP cannot impose maximum call duration limits and must allow calls to be of sufficient length to ensure adequate information is provided to the Enrollee.

2.9.1.2.6. STAR+PLUS MMPs shall ensure that after hours, on weekends, and on state and federal holidays the toll-free Enrollee services telephone line is answered by an automated system with the capability to provide callers with operating hours and instructions on what to do in cases of emergency.

2.9.1.2.7. All recordings must be in English, Spanish, and Prevalent Languages in the service area.

2.9.1.3. Call Center Performance

2.9.1.3.1. The STAR+PLUS MMP's customer service representative's must answer eighty (80) percent of all Enrollee telephone calls within thirty (30) seconds or less measured from the time the call is placed in queue after selecting an option;

2.9.1.3.2. The STAR+PLUS MMP must limit average hold time to (2) two minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.

2.9.1.3.3. The STAR+PLUS MMP must limit the disconnect rate of all incoming calls to five (5) percent.

2.9.1.3.4. The STAR+PLUS MMP must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches a customer service representative capable of responding to the Enrollee's question in a manner that is sensitive to the Enrollee's language and cultural needs.

2.9.1.3.5. The STAR+PLUS MMP must ensure that ninety-nine (99) percent of calls are answered by the fourth ring by a customer service representative or an automated call pick-up system.

2.9.1.3.6. The STAR+PLUS MMP must ensure no more than one (1) percent of incoming calls receive a busy signal.

2.9.1.3.7. The STAR+PLUS MMP must conduct ongoing quality assurance to ensure these standards are met.

2.9.1.3.8. The Enrollee Services Hotline may serve multiple HHSC Programs in addition to the STAR+PLUS MMP if Hotline staff is knowledgeable about all of the HHSC Programs. The Enrollee Services Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all Service Areas, including the Provider Network in each Service Area.

2.9.1.3.9. The STAR+PLUS MMP must monitor its performance regarding Enrollee Hotline standards and submit performance reports summarizing call center performance for the Enrollee Hotline.

2.9.1.3.10. If it is determined that it is necessary to conduct onsite monitoring of the STAR+PLUS MMP's Enrollee Hotline functions, the STAR+PLUS MMP is responsible for all reasonable travel costs incurred by HHSC or its Administrative Services Contractor(s) relating to such monitoring. For purposes of this section, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC or its Administrative Services Contractor in connection with the onsite monitoring.

2.9.1.3.11. Informational calls to the STAR+PLUS MMP's call centers that become sales/Enrollment calls at the proactive request of the beneficiary must be transferred to HHSC's Administrative Services Contractor.

2.9.2. Provider Hotline

2.9.2.1. The STAR+PLUS MMP must operate a toll-free telephone line for Provider inquiries from 8 a.m. to 5 p.m. local time for the Service Area, Monday through Friday, except for State-approved holidays.

2.9.2.1.1. The State-approved holiday schedule is updated annually and can be found at http://sao.hr.state.tx.us/compensation/holidays.html.

2.9.2.2. The Provider Hotline must be staffed with personnel who are knowledgeable about Covered Services for each applicable STAR+PLUS MMP.

2.9.2.3. The STAR+PLUS MMP 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 Enrollee with an Urgent Condition or an Emergency Medical Condition, as well as after-hours inquiries from Providers, provided, however, that the STAR+PLUS MMP and its Providers must not require such verification prior to providing Emergency Services.

2.9.2.4. The STAR+PLUS MMP must ensure that the Provider Hotline meets the following minimum performance requirements for all STAR+PLUS MMPs and Service Areas:

2.9.2.4.1. Ninety-nine (99) percent of calls are answered by the fourth ring by a customer service representative or an automated call pick-up system is used;

2.9.2.4.2. No more than one (1) percent of incoming calls receive a busy signal;

2.9.2.4.3. The average hold time is two (2) minutes or less; and

2.9.2.4.4. The call abandonment rate is seven (7) percent or less.

2.9.3. Coverage Determinations and Appeals Call Center Requirements

2.9.3.1. The STAR+PLUS MMP must operate a toll-free call center with live customer service representatives available to respond to Providers and Enrollees for information related to requests for coverage under Medicare and Medicaid, and Medicare and Medicaid appeals (including requests for Medicare and Medicaid exceptions and prior authorizations).

2.9.3.2. The STAR+PLUS MMP is required to provide immediate access to requests for Medicare and Medicaid covered benefits and services, including Medicare and Medicaid coverage determinations and redeterminations, via its toll-free call centers.

2.9.3.3. The coverage determination and appeals call centers must operate during normal business hours specified in the Medicare Marketing Guidelines and the Medicare-Medicaid marketing guidance.

2.9.3.4. The STAR+PLUS MMP must accept requests for Medicare and Medicaid coverage, including Medicare and Medicaid coverage determinations /redeterminations, outside of normal business hours, but is not required to have live customer service representatives available to accept such requests outside normal business hours.

2.9.3.5. A voice mailbox must be available after hours for callers to leave messages, provided that:

2.9.3.5.1. Calls received by the automated system must be returned on the next business day;

2.9.3.5.2. The message indicates that the mailbox is secure;

2.9.3.5.3. Lists the information that must be provided so the case can be worked (e.g., Provider identification, Enrollee identification, type of request (coverage determination or Appeal), physician support for an exception request, and whether the Enrollee is making an expedited or standard request);

2.9.3.5.4. For coverage determination calls (including exceptions requests), articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests; and

2.9.3.5.5. For Appeals calls, information articulates the process information needed and provide for a resolution within seventy-two (72) hours for expedited Appeal requests and seven (7) calendar days for standard Appeal requests.

2.9.4. 24-Hour Nurse Hotline

2.9.4.1. The STAR+PLUS MMP shall establish a toll-free advice line, available twenty-four (24) hours a day, seven (7) days a week, through which Enrollees may obtain medical guidance and support from a nurse. The STAR+PLUS MMP shall ensure that the nurses staffing the 24-Hour Nurse Hotline will be able to obtain physician support and advice by contacting the STAR+PLUS MMP's Medical Director if needed.

2.9.4.2. The STAR+PLUS MMP must provide a twenty-four (24) hour per day, seven (7) days-per-week toll-free system with access to a registered nurse who:

2.9.4.2.1. Is able to respond to Enrollee questions about health or medical concerns;

2.9.4.2.2. Has the experience and knowledge to provide clinical triage;

2.9.4.2.3. Is able to provide options other than waiting until business hours or going to the emergency room; and,

2.9.4.2.4. Is able to provide access to oral interpretation services available as needed, free-of-charge.

2.9.4.3. The STAR+PLUS MMP must train 24-hour Nurse Hotline staff about:

2.9.4.3.1. The emergency prescription process and what steps to take to immediately address Enrollees' problems when pharmacies do not provide a seventy-two (72)hour emergency supply of non-Part D drugs;

2.9.4.3.2. DME processes for obtaining services and how to address common problems.

2.9.4.4. 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 Enrollees 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 seventy-two (72)hour emergency supply policy for non-Part D drugs and DME processes.

2.9.4.5. The 24-Hour Nurse Hotline must meet the following performance standards:

2.9.4.5.1. At least ninety-nine (99%) percent of calls are answered by the fourth ring or an automated call pick-up system is used.

2.9.4.5.2. At least eighty (80%) percent of calls must be answered by toll-free line staff within thirty (30) seconds.

2.9.4.5.3. The call abandonment rate is seven (7%) percent or less.

2.9.4.5.4. The average hold time is two (2) minutes or less.

2.9.5. Behavioral Health Services Hotline

2.9.5.1. The STAR+PLUS MMP must have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, toll-free throughout the Service Area. Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess Behavioral Health emergencies. Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. It is not acceptable for an emergency intake line to be answered by an answering machine.

2.9.5.2. The STAR+PLUS MMP may operate one hotline to handle behavioral health calls (including emergency and crisis behavioral health calls) and routine Enrollee calls unrelated to behavioral health. However, the STAR+PLUS MMP must submit hotline performance reports separately as required by

UMCM Chapter 5.4.3, "Hotline Reports." The STAR+PLUS MMP cannot impose maximum call duration limits and must allow calls to be of sufficient length to ensure adequate information is provided to the Enrollee. Hotline services must meet Cultural Competency requirements and provide linguistic access to all Enrollees, including the interpretive services required for effective communication.

2.9.5.3. The Behavioral Health Services Hotline must meet the following performance standards:

2.9.5.3.1. At least ninety-nine (99%) percent of calls are answered by the fourth ring or an automated call pick-up system;

2.9.5.3.2. No incoming calls receive a busy signal;

2.9.5.3.3. At least eighty (80%) percent of calls must be answered by toll-free line staff within thirty (30) seconds measures from the time the call is placed in queue after selecting an option;

2.9.5.3.4. The call abandonment rate is seven (7%) percent or less; and

2.9.5.3.5. The average hold time is two (2) minutes or less.

2.10. Enrollee Advisory Committee

2.10.1. General

2.10.1.1. The STAR+PLUS MMP shall establish an Enrollee Advisory Group that will provide regular feedback to the STAR+PLUS MMP's governing board on issues of Demonstration management and Enrollee care. The STAR+PLUS MMPshall ensure that the Enrollee Advisory Group:

2.10.1.1.1. Meets at least quarterly throughout the Demonstration; and

2.10.1.1.2. Is comprised of Enrollees, their family members, and other caregivers that reflect the diversity of the Demonstration population, including individuals with disabilities.

2.10.1.2. The STAR+PLUS MMP should make its best efforts to ensure that at least three (3) Enrollees attend each Enrollee Advisory Group meeting and allow for Enrollee advocates to participate.

2.10.1.3. The STAR+PLUS MMP must maintain a record of Enrollee Advisory Group meetings, including agendas and minutes, for at least three years.

2.10.1.4. The STAR+PLUS MMP shall also include Ombudsman reports in quarterly updates to the Enrollee Advisory Group and shall participate in all statewide stakeholder and oversight convenings as requested by HHSC and/or CMS.

2.10.1.5. The State will maintain additional processes for ongoing stakeholder participation and public comment, including through stakeholder and Enrollee participation in the Promoting Independence Advisory Committee, the Quality Improvement Advisory Committee, STAR+PLUS stakeholder meetings, STAR+PLUS Quality Council, Medicaid Managed Care Advisory Committee and other various advisory and stakeholder meetings devoted to services for Medicare-Medicaid Enrollees.

2.11. Enrollee Grievances

2.11.1. General

2.11.1.1. The Enrollee or Enrollee's LAR may file a Grievance either orally or in writing.

2.11.1.2. The STAR+PLUS MMP must have a routine process to detect patterns of Grievances. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Grievances.

2.11.1.3. The STAR+PLUS MMP must designate an officer of the STAR+PLUS MMP who has primary responsibility for ensuring that Grievances are resolved in compliance with written policy and within the required timeframe. For purposes of Sections 2.11 and 2.12, an "officer" of the STAR+PLUS MMP 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.

2.11.1.4. The STAR+PLUS MMP is prohibited from discriminating or taking punitive action against an Enrollee or his or her LAR for making a Grievance.

2.11.1.5. If the Enrollee makes a request for disenrollment the STAR+PLUS MMP must give the Enrollee information on the disenrollment process and direct the Enrollee to the HHSC

Administrative Services Contractor. If the request for disenrollment includes a Grievance by the Enrollee, the Grievance will be processed separately from the disenrollment request, through the Grievance process.

2.11.1.6. The STAR+PLUS MMP will cooperate with CMS and HHSC or its designee to resolve all Enrollee Grievances. Such cooperation may include, but is not limited to, providing information or assistance to HHSC Grievance team members.

2.11.2. Enrollee Advocates

2.11.2.1. The STAR+PLUS MMP must provide designated Enrollee Advocates to assist Enrollees in understanding and using the STAR+PLUS MMP's Grievance system. The STAR+PLUS MMP's Enrollee Advocates must assist Enrollees in writing or filing a Grievance and monitoring the Grievance through the STAR+PLUS MMP's Grievance process until the issue is resolved. Enrollee Advocates must be physically located within the Service Area unless an exception is approved by the CMT.

2.11.2.2. Enrollee Advocates must inform Enrollees of the following:

2.11.2.2.1. Their rights and responsibilities,

2.11.2.2.2. The Grievance process,

2.11.2.2.3. The Appeal process,

2.11.2.2.4. Covered Services available to them, including preventive services, and

2.11.2.2.5. Non-Capitated Services available to them.

2.11.2.3. Enrollee Advocates must assist Enrollees in writing Grievances and are responsible for monitoring the Grievance through the STAR+PLUS MMP's Grievance process.

2.11.2.4. Enrollee Advocates are responsible for making recommendations to the STAR+PLUS MMP's management on any changes needed to improve either the care provided or the way care is delivered. Enrollee Advocates are also responsible for helping or referring Enrollees to community resources that are available to meet Enrollees' needs if services are not available from the STAR+PLUS MMP as Covered Services.

2.11.3. Grievance Filing

2.11.3.1. Internal Grievance Filing (STAR+PLUS MMP) – An Enrollee, or a LAR, may file an Internal Grievance at any time with the STAR+PLUS MMP or its Providers by calling or writing to the STAR+PLUS MMP or Provider. If the Internal Enrollee Grievance is filed with a Provider, the STAR+PLUS MMP must require the Provider to forward it to the STAR+PLUS MMP. If remedial action is requested regarding a Medicare or Medicaid issue, the Enrollee must file the Grievance with the STAR+PLUS MMP or Provider no later than ninety (90) days after the event or incident triggering the Grievance.

2.11.3.2. External Grievance Filing – The STAR+PLUS MMP shall inform Enrollees that they may file an external Grievance through 1-800 Medicare or to HHSC. The STAR+PLUS MMP must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the STAR+PLUS MMP's main Web page per 42 C.F.R. § 422.504(b)(15)(ii). The STAR+PLUS MMP must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance may be filed. External Grievances filed with HHSC shall be forwarded to the CMT and entered into the CMS Complaints Tracking Module (CTM), which will be accessible to the STAR+PLUS MMP.

2.11.3.3. LARs may file Grievances on behalf of Enrollees to the extent allowed under applicable federal or State law.

2.11.4. Grievance Administration

2.11.4.1. Internal (STAR+PLUS MMP level) Grievance

2.11.4.1.1. The STAR+PLUS MMP must have a formally structured Grievance system, consistent with 42 C.F.R. § 431 Subpart E and 42 C.F.R. § 438 Subpart F and the provisions of 1 T.A.C. Chapter 357, relating to Medicaid managed care organizations, and 42 C.F.R. § 422 Subpart M relating to Medicare grievances, in place for addressing Enrollee Grievances, including Grievances regarding reasonable accommodations and access to services under the ADA.

2.11.4.1.2. The STAR+PLUS MMP must maintain written records of all Grievance activities, and notify CMS and HHSC of all internal Enrollee Grievances. The STAR+PLUS MMP must also submit to HHSC, in the format required by the State, a quarterly report summarizing all Grievances heard by the Grievance Committee and the responses to and disposition of those Grievances.

2.11.4.1.3. The STAR+PLUS MMP's internal Grievance process must be the same for all Enrollees and must be reviewed and approved in writing by HHSC or its designee. Modifications and amendments to the Enrollee Grievance process must be submitted for HHSC's and or CMS' approval at least thirty (30) days prior to the implementation.

2.11.4.1.4. The internal Grievance process must meet the following standards:

2.11.4.1.4.1. Timely acknowledgement of receipt of each Enrollee Grievance;

2.11.4.1.4.2. Timely review of each Enrollee Grievance;

2.11.4.1.4.3. Standard response, electronically, orally, or in writing, to each Enrollee Grievance within a reasonable time, but no later than thirty (30) days after the STAR+PLUS MMP receives the Grievance, with the following exceptions:

2.11.4.1.4.3.1. For Grievances that are received in person or by telephone, if the Grievance cannot be resolved within one (1) business day of receipt, the STAR+PLUS MMP must provide Enrollees or their LARs with written notice of resolution.

2.11.4.1.4.3.2. The STAR+PLUS MMP must provide an expedited response, orally or in writing, within twenty-four (24) hours from receipt of the Grievance when the Grievance relates to the extension of a coverage decision or Appeal timeframe or the denial of a request for an expedited coverage decision or Appeal under 42 C.F.R. § 422.564.;

2.11.4.1.4.4. In accordance with 42 C.F.R § 438.406(a)(3)(ii), the STAR+PLUS MMP's policies and procedures must require that individuals who make decisions on grievances regarding denial of expedited resolution of an Appeal or on grievances that involve clinical issues are not involved in any previous level of review or decision-making, and are health care professionals who have the appropriate clinical and other expertise in treating the Enrollee's condition or disease; and

2.11.4.1.4.5. Availability to Enrollees of information about Enrollee Grievances and Appeals, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

2.11.4.1.5. The STAR+PLUS MMP must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting, and resolving Grievances by Enrollees or their LARs. The STAR+PLUS MMP's process must require that every Grievance received in person, by telephone, or in writing must be acknowledged and recorded in a written record and logged with the following details:

2.11.4.1.5.1. Date of the Grievance;

2.11.4.1.5.2. Identification of the individual filing the Grievance;

2.11.4.1.5.3. Identification of the individual recording the Grievance;

2.11.4.1.5.4. Nature of the Grievance;

2.11.4.1.5.5. Disposition of the Grievance (i.e., how the STAR+PLUS MMP resolved the Grievance);

2.11.4.1.5.6. Corrective action required; and

2.11.4.1.5.7. Date resolved.

2.11.4.1.6. Unless the CMT has granted a written extension, the STAR+PLUS MMP is subject to contractual remedies, including liquidated damages, if Enrollee Grievances are not resolved by the timeframes indicated herein.

2.11.4.1.7. The STAR+PLUS MMP must also inform Enrollees how to file a Grievance directly with HHSC, once the Enrollee has exhausted the STAR+PLUS MMP's Grievance process.

2.11.4.2. External Grievances

2.11.4.2.1. If the Enrollee files a Grievance with 1-800-Medicare or HHSC regarding disatisfaction with the STAR+PLUS MMP, the STAR+PLUS MMP must respond to each Enrollee Grievance according to the earlier of the timeframes outlined in the CTM or fourteen (14) days from the date the Enrollee files the external Grievance.

2.12. Enrollee Appeals

2.12.1. General Requirements

2.12.1.1. Medicare Part D Appeals – All STAR+PLUS MMPs shall utilize and all Enrollees may access the existing Part D Appeals Process, as described in Appendix E. Consistent with existing rules, Part D Appeals will be automatically forwarded to the CMS Medicare Independent Review Entity (IRE) if the STAR+PLUS MMP misses the applicable adjudication timeframe. The CMS IRE is contracted by CMS. The STAR+PLUS MMP must maintain written records of all Appeal activities, and notify CMS and HHSC of all internal Appeals.

2.12.1.2. The STAR+PLUS MMP agrees to be fully compliant with all state and federal laws, regulations, and policies governing the Fair Hearing process, and all statutory and regulatory timelines related thereto. This includes the requirements for both standard and expedited requests. The STAR+PLUS MMP shall be financially liable for all judgments, penalties, costs and fees related to an appeal in which the STAR+PLUS MMP has failed to comply fully with said requirements. The STAR+PLUS MMP must maintain written records of all Appeal activities, and notify CMS and HHSC of all internal Appeals.

2.12.2. Appeals Process Overview

2.12.2.1. Notice of Adverse Action – In accordance with 42 C.F.R. §§ 438.404 and 422.568, the STAR+PLUS MMP must give the Enrollee written notice of any Adverse Action. Such notice shall be provided at least ten (10) days in advance of the date of its action, in accordance with 42 C.F.R. § 438.404. An Enrollee or a Provider acting on behalf of an Enrollee and with the Enrollee's written consent mayAppeal the STAR+PLUS MMP's decision to deny, terminate, suspend, or reduce services. In accordance with 42 C.F.R. §§ 438.402 and 422.574, an Enrollee or Provider on behalf of an Enrollee and may also Appeal the STAR+PLUS MMP's delay in providing or arranging for a Covered Service.

2.12.2.2. The STAR+PLUS MMP must develop, implement and maintain an Appeal procedure that complies with state and federal laws and regulations, including 42 CFR § 422.560 et seq., 42 C.F.R.§ 431.200 *et seq* and 42 C.F.R. § 438, Subpart F, "Grievance System." The Appeal procedure must be the same for all Enrollees. When an Enrollee or his or her LAR expresses orally or in writing any dissatisfaction or disagreement with an Adverse Action, the STAR+PLUS MMP must regard the expression of dissatisfaction as a request to Appeal an Adverse Action.

2.12.2.3. The STAR+PLUS MMP must require that every oral Appeal received must be confirmed by a written, signed Appeal by the Enrollee or his or her LAR, unless the Enrollee or his or her LAR requests an Expedited Appeal. All Appeals must be recorded in a written record and logged with the following details:

2.12.2.3.1. Date notice is sent;

2.12.2.3.2. Effective date of the action;

2.12.2.3.3. Date the Enrollee or his or her LAR requested the Appeal;

2.12.2.3.4. Date the Appeal was followed up in writing;

2.12.2.3.5. Identification of the individual filing;

2.12.2.3.6. Nature of the Appeal; and

2.12.2.3.7. Disposition of the Appeal, including a copy of the notice of disposition and the date it was sent to Enrollee.

2.12.2.4. The STAR+PLUS MMP must provide designated Enrollee Advocates, as described in Section 2.11.2, to assist Enrollees

in understanding and using the Appeal process. The STAR+PLUS MMP's Enrollee Advocates must assist Enrollees in writing or filing an Appeal and monitoring the Appeal through the STAR+PLUS MMP's Appeal process until the issue is resolved.

2.12.2.5. The STAR+PLUS MMP's Appeal procedures must:

2.12.2.5.1. Provide for resolution with the timeframes specified herein; and

2.12.2.5.2. Assure the participation of individuals with authority to require corrective action.

2.12.2.6. Appeals procedures must be consistent with 42 C.F.R. § 422.560 et seq. and 42 C.F.R. § 438.400 et seq.

2.12.2.7. The STAR+PLUS MMP must have a diverse committee in place for reviewing Appeals made by Enrollees. The STAR+PLUS MMP Medical Director must have a significant role in monitoring, investigating and hearing Appeals. In accordance with 42 C.F.R.§ 438.406(a)(3)(ii), the STAR+PLUS MMP's policies and procedures must require that individuals who make decisions on Grievances and Appeals are not involved in any previous level of review or decision-making, and are health care professionals who have the appropriate clinical and other expertise in treating the Enrollee's condition or disease.

2.12.2.8. The STAR+PLUS MMP must have a routine process to detect patterns of Appeals. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Appeals.

2.12.2.9. The STAR+PLUS MMP shall review its Appeal procedures at least annually for the purpose of amending such procedures when necessary.

2.12.2.10. If the STAR+PLUS MMP or State Fair Hearing Officer reverses a decision to deny authorization of services and the Enrollee received the disputed services while the Appeal was pending, the STAR+PLUS MMP is responsible for the payment of services.

2.12.2.10.1. If a State Fair Hearing Officer reverses an STAR+PLUS MMP's denial of a prior authorization for a DME service/equipment after the Enrollee has enrolled with a second STAR+PLUS MMP, the original STAR+PLUS MMP must pay for the DME service/equipment from the date it denied the authorization until the date the Enrollee enrolled with the second STAR+PLUS MMP. In the case of custom DME, the original STAR+PLUS MMP must pay for the custom DME if the denial is reversed.

2.12.2.11. The STAR+PLUS MMP is prohibited from discriminating or taking punitive action against a Enrollee or his or her LAR for making an Appeal.

2.12.2.12. Integrated Notice

2.12.2.12.1. Enrollees will be notified of all applicable Demonstration, Medicare, and Medicaid Appeal rights through a single notice. The form and content of the notice must be prior approved by CMS and HHSC. The STAR+PLUS MMP shall notify the Enrollee of its decision at least ten (10) days in advance of the effective date of its Adverse Action. The notice must explain:

2.12.2.12.1.1. The Adverse Action the STAR+PLUS MMP has taken or intends to take;

2.12.2.12.1.2. The reasons for the Adverse Action;

2.12.2.12.1.3. The citation to the regulations supporting such Adverse Action;

2.12.2.12.1.4. The Enrollee’s or the Provider’s right to file an internal Appeal with the STAR+PLUS MMP;

2.12.2.12.1.5. Procedures for exercising Enrollee’s rights to Appeal;

2.12.2.12.1.6. The Enrollee’s right to request a Fair Hearing in accordance with 1 T.A.C. Chapter 357 and 42 CFR 431 subpart E, as described in Section 2.12.2.13.1.2;

2.12.2.12.1.7. Circumstances under which expedited resolution is available and how to request it; and

2.12.2.12.1.8. The Enrollee's rights to have benefits continue pending the resolution of the Appeal.

2.12.2.12.2. Written material must use easily understood language and format, be available in Alternative Formats and in an appropriate manner that takes into consideration those with special needs. All Enrollees and Eligible Beneficiaries must be informed that information is available in Alternative Formats and how to access those formats.

2.12.2.12.3. Written notice must be translated for the individuals who speak Prevalent Languages.

2.12.2.12.4. Written notices must include language clarifying that oral interpretation is available for all languages and how to access it.

2.12.2.13. Appeal levels

2.12.2.13.1. Initial Appeals may be filed with the STAR+PLUS MMP.

2.12.2.13.1.1. Subsequent appeals for traditional Medicare A and B services that are not fully in favor of the Enrollee will be automatically forwarded to the Medicare Independent Review Entity (IRE) by the STAR+PLUS MMP.

2.12.2.13.1.2. Appeals for services covered by HHSC only (including but not limited to, LTSS, Texas Medicaid-covered drugs excluded from Medicare Part D, and some Behavioral Health Care Services) may also be appealed to the HHSC Appeals Division for a Fair Hearing at any time.

2.12.2.13.1.3. For services for which Medicare and Medicaid overlap (including, but not limited to, Home Health, Durable Medical Equipment and skilled therapies, but excluding Part D), decisions made by the STAR+PLUS MMP that are not fully in favor of the Enrollee will be auto-forwarded to the IRE by the STAR+PLUS MMP. An Enrollee may also file a request for a hearing with the HHSC Appeals Division. If an Appeal is both auto-forwarded to the IRE and filed with the HHSC Appeals Division, any determination in favor of the Enrollee will bind the STAR+PLUS MMP and will require payment by the STAR+PLUS MMP for the service or item in question granted in the Enrollee's favor which is closest to the Enrollee's relief requested on Appeal.

2.12.2.13.2. Prescription Drugs

2.12.2.13.2.1. Part D Appeals may not be filed with the HHSC Appeals Division.

2.12.2.13.2.2. Appeals related to drugs excluded from Part D that are covered by Medicaid must be filed with the HHSC Appeals Division.

2.12.2.14. Continuation of Benefits Pending an Appeal and Fair Hearing

2.12.2.14.1. The STAR+PLUS MMP must provide continuing benefits for all prior approved non-Part D benefits that are terminated or modified pending internal STAR+PLUS MMP Appeals, per timeframes and conditions in 42 C.F.R. § 438.420. This means that such benefits will continue to be provided by Providers to Enrollees and that the STAR+PLUS MMPs must continue to pay Providers for providing such services or benefits pending an internal Appeal.

2.12.2.14.2. For all Appeals filed with the HHSC Appeals Division, an Enrollee may request Continuing Services. HHSC will make a determination on continuation of services in accordance with the State's existing Appeals policy, in accordance with 42 C.F.R. §438.420.

2.12.2.14.3. If the HHSC Appeals Division decides in the Enrollee's favor and reverses the STAR+PLUS MMP's decision, the STAR+PLUS MMP must authorize the service under dispute as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date the STAR+PLUS MMP receives the notice reversing the decision.

2.12.2.14.4. If the STAR+PLUS MMP or the HHSC Appeals Division reverses a decision to deny authorization of Covered Services, and the Enrollee received the disputed services while the Appeal was pending, the STAR+PLUS MMP must pay for those services in accordance with state rules and policy.

2.12.2.14.5. If services were furnished while the internal Appeal or Fair Hearing was pending, payments will not be recouped based on the outcome of the Appeal for services covered during pending Appeal(s) unless explicitly approved by the CMT.

2.12.3. Internal Appeals Filing Timeframes

2.12.3.1. Timelines for filing

2.12.3.1.1. Enrollees and their LARs, including Providers, may file an oral or written Appeal with the STAR+PLUS MMP within sixty (60) calendar days following the date of the notice of Adverse Action that generates such Appeal.

2.12.3.1.2. For a reduction or denial of previously authorized services, an Appeal requesting continuation of benefits must be filed within ten (10) days from the later of:

2.12.3.1.2.1. The notice of action, or

2.12.3.1.2.2. The intended effective date of the STAR+PLUS MMP's proposed action, in order for the Enrollee to continue accessing services pending the Appeal result. See 42 CFR § 438.420.

2.12.3.2. Standard Appeals

2.12.3.2.1. The STAR+PLUS MMP's Appeals process must comply with 42 CFR § 438.406 and include the following requirements:

2.12.3.2.1.1. Acknowledge receipt of each Appeal;

2.12.3.2.1.2. Ensure that the individuals who make decisions on Appeals were not involved in any previous level of review or decision making;

2.12.3.2.1.3. Provide that oral inquiries seeking to appeal an action are treated as Appeals (to establish the earliest possible filing date for the Appeal) and must be confirmed in writing unless the Enrollee or the Provider appealing on the Enrollee's behalf requests expedited resolution;

2.12.3.2.1.4. Provide the Enrollee a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. The STAR+PLUS MMP must inform the Enrollee of the limited time available for this, especially in the case of expedited resolution;

2.12.3.2.1.5. Provide the Enrollee and his or her LAR opportunity, before and during the Appeals process, to examine the Enrollee's case file, including any medical records and any other documents and records considered during the Appeals process; and

2.12.3.2.1.6. Consider the Enrollee, LAR, or estate representative of a deceased Enrollee as parties to the Appeal.

2.12.3.2.2. For Appeals filed with the STAR+PLUS MMP, if the Enrollee does not request an Expedited Appeal pursuant to 42 C.F.R. § 438.410, the STAR+PLUS MMP may require the Enrollee to follow an oral Appeal with a written, signed Appeal.

2.12.3.2.3. The STAR+PLUS MMP shall respond in writing to standard Appeals as expeditiously as the Enrollee's health condition requires and shall not exceed thirty (30) calendar days from the initial date of receipt of the Appeal. The STAR+PLUS MMP may extend this timeframe by up to an additional fourteen (14) calendar days if the Enrollee requests the extension or if the STAR+PLUS MMP provides evidence satisfactory to HHSC that a delay in rendering the decision is in the Enrollee's interest. For any Appeals decisions not rendered within thirty (30) calendar days where the Enrollee has not requested an extension, the STAR+PLUS MMP shall provide written notice to the Enrollee of the reason for the delay.

2.12.3.3. Expedited Appeals

2.12.3.3.1. The STAR+PLUS MMP shall establish and maintain an expedited review process for Appeals where either the STAR+PLUS MMP or the Enrollee's Provider determines that the time expended in a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. The STAR+PLUS MMP shall ensure that punitive action is neither taken against a Provider that requests an expedited resolution nor supports the Enrollee's Appeal. In instances where the Enrollee's request for an Expedited Appeal is denied, the Appeal must be transferred to the timeframe for standard resolution of Appeals, and the Enrollee must be given prompt oral notice of the denial (make reasonable efforts) and a written notice within two (2) calendar days and be informed of his/her right to file a Grievance in accordance with Section 2.11.4.

2.12.3.3.2. The STAR+PLUS MMP shall issue decisions for Expedited Appeals as expeditiously as the Enrollee's health condition requires, not to exceed seventy-two (72) hours from the initial receipt of the Appeal. The STAR+PLUS MMP may extend this timeframe by up to an additional fourteen (14) calendar days if the Enrollee requests the extension or if the STAR+PLUS MMP provides evidence satisfactory to HHSC that a delay in rendering the decision is in the Enrollee's interest. For any extension not requested by the Enrollee, the STAR+PLUS MMP shall provide written notice to the Enrollee of the reason for the delay. The STAR+PLUS MMP shall make reasonable efforts to provide the Enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the Enrollee and shall follow-up within two (2) calendar days with a written notice of action.

2.12.3.3.3. All STAR+PLUS MMP Appeal decisions must be provided to the Enrollee in writing and shall include, but not be limited to, the following information, consistent with 42 C.F.R. § 438.408:

2.12.3.3.3.1. The decision reached by the STAR+PLUS MMP;

2.12.3.3.3.2. The date of decision; and

2.12.3.3.3.3. For Appeals not resolved wholly in favor of the Enrollee:

2.12.3.3.3.3.1. The right to request a Fair Hearing and how to do so; and

2.12.3.3.3.3.2. The right to request to receive benefits while the hearing is pending and how to make the request.

2.12.4. External Appeals

2.12.4.1. The CMS Independent Review Entity (IRE)

2.12.4.1.1. If, on internal Appeal, the STAR+PLUS MMP does not decide fully in the Enrollee's favor within the relevant time frame, the STAR+PLUS MMP shall automatically forward the case file regarding Medicare services to the CMS Independent Review Entity (IRE) for a new and impartial review.

2.12.4.1.2. For standard External Appeals, the CMS IRE will send the Enrollee and the STAR+PLUS MMP a letter with its decision within thirty (30) calendar days after it receives the case from the STAR+PLUS MMP, or at the end of up to a fourteen (14) calendar day extension, and a payment decision within sixty (60) calendar days.

2.12.4.1.3. If the CMS IRE decides in the Enrollee's favor and reverses the STAR+PLUS MMP's decision, the STAR+PLUS MMP must authorize the service under dispute as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date the STAR+PLUS MMP receives the notice reversing the decision.

2.12.4.1.4. For expedited External Appeals, the CMS IRE will send the Enrollee and the STAR+PLUS MMP a letter with its decision within seventy-two (72) hours after it receives the case from the STAR+PLUS MMP (or at the end of up to a fourteen (14) calendar day extension).

2.12.4.1.5. If the STAR+PLUS MMP or the Enrollee disagrees with the CMS IRE's decision, further levels of Appeal are available, including a hearing before an Administrative Law Judge, a review by the Departmental Appeals Board, and judicial review. The STAR+PLUS MMP must comply with any requests for information or participation from such further Appeal entities.

2.12.4.2. The Medicaid Fair Hearing Process

2.12.4.2.1. If the STAR+PLUS MMP's internal Appeal decision is not fully in the Enrollee's favor, the Enrollee may Appeal to the HHSC Appeals Division for Medicaid-based adverse decisions. Appeals to the external Medicaid Fair Hearing process will not be automatically forwarded to the HHSC Appeals Division by the STAR+PLUS MMP. Such appeals must be made in writing and may be made via US Mail, fax transmission, hand-delivery or electronic transmission. Enrollees have the option of filing an expedited Appeal by telephone.

2.12.4.2.2. Appeals to the external Medicaid Fair Hearing process must be filed within ninety (90) days of the notice of action, unless the time period is extended by HHSC upon a finding of good cause.

2.12.4.2.3. External Appeals to the Medicaid Fair Hearing process that qualify as expedited Appeals shall be resolved within seventy-two (72) hours or as expeditiously as the Enrollee's condition requires. The STAR+PLUS MMP may extend this timeframe by up to an additional fourteen (14) calendar days if the Enrollee requests the extension or if the STAR+PLUS MMP provides evidence satisfactory to HHSC that a delay in rendering the decision is in the Enrollee's interest. For any extension not requested by the Enrollee, the STAR+PLUS MMP shall provide written notice to the Enrollee of the reason for the delay.

2.12.4.2.4. External appeals to the Medicaid Fair Hearing process that do not qualify as expedited shall be resolved or a decision issued within ninety (90) calendar days of the date of filing the Appeal with the STAR+PLUS MMP, not including the number of days the Enrollee took to file for a Fair Hearing.

2.12.5. Hospital Discharge Appeals

2.12.5.1. When an Enrollee is being Discharged from the hospital, the STAR+PLUS MMP must comply with the hospital Discharge Appeal requirements at 42 C.F.R. §§ 422.620-422.622.

2.12.5.2. The Enrollee has the right to request an expeditied Discharge Appeal review by a Quality Improvement Organization (QIO) of any hospital Discharge notice. The notice includes information on filing the QIO Appeal. The Enrollee must contact the QIO before 12 noon of the first calendar day after receiving the notice for Discharge but no later than the planned Discharge date.

2.12.5.3. If the Enrollee asks for an expedited Discharge appeal, the Enrollee will be entitled to this process instead of the standard Appeals process described above. The STAR+PLUS MMP must ensure that the Enrollee receives the Detailed Notice of Discharge (CMS-10066). Note: an Enrollee may file an oral or written request for an expedited seventy-two (72)hour STAR+PLUS MMP Appeal if the Enrollee has missed the deadline for requesting the QIO review.

2.12.5.4. The QIO will make its decision within one (1) full business day after it receives the Enrollee's request, medical records, and any other information it needs to make its decision as per 42 C.F.R. § 422.626 (g).

2.12.5.5. If the QIO agrees with the STAR+PLUS MMP's decision, the STAR+PLUS MMP is not responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO notifies the Enrollee of its decision.

2.12.5.6. If the QIO overturns the STAR+PLUS MMP's decision, the STAR+PLUS MMP must pay for the remainder of the hospital stay.

2.12.6. Other QIO Appeals

2.12.6.1. The STAR+PLUS MMP must comply with the termination of services Appeal requirements for individuals receiving services from a Comprehensive Outpatient Rehabilitation Facility (CORF), Skilled Nursing Facility (SNF), or Home Health Agency (HHA) at 42 C.F.R. §§ 422.624 and 422.626.

2.13. Quality Improvement Program

2.13.1. General

2.13.1.1. The STAR+PLUS MMP must provide for the delivery of quality care with the primary goal of improving the health status of Enrollees and, where the Enrollee's condition is not amenable to improvement, maintain the Enrollee's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The STAR+PLUS MMP must work in collaboration with Providers to actively improve the quality of care provided to Enrollees, consistent with the quality improvement goals and all other requirements of the Contract. The STAR+PLUS MMP must provide mechanisms for Enrollees and Providers to offer input into the STAR+PLUS MMP's quality improvement activities. The STAR+PLUS MMP shall:

2.13.1.1.1. Deliver quality care that enables Enrollees to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

2.13.1.1.1.1. Quality of physical health care, including primary and specialty care;

2.13.1.1.1.2. Quality of behavioral health care focused on recovery, resiliency and rehabilitation;

2.13.1.1.1.3. Quality of LTSS;

2.13.1.1.1.4. Adequate access and availability to primary, behavioral health care, pharmacy, specialty health care, and LTSS Providers and services;

2.13.1.1.1.5. Continuity and coordination of care across all care and services settings, and for transitions in care; and

2.13.1.1.1.6. Enrollee experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.

2.13.1.1.2. Apply the principles of continuous quality improvement to all aspects of the STAR+PLUS MMP's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

2.13.1.1.2.1. Quantitative and qualitative data collection and data-driven decision-making;

2.13.1.1.2.2. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

2.13.1.1.2.3. Feedback provided by Enrollees and network Providers in the design, planning, and implementation of its CQI activities; and

2.13.1.1.2.4. Issues identified by the STAR+PLUS MMP, HHSC and/or CMS.

2.13.1.1.3. Ensure that the quality improvement (QI) requirements of this Contract are applied to the delivery of primary and specialty health care services, Behavioral Health behavioral health services, and LTSS across settings.

2.13.2. QI Program Structure

2.13.2.1. The STAR+PLUS MMP shall structure its QI program for the Demonstration separately from any of its existing Medicaid, Medicare, or commercial lines of business. For example,

required measures for this Demonstration must be reported for the STAR+PLUS MMP population only. Integrating the Demonstration population into an existing line of business shall not be acceptable.

2.14. Quality Assessment and Performance Improvement

2.14.1. General

2.14.1.1. The STAR+PLUS MMP must develop, maintain, and operate a well-defined QAPI program consistent with this Contract and TDI requirements, including 28 T.A.C. §11.1901(a)(5) (relating to Quality Improvement Structure for Basic and Limited Services HMOs) and §11.1902 (relating to Quality Improvement Program for Basic and Limited Services HMOs). The QAPI program must support the application of the principles of CQI to all aspects of the STAR+PLUS MMP service delivery system. The QAPI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The QAPI program shall comply with all applicable provisions of 42 C.F.R. § 438, including Subpart D, Quality Assessment and Performance Improvement, 42 C.F.R. § 422, Subpart D Quality Improvement.

2.14.1.2. The STAR+PLUS MMP must also meet the requirements of 42 C.F.R. § 438.240.

2.14.1.3. The STAR+PLUS MMP shall:

2.14.1.3.1. Ensure participating physicians and other Network Providers are informed about the QAPI Program and related activities.

2.14.1.3.2. Include in Provider Contracts a requirement securing cooperation with the QAPI.

2.14.1.3.3. Approach all clinical and non-clinical aspects of quality assessment and performance improvement based on principles of continuous quality managment/total quality management and must:

2.14.1.3.3.1. Evaluate performance using objective quality indicators;

2.14.1.3.3.2. Foster data-driven decision-making;

2.14.1.3.3.3. Recognize that opportunities for improvement are unlimited;

2.14.1.3.3.4. Solicit Enrollee and Provider input on performance and QAPI activities;

2.14.1.3.3.5. Support continuous ongoing measurement of clinical and non-clinical effectiveness and Enrollee satisfaction;

2.14.1.3.3.6. Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and

2.14.1.3.3.7. Support re-measurement of effectiveness and conduct surveys of Enrollee satisfaction and support, and continued development and implementation of improvement interventions as appropriate.

2.14.1.4. The STAR+PLUS MMP shall maintain a well-defined QAPI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes.

2.14.1.5. The STAR+PLUS MMP must designate a senior executive responsible for the QAPI program, and the Medical Director must have substantial involvement in QAPI program activities.

2.14.1.6. At a minimum, the STAR+PLUS MMP must ensure that the QAPI program structure:

2.14.1.6.1. Is organization-wide, with clear lines of accountability within the organization;

2.14.1.6.2. 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;

2.14.1.6.3. Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and

2.14.1.6.4. Evaluates the effectiveness of clinical and non-clinical initiatives.

2.14.1.7. The STAR+PLUS MMP shall establish internal processes to ensure that the quality management activities for primary, specialty, and behavioral health services, and LTSS reflect utilization across the network and include all of the activities in Section 2.14 of this Contract and, in addition, the following elements:

2.14.1.7.1. A process to utilize Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Health Outcomes Survey (HOS) and other measurement results in designing QI activities;

2.14.1.7.2. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care consistent with the utilization control requirements of 42 C.F.R. Part 456. Such process shall include the sampling method used which shall be proportionate to utilization by service type. The STAR+PLUS MMP shall submit its process for medical record reviews and the results of its medical record reviews to HHSC;

2.14.1.7.3. A process to measure Network Providers and Enrollees, at least annually, regarding their satisfaction with the STAR+PLUS MMP. The STAR+PLUS MMP shall submit a survey plan to HHSC for approval and shall submit the results of the survey to HHSC and CMS;

2.14.1.7.4. A process to measure clinical reviewer consistency in applying clinical criteria to Utilization Management activities, using inter-rater reliability measures;

2.14.1.7.5. A process for including Enrollees and their families in quality management activities, as evidenced by participation in Enrollee Advisory Committees; and

2.14.1.7.6. In collaboration with and as further directed by HHSC, develop a customized medical record review process to monitor the assessment for and provision of LTSS.

2.14.1.7.7. Have in place a written description of the QAPI program that delineates the structure, goals, and objectives of the STAR+PLUS MMP's QI initiatives. Such description shall:

2.14.1.7.7.1. Address all aspects of health care, including specific reference to behavioral health care and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral health and LTSS aspects of the QAPI program may be included in the QI description, or in a separate QI Plan referenced in the QI description;

2.14.1.7.7.2. Address the roles of the designated physician(s), behavioral health clinician(s), and LTSS Providers with respect to the QAPI program;

2.14.1.7.7.3. Identify the resources dedicated to the QAPI program, including staff, or data sources, and analytic programs or IT systems; and

2.14.1.7.7.4. Include organization-wide policies and procedures that document processes through which the STAR+PLUS MMP ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and Grievances and Utilization Management.

2.14.1.7.8. Submit to HHSC and CMS an approved plan describing its QAPI that shall include how the STAR+PLUS MMP will accomplish the activities of this section as well the following components or other components as directed by HHSC and CMS:

2.14.1.7.8.1. Planned clinical and non-clinical initiatives;

2.14.1.7.8.2. The objectives for planned clinical and non-clinical initiatives;

2.14.1.7.8.3. The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

2.14.1.7.8.4. The individual(s) responsible for each clinical and non-clinical initiative;

2.14.1.7.8.5. Any issues identified by the STAR+PLUS MMP, HHSC, Enrollees, and Providers, and how those issues are tracked and resolved over time;

2.14.1.7.8.6. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and

2.14.1.7.8.7. Process for correcting deficiencies.

2.14.1.8. The STAR+PLUS MMP shall evaluate the results of QI initiatives at least annually, and submit the results of the evaluation to the CMT following the format and timeframe as specified in Uniform Managed Care Manual, Chapter 5.7, "Quality Reports". The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the STAR+PLUS MMP's assessment of the quality of physical and behavioral health care rendered, the effectiveness of LTSS services, and accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan;

2.14.1.9. The STAR+PLUS MMP shall maintain sufficient and qualified staff employed by the STAR+PLUS MMP to manage the QI activities required under this Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for QM. QI staff shall include:

2.14.1.9.1. At least one (1) designated physician, who shall be a Medical Director or associate Medical Director, at least one (1) designated behavioral health clinician, and a professional with expertise in the assessment and delivery of long term services and supports with substantial involvement in the QI program;

2.14.1.9.2. A qualified individual to serve as the Demonstration QI director who will be directly accountable to the STAR+PLUS MMP's Executive Director and, in addition, if the STAR+PLUS MMP offers multiple products or services in multiple states, will have access to the STAR+PLUS MMP's executive leadership team. This individual shall be responsible for:

2.14.1.9.2.1. Overseeing all QI activities related to Enrollees, ensuring compliance with all such activities, and maintaining accountability for the execution of, and performance in, all such activities;

2.14.1.9.2.2. Maintaining an active role in the STAR+PLUS MMP's overall QI structure; and

2.14.1.9.2.3. Ensuring the availability of staff with appropriate expertise in all areas, as necessary for the execution of QI activities including, but not limited to, the following:

2.14.1.9.2.3.1. Physical and behavioral health care;

2.14.1.9.2.3.2. Pharmacy management;

2.14.1.9.2.3.3. Care management;

2.14.1.9.2.3.4. LTSS;

2.14.1.9.2.3.5. Financial;

2.14.1.9.2.3.6. Statistical/analytical;

2.14.1.9.2.3.7. Information systems;

2.14.1.9.2.3.8. Marketing, publications;

2.14.1.9.2.3.9. Enrollment; and

2.14.1.9.2.3.10. Operations management;

2.14.1.9.2.4. Actively participating in, or assigning staff to actively participate in, QI workgroups and other meetings, including any quality management workgroups or activities that may be facilitated by HHSC, or its designee, that may be attended by representatives of HHSC, a HHSC contractor, the STAR+PLUS MMP, and other entities, as appropriate; and

2.14.1.9.2.5. Serving as liaison to, and maintain regular communication with, Texas QI representatives. Responsibilities shall include, but are not limited to, promptly responding to requests by the CMT for information and/or data relevant to all QI activities.

2.14.2. QI Activities

2.14.2.1. The STAR+PLUS MMP shall engage in performance measurement and quality improvement projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes and Enrollee experience. This will include the ability to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

2.14.2.2. The STAR+PLUS MMP's QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. §§ 438.242(a), 422.516(a) and 423.514.

2.14.2.3. Performance Measurement

2.14.2.3.1. STAR+PLUS MMP shall perform and report the quality and utilization measures identified by CMS and HHSC and in accordance with requirements in the MOU between CMS and the State of Texas dated May 23, 2014, Table 7-1 Core Quality Measures under the Demonstration and Table 7-2 Texas-Specific Duals Quality Measures and as articulated in this Contract and shall include, but are not limited to:

2.14.2.3.1.1. All HEDIS, HOS, and CAHPS data, as well as all other measures specified in Tables 7-1 and 7-2 of the MOU referenced above. HEDIS, HOS and CAHPS must be reported consistent with prevailing Medicare requirements. All existing Medicare Part D metrics will be collected as well. Additional details, including technical specifications, will be provided in annual guidance for the upcoming reporting year.

2.14.2.3.2. STAR+PLUS MMP shall not modify the reporting specifications methodology prescribed by CMS and HHSC without first obtaining CMS and the state's written approval. The STAR+PLUS MMP must obtain an independent validation of its findings by a recognized entity, e.g., NCQA-certified auditor, as approved by CMS and HHSC. CMS and HHSC (or its designee) will perform an independent validation of at least a sample of STAR+PLUS MMP's findings.

2.14.2.3.3. The STAR+PLUS MMP shall monitor other performance measures not specifically stated in this Contract that are required by CMS.

2.14.2.3.4. The STAR+PLUS MMP shall collect data, or cooperate with HHSC or its designee to collect data, and contribute to all Demonstration QI-related processes, as directed by HHSC and CMS, as follows:

2.14.2.3.4.1. Collect and submit to HHSC, CMS and/or CMS' contractors, in a timely manner, data for the measures specified in Tables 7-1 and 7-2 of the MOU;

2.14.2.3.4.2. Contribute to all applicable HHSC and CMS data quality assurance processes, which shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by HHSC and rectifying those inadequacies, as directed by HHSC;

2.14.2.3.4.3. Contribute to HHSC and CMS data regarding the individual and aggregate performance of HHSC STAR+PLUS MMPs with respect to the noted measures; and

2.14.2.3.4.4. Contribute to HHSC processes culminating in the publication of any additional technical or other reports by HHSC related to the noted measures.

2.14.2.3.5. The STAR+PLUS MMP shall demonstrate how it utilizes results of the measures specified in Tables 7-1 and 7-2 in designing QI initiatives as outlined in Section 2.14.2.

2.14.2.3.6. HHSC will use a performance indicator dashboard that assembles indicators to assess the STAR+PLUS MMP's performance on measures required for all HHSC programs, that, when publicly shared, will also serve to incentivize excellence. HHSC will compile the Performance Indicator Dashboard based on STAR+PLUS MMP submissions and other data available to HHSC. HHSC will share the Performance Indicator Dashboard with the STAR+PLUS MMP on an annual basis.

2.14.2.3.7. As described in Section 2.14.3, HHSC and CMS will collaborate with each STAR+PLUS MMP to establish quality/performance improvement projects (Q/PIPs). The STAR+PLUS MMP will be committed to making its best efforts to achieve the established projects. These projects will be highly specified and measurable. The projects will reflect areas that present significant opportunities for performance improvement. Once finalized and approved by HHSC and CMS, the projects will become part of each STAR+PLUS MMP's annual plan for its QAPI Program.

2.14.2.4. Enrollee Experience Surveys:

2.14.2.4.1. The STAR+PLUS MMP shall conduct Enrollee experience survey activities, as directed by HHSC and/or CMS, as follows:

2.14.2.4.1.1. Conduct, as directed by HHSC and CMS, with an annual CAHPS survey, including the Persons with Mobility Impairment Supplemental Questions, using an approved CAHPS vendor;

2.14.2.4.1.2. Contribute, as directed by HHSC and CMS, to data quality assurance processes, including responding, in a timely manner, to data quality inadequacies identified by HHSC and CMS and rectifying those inadequacies, as directed by HHSC and CMS;

2.14.2.4.1.3. Contribute, as directed by HHSC, to processes culminating in the development of an annual report by HHSC regarding the individual and aggregate performance of STAR+PLUS MMPs; and

2.14.2.4.1.4. The STAR+PLUS MMP shall demonstrate best efforts to utilize Enrollee experience survey results in designing QI initiatives.

2.14.3. Quality/Performance Improvement Project (Q/PIP) Requirements

2.14.3.1. The STAR+PLUS MMP shall implement and adhere to all processes relating to the Q/PIP project requirements, as directed by HHSC and CMS, as follows:

2.14.3.1.1. In accordance with 42 C.F.R. §438.240 (d) and 42 C.F.R. § 422.152 (d), collect information and data in accordance with Q/PIP specifications for its Enrollees; using the format and submission guidelines specified by HHSC and CMS in annual guidance provided for the upcoming contract year;

2.14.3.1.2. On an annual basis, HHSC, in consultation with CMS and the external quality review organization, will provide the STAR+PLUS MMP with two Q/PIP topics. The STAR+PLUS MMP must develop one Q/PIP per topic. The STAR+PLUS MMP may conduct one Q/PIP in collaboration with other STAR+PLUS MMPs, participants in Delivery System Reform Incentive Payment (DSRIP) projects established under the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, or the NorthSTAR behavioral health organization (as appropriate) in the Service Area.

2.14.3.1.3. STAR+PLUS MMPs must use the following ten (10)step CMS protocol when conducting PIPs:

2.14.3.1.3.1. Select the study topic(s);

2.14.3.1.3.2. Define the study question(s);

2.14.3.1.3.3. Select the study indicator(s);

2.14.3.1.3.4. Use a representative and generalizable study population;

2.14.3.1.3.5. Use sound sampling techniques (if sampling is used);

2.14.3.1.3.6. Collect reliable data;

2.14.3.1.3.7. Implement intervention and improvement strategies;

2.14.3.1.3.8. Analyze data and interpret study results;

2.14.3.1.3.9. Plan for "real" improvement; and

2.14.3.1.3.10. Achieve sustained improvement.

2.14.3.1.4. The STAR+PLUS MMP must participate in semi-annual Contract Status Meetings (CSMs) with HHSC for the primary purpose of reviewing progress toward the achievement of Q/PIPs and Contract requirements.

2.14.3.1.5. HHSC may request additional CSMs as it deems necessary to address areas of noncompliance. HHSC will provide the STAR+PLUS MMP with reasonable advance notice of additional CSMs, generally at least five (5) business days.

2.14.3.1.6. The STAR+PLUS MMP must provide to HHSC, no later than fourteen (14) business days prior to each semi-annual CSM, an electronic report detailing the STAR+PLUS MMP's progress toward and any barriers in meeting the Q/PIPs.

2.14.3.1.7. In accordance with 42 C.F.R. §422.152 (c), develop a chronic care improvement program (CCIP) and establish criteria for participation in the program. The CCIP must be relevant to and target the STAR+PLUS MMP's population. Although the STAR+PLUS MMP has the flexibility to choose the design of their CCIPs, HHSC and CMS may require them to address specific topic areas.

2.14.3.2. CMS-Specified Performance Measurement and Performance Improvement Projects

2.14.3.2.1. The STAR+PLUS MMP shall conduct additional performance measurement if mandated by CMS pursuant to 42 C.F.R. § 438.240(a)(2).

2.14.4. External Quality Review (EQR) Activities

2.14.4.1. The STAR+PLUS MMP shall take all steps necessary to support the External Quality Review Organization (EQRO) contracted by HHSC and the QIO to conduct EQR activities, in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422.153. EQR activities shall include, but are not limited to:

2.14.4.1.1. Annual validation of performance measures reported to HHSC, as directed by HHSC, or calculated by HHSC;

2.14.4.1.2. Annual validation of quality improvement projects required by HHSC and CMS; and

2.14.4.1.3. At least once every three (3) years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart D, and at the direction of HHSC, regarding access, structure and operations, and quality of care and services furnished to Enrollees.

2.14.4.1.4. The STAR+PLUS MMP shall take all steps necessary to support the EQRO and QIO in conducting EQR activities including, but not limited to:

2.14.4.1.4.1. Designating a qualified individual to serve as project director for each EQR activity who shall, at a minimum:

2.14.4.1.4.1.1. Oversee and be accountable for compliance with all aspects of the EQR activity;

2.14.4.1.4.1.2. Coordinate with staff responsible for aspects of the EQRO activity and ensure that staff respond to requests by the EQRO, QIO, HHSC and/or CMS staff in a timely manner;

2.14.4.1.4.1.3. Serve as the liaison to the EQRO, QIO HHSC and CMS and answer questions or coordinate responses to questions from the EQRO, QIO, CMS and HHSC in a timely manner; and

2.14.4.1.4.1.4. Ensure timely access to information systems, data, and other resources, as necessary for the EQRO and/or QIO to perform the EQR activity and as requested by the EQRO, QIO, CMS or HHSC.

2.14.4.1.4.2. Maintaining data and other documentation necessary for completion of EQR activities specified above. The STAR+PLUS MMP shall maintain such documentation for a minimum of ten (10) years.

2.14.4.1.5. Participating in STAR+PLUS MMP-specific and cross-STAR+PLUS MMP meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and HHSC;

2.14.4.1.6. Implementing actions, as directed by HHSC and/or CMS, to address recommendations for QI made by the EQRO or QIO, and sharing outcomes and results of such activities with the EQRO or QIO, HHSC, and CMS in subsequent years; and

2.14.4.1.7. Participating in any other activities deemed necessary by the EQRO and/or QIO and approved by HHSC and CMS.

2.14.5. QI for Utilization Management Activities

2.14.5.1. The STAR+PLUS MMP shall utilize QI to ensure that it maintains a well-structured UM program that supports the application of fair, impartial and consistent UM determinations.

2.14.5.2. The QI activities for the UM program shall include:

2.14.5.2.1. Assurance that such UM mechanisms do not provide incentives for those responsible for conducting UM activities to deny, limit, or discontinue Medically Necessary Services;

2.14.5.2.2. At least one (1) designated senior physician, who may be a Medical Director, associate Medical Director, or other practitioner assigned to this task, at least one (1) designated Behavioral Health Service Provider, who may be a Medical Director, associate Medical Director, or other practitioner assigned to this task, and a professional with expertise in the assessment and delivery of LTSS representative of the STAR+PLUS MMP or First Tier, Downstream, and Related Entity, with substantial involvement in the UM program; and

2.14.5.2.3. A written document that delineates the structure, goals, and objectives of the UM program and that describes how the STAR+PLUS MMP utilizes QI processes to support its UM program. Such document may be included in the QI description, or in a separate document, and shall address how the UM program fits within the QI structure, including how the STAR+PLUS MMP collects UM information and uses it for QI activities.

2.14.6. Clinical Practice Guidelines

2.14.6.1. The STAR+PLUS MMP must adopt not less than two (2) evidence-based clinical practice guidelines that:

2.14.6.1.1. Are based on valid and reliable clinical evidence;

2.14.6.1.2. Consider the needs of the STAR+PLUS MMP's Enrollees;

2.14.6.1.3. Are adopted in consultation with Network Providers; and

2.14.6.1.4. Are reviewed and updated periodically, as appropriate.

2.14.6.2. Such practice guidelines must be reviewed and updated periodically, as appropriate.

2.14.6.3. The STAR+PLUS MMP must disseminate the practice guidelines to all affected Providers and, upon request, to Enrollees and Eligible Beneficiaries.

2.14.6.4. The STAR+PLUS MMP must take steps to encourage adoption of the guidelines, and to measure compliance with the guidelines, until such point that ninety (90) percent or more of the Providers are consistently in compliance, based on STAR+PLUS MMP measurement findings.

2.14.6.5. The STAR+PLUS MMP must employ substantive Provider motivational incentive strategies, such as financial and non-financial incentives, to improve Provider compliance with clinical practice guidelines.

2.14.6.6. The STAR+PLUS MMP's decisions regarding UM, Enrollee education, coverage of services, and other areas included in the practice guidelines must be consistent with the STAR+PLUS MMP's clinical practice guidelines.

2.14.7. QI Workgroups

2.14.7.1. As directed by HHSC, the STAR+PLUS MMP shall actively participate in QI workgroups that are led by HHSC, including any quality management workgroups or activities, attended by representatives of HHSC, STAR+PLUS MMPs, and other entities, as appropriate, and that are designed to support QI activities and to provide a forum for discussing relevant issues. Participation may involve contributing to QI initiatives identified and/or developed collaboratively by the workgroup.

2.14.7.2. HHSC Directed Performance Incentive Program

2.14.7.2.1. HHSC and CMS will require that the STAR+PLUS MMP meet specific performance requirements in order to receive payment of withheld amounts over the course of the Contract. These withhold measures are detailed in Section 4.4.5.

2.14.7.2.2. In order to receive any withhold payments, the STAR+PLUS MMP shall comply with all HHSC and CMS withhold measure requirements while maintaining satisfactory performance on all other Contract requirements.

2.14.7.3. Enrollee Incentives

2.14.7.3.1. The STAR+PLUS MMP may implement Enrollee incentives, as appropriate, to promote engagement in specific behaviors (e.g., guideline-recommended clinical screenings and PCP visits, Wellness Initiatives). The STAR+PLUS MMP shall:

2.14.7.3.1.1. Take measures to monitor the effectiveness of such Enrollee incentives, and to revise incentives as appropriate, with consideration of Enrollee feedback;

2.14.7.3.1.2. Ensure that incentives have a value that may be expected to affect Enrollee behavior but not exceed the value of the health related service or activity itself, consistent with the Medicare Managed Care Manual;

2.14.7.3.1.3. Submit to HHSC, at the direction of HHSC, ad hoc report information relating to planned and implemented Enrollee incentives and assure that all such Enrollee incentives comply with all applicable Medicare-Medicaid marketing guidance, as well as state and federal laws.

2.14.7.4. Behavioral Health Services Outcomes

2.14.7.4.1. The STAR+PLUS MMP must integrate behavioral health into its QAPI Program and include a systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Enrollees.

2.14.7.4.2. The STAR+PLUS MMP must collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Enrollee's overall care.

2.14.7.4.3. The STAR+PLUS MMP's Behavioral Health Service Provider Contracts shall require the Provider to make available behavioral health clinical assessment and outcomes data for quality management and network management purposes;

2.14.7.5. External Audit/Accreditation Results

2.14.7.5.1. The STAR+PLUS MMP shall inform HHSC if it is nationally accredited or if it has sought and been denied such accreditation, and submit to HHSC, at HHSC' direction, a summary of its accreditation status and the results, if any, in addition to the results of other quality-related external audits, if any.

2.14.7.6. Health Information System

2.14.7.6.1. The STAR+PLUS MMP shall maintain a health information system or systems consistent with the requirements established in the Contract and that supports all aspects of the QI Program.

2.14.8. Evaluation Activities

2.14.8.1. The STAR+PLUS MMP will collaborate with HHSC's EQRO to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The purpose of the studies,

surveys, or other analytical approaches is to assess the quality of care and service provided to Enrollees and to identify opportunities for STAR+PLUS MMP improvement.

2.14.8.2. HHSC, CMS, and its designated agent(s) will conduct periodic evaluations of the Demonstration over time from multiple perspectives using both quantitative and qualitative methods. These evaluations and methods may include the following as required by 42 C.F.R. § 438.364 and § 438.358:

2.14.8.2.1. Review and evaluation of MMP QAPI programs.

2.14.8.2.2. Review and evaluation of MMP performance improvement projects.

2.14.8.2.3. Encounter data certification and validation.

2.14.8.2.4. Conduct STAR+PLUS MMP administrative interviews, including telephonic and on-site interviews to assess the following domains:

2.14.8.2.4.1. Organizational structure,

2.14.8.2.4.2. Service Coordination and Disease Management programs,

2.14.8.2.4.3. Utilization and referral management,

2.14.8.2.4.4. Provider Network and contractual relationships,

2.14.8.2.4.5. Provider reimbursement and incentives,

2.14.8.2.4.6. Enrollment and Enrollee rights and Grievance and Appeals procedures, and

2.14.8.2.4.7. Data acquisition and health information management.

2.14.8.2.5. Collection of data to measure MMP performance using the following nationally recognized methods:

2.14.8.2.5.1. NCQA Healthcare Effectiveness Data and Information Set (HEDIS); and

2.14.8.2.5.2. Agency for Healthcare Research and Quality Pediatric Quality Indicators /Prevention Quality Indicators.

2.14.8.3. The evaluations will be used for program improvement purposes and to assess the Demonstration's overall impact on various outcomes including (but not limited to) Enrollment/disenrollment patterns, beneficiary access and quality of care experiences, utilization and costs by service type (e.g., inpatient, outpatient, home health, prescription drugs, nursing facility, and home and community based waiver), and program staff and Provider experiences.

2.14.8.4. As such, the evaluations will include surveys, site visits, analysis of Claims and encounter data, key informant interviews, and document reviews. The STAR+PLUS MMP shall participate in evaluation activities as directed by CMS and/or HHSC and provide information or data upon request.

2.15. Marketing, Outreach, and Member Materials Standards

2.15.1. General

2.15.1.1. The STAR+PLUS MMP is subject to rules governing marketing and Member Materials as specified under Section 1851(h) of the Social Security Act; 42 CFR § 422.111, § 422.2260 et. seq., § 423.120(b) and (c), § 423.128, and § 423.2260 et. seq.; and the Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual), with the following exceptions or modifications:

2.15.1.1.1. The STAR+PLUS MMP must refer to HHSC' Administrative Services Contractor and Eligible Beneficiaries who inquire about Demonstration eligibility or Enrollment, although the STAR+PLUS MMP may provide Enrollees and Potential Enrollees with factual information about the STAR+PLUS MMP's plan and its benefits prior to referring a request regarding eligibility or Enrollment to the HHSC Administrative Services Contractor;

2.15.1.1.2. The STAR+PLUS MMP must make available to CMS and HHSC, upon request, current schedules of all educational events conducted by the STAR+PLUS MMP to provide information to Enrollees or Potential Enrollees;

2.15.1.1.3. The STAR+PLUS MMP must convene all educational and marketing/sales events at sites within the STAR+PLUS MMP's Service Area that are physically accessible to all Enrollees or Potential Enrollees, including persons with disabilities and persons using public transportation.

2.15.1.1.4. The STAR+PLUS MMP may not offer financial or other incentives, including private insurance, to induce Enrollees or Eligible Beneficiaries to enroll with the STAR+PLUS MMP or to refer a friend, neighbor, or other person to enroll with the STAR+PLUS MMP;

2.15.1.1.5. The STAR+PLUS MMP may not directly or indirectly conduct door-to-door, telephone, or other unsolicited contacts;

2.15.1.1.6. The STAR+PLUS MMP's sales agents are not permitted to conduct unsolicited, individual, in-person appointments. The STAR+PLUS MMP may provide responses to Enrollee-initiated requests for information and/or Enrollment. To the extent a STAR+PLUS MMP offers individual appointments, they must be staffed by trained customer service representatives;

2.15.1.1.7. STAR+PLUS MMP may participate in group marketing events and provide general audience materials (such as general circulation brochures, and media and billboard advertisements).

2.15.1.1.8. The STAR+PLUS MMP may not use any marketing, outreach, or Member Materials that contain any assertion or statement (whether written or oral) that:

2.15.1.1.8.1. The Enrollee or Potential Enrollee must enroll with the STAR+PLUS MMP in order to obtain benefits or in order not to lose benefits; and

2.15.1.1.8.2. The STAR+PLUS MMP is endorsed by CMS, Medicare, Medicaid, the Federal government, HHSC or similar entity.

2.15.1.2. The STAR+PLUS MMP's Marketing, Outreach, and Member Materials must be:

2.15.1.2.1. Made available in Alternative Formats, upon request and as needed to assure effective communication for blind and vision-impaired Enrollees;

2.15.1.2.2. Provided in a manner, format, and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments;

2.15.1.2.3. Translated into Prevalent Languages for all written vital materials, as specified in the Medicare-Medicaid Marketing Guidelines and annual guidance to STAR+PLUS MMPs on specific translation requirements for their service areas;

2.15.1.2.4. Mailed with a multi-language insert that indicates that the Enrollee can access free interpreter services to answer any questions about the plan. This message shall be written in the languages required in the Medicare Marketing Guidelines provisions on the multi-language insert and any Prevalent Languages.

2.15.1.2.5. Distributed to the STAR+PLUS MMP's entire Service Area as specified in Appendix H of this Contract.

2.15.2. Requirements for the Submission, Review, and Approval of Materials

2.15.2.1. The STAR+PLUS MMP must receive prior approval of all marketing and Member Materials in categories of materials that CMS and HHSC require to be prospectively reviewed. Review timelines for STAR+PLUS MMP Member Materials will follow those as outlined in the Medicare Marketing Guidelines. CMS and HHSC may agree to defer to one or the other party for review of certain types of marketing and Member Materials, as agreed in advance by both parties. STAR+PLUS MMPs must submit all materials that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.

2.15.2.2. CMS and HHSC may conduct additional types of review of STAR+PLUS MMP marketing, outreach, and Enrollee Communications activities, including, but not limited to:

2.15.2.2.1. Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.

2.15.2.2.2. Random review of actual marketing, outreach, and Member Materials pieces as they are used in the marketplace.

2.15.2.2.3. "For cause" review of materials and activities when complaints are made by any source, and CMS or HHSC determine it is appropriate to investigate.

2.15.2.2.4. "Secret shopper" activities where CMS or HHSC request STAR+PLUS MMP materials, such as Enrollment packets.

2.15.3. Beginning of Marketing, Outreach, and Member Materials Activity

2.15.3.1. The STAR+PLUS MMP may not begin Marketing, Outreach, and Member Materials activities to new Enrollees more than ninety (90) days prior to the effective date of Enrollment for the Contract year.

2.15.3.2. In addition, for the first year of the Demonstration, the STAR+PLUS MMP may not begin marketing activity until the STAR+PLUS MMP has entered into this Contract, passed the joint CMS-Texas Readiness Review, and is connected to CMS Enrollment and payment systems such that the STAR+PLUS MMP is able to receive payment and Enrollments.

2.15.4. Requirements for Dissemination of Member Materials

2.15.4.1. Member Materials sent upon Enrollment

2.15.4.1.1. For Passive Enrollments, the STAR+PLUS MMP shall send the following materials for Enrollee receipt thirty (30) days prior to the Enrollee's effective date of coverage:

2.15.4.1.1.1. A STAR+PLUS MMP-specific Summary of Benefits for those offered Passive Enrollment (this document is not required for opt-in Enrollments). The Summary of Benefits is considered marketing material normally provided prior to the individual making an Enrollment request. Providing the Summary of Benefits ensures that those who are offered Passive Enrollment have a similar scope of information as those who voluntarily enroll.

2.15.4.1.1.2. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the STAR+PLUS MMP.

2.15.4.1.1.3. A combined Provider and Pharmacy Directory that includes all Providers of Medicare, Medicaid, and Flexible Benefits and is consistent with the requirements in Section 2.8, or a separate notice on how to access this information online and how to request a hard copy, as well as information on how to request a copy in Alternate Formats.

2.15.4.1.1.4. Proof of health insurance coverage so that the Enrollee may begin using STAR+PLUS MMP services as of the effective date. This proof must include the 4Rx prescription drug data necessary to access benefits.

2.15.4.1.1.4.1. NOTE: This proof of coverage is not the same as the Evidence of Coverage (EOC) document described in the State-specific Demonstration Marketing Guidelines. The proof of coverage may be in the form of an Enrollee ID card, the Enrollment form, and/or a notice to the Enrollee. As of the effective date of Enrollment, the STAR+PLUS MMP's systems should indicate active membership.

2.15.4.1.2. For Passive Enrollment, the STAR+PLUS MMP must send the following for Enrollee receipt no later than the last calendar day of the month prior to the effective date of coverage:

2.15.4.1.2.1. A single ID card for accessing all Covered Services under the STAR+PLUS MMP; and

2.15.4.1.2.2. A Member Handbook to ensure that the individual has sufficient information about STAR+PLUS MMP benefits to make an informed decision prior to the Enrollment effective date.

2.15.4.1.3. For the individuals who opt into the Demonstration, the STAR+PLUS MMP shall send the following materials for Enrollee receipt no later than ten (10) calendar days from receipt of CMS confirmation of Enrollment or by the last calendar day of the month prior to the effective date, whichever occurs later:

2.15.4.1.3.1. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the STAR+PLUS MMP;

2.15.4.1.3.2. A combined Provider and Pharmacy Directory that includes all Providers of Medicare, Medicaid, and Flexible Benefits and is consistent with the requirements in Section 2.8, or a separate notice on how to access this information online and how to request a hard copy, as well as information onhow to request a copy in Alternate Formats;

2.15.4.1.3.3. A single ID card for accessing all Covered Services under the STAR+PLUS MMP; and

2.15.4.1.3.4. A Member Handbook.

2.15.4.1.3.4.1. NOTE: For opt-in Enrollment requests received late in the month, see §30.4.2 of the Enrollment guidance (After the effective date of Enrollment) for more information.

2.15.4.1.4. For all Enrollments, regardless of how the Enrollment request is made, the STAR+PLUS MMP must explain:

2.15.4.1.4.1. The charges for which the prospective Enrollee will be liable (e.g., LIS copayments for Part D covered drugs), if this information is available at the time the acknowledgement notice is issued (confirmation notices and combination acknowledgement/confirmation notices must contain this information).

2.15.4.1.4.2. For Passive Enrollment, if the individual does not decline Passive Enrollment, that is considered to be the required acknowledgement. There is potential for financial liability if it is found that the individual is not entitled to Medicare Part A and Part B and enrolled in Medicaid at the time coverage begins and he/she has used plan services after the effective date.

2.15.4.1.4.3. The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the STAR+PLUS MMP has not yet provided the ID card).

2.15.4.2. After the Effective Date of Enrollment

2.15.4.2.1. CMS recognizes that in some instances HHSC, or its Administrative Services Contractor, will be unable to provide the materials and required notifications to new Enrollees prior to the effective date, as required in §30.4.1 of the Enrollment Guidance. These cases will generally occur when a voluntary Enrollment request is received late in a month with an effective date of the first of the next month. In these cases, HHSC still must provide the Enrollee all materials described in §30.4.1 of the Enrollment Guidance no later than ten (10) calendar days after receipt of the completed Enrollment request.

2.15.4.2.2. Additionally, the STAR+PLUS MMP is also strongly encouraged to call these new Enrollees as soon as possible (within one to three calendar days of receiving the Enrollment transaction) to inform the Enrollee of the effective date of coverage, provide information necessary to access benefits, and to explain the STAR+PLUS MMP rules. The Enrollee's coverage will be active on the effective date regardless of whether or not the Enrollee has received all the information by the effective date. It is expected that all of the items outlined in §30.4.1 of the Enrollment Guidance will be sent prior to the effective date for Passive Enrollment.

2.15.4.3. Member Materials sent annually

2.15.4.3.1. Consistent with the timelines specified in the Medicare-Medicaid marketing guidance, the STAR+PLUS MMP must provide Enrollees with the following materials, which, with the exception of ID card, must also be provided annually thereafter:

2.15.4.3.1.1. A Member Handbook document that is consistent with the requirements at 42 C.F.R. §§ 438.10, 422.111, and 423.128, that uses the model document developed by CMS and HHSC, and includes information about all Covered Services, as outlined below:

2.15.4.3.1.1.1. An explanation of the Enrollee Medical Record and the process by which clinical information, including diagnostic and medication information, will be available to key caregivers;

2.15.4.3.1.1.2. How to obtain a copy of the Enrollee's Enrollee Medical Record;

2.15.4.3.1.1.3. How to obtain access to specialty, behavioral health, pharmacy and LTSS Providers;

2.15.4.3.1.1.4. How to obtain services and prescription drugs for Emergency Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:

2.15.4.3.1.1.4. 1. What constitutes Emergency Medical Condition, emergency services, and Post-Stabilization Services, with reference to the definitions is 42 C.F.R. §438.114(a);

2.15.4.3.1.1.4. 2. The fact that prior authorization is not required for Emergency Services;

2.15.4.3.1.1.4. 3. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent;

2.15.4.3.1.1.4. 4. The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered under the Contract;

2.15.4.3.1.1.4. 5. That the Enrollee has a right to use any hospital or other setting for emergency care; and

2.15.4.3.1.1.4. 6. The Post-stabilization Care Services rules at 42 C.F.R. §422.113(c).

2.15.4.3.1.1.5. Information about advance directives (at a minimum those required in 42 C.F.R. §§ 489.102 and 422.128), including:

2.15.4.3.1.1.5. 1. Enrollee rights under the law of the State of Texas and as outlined in Appendix B of this Contract;

2.15.4.3.1.1.5. 2. The STAR+PLUS MMP's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;

2.15.4.3.1.1.5. 3. That Grievances concerning noncompliance with the advance directive requirements may be filed with HHSC or CMS;

2.15.4.3.1.1.5. 4. Designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desires of the Enrollee;

2.15.4.3.1.1.5. 5. The STAR+PLUS MMP must update materials to reflect any changes in state law as soon as possible, but no later than ninety (90) days after the effective date of change;

2.15.4.3.1.1.5. 6. Enrollee's right to self-determination in making health care decisions;

2.15.4.3.1.1.5. 7. The Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:

i. Enrollee'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;

ii. Enrollee's right to make written and non-written out-of-Hospital do-not-resuscitate (DNR) orders;

iii. Enrollee's right to execute a Medical Power of Attorney to appoint an agent to make health care decisions on the Enrollee's behalf if the Enrollee becomes incompetent; and

iv. Chapter 137, Texas Civil Practice and Remedies Code, which includes an Enrollee's right to execute a Declaration

for Mental Health Treatment in a document making a declaration of preferences or instructions regarding mental health treatment.

2.15.4.3.1.1.6. How to obtain assistance from customer service representatives;

2.15.4.3.1.1.7. How to file Grievances and internal and external Appeals, including:

2.15.4.3.1.1.8. Grievance, Appeal, and Fair Hearing procedures and timeframes;

2.15.4.3.1.1.9. Toll free numbers that the Enrollee can use to file a Grievance or an Appeal by phone for expedited external Appeals only (only expedited Appeals may be received telephonically for external Appeals through the Fair Hearing process);

2.15.4.3.1.1.10. That when requested by the Enrollee, benefits will continue at the plan level for all benefits, and if the Enrollee files an Appeal or a request for Fair Hearing within the timeframes specified for filing; and

2.15.4.3.1.1.11. How the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;

2.15.4.3.1.1.12. How to obtain assistance with the Appeals processes through the customer service representative and other assistance mechanisms as HHSC or CMS may identify, including an Ombudsman;

2.15.4.3.1.1.13. The extent to which, and how Enrollees may obtain benefits, including family planning services, from Out-of-Network Providers;

2.15.4.3.1.1.14. How and where to access any benefits that are available under the Texas Medicaid State Plan or applicable waivers but are not covered under the Contract;

2.15.4.3.1.1.15. How to change Providers; and

2.15.4.3.1.1.16. How to disenroll voluntarily.

2.15.4.3.1.2. A Summary of Benefits (SB);

2.15.4.3.1.3. A combined Provider and Pharmacy Directory, or a separate notice on how to access this information online and how to request a hard copy;

2.15.4.3.1.4. An ID card;

2.15.4.3.1.5. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and HHSC' outpatient prescription drug benefit and that uses the model document developed by CMS and HHSC;

2.15.4.3.1.6. The procedures for an Enrollee to change STAR+PLUS MMPs or to Opt-Out of the Demonstration; and

2.15.4.3.1.7. An Annual Notice of Change (ANOC).

2.15.4.4. The STAR+PLUS MMP must provide all Medicare Part D required notices, with the exception of the late Enrollment penalty notices and the creditable coverage notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the late LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual.

2.15.4.4.1. Consistent with the requirement at 42 C.F.R. § 423.120(b)(5), the STAR+PLUS MMP must provide Enrollees with at least sixty (60) days advance notice regarding changes to Part D drugs on the comprehensive, integrated formulary.

2.15.4.4.2. The STAR+PLUS MMP must ensure that all information provided to Enrollees and Potential Enrollees (and families when appropriate) is provided in a manner and format that is easily understood and that is:

2.15.4.4.2.1. Made available in large print (at least sixteen (16) point font) to Enrollees as an Alternative Format, upon request;

2.15.4.4.2.2. For vital materials, available in Prevalent Languages, as provided for in the Medicare-Medicaid marketing guidance.

2.15.4.4.2.3. Written with cultural sensitivity and at or below a 6th grade reading level; and

2.15.4.4.2.4. Available in Alternative Formats, according to the needs of Enrollees and Potential Enrollees, including Braille, oral interpretation services in non-English languages, as specified in Section 2.15.4.4.2.2 of this Contract; audiotape; ASL video clips, and other alternative media, as requested.

2.15.5. Requirements for the Provider and Pharmacy Network Directory

2.15.5.1. Maintenance and Distribution – The STAR+PLUS MMP's Provider and Pharmacy Network Directory must:

2.15.5.1.1. Be approved by HHSC and/or CMS prior to publication and distribution, with the exception of PCP information changes or clerical corrections. The STAR+PLUS MMP is responsible for submitting draft Provider Directory updates to HHSC and/or CMS for prior review and approval.

2.15.5.1.2. Maintain a combined Provider and Pharmacy Network Directory that uses the model document developed by CMS and HHSC;

2.15.5.1.3. Provide either a print copy or a separate notice about how to access this information online or request a hard copy, as specified in the Marketing Guidance and Medicare-Medicaid marketing guidance, to all new Enrollees at the time of Enrollment and annually thereafter;

2.15.5.1.4. When there is a significant change to the network, the STAR+PLUS MMP must send a special mailing to Enrolle\es, as specified in the Marketing Guidance and Medicare-Medicaid marketing guidance;

2.15.5.1.5. Ensure an up-to-date version is available on the STAR+PLUS MMP's website, consistent with the requirements at 42 C.F.R. §§ 422.111(h) and 423.128(d) and the Marketing Guidance;

2.15.5.1.6. Consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice of termination of a contracted Provider or pharmacy at least thirty (30) calendar days before when practicable but no later than fifteen (15) days after the termination effective date to all Enrollees who regularly use the Provider or pharmacy's services; if a contract termination involves a primary care professional, all Enrollees who are patients of that primary care professional must be notified;

2.15.5.1.7. Include written and oral offers of such Provider and Pharmacy Directory in its outreach and orientation sessions for new Enrollees as well as at least annually for current Enrollees; and

2.15.5.1.8. Be updated as frequently as indicated in the STAR+PLUS MMP marketing guidance. The STAR+PLUS MMP must make such updates available to existing Enrollees on request.

2.15.5.2. Content of Provider and Pharmacy Directory – The Provider and Pharmacy Directory must include, at a minimum, the following information for all Providers in the STAR+PLUS MMP's Provider Network:

2.15.5.2.1. The names, addresses, and telephone numbers of all current network Providers, and the total number of each type of Provider, consistent with 42 C.F.R. § 422.111(h).;

2.15.5.2.2. As applicable, network Providers with training in and experience treating:

2.15.5.2.2.1. Persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with serious mental illness;

2.15.5.2.2.2. Individuals who are homeless;

2.15.5.2.2.3. Individuals who are Deaf or hard-of-hearing and blind or visually impaired;

2.15.5.2.2.4. Persons with co-occurring disorders; and

2.15.5.2.2.5. Other specialties.

2.15.5.2.3. For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based Network Providers, office hours, including the names of any Network Provider sites open after 5:00 p.m. (Central Time) weekdays and on weekends;

2.15.5.2.4. As applicable, whether the health care professional or non-facility based Network Provider has completed cultural competence training;

2.15.5.2.5. For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based Network Providers licensing information, such as license number or National Provider Identifier;

2.15.5.2.6. Whether the Network Provider has specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment;

2.15.5.2.7. Whether the Provider is accepting new patients as of the date of publication of the directory;

2.15.5.2.8. Whether the Network Provider is on a public transportation route;

2.15.5.2.9. Any languages other than English, including ASL, spoken by Network Providers or offered by skilled medical interpreters at the Provider's site;

2.15.5.2.10. As applicable, whether the Network Provider has access to language line interpreters;

2.15.5.2.11. For Behavioral Health Service Providers, training in and experience treating trauma, child welfare, and substance use;

2.15.5.2.12. A description of the roles of the Service Coordination Team and the process by which Enrollees select and change PCPs.

2.15.5.2.13. The directory must include, at a minimum, the following information for all pharmacies in the STAR+PLUS MMP's Pharmacy Network:

2.15.5.2.13.1. The names, addresses, and telephone numbers of all current Network Providers and pharmacies; and

2.15.5.2.13.2. Instructions for the Enrollee to contact the STAR+PLUS MMP's toll-free Enrollee Services telephone line (as described in Section 2.9.1) for assistance in finding a convenient pharmacy.

2.15.5.3. The Provider Directory must comply with the requirements of 28 T.A.C. §11.1600(b)(11), relating to the disclosure and notice of limited Provider Networks.

2.16. Financial Requirements

2.16.1. Financial Viability

2.16.1.1. Consistent with Section 1903 (m) of the Social Security Act, and regulations found at 42 C.F.R. § 422.402], and 42 C.F.R. § 438.116, the STAR+PLUS MMP shall meet all state and federal financial soundness requirements. These include:

2.16.1.1.1. The STAR+PLUS MMP must produce adequate documentation satisfying HHSC that it has met its solvency requirements per TDI.

2.16.1.1.2. The STAR+PLUS MMP must maintain reserves to remain solvent for a 45-day period, as may be specified and required by TDI, and if so required, provide satisfactory evidence to TDI of such reserves.

2.16.1.1.3. Corporate guarantee – The STAR+PLUS MMP must also include a statement that the STAR+PLUS MMP's ultimate parent organization will unconditionally guarantee performance by the STAR+PLUS MMP of each and every obligation, warranty, covenant, term, and condition of the Contract. This guarantee is not required for any STAR+PLUS MMPs owned by political subdivisions of the State (e.g., hospital districts).

2.16.2. Federal review of financial soundness – The STAR+PLUS MMP must submit a copy to HHSC of its required federal Health Plan Management System (HPMS) Fiscal Soundness Module (FSM), as may be required by and submitted to CMS.

2.16.3. Financial Statistical Reports

2.16.3.1. The STAR+PLUS MMP must submit Financial Statistical Reports (FSRs) that include revenue, cost, and other data broken out for Demonstration Enrollees separate from individuals served by other Texas Medicaid programs. The FSR will be designed by HHSC, and will be initially based on, and developed from, STAR+PLUS MCO FSRs. The FSR will be submitted quarterly, and done on a State Fiscal Year basis, and are generally audited every year. The period measured is not always a full twelve months. For example, for the first and last Demonstration Years under this Contract, the State Fiscal Year measured on the FSR will be the applicable portion of the SFY (i.e., from the Contract commencement date through August 31st; and at the end, from September 1st through the Contract termination date). Not all incurred costs are allowable for inclusion in the FSR; reporting is subject to the HHSC Cost Principles.

2.16.3.2. The STAR+PLUS MMP must file quarterly and SFY FSRs in the format, timeframe and per the instructions specified in the HHSC UMCM Chapter 5.3, “FSR and Instructions.” The STAR+PLUS MMP must incorporate financial and statistical data of delegated Networks (e.g., IPAs, limited Provider Networks), if any, in its FSRs. Administrative, subcontract, Affiliate, and other expenses reported in the FSRs must be reported in accordance with UMCM Chapter 6.1, “Cost Principles for Expenses.” Quarterly FSRs are due no later than thirty (30) days after the end of the quarter and must provide information by month for the current quarter and SFYtodate information through the end of the current quarter. The first annual FSR (the "90-day FSR") for a given SFY must reflect expenses incurred through the 90th day after the end of the SFY. This first annual report must be filed on or before the 120th day after the end of each SFY. Subsequent annual reports for each SFY (the "334-day FSR") must reflect data completed through the 334th day after the end of each SFY, and must be filed on or before the 365th day following the end of each SFY.

2.16.4. Annual audit of the FSR

2.16.4.1. The STAR+PLUS MMP agrees to pay for all reasonable costs incurred by HHSC to perform an examination, review or audit of the STAR+PLUS MMP’s books and records relating to this Contract. The STAR+PLUS MMP must provide, and cause its subcontractors to provide, at no cost, adequate access to any records that are related to the scope of this Contract.The access required must be provided to HHSC and to any independent

verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC.

2.16.4.2. At the discretion of HHSC, HHSC or its agent may audit the Financial Statistical Reports submitted by the STAR+PLUS MMP to HHSC. Generally, an FSR audit is done once a year, shortly after the submission of the 334-day FSR. Generally, HHSC engages a professional external audit firm to conduct an Agreed-Upon Procedures audit. This audit firm bills HHSC for the audit, and HHSC in turn communicates the cost of the audit to the STAR+PLUS MMP. The STAR+PLUS MMP must pay the billed amount to HHSC. Any such amount not paid is subject to interest, at the same rate as established for the Experience Rebate. Any such amount not paid within 30 days of notification, including any corresponding unpaid interest, may be withheld from a future Capitation Payment.

2.16.5. Other Financial Requirements

2.16.5.1. Annual audited financial statements – The STAR+PLUS MMP must submit to HHSC, during each SFY during the term of this Contract:

2.16.5.1.1. A set of externally audited financial statements of the legal entity of the STAR+PLUS MMP itself, including all business conducted by the STAR+PLUS MMP (not limited to the financial impacts of this Contract); and,

2.16.5.1.2. A set of audited financial statements of the legal entity that represents the ultimate parent / owner of the STAR+PLUS MMP.

2.16.5.1.3. In each case in Sections 2.16.4.1.1 and 2.16.4.1.2, the financial statements may be based on the fiscal year of the entity being audited. In each case, the full set of audited statements must be submitted, including the auditor's letter (signed, and on letterhead), audit notes, and any corresponding analysis or commentary. These audited statements are due to HHSC within ten calendar days of being signed by the external audit firm that was engaged by the entity. If the financial statements are not delivered by the STAR+PLUS MMP to HHSC within 120 calendar days of the end of the entity's fiscal year, the STAR+PLUS MMP must:

2.16.5.1.3.1. Advise HHSC in writing (by no later than 120 calendar days of the end of the entity's fiscal year) the anticipated date of the delivery of the statements;

2.16.5.1.3.2. Immediately furnish an unaudited set of statements as an interim measure; and,

2.16.5.1.3.3. Explain the nature of the delay. Any delay beyond 120 days from the end of the STAR+PLUS MMP's fiscal year for the statements pertaining to the STAR+PLUS MMP itself may be subject to liquidated damages.

2.16.5.1.4. If the legal entity of the STAR+PLUS MMP has not completed its first fiscal year as of the end of the first State Fiscal Year, then the requirement for the STAR+PLUS MMP financial statements will commence with the conclusion of the STAR+PLUS MMP's first fiscal year.

2.16.5.2. TDI Filings, Registration Statements, and Examination Reports – The STAR+PLUS MMP must submit searchable electronic file copies to HHSC of documents filed with TDI that specifically relate to the legal entity of the STAR+PLUS MMP, as well as any document produced by TDI regarding the STAR+PLUS MMP, within ten calendar days of the filing of the document. These include:

2.16.5.2.1. TDI Filings — any TDI filings, including, without limitation, annual figures for controlled risk-based capital, and quarterly financial statements. The annual financial statement must include all schedules, attachments, supplements, management discussion, analysis, and actuarial opinions.

2.16.5.2.2. Registration Statement (also known as the "Form B") — If the STAR+PLUS MMP is a part of an insurance holding company system, the STAR+PLUS MMP 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. The complete Form B must be submitted to HHSC even if the initial complete version was filed with TDI prior to the commencement of this Contract.

2.16.5.2.3. TDI Examination Report — As applicable, the STAR+PLUS MMP 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 by the STAR+PLUS MMP of the final report from TDI.

2.16.5.3. Claims Lag Report - The STAR+PLUS MMP must submit a Claims Lag Report as a SFY year-to-date report. The report must be submitted quarterly by the last day of the month following the reporting period. The report must be submitted to HHSC in a format specified by HHSC. The report must disclose the amount of incurred claims each month and the amount paid each month.

2.16.5.4. Third Party Recovery (TPR) Reports - The STAR+PLUS MMP must file quarterly TPR Reports in accordance with the format developed by HHSC in the Uniform Managed Care Manual. TPR reports must include total dollars recovered from third party payors for services to the STAR+PLUS MMP's Members, and the total dollars recovered through coordination of benefits, subrogation, and worker's compensation.

2.16.5.5. Employee Bonus and Incentive Payment Plan – If an MMP intends to include employee bonus or incentive payments as allowable administrative expenses, the STAR+PLUS MMP must furnish a written Employee Bonus or Incentive Payments Plan to HHSC so it may determine whether the payments are allowable administrative expenses in accordance with the HHSC Cost Principles. The written plan must include a description of the criteria for establishing bonus or incentive payments, the methodology to calculate bonus or incentive payments, and the timing of bonus or incentive payments. The Bonus or Incentive Payment Plan and description must be submitted to HHSC no later than 30 days after the Effective Date of the Contract and any Contract renewal. If the STAR+PLUS MMP substantively revises the Employee Bonus or Incentive Payment Plan, the STAR+PLUS MMP must submit the revised plan to HHSC for prior review. HHSC reserves the right to deny or disapprove all or part of the Plan.

2.16.5.6. Certain other HHSC reports – If the STAR+PLUS MMP: a) is Affiliated with an MCO that contracts with HHSC for other Medicaid managed care programs in Texas; and b) if that MCO submits the following reports on a timely and complete basis; and, c) if the reports comprehensively include the

STAR+PLUS MMP thereunder; then, the STAR+PLUS MMP is not required to submit these reports separately hereunder. Otherwise, the following reports are due to HHSC, as described in the HHSC Uniform Managed Care Manual:

2.16.5.6.1. Disclosure Statement – by September 1st each year, with an additional change notification abbreviated version within 30 days after the occurance of certain specfied events. Reference: http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp5/5_3_2.doc

2.16.5.6.2. Affiliate Report – by September 1st each year, and also on an as-occurs basis, due within 30 days of the event triggering the change. (http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp5/5-11.pdf).

2.16.5.6.3. Report of Legal and Other Proceedings and Related Events — by September 1st each year, and also on an as-occurs basis, due no later than 30 days after the event that triggered the notification requirement. Reference: http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp5/5_8.pdf

2.16.5.7. Other existing reports – To the extent that any of the following are appplicable to the STAR+PLUS MMP, the STAR+PLUS MMP must submit: a) the most recent existing version prior to the Operational Start Date; and, b) new versions as they are issued. These should be submitted in searchable electronic file form, within ten calendar days of issuance. If an item below is not applicable, state this affirmatively.

2.16.5.7.1. SEC Form 10-K and 10-Q – If the STAR+PLUS MMP or its ultimate parent is a publicly-traded (stock-exchange-listed) corporation, then submit a link (via EDGAR) to the most recent United States Securities and Exchange Commission (SEC) Form 10-K Annual Report, and the most-recent 10-Q Quarterly report. Note that in this one specific requirement we are not requesting the file; just a link to it.

2.16.5.7.2. IRS Form 990 – If the STAR+PLUS MMP and/or its ultimate parent is a non-profit entity, then submit the most recent annual Internal Revenue Service (IRS) Form 990 filing(s) (for each entity, as may be applicable), complete with all attachments or schedules. If the STAR+PLUS MMP or its ultimate parent is a non-profit entity that is exempt from the IRS 990 filing requirement, demonstrate this and explain the nature of the exemption.

2.16.5.7.3. Non-Profit Entities – If the STAR+PLUS MMP is a non-profit entity that is a component or subsidiary of a County Hospital District, or otherwise a political subdivision or entity of a government, then submit the most recent annual governmental financial statements as prepared under the relevant rules or statutes governing annual financial reporting and disclosure for the STAR+PLUS MMP, including all attachments, schedules, and supplements.

2.16.5.7.4. Bond or debt rating analysis – If the STAR+PLUS MMP (or its ultimate parent) is, becomes, or has been in the prior three years, the subject of any bond rating analysis, ratings affirmation, write-up, or related report, such as by AM Best, Fitch Ratings, Moody's, Standard & Poor, submit the most-recent detailed report from each rating entity that has produced a report.

2.16.5.7.5. Annual Report – If the STAR+PLUS MMP produces any written (including web-based) "annual report" or similar item that is in addition to the above-referenced documents, submit the most recent version. This might be a yearly report or letter to shareholders, the community, regulators, lenders, customers, employees, the STAR+PLUS MMP's owner, or other constituents.

2.16.5.7.6. Press Releases – If the STAR+PLUS MMP has issued any press releases in the 12 months prior to the Operational Start Date, or during the term of this Contract, and the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues, provide a copy of each press release. HHSC does not wish to receive other types of press releases that are primarily promotional in nature.

2.16.5.8. CMS Plan Payment Report (PPR) -- At HHSC's request, the STAR+PLUS MMP must submit a copy to HHSC of each monthly PPR pertaining to the duals demonstration that the STAR+PLUS MMP has received from CMS.

2.17. Data Submissions, Reporting Requirements, and Survey

2.17.1. General Requirements for Data

2.17.1.1. The STAR+PLUS MMP must provide and require its First Tier, Downstream, or Related Entities to provide:

2.17.1.1.1. All information CMS and HHSC require under the Contract related to the performance of the STAR+PLUS MMP's responsibilities, including non-medical information for the purposes of research and evaluation;

2.17.1.1.2. Any information CMS and HHSC require to comply with all applicable federal or State laws and regulations; and

2.17.1.1.3. Any information CMS or HHSC require for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Complaints and Appeals and Enrollment/disenrollment rates.

2.17.2. General Reporting Requirements

2.17.2.1. The STAR+PLUS MMP must:

2.17.2.1.1. Submit to HHSC applicable Texas reporting requirements in compliance with the STAR PLUS program;

2.17.2.1.2. Submit to CMS applicable Medicare reporting requirements in compliance with 42 C.F.R. §§ 422.516,. 423.514, and 438 et. seq.

2.17.2.1.3. Submit to CMS and HHSC all applicable Demonstration reporting requirements;

2.17.2.1.4. Submit to CMS and HHSC all required reports and data in accordance with the specifications, templates and time frames described in this Contract;

2.17.2.1.5. Report HEDIS, HOS, and CAHPS data, as well as measures related to LTSS. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS, plus additional Medicaid measures required by HHSC. All existing Part D metrics will be collected as well. Such measures shall include a combined set of core measures that the STAR+PLUS MMP must report to CMS and HHSC;

2.17.2.1.6. Upon request, submit to CMS and HHSC any internal reports that the STAR+PLUS MMP uses for internal management. Such reports shall include, but not be limited to, internal reports that analyze the medical/loss ratio, financial stability, or other areas where standard compliance reports indicate a problem in performance;

2.17.2.1.7. Pursuant to 42 C.F.R. § 438.6(f)(2)(ii), comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by HHSC; and

2.17.2.1.8. Provide to CMS and HHSC, in a form and format approved by CMS and HHSC and in accordance with the timeframes established by CMS and HHSC, all reports, data or other information CMS and HHSC determine are necessary for compliance with provisions of the Affordable Care Act of 2010, Subtitle F, Medicaid Prescription Drug Coverage, and applicable implementing regulations and interpretive guidance.

2.17.2.1.9. Submit at the request of CMS or HHSC additional ad hoc or periodic reports or analyses of data related to the Contract.

2.17.2.2. Material Subcontractor reporting requirements – The STAR+PLUS MMP shall provide a list of all Material Subcontractors and list the Material Subcontractors in descending order of estimated payments per year by the STAR+PLUS MMP to the Material Subcontractor, with respect to costs incurred under this Contract. Show the estimated annual payments to each for the forthcoming State Fiscal Year. Provide an updated such list each year by September 1st.

2.17.2.3. The STAR+PLUS MMP shall provide a copy of the contract between the STAR+PLUS MMP and each Material Subcontractor. Provide updated copies for any changes,

renewals, extensions, etc., including pricing changes; provide such updates within ten (10) calendar days of the execution of the contract.

2.17.2.4. Prior to the Operational Start Date, the STAR+PLUS MMP shall provide the following, separately, for each Material Subcontractor:

2.17.2.4.1. The Material Subcontractor's legal name, trade name, acronym, d.b.a., and any other name under which the Material Subcontractor does business.

2.17.2.4.2. The MMP's estimated annual payments to the Material Subcontractor, by program.

2.17.2.4.3. The physical address, mailing address, and telephone number of the Material Subcontractor's headquarters office, and the name of its Chief Executive Officer.

2.17.2.4.4. The URL for the homepage of any website operated, owned, or controlled by the Material Subcontractor, including any websites run by another entity on the Material Subcontractor's behalf. If the Material Subcontractor has a parent, then also provide the same for the parent organization, and any parent of the parent organization. If none exist, provide a clear and definitive statement to this effect.

2.17.2.4.5. Whether the Material Subcontractor is an Affiliate of the STAR+PLUS MMP, or an unrelated third party.

2.17.2.4.6. If the Material Subcontractor is an Affiliate, then additionally provide:

2.17.2.4.6.1. The name of the Material Subcontractor's parent organization, and the Material Subcontractor's relationship to the STAR+PLUS MMP;

2.17.2.4.6.2. The proportion, if any, of the Material Subcontractor's total revenues that are received from non-Affiliates. If the Material Subcontractor has significant revenues from non-Affiliates, then also indicate the portion, if any, of those external (non-Affiliate) revenues that are for services similar to those that the STAR+PLUS MMP plans to procure under the proposed subcontract;

2.17.2.4.6.3. A description of the proposed method of pricing under the subcontract;

2.17.2.4.6.4. Indicate if the STAR+PLUS MMP presently procures, or has ever procured, similar services from a non-Affiliate;

2.17.2.4.6.5. The number of employees (staff and management) who are dedicated full-time to the Affiliate's business;

2.17.2.4.6.6. Whether the Affiliate's office facilities are completely separate from the STAR+PLUS MMP and the STAR+PLUS MMP's parent. If not, identify the approximate number of square feet of office space that are dedicated solely to the Affiliate's business;

2.17.2.4.6.7. Attach an organization chart for the Affiliate, showing head count, key personnel names, titles, and locations; and

2.17.2.4.6.8. Indicate if the staff and management of the Affiliate are directly employed by the Affiliate itself, or are they legally employed by a different legal entity (such as a parent corporation). The employee's W-2 form identifies the name of the corporation and is indicative of the actual employer.

2.17.2.5. The STAR+PLUS MMP shall provide a brief description of each Material Subcontractor's corporate background and experience, including its estimated annual revenues from

unaffiliated parties, number of employees, location(s), and identification of three major clients.

2.17.3. Information Management and Information Systems

2.17.3.1. The STAR+PLUS MMP shall maintain information systems (Systems) that will enable the STAR+PLUS MMP to meet all requirements as outlined in this Contract. The STAR+PLUS MMP's Systems shall be able to support current HHSC requirements, any future IT architecture or program changes, all functions of the STAR+PLUS MMP's processes and procedures for the flow and use of STAR+PLUS MMP data. If the STAR+PLUS MMP subcontracts a Management Information System (MIS) function, the First Tier, Downstream, and Related Entity's MIS must comply with the requirements of this section. Such requirements include, but are not limited to, the following HHSC standards:

2.17.3.1.1. 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:

2.17.3.1.1.1. Enrollment/Eligibility Subsystem;

2.17.3.1.1.2. Provider Subsystem;

2.17.3.1.1.3. Encounter/Claims Processing Subsystem;

2.17.3.1.1.4. Financial Subsystem;

2.17.3.1.1.5. Utilization/Quality Improvement Subsystem;

2.17.3.1.1.6. Reporting Subsystem;

2.17.3.1.1.7. Interface Subsystem; and

2.17.3.1.1.8. Third Party Liability/Third Party Recovery (TPL/TPR) Subsystem, as applicable to the STAR+PLUS MMP.

2.17.3.1.2. The MIS must enable the STAR+PLUS MMP to meet the Contract requirements, including all applicable state and federal laws, rules, and regulations. The MIS must have the capacity and capability to capture and utilize various data elements required for STAR+PLUS MMP administration.

2.17.3.1.3. The STAR+PLUS MMP must have a system that can be adapted to changes in business practices and policies within the timeframes negotiated by the Parties. The STAR+PLUS MMP is expected to cover the cost of such systems modifications over the life of the Contract.

2.17.3.1.4. The STAR+PLUS MMP must provide HHSC and/or CMS written notice of Major Systems Changes and implementations no later than one hundred eighty (180) days prior to the planned change or implementation, including any changes relating to First Tier, Downstream, and Related Entities, in accordance with the requirements of this Contract. HHSC and CMS retain the right to modify or waive the notification requirement contingent upon the nature of the request from the STAR+PLUS MMP.

2.17.3.1.5. The STAR+PLUS MMP must notify the CMT of Major Systems Changes in writing, as well as by e-mail. The notification must detail the following:

2.17.3.1.5.1. The aspects of the system that will be changed and date of implementation;

2.17.3.1.5.2. How these changes will affect the Provider and Enrollee community, if applicable;

2.17.3.1.5.3. The communication channels that will be used to notify these communities, if applicable; and

2.17.3.1.5.4. A contingency plan in the event of downtime of system(s).

2.17.3.1.6. Major systems changes are subject to CMS and/or HHSC desk review and onsite review and approval of the STAR+PLUS MMP's facilities as necessary to test readiness and functionality prior to implementation. Prior to approval of the Major Systems Change, the STAR+PLUS MMP may not implement any changes to its operating systems. Failure to comply will result in contractual remedies, including damages. The CMT retains the right to modify or waive the notification requirement contingent upon the nature of the request from the STAR+PLUS MMP.

2.17.3.1.7. The STAR+PLUS MMP must provide HHSC and/or CMS any updates to the STAR+PLUS MMP's organizational chart relating to MIS key personnel and the description of MIS responsibilities at least thirty (30) days prior to the effective date of the change. The STAR+PLUS MMP must provide HHSC and/or CMS official points of contact for MIS issues on an ongoing basis.

2.17.3.1.8. If for any reason a STAR+PLUS MMP does not fully meet the MIS requirements, then the STAR+PLUS MMP must, upon request by the CMT, either correct such deficiency or submit to the CMT a corrective action plan and risk mitigation plan to address such deficiency. Immediately upon identifying a deficiency, the CMT may impose contractual remedies according to the severity of the deficiency.

2.17.3.1.9. Ensure a secure, HIPAA-compliant exchange of Enrollee information between the STAR+PLUS MMP and HHSC and any other entity deemed appropriate by HHSC. Such files shall be transmitted to HHSC through secure FTP, HTS, or a similar secure data exchange as determined by HHSC;

2.17.3.2. Claims processing system requirements

2.17.3.2.1. The STAR+PLUS MMP must maintain an automated Claims processing system that registers the date a Claim is received by the STAR+PLUS MMP the detail of each Claim transaction (or action) at the time the transaction occurs, and has the capability to report each Claim transaction by date and type to include interest payments. The Claims system must maintain information at the Claim and line detail level. The Claims system must maintain adequate audit trails and report accurate Claims performance measures to HHSC.

2.17.3.2.2. The STAR+PLUS MMP's Claims system must maintain online and archived files. The STAR+PLUS MMP must keep online automated Claims payment history for ten (10) years, including the most current eighteen (18) months in an electronic format. The STAR+PLUS MMP must retain other financial information and records, including all original Claims forms, for the time period established in Section 5.1.9 of this Contract. All Claims data must be easily sorted and produced in formats as requested by HHSC.

2.17.3.2.3. HHSC will provide the STAR+PLUS MMP or its designee with pharmacy interface files, including formulary, PDL, third party liability, master provider, and drug exception files. Due to the point-of-sale nature of outpatient pharmacy benefits, the STAR+PLUS MMP must ensure all applicable MIS systems (including pharmacy claims adjudication systems) are updated to include the data provided in the pharmacy interface files. The STAR+PLUS MMP must update within two business days of the files becoming available through HHSC's file transfer process, unless clarification is needed or data/file exceptions are identified. If clarification is needed, the STAR+PLUS MMP must notify HHSC within the same two business days.

2.17.3.3. Providers must be able to send Claims directly to the STAR+PLUS MMP or its First Tier, Downstream, and Related Entity;

2.17.3.3.1. Provider Portal – The STAR+PLUS MMP must provide a Provider portal that supports functionality to reduce administrative burden on Network Providers at no cost to the Providers. A Provider portal brings information together from diverse sources in a uniform way. The Provider portal functionality must include the following:

2.17.3.3.1.1. Enrollee eligibility verification;

2.17.3.3.1.2. Submission of electronic Claims ;

2.17.3.3.1.3. Prior Authorization requests;

2.17.3.3.1.4. Claims Appeals and reconsiderations; and

2.17.3.3.1.5. Exchange of clinical data and other documentation necessary for prior authorization and Claim processing.

2.17.3.4. To the extent possible, the Provider portal should support both online and Batch Processing as applicable to the information being exchanged. To facilitate the exchange of clinical data and other relevant documentation, the Provider Portal must provide a secure exchange of information between the Provider and STAR+PLUS MMP, including, as applicable, a First Tier, Downstream, and Related Entity of the STAR+PLUS MMP.

2.17.3.5. The STAR+PLUS MMP shall cooperate with HHSC in its efforts to verify the accuracy of all STAR+PLUS MMP data submissions to HHSC; and

2.17.3.6. Actively participate in any HHSC Systems Workgroup, as directed by HHSC. The HHSC Systems Workgroup shall meet in the location and on a schedule determined by HHSC

2.17.4. Design Requirements

2.17.4.1. The STAR+PLUS MMP shall comply with HHSC requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract.

2.17.4.2. The STAR+PLUS MMP shall have adequate resources to support the MIS interfaces. The STAR+PLUS MMP shall demonstrate the capability to successfully send and receive interface files. Interface files, which include:

2.17.4.2.1. Inbound Interfaces:

2.17.4.2.1.1. Daily Inbound Demographic Change File;

2.17.4.2.1.2. HIPAA 834 History Request File;

2.17.4.2.1.3. Inbound Co-pay Data File (daily); and

2.17.4.2.1.4. Monthly STAR+PLUS MMP Provider and Pharmacy Directory.

2.17.4.2.2. Outbound Interfaces

2.17.4.2.2.1. HIPAA 834 Outbound Daily File;

2.17.4.2.2.2. HIPAA 834 Outbound Full File;

2.17.4.2.2.3. HIPAA 834 History Response;

2.17.4.2.2.4. Fee-For-Service Wrap Services;

2.17.4.2.2.5. HIPAA 820; and

2.17.4.2.2.6. TPL Carrier Codes File.

2.17.4.3. The STAR+PLUS MMP shall conform to HIPAA compliant standards for data management and information exchange.

2.17.4.4. The STAR+PLUS MMP shall demonstrate controls to maintain information integrity.

2.17.4.5. The STAR+PLUS MMP shall maintain appropriate internal processes to determine the validity and completeness of data submitted to HHSC.

2.17.5. Accepting and Processing Assessment Data

2.17.5.1. System Access Management and Information Accessibility Requirements

2.17.5.1.1. Consistent with 422.504(e)(1)(iii), the STAR+PLUS MMP shall make all Systems and system information available to authorized CMS, HHSC and other agency staff as determined by CMS or HHSC to evaluate the quality and effectiveness of the STAR+PLUS MMP's data and Systems.

2.17.5.1.2. The STAR+PLUS MMP is prohibited from sharing or publishing CMS or HHSC data and information without prior written consent from CMS or HHSC.

2.17.5.2. System Availability and Performance Requirements

2.17.5.2.1. The STAR+PLUS MMP shall ensure that its Provider web portal functions are available to Providers twenty-four (24) hours a day, seven (7) days a week.

2.17.5.2.2. The STAR+PLUS MMP shall draft an alternative plan that describes access to Enrollee and Provider information in the event of system failure. Such plan shall be contained in the STAR+PLUS MMP's Business Continuity Plan and shall be updated annually and submitted to the CMT upon request. In the event of System failure or unavailability, the STAR+PLUS MMP shall notify the CMT upon discovery and implement the Business Continuity Plan immediately.

2.17.5.2.3. The STAR+PLUS MMP shall preserve the integrity of Enrollee-sensitive data that resides in both a live and archived environment.

2.18. Encounter Reporting

2.18.1. Requirements

2.18.1.1. The STAR+PLUS MMP must meet any diagnosis and/or encounter reporting requirements that are in place for Medicare Advantage plans and Medicaid managed care organizations, as may be updated from time to time.

2.18.1.2. The STAR+PLUS MMP must provide complete Encounter Data for all Covered Services, as well as for any Flexible Benefits.

2.18.1.3. Furthermore, the STAR+PLUS MMP's systems shall generate and transmit Encounter Data files according to additional specifications as may be provided by CMS or HHSC and updated from time to time.

2.18.1.4. CMS and HHSC will provide technical assistance to the STAR+PLUS MMP for developing the capacity to meet encounter reporting requirements.

2.18.1.5. The STAR+PLUS MMP shall:

2.18.1.5.1. Collect and maintain one hundred (100) percent Encounter Data for all Covered Services provided to Enrollees, including from any First Tier, Downstream, and Related Entities. Such data must be able to be linked to HHSC eligibility data;

2.18.1.5.2. Participate in site visits and other reviews and assessments by CMS and HHSC, or its designee, for the purpose of evaluating the STAR+PLUS MMP's collection and maintenance of Encounter Data;

2.18.1.5.3. Upon request by CMS, HHSC, or their designee, provide Enrollees Medical Records and a report from administrative databases of the Encounters of such Enrollees in order to conduct validation assessments. Such validation assessments may be conducted annually;

2.18.1.5.4. Produce Encounter Data according to the specifications, format, and mode of transfer reasonably established by CMS, HHSC, or their designee, in consultation with the STAR+PLUS MMP. Such Encounter Data shall include elements and level of detail determined necessary by CMS and HHSC. As directed by CMS and HHSC, such Encounter Data shall also include the National Provider Identifier (NPI) or Atypical Provider Identifier (API) of the ordering and referring physicians and professionals and any National Drug Code (NDC);

2.18.1.5.5. Submit complete, timely, reasonable, and accurate Encounter Data directly to CMS and to HHSC no less than monthly and in the form and manner specified by HHSC and CMS;

2.18.1.5.5.1. In addition, Pharmacy Encounter Data must be submitted no later than twenty-five (25) calendar days after the date of adjudication and include all Encounter Data and adjustments processed by the STAR+PLUS MMP.

2.18.1.5.6. Submit Encounter Data that meets minimum standards for completeness and accuracy as defined by CMS and HHSC. The Contractor must also correct and resubmit denied encounters as necessary;

2.18.1.5.7. Report as a voided Claim in the monthly Encounter Data submission any Claims that the STAR+PLUS MMP pays, and then later determines should not have paid.

2.18.1.6. If CMS, HHSC, or the STAR+PLUS MMP, determines at any time that the STAR+PLUS MMP's Encounter Data is not complete and accurate, the STAR+PLUS MMP shall:

2.18.1.6.1. Notify CMS and HHSC, prior to Encounter Data submission, that the data is not complete or accurate, and provide an action plan and timeline for resolution;

2.18.1.6.2. Submit for CMS and HHSC approval, within a time frame established by CMS and HHSC, which shall in no event exceed thirty (30) days from the day the STAR+PLUS MMP identifies or is notified that it is not in compliance with the Encounter Data requirements, a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level;

2.18.1.6.3. Implement the CMS and HHSC-approved corrective action plan within a time frame approved by CMS and HHSC, which shall in no event exceed thirty (30) days from the date that the STAR+PLUS MMP submits the corrective action plan to CMS and HHSC for approval; and

2.18.1.6.4. Participate in a validation study to be performed by CMS, HHSC, and/or their designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Encounter Data is complete and accurate. The STAR+PLUS MMP may be financially liable for such validation study. The STAR+PLUS MMP must make original records available for inspection by HHSC for validation purposes.

2.18.1.7. For reporting Claims processed by the STAR+PLUS MMP and submitted on Encounter 837 and NCPDP format, the STAR+PLUS MMP must use the procedure codes, diagnosis codes, Provider identifiers, 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 STAR+PLUS MMP requesting an exception.

2.18.1.7.1. HHSC will use the Encounter Data to run the Quarterly Encounter Reconciliation Report, which reconciles the year-to-date paid claims reported in the FSR to the appropriate paid dollars reported in the Vision 21 Data Warehouse. This report is based on querying the Vision 21 Data Warehouse sixty (60) calendar days after the last day of the quarter.

2.18.1.8. The STAR+PLUS MMP's Provider Agreements must require Network Providers to comply with the requirements of Texas Government Code § 531.024161, regarding reimbursement of Claims based on orders or referrals by supervising Providers.

Section 3. **CMS and HHSC Responsibilities**

3.1. Contract Management

3.1.1. Administration

3.1.1.1. CMS and HHSC will designate a CMT that will include at least one (1) representative from CMS and at least one (1) contract manager from HHSC authorized and empowered to represent CMS and HHSC about all aspects of the Contract. Generally, the CMS part of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office (RO) lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The CMS representatives and HHSC representatives will act as liaisons between the STAR+PLUS MMP and CMS and HHSC for the duration of the Contract. The CMT will:

3.1.1.1.1. Monitor compliance with the terms of the Contract including issuance of joint notices of non-compliance/enforcement.

3.1.1.1.2. Coordinate periodic audits and surveys of the STAR+PLUS MMP;

3.1.1.1.3. Receive and respond to complaints;

3.1.1.1.4. Conduct regular meetings with the STAR+PLUS MMP;

3.1.1.1.5. Coordinate requests for assistance from the STAR+PLUS MMP and assign CMS and HHSC staff with appropriate expertise to provide technical assistance to the STAR+PLUS MMP;

3.1.1.1.6. Make best efforts to resolve any issues applicable to the Contract identified by the STAR+PLUS MMP, CMS, or HHSC;

3.1.1.1.7. Inform the STAR+PLUS MMP of any discretionary action by CMS or HHSC under the provisions of the Contract;

3.1.1.1.8. Coordinate review of marketing materials and procedures; and

3.1.1.1.9. Coordinate review of Grievance and Appeals data, procedures.

3.1.1.2. CMS and HHSC will review, approve, and monitor the STAR+PLUS MMP's outreach and orientation materials and procedures and Complaint and Appeals procedures.

3.1.1.3. CMS and HHSC will apply one or more of the sanctions provided in Section 5.3.15, , including termination of the Contract in accordance with Section 5.5, if CMS and the HHSC determine that the STAR+PLUS MMP is in violation of any of the terms of the Contract stated herein**.**

3.1.1.4. CMS and HHSC will conduct site visits as determined necessary by CMS and HHSC to verify the accuracy of reported data.

3.1.1.5. CMS and HHSC will coordinate the STAR+PLUS MMP's external quality reviews conducted by the EQRO.

3.1.1.6. CMS and HHSC will send transition reports to the STAR+PLUS MMP in an electronic format.

3.1.2. Performance Evaluation

3.1.2.1. CMS and HHSC will, at their discretion:

3.1.2.1.1. Evaluate, through inspection or other means, the STAR+PLUS MMP's compliance with the terms of this Contract, including but not limited to the reporting requirements in Sections 2.17 and 2.18, the quality, appropriateness, and timeliness of services performed by the STAR+PLUS MMP and its Provider Network. CMS and HHSC will provide the STAR+PLUS MMP with the written results of these evaluations;

3.1.2.1.2. Conduct periodic audits of the STAR+PLUS MMP, including, but not limited to an annual independent external review and an annual site visit;

3.1.2.1.3. Conduct annual Enrollee surveys and provide the STAR+PLUS MMP with written results of such surveys; and

3.1.2.1.4. Meet with the STAR+PLUS MMP at least semi-annually to assess the STAR+PLUS MMP's performance.

3.1.2.2. Upon reasonable notice from CMS, and/or HHSC or both, the STAR+PLUS MMP will provide, and will cause its First Tier, Downstream, and Related Entities to provide, such auditors and inspectors as CMS and/or HHSC may from time to time

designate, with access to service locations, facilities, or installations; records; and software and equipment. The access described in this Section will be for the purpose of examining, auditing, or investigating:

3.1.2.2.1. STAR+PLUS MMP's capacity to bear the risk of potential financial losses;

3.1.2.2.2. The services and deliverables provided;

3.1.2.2.3. A determination of the amounts payable under this Contract;

3.1.2.2.4. A determination of the allowability of costs reported under this Contract;

3.1.2.2.5. An examination of First Tier, Downstream, and Related Entity agreement terms and/or transactions;

3.1.2.2.6. An assessment of financial results under this Contract;

3.1.2.2.7. Detection of Fraud, Waste and/or Abuse; or

3.1.2.2.8. Other purposes CMS and/or HHSC deem necessary to perform its oversight function and/or enforce the provisions of this Contract.

3.1.2.3. If, as a result of an audit or review of payments made to the STAR+PLUS MMP, CMS and/or HHSC discovers a payment error or overcharge, CMS and/or HHSC will notify the STAR+PLUS MMP of such error or overcharge. CMS and/or HHSC will be entitled to recover such funds as an offset to future payments to the STAR+PLUS MMP, or to collect such funds directly from the STAR+PLUS MMP. STAR+PLUS MMP 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 12% per annum, compounded daily.

3.1.2.4. In the event that an audit reveals that errors in reporting by the STAR+PLUS MMP have resulted in errors in payments to the STAR+PLUS MMP or errors in the calculation of the Experience Rebate, the STAR+PLUS MMP will indemnify CMS and/or HHSC for any losses resulting from such errors, including the cost of audit.

3.2. Enrollment and Disenrollment Systems

3.2.1. General

3.2.1.1. CMS and HHSC will maintain systems to provide Enrollment and disenrollment information to the STAR+PLUS MMP and continuous verification of eligibility status.

3.2.1.2. HHSC or its Administrative Services Contractor shall assign a staff person(s) who shall have responsibility to:

3.2.1.2.1. Develop generic materials to assist Eligible Enrollees in choosing whether to enroll in the Demonstration. Said materials shall present the STAR+PLUS MMP in an unbiased manner to prospective Enrollees eligible to enroll in the STAR+PLUS MMP. HHSC may collaborate with the STAR+PLUS MMP in developing STAR+PLUS MMP-specific materials;

3.2.1.2.2. Present the STAR+PLUS MMP in an unbiased manner to eligible Enrollees or those seeking to transfer from one STAR+PLUS MMP to another. Such presentation(s) shall ensure that Enrollees are informed prior to Enrollment of the following:

3.2.1.2.2.1. The rights and responsibilities of participation in the Demonstration;

3.2.1.2.2.2. The nature of the STAR+PLUS MMP's care delivery system, including, but not limited to the Provider Network; and the Comprehensive Health Risk Assessment, and the Service Coordination Team; and

3.2.1.2.2.3. Orientation and other Enrollee services made available by the STAR+PLUS MMP.

3.2.1.2.3. Enroll, disenroll, and process transfer requests of Enrollees in the STAR+PLUS MMP, including completion of HHSC's Enrollment and disenrollment forms;

3.2.1.2.4. Ensure that Enrollees are informed at the time of Enrollment or transfer of their right to terminate their Enrollment voluntarily at any time, unless otherwise provided by federal law or waiver;

3.2.1.2.5. Be knowledgeable about the STAR+PLUS MMP's policies, services, and procedures; and

3.2.1.2.6. Develop and implement processes and standards to measure and improve the performance of the HHSC Administrative Services Contractor staff. HHSC shall monitor the performance of the Administrative Services Contractor.

3.2.1.3. STAR+PLUS MMPs must refer all Eligible Beneficiaries to the Administrative Services Contractor for Enrollment. The State reserves the right to develop predetermined marketing scripts for STAR+PLUS MMP staff, subject to CMS review and approval.

Section 4. **Payment and Financial Provisions**

4.1. General Financial Provisions

4.1.1. Capitation Payments

4.1.1.1. CMS and HHSC will each contribute to the total Capitation Payment paid to the STAR+PLUS MMP. CMS and HHSC will each make monthly payments for each Enrollee to the STAR+PLUS MMP for their portion of the Capitation Payment, in accordance with the payment provisions set forth herein and subject to all applicable federal and state laws, regulations, rules, billing instructions, and bulletins, as amended.

4.1.1.2. The STAR+PLUS MMP will receive three (3) monthly payments for each Enrollee: one amount from CMS reflecting coverage of Medicare Parts A/B services (Medicare Parts A/B Component), one amount from CMS reflecting coverage Medicare Part D services (Medicare Part D Component), and a third amount from HHSC reflecting coverage of Medicaid services (Medicaid Component).

4.1.1.3. The Medicare Parts A/B payment will be risk adjusted using the Medicare Advantage CMS-HCC Model. The Medicare Part D payment will be risk adjusted using the Part D RxHCC Model. The Medicaid Component will utilize the Rate Cell methodology described in Section 4.2.

4.1.1.4. CMS and HHSC will provide the STAR+PLUS MMP with a rate report on an annual basis for the upcoming calendar year. Updates to the Medicaid portion of the rate will take place at least once at the beginning of the State Fiscal Year on September 1st and may be more often as necessary to match adjustments made to the Medicaid capitation rates in the contracts that support the THTQIP section 1115(a) demonstration program that would apply for beneficiaries in the target population who do not enroll in the Demonstration. Adjustments to the Medicaid component of the rates may be done retroactively, if necessary to match the Medicaid baseline rates.

4.1.1.5. On a regular basis, CMS will provide HHSC with the STAR+PLUS MMP-level payment information in the Medicare Plan Payment Report. The use of such information by HHSC will be limited to financial monitoring, performing financial audits, and related activities, unless otherwise agreed

to by CMS and the STAR+PLUS MMP. On a regular basis, HHSC will also provide to CMS STAR+PLUS MMP-level payment information including the Medicaid Capitation Payments.

4.1.2. Demonstration Year Dates

4.1.2.1. While Capitation Rate updates will take place each State Fiscal Year and calendar year or more frequently, as described in this section, savings percentages and quality withhold percentages (see Sections 4.2.4 and 4.4.5) will be applied based on Demonstration Years, as follows:

4.1.2.1.1. Demonstration Year 1.a: March 1-December 31, 2015

4.1.2.1.2. Demonstration Year 1.b: January 1-December 31, 2016

4.1.2.1.3. Demonstration Year 2: January 1-December 31, 2017

4.1.2.1.4. Demonstration Year 3: January 1-December 31, 2018

4.2. Capitated Rate Structure

4.2.1. General

4.2.1.1. Any and all costs incurred by the STAR+PLUS MMP in excess of the capitation payment will be borne in full by the STAR+PLUS MMP, except as relates to the Part D Component.

4.2.2. Medicaid Component of the Capitation Payment

4.2.2.1. HHSC shall pay the STAR+PLUS MMP a monthly capitation amount (the Medicaid Component) based on the Rate Cell of the Enrollee, a sum equal to the product of the approved Capitation Rate and the number of Enrollees enrolled in that category as of the first day of that month.

4.2.2.2. After the first monthly Capitation Payment, amounts will be added or subtracted to this base amount as may be necessary to reflect prior-month adjustments, as referenced in Section 4.7, Reconciliation.

4.2.2.3. Under the Demonstration's quality withhold policy, both CMS and HHSC will withhold a percentage of their respective components of the Capitation Payment, with the exception of the Part D Component. The withheld amounts will be paid at a later date, subject to the STAR+PLUS MMP's performance.

Thus, STAR+PLUS MMPs should not expect to receive one hundred (100) percent of their monthly capitation payment each month; instead, a portion of it will be remitted at later point in time, subject to performance.

4.2.2.4. The baseline spending data for Medicaid services used for calculating the Medicaid Component of Demonstration Year 1.a and 1.b Capitation Rates is experience from the historical data from the total population that would have been eligible for Enrollment in the Demonstration during the historical baseline period. Completion factors are calculated and applied to the baseline data, in order to include expenditures for services that were incurred but not paid in the available data. The data are then adjusted for known policy and program changes that will be in effect during the Contract period. The completed and adjusted data are trended forward to the midpoint of the Contract period and used to develop Capitation Rates. All steps in this process are subject to CMS review.

4.2.2.5. The Capitation Payments are based on the Rate Cell structure for the STAR+PLUS program. Table 4-1 lists the 2015 Rate Cells. HHSC will use its eligibility system to determine an Enrollee's Rate Cell.

Table 4-1 2015 Rate Cells

Rating Category	Description
HCBS	• Receive state plan services, as well as section 1115(a) HCBS STAR+PLUS Waiver services, and • Elderly or adults with disabilities who qualify for nursing facility level of care, but do not reside in a nursing facility
Other Community Care (OCC)	• Receive state plan services only, and • Do not reside in a nursing facility
Nursing Facility	• Receive state plan services only, and • Reside in a nursing facility

4.2.3. Medicare Component of the Capitation Rate

4.2.3.1. Medicare will pay the STAR+PLUS MMP a monthly capitation amount for the Medicare Parts A/B services (the Medicare A/B Component), risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in Section 4.2.5. Medicare will also pay the STAR+PLUS MMP a monthly capitation amount for Medicare Part D services, risk adjusted using the Part D RxHCC Model (the Medicare Part D Component).

4.2.3.2. Medicare Parts A/B Component

4.2.3.2.1. The Medicare baseline spending for Parts A/B services are a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the target population projected to otherwise be in each program in the absence of the Demonstration. The Medicare Advantage baseline spending will include costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans. The FFS county rates will generally reflect amounts published with the annual April Medicare Advantage Final Rate Announcement. CMS may adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

4.2.3.2.2. Separate baselines will exist for Enrollees meeting the Medicare ESRD criteria. For Enrollees with ESRD in the dialysis or transplant status phases, the Medicare Parts A/B baseline will be the ESRD dialysis state rate. For Enrollees in the functioning graft status phase, the Medicare Parts A/B baseline will be the Medicare Advantage 3.5%-bonus county rate (benchmark) for the applicable county.

4.2.3.2.3. Both baseline spending and payment rates under the Demonstration for Medicare Parts A/B services will be calculated as PMPM standardized amounts for each county participating in the Demonstration for each year. Enrollee risk scores will be applied to the standardized rates at the time of payment.

4.2.3.2.4. The Medicare A/B Component will be updated annually consistent with annual FFS estimates and Medicare Advantage rates released each year with the annual rate announcement.

4.2.3.3. Medicare Part D Component

4.2.3.3.1. The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount (NAMBA) for the calendar year. CMS will estimate an average monthly prospective payment amount for the low income Cost Sharing subsidy (LIS) and federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors. The CY 2015 Part D NAMBA is $70.18.

4.2.3.3.2. The monthly Medicare Part D Component for an Enrollee can be calculated by multiplying the Part D NAMBA by the RxHCC risk score assigned to the individual, and then adding to this the estimated average monthly prospective payment amount for the LIS subsidy and federal reinsurance amounts.

4.2.4. Aggregate Savings Percentages

4.2.4.1. Aggregate savings percentages, as follows, will be applied equally to the baseline spending amounts for the Medicare Parts A/B Component and the Medicaid Component of the capitated rate, provided that such savings percentages may be adjusted in accordance with Section 4.2.4.2.

4.2.4.1.1. Demonstration Year 1.a: 1.25%

4.2.4.1.2. Demonstration Year 1.b: 2.75%

4.2.4.1.3. Demonstration Year 2: 3.75%

4.2.4.1.4. Demonstration Year 3: 5.5%

4.2.4.2. Rate updates will take place on January 1st and September 1st of each calendar year, however savings percentages will be calculated and applied based on Demonstration Years.

4.2.4.3. Savings percentages will not be applied to the Part D Component of the rate. CMS will monitor Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

4.2.5. Risk Adjustment Methodology

4.2.5.1. Medicare Parts A/B: The Medicare Parts A/B Component will be risk adjusted based on the risk profile of each Enrollee. Except as specified below, the existing Medicare Advantage CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be used for the Demonstration.

4.2.5.1.1. In calendar year 2015, CMS will calculate and apply a coding intensity adjustment reflective of all Demonstration Enrollees. This will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Enrollees in 2015 with Medicare Advantage experience in 2014, prior to the Demonstration.

4.2.5.1.2. In calendar year 2016, CMS will apply an appropriate coding intensity adjustment reflective of all Demonstration Enrollees; this will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Enrollees in CY 2016 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's Enrollment phase-in, as of September 30, 2015.

4.2.5.1.3. After calendar year 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Enrollees.

4.2.5.1.4. The coding intensity adjustment factor will not be applied during the Demonstration to risk scores for Enrollees with an ESRD status of dialysis or transplant, consistent with Medicare Advantage policy.

4.2.5.2. Medicare Part D: The Medicare Part D NAMBA will be risk adjusted in accordance with existing Part D RxHCC methodology. The estimated average monthly prospective

payment amount for the LIS and federal reinsurance amounts will not be risk adjusted.

4.2.5.3. Medicaid: The Medicaid component will employ Rate Cells described in Section 4.2.1.

4.3. Experience Rebate

4.3.1. General

4.3.1.1. The Demonstration will utilize a one-sided Experience Rebate, similar to, but separate from, that used in Texas' STAR+PLUS program (for those groups of STAR+PLUS Enrollees that are not part of this Demonstration, the previously existing STAR+PLUS Experience Rebate will continue to apply). The Experience Rebate is designed to limit the profits received by STAR+PLUS MMPs to a reasonable percentage of total revenue, and to encourage use of revenues for services rather than administrative expenses by putting a limit (Admin Cap) on the amount of administrative expenses that can be used to calculate Net Income Before Taxes when determining the Experience Rebate. The Experience Rebate will apply for all state fiscal years and will include all Medicare A/B and Medicaid Allowable Expenses.

4.3.1.2. The Admin Cap will become effective for the second SFYr of the demonstration. The Experience Rebate and the Admin Cap will be calculated on a SFY basis. Audits of the FSRs will be conducted on a SFY basis, and any audit findings will be applied to the FSRs on a State Fiscal Year basis.

4.3.1.3. Under this Demonstration, at an appropriate time after the end of each SFY, the STAR+PLUS MMP must pay to the State an Experience Rebate if the STAR+PLUS MMP's Net Income Before Taxes is greater than the percentage set forth of the total Revenue for the period. There will be specified time frames for the payment of the Experience Rebates, and interest will be applied for late payment or inappropriate reporting that ultimately results in delayed payment. The Experience Rebate will be calculated in accordance with a tiered rebate method summarized in Table 4-2, below. The State will remit to CMS a share as described in Section 4.3.1.5.

4.3.1.4. Revenue will include Capitation Payments received by the STAR+PLUS MMP, including the impact of risk adjustment methodologies and cost reconciliation, if any, not including the Part D Component. In calculating the Experience Rebate,

Revenues will not be reduced by any quality withhold hereunder, and any such withheld payment will not be an Allowable Expense hereunder. Thus, any payment forfeited under the quality withhold terms will not reduce the Net Income Before Taxes used in the Experience Rebate calculation. The Experience Rebate would be calculated as if the payment had not been withheld.

4.3.1.5. Rebate amounts collected from STAR+PLUS MMPs will be distributed back to the Medicare and Medicaid programs, with the amount to each payor in proportion to their contributions to the Capitation Payments, not including the Part D Component. The share of the rebate attributed to the Medicaid Component will be treated as recoupment of Medicaid expenditures subject to federal matching rules. At the option of CMS and the State, any Experience Rebate payments (along with any associated interest) may be recovered either by requiring the STAR+PLUS MMP to make a payment or by an offset to future Capitation Payments. Any such amount that may be recovered by an offset will not reduce the amount of Revenues attributable to the period in which the offset was effected. As such, offsets will be treated as simply a collection methodology, and not as a component in calculating Revenues, Allowable Costs, Net Income Before Taxes, or Experience Rebates.

4.3.1.6. CMS and HHSC will use the following graduated tiers to determine STAR+PLUS MMPs' applicable Experience Rebates:

4.3.1.6.1. the STAR+PLUS MMP will retain all the Net Income Before Taxes that is equal to or less than 3% of the Adjusted Revenue received by the STAR+PLUS MMP;

4.3.1.6.2. HHSC/CMS and the STAR+PLUS MMP will share that portion of the Net Income Before Taxes that is over 3% and less than or equal to 5% of the Adjusted Revenue received by the STAR+PLUS MMP, with 80% to the STAR+PLUS MMP and 20% to HHSC/CMS.

4.3.1.6.3. HHSC/CMS and the STAR+PLUS MMP will share that portion of the Net Income Before Taxes that is over 5% and less than or equal to 7% of the Adjusted Revenue received by the STAR+PLUS MMP, with 60% to the STAR+PLUS MMP and 40% to HHSC/CMS.

4.3.1.6.4. HHSC/CMS and the STAR+PLUS MMP will share that portion of the Net Income Before Taxes that is over 7% and less than or equal to 9% of the Adjusted Revenue received by the STAR+PLUS MMP, with 40% to the STAR+PLUS MMP and 60% to HHSC/CMS.

4.3.1.6.5. HHSC/CMS and the STAR+PLUS MMP will share that portion of the Net Income Before Taxes that is over 9% and less than or equal to 12% of the Adjusted Revenue received by the STAR+PLUS MMP, with 20% to the STAR+PLUS MMP and 80% to HHSC/CMS.

4.3.1.6.6. HHSC/CMS will recoup the entire portion of the Net Income Before Taxes that exceeds 12% of the Adjusted Revenue received by the STAR+PLUS MMP.

4.3.1.7. For all Demonstration Years in which the Experience Rebate applies, the Medicare Advantage MLR requirements are waived. To the extent the Experience Rebate ceases, the Medicare Advantage MLR requirements will be reinstated for any applicable years in which the Experience Rebate is not in effect.

Table 4-2 Experience Rebate Tiers

Net Income Before Taxes as a % of Adjusted Revenue	STAR+PLUS MMP Share	Combined CMS/Texas 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%

4.3.2. Basis of Consolidation of the Experience Rebate

4.3.2.1. There will be no consolidation of the Experience Rebate with other HHSC programs. The Experience Rebate for the STAR+PLUS MMPs will be separate, and will not have offsets of income or losses with other HHSC programs. All service areas for a given STAR+PLUS MMP will be consolidated into a single Experience Rebate for the Demonstration, for each State Fiscal Year.

4.3.3. Net Income Before Taxes subject to the Experience Rebate

4.3.3.1. Net Income Before Taxes, as well as Revenues and Allowable Expenses, will be measured through the established Texas Financial Statistical Reporting (FSR) system, and reviewed and confirmed by HHSC and CMS. HHSC's Cost Principles will apply with respect to the FSR, and STAR+PLUS MMPs will be subject to standard FSR audits.

4.3.3.2. For purposes of this Contract, the calculation of Net Income Before Taxes will exclude the impact of Medicare Part D, both in terms of the CMS premium payments to the STAR+PLUS MMP for the Part D Component, and the associated Part D costs incurred by the STAR+PLUS MMP.

4.3.3.3. The STAR+PLUS MMP must compute the Net Income Before Taxes in accordance with applicable federal regulations and the HHSC Uniform Managed Care Manual's "Cost Principles for Expenses", "FSR Instructions for Completion", and similar such instructions. The Net Income Before Taxes will be confirmed by HHSC or its agent for the State Fsical Year relating to all Revenues and Allowable Expenses incurred pursuant to the Contract. HHSC reserves the right to modify the "Cost Principles for Expenses" and "FSR Instructions for Completion."

4.3.3.4. For purposes of calculating Net Income Before Taxes, certain amounts are not Allowable Expenses deducted from Revenue and therefore are not counted toward the calculation of the Experience Rebate; these include, but are not limited to, the following:

4.3.3.4.1. The payment of an Experience Rebate;

4.3.3.4.2. Any interest expense associated with late or underpayment of the Experience Rebate;

4.3.3.4.3. Quality Withhold amounts, as described in Section 4.4.5;

4.3.3.4.4. Liquidated damages, and any interest expense associated with them; and

4.3.3.4.5. Financial incentives and financial disincentives, if any.

4.3.3.5. 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.

4.3.3.6. 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.

4.3.4. Carry Forward of Prior Year Losses

4.3.4.1. For Experience Rebate calculation purposes, the calculation of any loss carry-forward will be based on the allowable pre-tax loss as determined under the Admin Cap.

4.3.4.2. Losses incurred by the STAR+PLUS MMP for a given SFY may be carried forward to the next SFY, and applied as an offset against pre-tax net income for determination of any Experience Rebate due. Any such prior losses may be carried forward for the next two (2) contiguous SFYs.

4.3.4.3. In the case when a loss in a given SFY is carried forward and applied against profits in either or both of the next two (2) SFYs, the loss must first be applied against the first subsequent SFY such that the profit in the first subsequent SFY 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 SFY. In such case, the revised income in the third SFY would be equal to the cumulative income of the three (3) contiguous State Fiscal Years. In no case could the loss be carried forward to the fourth SFY or beyond.

4.3.4.4. Carrying forward of losses may be impacted by the Admin Cap, as referenced in Section 4.3.7.

4.3.4.5. In order for a loss to be eligible for potential carry forward as an offset against future income, the STAR+PLUS MMP must have a negative Net Income Before Taxes for a SFY.

4.3.5. Settlements for Payment

4.3.5.1. There may be one or more STAR+PLUS MMP payment(s) of the State/CMS share of the Experience Rebate on income generated for a given State Fiscal Year. The first scheduled payment (the “Primary Settlement”) will equal 100% of the

State/CMS share of the Experience Rebate as derived from the FSR, and will be paid on (or before) the same day the 90-day FSR report is due to HHSC.

4.3.5.2. 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 STAR+PLUS MMP may tender a payment. For example, an STAR+PLUS MMP 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.

4.3.5.3. The next scheduled payment will be an adjustment to the Primary Settlement, if required, and will be paid on (or before) the same day that the 334-day FSR Report is due to HHSC if the adjustment is a payment from the STAR+PLUS MMP to HHSC. Section 4.3.6 describes the interest expenses associated with any payment after the Primary Settlement.

4.3.5.4. A STAR+PLUS MMP may make non-scheduled payments at any time to reduce the accumulation of interest under Section 4.3.6. For any nonscheduled payments prior to the 334-day FSR, the STAR+PLUS MMP 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 "Part 1: Summary Income Statement."

4.3.5.5. 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 STAR+PLUS MMP within thirty (30) days of the earlier of:

4.3.5.5.1. The date of the management representation letter resulting from the audit; or

4.3.5.5.2. The date of any invoice or similar written notification issued by HHSC.

4.3.5.6. Payment within this 30-day timeframe will not relieve the STAR+PLUS MMP of any interest payment obligation that may exist under Section 4.3.6.

4.3.5.7. 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 STAR+PLUS MMP. HHSC may adjust the Experience Rebate if HHSC determines the STAR+PLUS MMP has paid amounts for goods or services that are not reasonable, necessary, or allowable in accordance with Uniform Managed Care Manual Chapter 6.1, "Cost Principles for Expenses," and 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.

4.3.6. Interest on the Experience Rebate

4.3.6.1. 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 4.3.5, Settlements for Payment. Thus, any Experience Rebate due or paid on or after the Primary Settlement will accrue interest starting at thirty-five (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 thirty-five (35) days after the due-date for submission of the 90-day FSR.

4.3.6.2. The STAR+PLUS MMP 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.

4.3.6.3. 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 STAR+PLUS MMP.

4.3.6.4. Any interest obligations that are incurred pursuant to Section 4.3.6, 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.

4.3.6.5. All interest assessed pursuant to Section 4.3.6 will continue to accrue until such point as a payment is received by HHSC, at

which point interest on the amount received will stop accruing. If a balance remains at that point that is subject to interest, then the balance will continue to accrue interest. If interim payments are made, then any interest that may be due will only be charged on amounts for the time period during which they remained unpaid. By way of example only, if $100,000 is subject to interest commencing on a given day, and a payment is received for $75,000 45 days after the start of interest, then the $75,000 will be subject to forty-five (45) days of interest, and the $25,000 balance will continue to accrue interest until paid. The accrual of interest as defined under Section 4.3.6 will not stop during any period of dispute. If a dispute is resolved in the STAR+PLUS MMP's favor, then interest will only be assessed on the revised unpaid amount.

4.3.6.6. If the STAR+PLUS MMP incurs an interest obligation pursuant to Section 4.3.6 for an Experience Rebate payment 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 the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

4.3.6.7. Any such interest expense incurred pursuant to Section 4.3.6 is not an Allowable Expense for reporting purposes on the FSR.

4.3.7. Administrative Expense Cap

4.3.7.1. General requirement – The calculation methodology of Experience Rebates described in Section 4.3 will be adjusted by an Administrative Expense Cap ("Admin Cap"). The Admin Cap will be introduced during the second SFY of the demonstration. The Admin Cap is a calculated maximum amount of administrative expense dollars that can be deducted from Revenues for purposes of determining income subject to the Experience Rebate. While Administrative Expenses may be limited by the Admin Cap to determine Experience Rebates, all valid Allowable Expenses will continue to be reported on the Financial Statistical Reports (FSRs). Thus, the Admin Cap does not impact FSR reporting, but may impact any associated Experience Rebate calculation.

4.3.7.1.1. The calculation of any Experience Rebate due will be subject to limitations on total deductible administrative expenses. Such limitations will be calculated as follows below.

4.3.7.2. Calculation methodology – HHSC and CMS will determine the actual or inferred administrative expense component of the applicable Capitation Rate structure prior to each applicable Rate Period. At the conclusion of an State Fiscal Year, HHSC will apply that predetermined administrative expense component against the STAR+PLUS MMP's actually incurred number of Member Months and aggregate premiums received (monthly Capitation Payments, which excludes any investment income or interest earned), to determine the specific Admin Cap, in aggregate dollars, for a given MMP.

4.3.7.2.1. If rates are changed during the State Fiscal Year, HHSC will use this same methodology of multiplying the predetermined rates for a given month against the ultimate actual number of Member Months or Revenues that occurred during that month, such that HHSC will apply each month's actual results against the rates that were in effect for that month.

4.3.7.2.2. Classification of certain expenses as "administrative" vs. "medical" – Labor and benefit costs of Service Coordination, when provided by Service Coordinators (or someone who is clearly an integral member of the Service Coordination Team) strictly in accordance with the terms herein, will not be accounted for as an administrative expense on the FSR, but will instead be accounted for as a type of medical expense. Expenses classified as such on the FSR will be narrowly limited to specified Service Coordination tasks performed by these specifically identified individuals.

4.3.7.2.3. Note that Service Coordination, as defined herein, is one part of the broader concept of Care Management, and as such, this FSR reporting cost classification treatment only applies to the narrower application of Service Coordination.

4.3.7.3. Data Sources

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

4.3.7.3.2. The total premiums paid by HHSC and CMS (excluding premiums for Medicare Part D), and corresponding Member Months, will be taken from the relevant FSR (or audit report) for the State Fiscal Year.

4.3.7.3.3. There are several components of the administrative expense portion of the Capitation Rate structure. These will be supplied by HHSC and CMS.

4.3.7.4. Consolidation and Offsets

4.3.7.4.1. The Admin Cap for the STAR+PLUS MMP will not be consolidated with other programs. Administrative expenses for the STAR+PLUS MMP will be reported separately from those reported for STAR, STAR+PLUS, CHIP, STAR Health, Dental, etc. The Admin Cap for the Demonstration will be consolidated across multiple SDAs, if a given STAR+PLUS MMP is contracted to serve multiple service areas.

4.3.7.4.2. There will be one aggregate amount of dollars determined as the total Admin Cap for a given State Fiscal Year under the Demonstration, which will be applied to the aggregate administrative expenses of the STAR+PLUS MMP under this contract. The net impact of the Admin Cap will be applied to the Experience Rebate calculation.

4.3.8. Reinsurance Cap

4.3.8.1. Beginning with the commencement of the Demonstration, the STAR+PLUS MMP is subject to the Reinsurance Cap.

4.3.8.2. Reinsurance is reported on HHSC's FSR report format as: 1) gross reinsurance premiums paid, and 2) reinsurance recoveries received. The premiums paid are treated as a part of medical expenses, and the recoveries received are treated as an offset to those medical expenses (also known as a contra-cost). The net of the gross premiums paid minus the recoveries received is called the net reinsurance cost. The net reinsurance cost, as measured in aggregate dollars over the FSR Reporting Period, divided by the number of Member Months for that same period, is referred to as the net reinsurance cost per-member-per-month (PMPM).

4.3.8.3. The STAR+PLUS MMP will be limited to a maximum amount of net reinsurance cost PMPM for purposes of calculating the pre-tax net income that is subject to the Experience Rebate.

This limitation does not impact an STAR+PLUS MMP's ability to purchase or arrange for reinsurance. It only impacts what is factored into the Experience Rebate calculation. The maximum amount of allowed net reinsurance cost PMPM (reinsurance cap) will be provided by HHSC and CMS. At present, the rates reflect that there should be no net reinsurance cost in the Demonstration. As such, the Reinsurance Cap is zero, unless at a future point the rates are revised to include a positive amount. Thus, any net reinurance cost PMPM reported on the FSR will be removed from expenses in the calculation of the Experience Rebate.

4.3.8.4. Regardless of the maximum amounts as represented by the Reinsurance Cap, all reinsurance reported on the FSR is subject to audit, and must comply with the UMCM Cost Principles.

4.4. Payment Terms

4.4.1. Enrollee Contribution to Care

4.4.1.1. With respect to Medicaid long-term care, Enrollee contribution to care amounts (which are paid to Nursing Facilities by certain Enrollees with higher incomes) will be deducted from total Nursing Facility costs in the rate setting process, such that the Medicaid Component of the monthly Capitation Rate will reflect an appropriate net Payment amount. Thus, no additional adjustments will be necessary on a monthly basis to aggregate Capitation Payments.

4.4.2. Timing of Capitation Payments

4.4.2.1. CMS and HHSC will each make monthly payments to the STAR+PLUS MMP. The STAR+PLUS MMP shall accept electronic transfer of funds to receive Capitation Payments.

4.4.3. Enrollments

4.4.3.1.1. The payment for a particular month will reflect payment for the individuals with effective Enrollment into the STAR+PLUS MMP as of the first day of that month.

4.4.3.1.2. HHSC will make monthly payments to the STAR+PLUS MMP for the current month's Enrollment by the 10th business day of the month.

4.4.3.2. Disenrollments

4.4.3.2.1. The final PMPM capitation payment made by CMS and HHSC to the STAR+PLUS MMP for each Enrollee will be for the month: a) in which the disenrollment was submitted, b) the Enrollee loses eligibility, or c) the Enrollee dies (see Section 2.3.5).

4.4.4. Modifications to Capitation Rates

4.4.4.1. CMS and HHSC will jointly notify the STAR+PLUS MMP in advance and in writing as soon as practicable, but no less than thirty (30) days prior to processing the change to the Capitation Rate, of any proposed changes to the Capitation Rates, and the STAR+PLUS MMP shall accept such changes as payment in full as described in Section 4.8.

4.4.4.2. Rates will be updated using a similar process for each year. Subject to Section 4.4.4.3 below, changes to the Medicare and Medicaid baselines (and therefore to the corresponding payment rate) outside of the annual Medicare Advantage and Part D rate announcement and annual Medicaid rate update will be made only if and when CMS and HHSC jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. Such changes may be based on the following factors: shifts in Enrollment assumptions; major changes or discrepancies in federal law and/or state policy used in the development of baseline estimates; and changes to coding intensity.

4.4.4.3. For changes solely affecting the Medicare program baseline, CMS will consult with HHSC prior to making any adjustment, but HHSC concurrence will not be required. CMS will update baselines by amounts necessary to best effectuate accurate payment rates for each month, as identified by the independent CMS Office of the Actuary.

4.4.4.4. Subject to Section 4.4.4.3 above, if other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and HHSC to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.

4.4.4.5. CMS and/or HHSC will make changes to baseline estimates after identification of the need for such changes, and changes will be applied, including on a retrospective basis if necessary, to effectuate accurate payment rates for each month.

4.4.4.6. Any material changes in the Medicaid State plan, including pertaining to Covered Services, payment schedules and related methodologies, shall be reflected in corresponding Capitation Rate adjustments. The STAR+PLUS MMP will not be required to implement such changes without advance notice and corresponding adjustment in the capitation payment. In addition, to the extent other Medicaid costs are incurred absent the Demonstration, such costs shall be reflected in corresponding Capitation Rate adjustments.

4.4.4.7. Changes to the savings percentages will be made if and when CMS and HHSC jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

4.4.5. Quality Withhold Policy

4.4.5.1. Under the Demonstration, both CMS and HHSC will withhold a percentage of their respective components of the Capitation Payment, with the exception of the Part D Component. The withheld amounts will be repaid subject to the STAR+PLUS MMP's performance consistent with established quality thresholds.

4.4.5.2. CMS and HHSC will evaluate the STAR+PLUS MMP's performance according to the specified metrics required in order to earn back the quality withhold for a given year.

4.4.5.3. Whether or not the STAR+PLUS MMP has met the quality requirements in a given year will be made public.

4.4.5.4. Additional details regarding the quality withholds, including more detailed specifications, required thresholds and other information regarding the methodology will be made available in separate technical guidance.

4.4.5.5. Withhold Measures in Demonstration Year 1

4.4.5.5.1. Table 4-3 below identifies the withhold measures for Demonstration Years 1.a and 1.b. Together, these will be utilized as the basis for a 1% withhold.

4.4.5.5.2. For Demonstration Year 1, which crosses calendar and Contract years, the STAR+PLUS MMP will be evaluated to determine whether it has met required quality withhold requirements at the end of both Calendar Year 2015 and Calendar Year 2016. The determination in CY 2015 will be based solely on those measures that can appropriately be calculated based on the actual Enrollment volume during CY 2015. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year. Note that, with respect to FSR reporting, neither the withholds, nor any later payment of amounts withheld, will impact the reporting of either Revenues, Allowable Costs, or Net Income Before Taxes, or, the calculation of the Experience Rebate. Revenues will be reported at their 100% value, as though there had not been anything withheld. Income will be calculated likewise, irrespective of whether the withholds are earned for later payment, or lost and forfeited. Withholds and later payments may be captured on a memo basis on the FSR, but this will not impact the financial results calculated and reported.

Table 4-3 Quality Withhold Measures for Demonstration Years 1.a and 1.b

Domain	Measure	Source	CMS Core Withhold Measure	State-Specified Withhold Measure
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure	X	
Assessments	Percent of Enrollees with initial assessments completed within 90 days of enrollment.	CMS/State defined process measure	X	
Beneficiary governance board	Establishment of beneficiary advisory board or inclusion of beneficiaries on governance board consistent with contract requirements.	CMS/State defined process measure	X	
Customer Service (DY 1.b only)	Percent of best possible score the plan earned on how easy it is to get information and help when needed. • In the last six months, how often did your health plan's	AHRQ/CAHPS	X	

	customer service give you the information or help you needed? • In the last six months, how often did your health plan's customer service treat you with courtesy and respect? • In the last six months, how often were the forms for your health plan easy to fill out?			
Getting Appointments and Care Quickly (DY 1.b only)	Percent of best possible score the plan earned on how quickly Enrollees get appointments and care • In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last six months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? • In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?	AHRQ/CAHPS	X	
LTSS (DY 1.b only)	Percent of Enrollees reporting that Service Coordinators involved them in decisions about their LTSS.	State-defined measure		X
Nursing Facility transition	Percent of individuals who went from the community to the hospital to the nursing facility and remained in nursing facility	State-defined measure		X
Annual Plan of Care update	Percent of Enrollees who's Plan of Care was updated annually before the expiration date.	State-defined measure		X

4.4.5.6. Demonstration Years 2 and 3

4.4.5.6.1. The quality withhold will increase to 2% in Demonstration Year 2 and 3% in Demonstration Year 3.

4.4.5.6.2. Payment will be based on performance on the quality withhold measures listed in Table 4-4 below.

Table 4-4 Quality Withhold Measures for Demonstration Years 2 and 3

Domain	Measure	Source	CMS Core Withhold Measure	State-Specified Withhold Measure
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure	X	
Plan all-cause readmissions	Percent of Enrollees Discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Annual flu vaccine	Percent of plan Enrollees who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental illness	Percentage of Discharges for Enrollees six years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	
Screening for clinical depression and follow-up care	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	
Reducing the risk of falling	Percent of Enrollees with a problem falling, walking or balancing who discussed it with their doctor and got	NCQA/HEDIS HOS	X	

Domain	Measure	Source	CMS Core Withhold Measure	State-Specified Withhold Measure
	treatment for it during the year.			
Controlling blood pressure	Percentage of Enrollees 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year.	NCQA/HEDIS	X	
Part D medication adherence for diabetes medications	Percent of plan Enrollees with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	
LTSS	Percent of Enrollees reporting that service coordinators involved them in decisions about their LTSS.	State-defined measure		X
Nursing Facility transition	Percent of individuals who went from the community to the hospital to the nursing facility and remained in nursing facility	State-defined measure		X
Plan of Care update	Percent of Enrollees who's Plan of Care was updated annually before the expiration date.	State-defined measure		X

4.4.6. American Recovery and Reinvestment Act of 2009

4.4.6.1. All payments to the STAR+PLUS MMP are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009.

4.4.7. Nursing facility shared savings program

4.4.7.1. The STAR+PLUS MMP must participate in the nursing facility shared savings Program. This program will require the STAR+PLUS MMP to pass a percentage of HHSC's savings achieved as a result of the demonstration to nursing facilities participating in the demonstration who meet specific performance standards.

4.4.7.2. The STAR+PLUS MMP will develop its own nursing facility shared savings program based on the unique characteristics of the STAR+PLUS MMP's population and nursing facilities.

4.4.7.3. HHSC will determine areas of focus for the initiative, and CMS will review the program parameters, including any impact on the Medicaid Component of the Capitation Rates. Additional details regarding the nursing facility shared savings program will be made available in separate technical guidance.

4.5. Suspension of Payments

4.5.1. General

4.5.1.1. HHSC may suspend payments to the STAR+PLUS MMP in accordance with 42 C.F.R. § 455.23, *et seq*.

4.6. Transitions between Rate Cells and Risk Score Changes

4.6.1. Rate Cell Changes

4.6.1.1. The Medicaid Component of the Capitation Payment will be updated following a change in an Enrollee's status relative to the Rate Cells in Section 4.2.1. On a monthly basis, as part of Capitation Payment processing, the Rate Cell of each Enrollee will be determined.

4.6.2. Medicare Risk Score Changes

4.6.2.1. Medicare CMS-HCC, HCC-ESRD, and RxHCC risk scores will be updated consistent with prevailing Medicare Advantage regulations and processes.

4.7. Reconciliation

4.7.1. General

4.7.1.1. CMS and HHSC will implement a process to reconcile Enrollment and Capitation Payments for the STAR+PLUS MMP that will take into consideration the following circumstances:

4.7.1.1.1. Transitions between Rate Cells;

4.7.1.1.2. Retroactive changes in eligibility, Rate Cells, or Enrollee contribution amounts;

4.7.1.1.3. Changes in CMS-HCC and RxHCC risk scores; and,

4.7.1.1.4. Changes through new Enrollment, disenrollment, or death.

4.7.1.2. The reconciliation may identify underpayments or overpayments to the STAR+PLUS MMP. Any such underpayments or overpayments will be added, or subtracted, as appropriate, to/from a following month's aggregate Capitation Payment.

4.7.2. Medicaid Capitation Reconciliation

4.7.2.1. HHSC may adjust a payment made to the STAR+PLUS MMP for an Enrollee if:

4.7.2.1.1. Enrollee's eligibility status or program type is changed, corrected as a result of error, or is retroactively adjusted;

4.7.2.1.2. Enrollee is enrolled into the STAR+PLUS MMP in error;

4.7.2.1.3. Enrollee moves outside the United States;

4.7.2.1.4. Enrollee dies before the first day of the month for which the payment was made; or

4.7.2.1.5. Payment has been denied by the CMS in accordance with the requirements in 42 C.F.R. § 438.730.

4.7.2.2. Appeal of adjustment

4.7.2.2.1. The STAR+PLUS MMP may Appeal the adjustment of capitation payments in the above circumstances using the HHSC dispute resolution process.

4.7.3. Medicare Capitation Reconciliation

4.7.3.1. Medicare capitation reconciliation will comply with prevailing Medicare Advantage and Part D regulations and processes.

4.7.4. Audits/Monitoring

4.7.4.1. CMS and HHSC will conduct periodic audits to validate Rate Cell assignments or other coding. Audits may be conducted by

a peer review organization or other entity assigned this responsibility by CMS and HHSC.

4.7.4.2. The STAR+PLUS MMPs must adhere to the requirements for audits outlined in Sections 2.16.4 and 5.4

4.8. Payment in Full

4.8.1. General

4.8.1.1. The STAR+PLUS MMP must accept as payment in full for all services under this Contract, (including Covered Services, deliverables, and administrative services), the Capitation Payment and the terms and conditions of payment set forth herein, except as provided in Appendix A Section A.3.

4.8.1.2. Notwithstanding any contractual provision or legal right to the contrary, the three parties to this Contract (CMS, HHSC and the STAR+PLUS MMP), for this Demonstration agree there shall be no redress against either of the other two parties, or their actuarial contractors, over the actuarial soundness of the Capitation Rates.

4.8.1.3. By signing this contract, the STAR+PLUS MMP accepts that the Capitation Rate offered is reasonable; that operating within this Capitation Rate is the sole responsibility of the STAR+PLUS MMP; and that while data is made available by the Federal Government to the STAR+PLUS MMP, any entity participating in the Demonstration must rely on their own resource to project likely experience under the Demonstration.

4.9. Insurance Coverage

4.9.1. Statutory and General Coverage

4.9.1.1. STAR+PLUS MMP will maintain, at the STAR+PLUS MMP's expense, the following insurance coverage:

4.9.1.2. Business automobile liability insurance for all owned, non-owned, and hired vehicles for bodily injury and property damage;

4.9.1.3. Comprehensive general liability insurance of at least $1,000,000.00 per occurrence and $5,000,000.00 in the aggregate (including bodily injury coverage of $100,000.00 per each occurrence and property damage coverage of $25,000.00 per occurrence); and

4.9.1.4. If STAR+PLUS MMP's current comprehensive general liability insurance coverage does not meet the above stated requirements, STAR+PLUS MMP will obtain umbrella liability insurance to compensate for the difference in the coverage amounts. If umbrella liability insurance is provided, it must follow the form of the primary coverage.

4.9.2. Professional Liability Coverage

4.9.2.1. STAR+PLUS MMP 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.

4.9.2.2. STAR+PLUS MMP 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 Enrollees enrolled in the STAR+PLUS MMP in the first month of the applicable State Fiscal Year multiplied by $150.00, not to exceed $10,000,000.00.

4.9.3. General Requirements for All Insurance Coverage

4.9.3.1. 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:

4.9.3.2. A STAR+PLUS MMP or a Network Provider is not required to obtain the insurance coverage described in Section 4.9.2 if the STAR+PLUS MMP 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.

4.9.3.3. Waivers for LTSS and DME

4.9.3.3.1. LTSS. A STAR+PLUS MMP may waive the professional liability insurance requirement described in Section 4.9.2 for a Network Provider of Community-Based LTSS. A STAR+PLUS MMP may not waive this requirement if the Network Provider provides other Covered Services in addition to Community-Based LTSS, or if a Texas licensing entity requires the Network Provider to carry such professional liability coverage. A STAR+PLUS MMP 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.

4.9.3.3.2. DME. A STAR+PLUS MMP may waive the professional liability insurance requirement described in 4.9.2 for Network Providers of durable medical equipment. A STAR+PLUS MMP 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.

4.9.3.4. The professional liability insurance requirements described in Section 4.9.2.1 do not apply to Nursing Facility Providers.

4.9.3.5. The STAR+PLUS MMP or the Network Provider is responsible for any and all deductibles stated in the insurance policies.

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

4.9.3.7. 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 exception of professional liability insurance maintained by Network Providers and business automobile liability insurance, all insurance coverage must name HHSC as a loss payee.

4.9.3.8. Insurance coverage kept by the STAR+PLUS MMP 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.

4.9.3.9. 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 (2) years. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, the Contract Effective Date.

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

4.9.3.11. The parties expressly understand and agree that any insurance coverages and limits furnished by STAR+PLUS MMP will in no way expand or limit STAR+PLUS MMP's liabilities and responsibilities specified within the Contract documents or by applicable law.

4.9.3.12. STAR+PLUS MMP expressly understands and agrees that any insurance maintained by HHSC will apply in excess of and not contribute to insurance provided by STAR+PLUS MMP under the Contract.

4.9.3.13. If STAR+PLUS MMP, or its Network Providers, desire additional coverage, higher limits of liability, or other modifications for its own protection, STAR+PLUS MMP 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.

4.9.3.14. STAR+PLUS MMP will require all insurers to waive their rights of subrogation against HHSC for Claims arising from or relating to this Contract.

4.9.4. Proof of Insurance Coverage

4.9.4.1. Except as provided in Section 4.9.2, the STAR+PLUS MMP must furnish the the CMT with original certificates or copies 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 STAR+PLUS MMP must furnish the CMT with renewal certificates of insurance, or such similar evidence, within five (5) business days of renewal. The failure of the CMT to obtain such evidence from STAR+PLUS MMP will not be deemed to

be a waiver by the CMT and STAR+PLUS MMP will remain under continuing obligation to maintain and provide proof of insurance coverage.

4.9.4.2. The STAR+PLUS MMP is not required to furnish the CMT with proof of professional liability insurance maintained by Network Providers on or before the Effective Date of the Contract, but must provide such information upon the CMT's request during the term of the Contract.

4.10. Bonds

4.10.1. Performance Bond

4.10.1.1. The STAR+PLUS MMP 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. STAR+PLUS MMP must obtain and maintain the performance bonds in the form prescribed by HHSC and approved by TDI, naming HHSC as obligee, securing STAR+PLUS MMP's faithful performance of the terms and conditions of this Contract. The performance bonds must comply with Chapter 843 of the Texas Insurance Code and 28 T.A.C. §11.1805. At least one (1) performance bond must be issued. The amount of the performance bond(s) should total $100,000.00 for each Service Area that the STAR+PLUS MMP covers under this Contract. Performance bonds must be issued by a surety licensed by TDI, and specify cash payment as the sole remedy. STAR+PLUS MMP must deliver each renewal prior to the first day of the State Fiscal Year.

4.10.2. Fidelity Bond

4.10.2.1. The STAR+PLUS MMP 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 STAR+PLUS MMP must promptly provide the CMT with copies of the bond and any amendments or renewals thereto.

Section 5. **Additional Terms and Conditions**

5.1. Administration

5.1.1. Notification of Administrative Changes

5.1.1.1. The STAR+PLUS MMP must notify CMS and HHSC through HPMS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The STAR+PLUS MMP must notify CMS and HHSC in HPMS no later than thirty (30) calendar days prior to any significant change to the manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a First Tier, Downstream, or Related Entity pursuant to Appendix C. The STAR+PLUS MMP must notify CMS and HHSC in HPMS of all other changes no later than five (5) business days prior to the effective date of such change.

5.1.2. Assignment

5.1.2.1. The STAR+PLUS MMP may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of CMS and HHSC, which may be withheld for any reason or for no reason at all.

5.1.3. Independent STAR+PLUS MMPs

5.1.3.1. The STAR+PLUS MMP, its employees, First Tier, Downstream and Related Entities, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers or employees of the Federal government, HHSC, or its Administrative Services Contractor.

5.1.4. Subrogation

5.1.4.1. Subject to CMS and HHSC lien and third-party recovery rights, the STAR+PLUS MMP must:

5.1.4.1.1. Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;

5.1.4.1.2. Require that the Enrollee pay to the STAR+PLUS MMP all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. The STAR+PLUS MMP may ask the Enrollee to:

5.1.4.1.2.1. Take such action, furnish such information and assistance, and execute such instruments as the STAR+PLUS MMP may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the STAR+PLUS MMP hereunder; and

5.1.4.1.2.2. Notify the STAR+PLUS MMP hereunder and authorize the STAR+PLUS MMP to make such investigations and take such action as the STAR+PLUS MMP may deem appropriate to protect its rights hereunder whether or not such notice is given.

5.1.5. Prohibited Affiliations

5.1.5.1. In accordance with 42 USC §1396 u-2(d)(1), the STAR+PLUS MMP shall not knowingly have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the STAR+PLUS MMP's obligations under this Contract with any person, or affiliate of such person, who is excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent of the STAR+PLUS MMP's equity or be permitted to serve as a director, officer, or partner of the STAR+PLUS MMP.

5.1.6. Disclosure Requirements

5.1.6.1. The STAR+PLUS MMP must disclose to CMS and HHSC information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B. The STAR+PLUS MMP must obtain federally required disclosures from all Network Providers and applicants in accordance with 42 C.F.R. 455 Subpart B and 42 C.F.R. § 1002.3, and as specified by HHSC, including but not limited to obtaining such information through Provider

Enrollment forms and credentialing and recredentialing packages. The STAR+PLUS MMP must maintain such disclosed information in a manner which can be periodically searched by the STAR+PLUS MMP for exclusions and provided to HHSC in accordance with this Contract and relevant state and federal laws and regulations. In addition, the STAR+PLUS MMP must comply with all reporting and disclosure requirements of 42 U.S.C. § 1396b(m)(4)(A) if the STAR+PLUS MMP is not a federally qualified health maintenance organization under the Public Health Service Act.

5.1.7. Physician Incentive Plans

5.1.7.1. The STAR+PLUS MMP may, in its discretion, operate a physician incentive plan only if:

5.1.7.1.1. No single physician is put at financial risk for the costs of treating an Enrollee that are outside the physician's direct control;

5.1.7.1.2. No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically appropriate services furnished to an individual Enrollee; and

5.1.7.1.3. The applicable stop/loss protection, Enrollee survey, and disclosure requirements of 42 C.F.R. Part 417 are met.

5.1.7.2. The STAR+PLUS MMP and its First Tier, Downstream, and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.6(h), and 1003. The STAR+PLUS MMP must submit all information required to be disclosed to CMS and the HHSC in the manner and format specified by CMS and the HHSC which, subject to Federal approval, must be consistent with the format required by CMS for Medicare contracts.

5.1.7.3. The STAR+PLUS MMP shall be liable for any and all loss of FFP incurred by HHSC that results from the STAR+PLUS MMP's or its First Tier, Downstream, and Related Entities' failure to comply with the requirements governing physician incentive plans at 42 C.F.R. Parts 417, 434 and 1003; however, the STAR+PLUS MMP shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the STAR+PLUS MMP's plan, and the STAR+PLUS MMP shall not be liable if it can

demonstrate, to the satisfaction of CMS and HHSC, that it has made a good faith effort to comply with the cited requirements.

5.1.7.4. The STAR+PLUS MMP cannot make payments under a physician incentive plan if the payments are designed to induce Providers to reduce or limit Medically Necessary Covered Services to Enrollees.

5.1.7.5. In accordance with 42 C.F.R. § 422.208, if the physician incentive plan places a physician or physician group at a substantial financial risk for services not provided by the physician or physician group, the STAR+PLUS MMP must ensure adequate stop-loss protection and conduct and submit annual Enrollee surveys no later than five (5) business days after the STAR+PLUS MMP finalizes the survey results.

5.1.7.6. If the STAR+PLUS MMP implements a physician incentive plan, the plan must comply with all applicable law, including 42 C.F.R. § 422.208 and § 422.210. The STAR+PLUS MMP cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Enrollees.

5.1.7.7. No later than five (5) business days prior to implementing or modifying a physician incentive plan, the STAR+PLUS MMP must provide the following information to the CMT:

5.1.7.7.1. Whether the physician incentive plan covers services that are not furnished by a physician or physician group;

5.1.7.7.2. The type of incentive arrangement (e.g., withhold, bonus, capitation);

5.1.7.7.3. The percent of withhold or bonus (if applicable); and

5.1.7.7.4. The panel size, and if patients are pooled, the method used (HHSC approval is required for the method used).

5.1.8. Physician Identifier

5.1.8.1. The STAR+PLUS MMP must require each physician providing Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. § 1320d-2(b). The STAR+PLUS MMP must provide such unique identifier to CMS and HHSC for each of its PCPs in the format and time-frame established by CMS and HHSC in consultation with the STAR+PLUS MMP.

5.1.9. Timely Provider Payments

5.1.9.1. The STAR+PLUS MMP must make timely payments to its Providers in accordance with Section 2.17.3.2. The STAR+PLUS MMP must include a prompt payment provision in its contracts with Providers and suppliers, the terms of which are developed and agreed to by both the STAR+PLUS MMP and the relevant Provider and further detailed in Appendix C. The STAR+PLUS MMP must ensure that ninety-eight (98) percent of Clean Claims from physicians who are in individual or group practice will be paid within thirty (30) days of the date of receipt of the Claim and ninety-nine (99)% within ninety (90) days. The STAR+PLUS MMP and its Providers may by mutual agreement, in writing, establish an alternative payment schedule.

5.1.9.2. Payment of Part D pharmacy Claims must follow the requirements set forth in Appendix D.

5.1.9.3. The STAR+PLUS MMP must process and adjudicate all Provider Claims for:

5.1.9.3.1. Medically Necessary Covered Services that are filed within the timeframes specified in Uniform Managed Care Manual Chapter 2.0, "Claims Manual;"

5.1.9.3.2. Medicaid covered pharmacy Claims that are filed in accordance with the timeframes specified in Uniform Managed Care Manual Chapter 2.2, "Pharmacy Claims Manual;" and

5.1.9.3.3. Nursing Facility Claims that are filed in accordance with the timeframes specified in Uniform Managed Care Manual Chapter 2.3, "Nursing Facility Claims Manual."

5.1.9.4. The STAR+PLUS MMP is subject to contractual remedies, including liquidated damages and interest, if the STAR+PLUS MMP does not process and adjudicate Claims in accordance with the procedures and the timeframes listed in Uniform Managed Care Manual Chapters 2.0, 2.1, 2.2, and 2.3 as well as the requirements set forth under Appendix D.

5.1.9.5. The STAR+PLUS MMP must administer an effective, accurate, and efficient Claims payment process in compliance with federal laws and regulations, applicable state laws and rules, and the Contract, including Uniform Managed Care Manual Chapters 2.0, 2.1, 2.2, and 2.3. In addition, STAR+PLUS MMPmust be able to accept and process

Provider Claims in compliance with the Texas Medicaid Provider Procedures Manual. The STAR+PLUS MMP and its First Tier, Downstream, and Related Entities cannot directly or indirectly charge or hold an Enrollee or Provider responsible for Claims adjudication or transaction fees.

5.1.9.6. The STAR+PLUS MMP must offer its Providers/First Tier, Downstream, and Related Entities 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.

5.1.9.7. The STAR+PLUS MMP must make an electronic funds transfer (EFT) payment process (for direct deposit) available to Network Providers.

5.1.9.8. The STAR+PLUS MMP may deny a Claim submitted by a Provider for failure to file in a timely manner as provided for in Uniform Managed Care Manual Chapters 2.0, 2.1, 2.2, and 2.3. The STAR+PLUS MMP must not pay any Claim submitted by a Provider:

5.1.9.8.1. Excluded or suspended from the Medicare or Medicaid programs for Fraud, Abuse, or Waste;

5.1.9.8.2. On payment hold under the authority of HHSC or its authorized agent(s);

5.1.9.8.3. With pending accounts receivable with HHSC; or

5.1.9.8.4. For a Nursing Facility Service, that does not comply with DADS' criteria for Clean Claims.

5.1.9.9. In accordance with Texas Health and Safety Code § 241.186, the restriction on payment identified in Section 5.1.9.8.4 above does not apply to Emergency Services that must be provided or reimbursed under state or federal law.

5.1.9.10. With the following exceptions, the STAR+PLUS MMP must complete all audits of a Provider Claim no later than two (2) years after receipt of a clean Claim, regardless of whether the Provider participates in the STAR+PLUS MMP's Network. This limitation does not apply in cases of Provider Fraud, Waste, or Abuse that the STAR+PLUS MMP did not discover within the two-year period following receipt of a Claim.

5.1.9.11. The two-year limitation does not apply when the following officials or entities conclude an examination, audit, or inspection of a Provider more than two years after the STAR+PLUS MMP received the Claim:

5.1.9.12. The United States Department of Health and Human Services or its designee;

5.1.9.13. The Comptroller General of the United States or its designee;

5.1.9.14. Personnel from HHSC or its designee;

5.1.9.15. The Office of Inspector General;

5.1.9.16. The Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;

5.1.9.17. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC or CMS;

5.1.9.18. The Office of the State Auditor of Texas or its designee;

5.1.9.19. A state or federal law enforcement agency;

5.1.9.1. A special or general investigating committee of the Texas Legislature or its designee; and

5.1.9.2. Any other state or federal entity identified.

5.1.9.3. The two-year limitation does not apply when HHSC has recovered a capitation from the STAR+PLUS MMP based on an Enrollee's ineligibility. If an exception to the two-year limitation applies, then the STAR+PLUS MMP may recoup related payments from Providers.

5.1.9.4. If an additional payment is due to a Provider as a result of an audit, the STAR+PLUS MMP must make the payment no later than thirty (30) days after it completes the audit. If the audit indicates that the STAR+PLUS MMP is due a refund from the Provider, the STAR+PLUS MMP must send the Provider written notice of the basis and specific reasons for the recovery no later than thirty (30) days after it completes the audit. If the Provider disagrees with the STAR+PLUS MMP's request, the STAR+PLUS MMP must give the Provider an opportunity to appeal, and may not attempt to recover the payment until the Provider has exhausted all appeal rights.

5.1.9.5. The STAR+PLUS MMP is subject to the requirements related to coordination of benefits for secondary payors in the Texas Insurance Code Section 843.349(e-f).

5.1.9.6. The STAR+PLUS MMP must make available to Providers Claims coding and processing guidelines for the applicable Provider type. Providers must receive ninety (90) days notice prior to the STAR+PLUS MMP's implementation of changes to Claims guidelines.

5.1.9.7. The STAR+PLUS MMP must maintain a system for tracking and resolving all Medicaid Provider Grievances and Appeals related to Claims payment, as required by Texas Government Code § 533.005(a)(15) and § 533.005(a)(19).

5.1.10. Protection of Enrollee-Provider Communications

5.1.10.1. In accordance with 42 USC §1396 u-2(b)(3), the STAR+PLUS MMP shall not prohibit or otherwise restrict a Provider or clinical First Tier, Downstream or Related Entity from advising an Enrollee about the health status of the Enrollee or medical care or treatment options for the Enrollee's condition or disease; information the Enrollee needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or the Enrollee's rights to participate in decisions about his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions, regardless of whether benefits for such care or treatment are provided under the Contract, if the Provider or clinical subcontractor is acting within the lawful scope of practice. The STAR + PLUS MMP may take no punitive action against a provider who either requests an expedited resolution or supports an Enrollee's Appeal.

5.1.11. Protecting Enrollee from Liability for Payment

5.1.11.1. The STAR+PLUS MMP must:

5.1.11.1.1. In accordance with 42 C.F.R. § 438.106, not hold an Enrollee liable for:

5.1.11.1.1.1. Debts of the STAR+PLUS MMP, in the event of the STAR+PLUS MMP's insolvency;

5.1.11.1.1.2. Covered Services provided to the Enrollee in the event that the STAR+PLUS MMP fails to receive payment from CMS or HHSC for such services; or

5.1.11.1.1.3. Payments to a clinical First Tier, Downstream, or Related Entity in excess of the amount that would be owed by the Enrollee if the STAR+PLUS MMP had directly provided the services.

5.1.11.1.2. Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in Appendix A;

5.1.11.1.3. Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any applicable charge;

5.1.11.1.4. Not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible for the Texas Dual Eligibles Integrated Care Demonstration Project, incurred a bill that has not been paid; and

5.1.11.1.5. Ensure Provider Network compliance with all Enrollee payment restrictions, including balance billing restrictions, and develop and implement a plan to identify and revoke or provide other specified remedies for any member of the STAR+PLUS MMP's Provider Network that does not comply with such provisions. However, the STAR+PLUS MMP will work with Enrollees or their LARs to help Nursing Facilities collect applied income where applicable.

5.1.12. Moral or Religious Objections

5.1.12.1. The STAR+PLUS MMP is not required to provide, reimburse for, or provide coverage of, a counseling or referral service that would otherwise be required if the STAR+PLUS MMP objects to the service on moral or religious grounds. If the STAR+PLUS MMP elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

5.1.12.1.1. To HHSC;

5.1.12.1.2. With its application for a Contract;

5.1.12.1.3. Whenever it adopts the policy during the term of the Contract; and

5.1.12.1.4. The information provided must be:

5.1.12.1.4.1. Consistent with the provisions of 42 C.F.R. § 438.10;

5.1.12.1.4.2. Provided to Potential Enrollees before and during Enrollment; and

5.1.12.1.4.3. Provided to Enrollees within ninety (90) days after adopting the policy with respect to any particular service.

5.1.13. Third Party Health Insurance and Third Party Liability and Recovery

5.1.13.1. General Requirements

5.1.13.1.1. Enrollees, determined by HHSC, CMS or the STAR+PLUS MMP as having Third Party Health Insurance are excluded from Passive Enrollment . Any such Enrollee will be disenrolled from the Demonstration, effective the first day of the month following the month in which the coverage was verified. Enrollees will not be retroactively disenrolled due to Third Party Health Insurance coverage. Until disenrollment occurs, the STAR+PLUS MMP is responsible for coordinating all benefits covered under this Contract.

5.1.13.1.2. Under Section 1902 (a)(25) of the Social Security Act (42 U.S.C. §1396 a (a)(25)), the state is required to take all reasonable measures to identify legally liable third parties and pursue verified resources. In cases in which the Enrollee was not identified for exclusion prior to Enrollment in the STAR+PLUS MMP, the STAR+PLUS MMP shall take responsibility for identifying and pursuing Third Party Health Insurance. Any moneys recovered by third parties shall be retained by the STAR+PLUS MMP and identified monthly to HHSC and CMS. The STAR+PLUS MMP shall notify HHSC and CMS on a monthly basis of any Enrollees identified during that past month who were discovered to have Third Party Health Insurance.

5.1.13.1.3. STAR+PLUS MMPs are responsible for establishing a plan and process for avoiding and recovering costs for services that should have been paid through a third party. The plan and process must be in accordance with state and federal law and regulations, including Section 1902(a)(25)(E) and (F) of the Social Security Act, which require STAR+PLUS MMPs to pay and later seek recovery from liable third parties: (1) for prenatal care, and (2) in the context of a state child support enforcement action. The projected amount of TPR that the STAR+PLUS MMP is expected to recover may be factored into the rate setting process.

5.1.13.1.4. HHSC will provide the STAR+PLUS MMP, by Plan code, a monthly Enrollee file (also known as a TPR client file). The file is an extract of those Medicaid Enrollees who are known or believed to have other insurance. The file contains any Third Party Recovery (TPR) data that HHSC's Claims administration agent has on file for individual Medicaid beneficiaries, organized by name and beneficiary number, and adding additional relevant information where available, such as the insured's name/contact information, type of coverage, the insurance carrier, and the effective dates.

5.1.13.1.5. The STAR+PLUS MMP must submit TPL/TPR reports quarterly, by STAR+PLUS MMP and Service Area. TPL/TPR reports must include total dollars costs avoided, and total dollars recovered from third party payers through the STAR+PLUS MMP's coordination of benefits and subrogation efforts during the Quarter.

5.1.13.1.6. After one hundred twenty (120) days from the date of adjudication of a Claim that is subject to TPR, HHSC has the right to attempt recovery, independent of any STAR+PLUS MMP action. HHSC will retain, in full, all funds received as a result of any state-initiated TPR or subrogation action.

5.1.14. Abuse, Neglect, or Exploitation

5.1.14.1. The STAR+PLUS MMP, its First Tier, Downstream, and Related Entities, and Providers must report any suspicion or allegation of ANE in accordance with Texas Human Resources Code § 48.051; Texas Health and Safety Code § 260A.002; and Texas Family Code § 261.101.

5.1.14.2. At the time a STAR+PLUS MMP Enrollee is approved for LTSS, the STAR+PLUS MMP must ensure that the Enrollee is informed orally and in the Enrollee Handbook of the processes for reporting allegations of ANE. The toll-free numbers for DADS and DFPS must be provided.

5.1.15. E-Verify System

5.1.15.1. By entering into this Contract, the STAR+PLUS MMP certifies and ensures that it utilizes and will continue to utilize, for the Contract Term, the U.S. Department of Homeland Security's E-Verify system to determine the eligibility of:

5.1.15.1.1. All persons employed to perform duties within Texas, during the term of the Contract; and

5.1.15.1.2. All persons (including First Tier, Downstream, and Related Entities) assigned by the STAR+PLUS MMP to perform work pursuant to the Contract, within the United States of America.

5.1.15.2. HHSC requires STAR+PLUS MMPs to contract with Electronic Visit Verification (EVV) Vendors who use a system to verify, attendant care services and other services identified by UMCM Chapter 8.7. The STAR+PLUS MMP's must contract with EVV Vendors for the provision of EVV services in a manner consistent with the UMCM. The STAR+PLUS MMP may not pass EVV transaction cost to providers.

5.2. Confidentiality

5.2.1. Statutory Requirements

5.2.1.1. The STAR+PLUS MMP understands and agrees that CMS and HHSC may require specific written assurances and further agreements regarding the security and Privacy of protected health information that are deemed necessary to implement and comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as implemented in 45 C.F.R., parts 160 and 164. The STAR+PLUS MMP further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal data. The STAR+PLUS MMP represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under this Contract in accordance with applicable state and federal laws. The STAR+PLUS MMP is required to design, develop, or

operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 U.S.C.552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

5.2.2. Personal Data

5.2.2.1. The STAR+PLUS MMP must inform each of its employees having any involvement with personal data or other Confidential Information, whether with regard to design, development, operation, or maintenance, of the laws and regulations relating to confidentiality.

5.2.3. Data Security

5.2.3.1. The STAR+PLUS MMP must take reasonable steps to ensure the physical security of personal data or other Confidential Information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Enrollee names.

5.2.3.2. The STAR+PLUS MMP must put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the Privacy and security of protected health information in accordance with 45 C.F.R. §164.530(c).

5.2.3.3. The STAR+PLUS MMP must meet the security standards, requirements, and implementation specifications as set forth in 45 C.F.R. part 164, subpart C, the HIPAA Security Rule.

5.2.3.4. The STAR+PLUS MMP must follow the National Institute for Standards and Technology (NIST) Guidelines for the Risk Management Framework (RMF) to establish an information security program in accordance with the Federal Information Security Management Act (FISMA).

5.2.4. Return of Personal Data

5.2.4.1. The STAR+PLUS MMP must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of CMS or HHSC in whatever form it is maintained by the STAR+PLUS MMP.

5.2.4.2. Upon the termination or completion of this Contract, the STAR+PLUS MMP shall not use any such data or any material derived from the data for any purpose, and, where so instructed by CMS or HHSC will destroy such data or material.

5.2.5. Destruction of Personal Data

5.2.5.1. For any protected health information (PHI) received regarding an Eligible Beneficiary referred to the STAR+PLUS MMP by HHSC but who does not enroll in STAR+PLUS MMP, the STAR+PLUS MMP must destroy the PHI in accordance with standards set forth in NIST Special Publication 800-88, Guidelines for Media Sanitizations, and all applicable state and federal privacy and security laws including HIPAA and its related implementing regulations, at 45 C.F.R. Parts 160, 162, and 164, as may be amended from time to time.

5.2.5.2. The STAR+PLUS MMP shall also adhere to standards described in OMB Circular No. A-130, Appendix III-Security of Federal Automated Information Systems and NIST Federal Information Processing Standard 200 entitled “Minimum Security Requirements for Federal Information and Information Systems” while in possession of all PHI.

5.2.6. Research Data

5.2.6.1. The STAR+PLUS MMP must seek and obtain prior written authorization from CMS and HHSC for the use of any data pertaining to this Contract for research or any other purposes not directly related to the STAR+PLUS MMP’s performance under this Contract.

5.3. General Terms and Conditions

5.3.1. Applicable Law

5.3.1.1. The term "applicable law," as used in this Contract, means, without limitation, all federal and state law, and the regulations, policies, procedures, and instructions of CMS and HHSC all as existing now or during the term of this Contract. All applicable law is hereby incorporated into this Contract by reference.

5.3.2. Sovereign Immunity

5.3.2.1. Nothing in this Contract will be construed to be a waiver by the State of Texas or CMS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

5.3.3. Advance Directives

5.3.3.1. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicare or Medicaid program.

5.3.3.2. The STAR+PLUS MMP cannot require Enrollees to execute or issue an advance directive as a condition of receiving Health Care Services. The STAR+PLUS MMP cannot discriminate against an Enrollee based on whether or not the Enrollee has executed or issued an advance directive.

5.3.3.3. The STAR+PLUS MMP's policies and procedures must require the STAR+PLUS MMP and First Tier, Downstream, and Related Entities to comply with the requirements of state and federal law relating to advance directives. The STAR+PLUS MMP must provide education and training to employees and Enrollees on issues concerning advance directives.

5.3.3.4. All materials provided to Enrollees regarding advance directives must be written at a 7th - 8th grade reading comprehension level, except where a provision is required by state or federal law and the provision cannot be reduced or modified to a 7th - 8th grade reading level because it is a reference to the law or is required to be included "as written" in the state or federal law.

5.3.3.5. The STAR+PLUS MMP must notify Enrollees of any changes in state or federal laws relating to advance directives within ninety (90) days from the effective date of the change, unless the law or regulation contains a specific time requirement for notification.

5.3.4. Loss of Licensure

5.3.4.1. If, at any time during the term of this Contract, the STAR+PLUS MMP or any of its First Tier, Downstream, or Related Entities incurs loss of licensure at any of the

STAR+PLUS MMP's facilities or loss of necessary federal or state approvals, the STAR+PLUS MMP must report such loss to CMS and HHSC. Such loss may be grounds for termination of this Contract under the provisions of Section 6.

5.3.5. Indemnification

5.3.5.1. The STAR+PLUS MMP shall indemnify and hold harmless CMS, the federal government, the State of Texas, and their agencies, officers, employees, agents and volunteers from and against any and all liability, loss, damage, costs, or expenses which CMS and or HHSC may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the STAR+PLUS MMP, any person employed by the STAR+PLUS MMP, or any of its First Tier, Downstream, or Related Entities provided that:

5.3.5.1.1. The STAR+PLUS MMP is notified of any Claims within a reasonable time from when CMS and HHSC become aware of the Claim; and

5.3.5.1.2. The STAR+PLUS MMP is afforded an opportunity to participate in the defense of such Claims.

5.3.6. Prohibition against Discrimination

5.3.6.1. In accordance with 42 U.S.C. §1396 u-2(b)(7), the STAR+PLUS MMP shall not discriminate with respect to participation, reimbursement, or indemnification of any Provider in the STAR+PLUS MMP's Provider Network who is acting within the scope of the Provider's license or certification under applicable federal or state law, solely on the basis of such license or certification. This section does not prohibit the STAR+PLUS MMP from including Providers in its Provider Network to the extent necessary to meet the needs of the STAR+PLUS MMP's Enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the STAR+PLUS MMP.

5.3.6.2. The STAR+PLUS MMP shall abide by all federal and state laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, national origin, ancestry, age, physical or mental Disability, including, but not limited to, the Federal Civil Rights Act of 1964, the Americans with Disabilities Act (ADA) of 1990, the Federal Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age

Discrimination Act of 1975, state administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

5.3.6.3. The STAR+PLUS MMP further agrees to take affirmative action to ensure that no unlawful discrimination is committed in any manner including, but not limited to, the delivery of services under this Contract.

5.3.6.4. The STAR+PLUS MMP will not discriminate against Potential Enrollees, Prospective Enrollees, or Enrollees on the basis of health status or need for health services.

5.3.6.5. Nothing in this Contract may be construed to require the STAR+PLUS MMP to contract with Providers beyond the number necessary to meet the needs of its Enrollees; precludes the STAR+PLUS MMP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or precludes the STAR+PLUS MMP from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.

5.3.6.6. If a Grievance or Claim against the STAR+PLUS MMP is presented to HHSC for handling discrimination complaints, the STAR+PLUS MMP must cooperate with in the investigation and disposition of such Complaint or Claim.

5.3.6.1. Upon request, the STAR+PLUS MMP will provide HHSC Civil Rights Office with copies of all of the STAR+PLUS MMP's civil rights policies and procedures.

5.3.6.2. The STAR+PLUS MMP 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.

5.3.7. Anti-Boycott Covenant

5.3.7.1. During the time this Contract is in effect, neither the STAR+PLUS MMP nor any affiliated company, as hereafter defined, may participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful under comparable Texas state law or regulation. Without limiting such other rights as it may have,

CMS and HHSC will be entitled to rescind this Contract in the event of noncompliance with this Section.

5.3.7.2. As used herein, an affiliated company is any business entity directly or indirectly owning at least fifty-one (51) percent of the ownership interests of the STAR+PLUS MMP.

5.3.8. Information Sharing

5.3.8.1. During the course of an Enrollee's Enrollment or upon transfer or termination of Enrollment, whether voluntary or involuntary, and subject to all applicable federal and state laws, the STAR+PLUS MMP must arrange for the transfer, at no cost to CMS, HHSC, or the Enrollee, of medical information regarding such Enrollee to any subsequent Provider of medical services to such Enrollee, as may be requested by the Enrollee or such Provider or directed by CMS and HHSC the Enrollee, regulatory agencies of the State of Texas, or the United States Government. With respect to Enrollees who are in the custody of the State, the STAR+PLUS MMP must provide, upon reasonable request of the state agency with custody of the Enrollee, a copy of said Enrollee Medical Record s in a timely manner.

5.3.9. Other Contracts

5.3.9.1. Nothing contained in this Contract will be construed to prevent the STAR+PLUS MMP from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder; provided, however, that the STAR+PLUS MMP must provide CMS and HHSC with a complete list of such plans and services, upon request. CMS and HHSC will exercise discretion in disclosing information that the STAR+PLUS MMP may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent CMS or HHSC from contracting with other comprehensive health care plans, or any other Provider, in the same Service Area.

5.3.10. Counterparts

5.3.10.1. This Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

5.3.11. Entire Contract

5.3.11.1. This Contract constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Contract will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

5.3.12. No Third-Party Rights or Enforcement

5.3.12.1. No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

5.3.13. Tailored Remedies

5.3.13.1. Understanding of the parties

5.3.13.1.1. The STAR+PLUS MMP agrees and understands that the CMT may pursue tailored contractual remedies for noncompliance with the Contract. At any time and at its discretion, the CMT may impose or pursue one (1) or more remedies for each item of noncompliance and will determine remedies on a case-by-case basis. The CMT's pursuit or non-pursuit of a tailored remedy does not constitute a waiver of any other remedy that CMS and/or HHSC may have at law or equity.

5.3.13.1.2. Before the compliance actions outlined in this Contract are implemented, the CMT may provide opportunity to the STAR+PLUS MMP to cure deficiencies and come into compliance.

5.3.14. Corrective Action Plan

5.3.14.1. If, at any time, the CMT reasonably determines that the STAR+PLUS MMP is deficient in the performance of its obligations under the Contract, the CMT may require the STAR+PLUS MMP to develop and submit a corrective action plan that is designed to correct or resolve such deficiency. The CMT will approve, disapprove, or require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The STAR+PLUS MMP must promptly and diligently implement the corrective action plan as approved by CMS and HHSC. Failure to implement the corrective action plan may subject the STAR+PLUS MMP to termination of the Contract

by CMS and HHSC or other intermediate sanctions as described in Section.

5.3.14.2. The Corrective Action Plan must provide:

5.3.14.2.1. A detailed explanation of the reasons for the cited deficiency;

5.3.14.2.2. STAR+PLUS MMP's assessment or diagnosis of the cause; and

5.3.14.2.3. A specific proposal to cure or resolve the deficiency.

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

5.3.14.4. The CMT will notify STAR+PLUS MMP in writing of the final disposition of the CMT's concerns. If the CMT accepts STAR+PLUS MMP's proposed Corrective Action Plan, HHSC or CMS may:

5.3.14.4.1. Condition such approval on completion of tasks in the order or priority that the CMT may reasonably prescribe;

5.3.14.4.2. Disapprove portions of STAR+PLUS MMP's proposed Corrective Action Plan; or

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

5.3.14.5. Notwithstanding the submission and acceptance of a Corrective Action Plan, STAR+PLUS MMP remains responsible for achieving all written performance criteria

5.3.14.6. The CMT's acceptance of a Corrective Action Plan under this Section will not:

5.3.14.6.1. Excuse STAR+PLUS MMP's prior substandard performance;

5.3.14.6.1. Relieve STAR+PLUS MMP of its duty to comply with performance standards; or

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

5.3.15. Damages

5.3.15.1. CMS and HHSC will be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages resulting from STAR+PLUS MMP's breach of this Contract. In some cases, the actual damage to CMS and HHSC or State of Texas as a result of STAR+PLUS MMP'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 STAR+PLUS MMP in for failure to meet any aspect of the responsibilities of the Contract and/or to meet the specific performance standards identified by the CMT. Liquidated damages will be assessed if the CMT determines such failure is the fault of the STAR+PLUS MMP (including the STAR+PLUS MMP's First Tier, Downstream, or Related Entities, agents and/or consultants) and is not materially caused or contributed to by HHSC, CMS, or their agents. The CMT 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 representative of HHSC and/or CMS.

5.3.15.2. 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 the CMS and HHSC's projected financial loss and damage resulting from the STAR+PLUS MMP's nonperformance, including financial loss as a result of project delays. Accordingly, in the event STAR+PLUS MMP fails to perform in accordance with the Contract, CMS and HHSC may assess liquidated damages as specified below:

5.3.15.2.1. Up to $5,000 per calendar day for each incident of non-compliance with the terms of this Contract;

5.3.15.2.2. Up to $7,500 per calendar day for failure to perform any of the Covered Services described in the Contract;

5.3.15.2.3. Up to $250 per calendar day for reports and/or deliverables that are not submitted timely, or are incomplete or inaccurate; and

5.3.15.2.4. Up to $1000 if the report and/or deliverable is not submitted in the format or template required and up to $250 per calendar day until the report and/or deliverable is submitted in the required format or template.

5.3.15.3. CMS and HHSC may elect to collect liquidated damages:

5.3.15.3.1. Through direct assessment and demand for payment delivered to STAR+PLUS MMP; or

5.3.15.3.2. By deduction of amounts assessed as liquidated damages as set-off against payments then due to STAR+PLUS MMP or that become due at any time after assessment of the liquidated damages. CMS and HHSC will make deductions until the full amount payable by the STAR+PLUS MMP is collected by CMS and HHSC.

5.3.16. Equitable Remedies

5.3.16.1. STAR+PLUS MMP acknowledges that, if STAR+PLUS MMP breaches (or attempts or threatens to breach) its material obligation under this Contract, CMS and HHSC may be irreparably harmed. In such a circumstance, CMS and HHSC may proceed directly to court to pursue equitable remedies.

5.3.16.2. If a court of competent jurisdiction finds that STAR+PLUS MMP breached (or attempted or threatened to breach) any such obligations, STAR+PLUS MMP 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 STAR+PLUS MMP and restraining it from any further breaches (or attempted or threatened breaches).

5.3.17. Intermediate Sanctions and Civil Monetary Penalties

5.3.17.1. In addition to termination under Section 6, the CMT may impose any or all of the sanctions described in this Section upon any of the events below; provided, however, that CMS and HHSC will impose only those sanctions they determine to be reasonable and appropriate for the specific violations identified.

5.3.17.2. Sanctions may be imposed in accordance with state and federal regulations that are current at the time of the sanction.

5.3.17.3. Sanctions may be imposed in accordance with this section if the STAR+PLUS MMP:

5.3.17.3.1. Fails substantially to provide Covered Services required to be provided under this Contract to Enrollees;

5.3.17.3.2. Imposes charges on Enrollees in excess of any permitted under this Contract;

5.3.17.3.3. Discriminates among Enrollees or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, and uses any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;

5.3.17.3.4. Misrepresents or falsifies information provided to CMS, HHSC and/or the Administrative Services Contractor, Enrollees, prospective Enrollees, or its Provider Network;

5.3.17.3.5. Fails to comply with requirements regarding physician incentive plans (see Section 5.1.7);

5.3.17.3.6. Fails to comply with federal or state statutory or regulatory requirements related to this Contract;

5.3.17.3.7. Violates restrictions or other requirements regarding marketing;

5.3.17.3.8. Fails to comply with quality management requirements consistent with Section 2.13;

5.3.17.3.9. Fails to comply with any corrective action plan required by CMS and HHSC;

5.3.17.3.10. Fails to comply with financial solvency requirements;

5.3.17.3.11. Fails to comply with reporting requirements; or

5.3.17.3.12. Fails to comply with any other requirements of this Contract.

5.3.17.4. Sanctions that may be imposed include:

5.3.17.4.1. Financial penalties consistent with 42 C.F.R. § 422.760 and/or 42 C.F.R. § 438.704;

5.3.17.4.2. The appointment of temporary management to oversee the operation of the STAR+PLUS MMP in those circumstances set forth in 42 U.S.C. §1396 u-2(e)(2)(B);

5.3.17.4.3. Suspension of Enrollment (including assignment of Enrollees);

5.3.17.4.4. Suspension of payment to the STAR+PLUS MMP;

5.3.17.4.5. Disenrollment of Enrollees;

5.3.17.4.6. Suspension of marketing; and

5.3.17.4.7. Denial of payment as set forth in 42 C.F.R. § 438.730.

5.3.17.5. If CMS or HHSC have identified a deficiency in the performance of a First Tier, Downstream, or Related Entity, and the STAR+PLUS MMP has not successfully implemented an approved corrective action plan in accordance with Section5.3.14, CMS and HHSC may:

5.3.17.5.1. Require the STAR+PLUS MMP to subcontract with a different First Tier, Downstream, or Related Entity deemed satisfactory by CMS and HHSC; or

5.3.17.5.2. Require the STAR+PLUS MMP to change the manner or method in which the STAR+PLUS MMP ensures the performance of such contractual responsibility.

5.3.17.6. Before imposing any intermediate sanctions, HHSC and CMS must give the STAR+PLUS MMP timely written notice that explains the basis and nature of the sanction and other due process protections that HHSC and CMS elect to provide.

5.3.18. Additional Administrative Procedures

5.3.18.1. CMS and HHSC may, from time to time, issue program memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The STAR+PLUS MMP must comply with all such program memoranda.

5.3.19. Effect of Invalidity of Clauses

5.3.19.1. If any clause or provision of this Contract is officially declared to be in conflict with any federal or state law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

5.3.20. Conflict of Interest

5.3.20.1. Neither the STAR+PLUS MMP nor any First Tier, Downstream, or Related Entity may, for the duration of the Contract, have any interest that will conflict, as determined by CMS and HHSC with the performance of services under the Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, CMS and HHSC require that neither the STAR+PLUS MMP nor any First Tier, Downstream, or Related Entity has any financial, legal, contractual or other business interest in any entity performing STAR+PLUS MMP Enrollment functions for HHSC. The STAR+PLUS MMP further certifies that it will comply with Section 1932(d) of the Social Security Act.

5.3.21. Waiver

5.3.21.1. The STAR+PLUS MMP, CMS, or HHSC shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a LAR. No delay or omission on the part of the STAR+PLUS MMP, CMS, or HHSC in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by CMS and HHSC of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

5.3.22. Section Headings

5.3.22.1. The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

5.4. Record Retention, Inspection, and Audits

5.4.1. General

5.4.1.1. The STAR+PLUS MMP must maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for ten (10) years from the end of the final Contract period or completion of audit, whichever is later.

5.4.1.2. The STAR+PLUS MMP must make the records maintained by the STAR+PLUS MMP and its Provider Network, as required by CMS and HHSC and other regulatory agencies, available to CMS and HHSC and its agents or designees, or any other authorized representatives of the State of Texas or the United States Government, or their designees, at such times, places,

and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the STAR+PLUS MMP. The STAR+PLUS MMP must also adhere to the requirements for FSR audits as outlined in Section 2.16.4. Further, the STAR+PLUS MMP must submit copies of certain audited financial statements to HHSC, as outlined in Sections 2.16.5.1 and 2.16.5.2.3.

5.4.1.3. The STAR+PLUS MMP further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General or his or her designee, and the State Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the STAR+PLUS MMP and its First Tier, Downstream, and Related Entities that pertain to: the ability of the STAR+PLUS MMP to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

5.4.1.4. The STAR+PLUS MMP must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Enrollees, and any additional relevant information that CMS or HHSC may require, in a manner that meets CMS and HHSC' record maintenance requirements.

5.4.1.5. The STAR+PLUS MMP must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and their designees to inspect, evaluate, and audit records through ten (10) years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with federal and state requirements.

5.5. Suspension of Contract

5.5.1. General

5.5.1.1. HHSC and/or CMSmay suspend performance of all or any part of the Contract if:

5.5.1.1.1. The CMT determines that STAR+PLUS MMP has committed a material breach of the Contract;

5.5.1.1.2. The CMT has reason to believe that STAR+PLUS MMP has committed, or assisted in the commission of, Fraud, Abuse, Waste, malfeasance, misfeasance, or nonfeasance by any party concerning the Contract;

5.5.1.1.3. The CMT determines that the STAR+PLUS MMP knew, or should have known, of Fraud, Abuse, Waste, malfeasance, or nonfeasance by any party concerning the Contract, and the STAR+PLUS MMP failed to take appropriate action; or

5.5.1.1.4. The CMT 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.

5.5.1.2. The CMT will notify the STAR+PLUS MMP in writing of its intention to suspend the Contract in whole or in part. Such notice will:

5.5.1.2.1. Be delivered in writing to the STAR+PLUS MMP;

5.5.1.2.2. Include a concise description of the facts or matter leading to The CMT's decision; and

5.5.1.2.3. Unless the CMT is suspending the Contract for reasons unrelated to STAR+PLUS MMP performance, request a corrective action plan from the STAR+PLUS MMP or describe actions that the STAR+PLUS MMP may take to avoid the contemplated suspension of the Contract.

5.6. Termination of Contract

5.6.1. General

5.6.1.1. In the event the STAR+PLUS MMP materially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or Texas Medicaid programs, CMS or HHSC may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract. CMS or HHSC may terminate the contract in accordance with regulations that are current at the time of the termination.

5.6.2. Termination without Prior Notice

5.6.2.1. Without limiting the above, if CMS and HHSC determine that participation of the STAR+PLUS MMP in the Medicare or Texas Medicaid program or in the Demonstration, may

threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the Medicare or Texas Medicaid program, CMS or HHSC, without prior notice, may immediately terminate this Contract, suspend the STAR+PLUS MMP from participation, withhold any future payments to the STAR+PLUS MMP, or take any or all other actions under this Contract, law, or equity. Such action may precede beneficiary Enrollment into any STAR+PLUS MMP, and shall be taken upon a finding by CMS or HHSC that the STAR+PLUS MMP has not achieved and demonstrated a state of readiness that will allow for the safe and efficient provision of Medicare-Medicaid services to Enrollees.

5.6.2.2. United States law will apply to resolve any Claim of breach of this Contract.

5.6.3. Termination with Prior Notice

5.6.3.1. CMS or HHSC may terminate this Contract without cause upon no less than one-hundred eighty (180) days prior written notice to the other party specifying the termination date, unless applicable law requires otherwise. Per Section 5.8, plans may choose to non-renew prior to the end of each term pursuant to 42 C.F.R. 422.506(a), except in Demonstration Year 1, in which the STAR+PLUS MMP may choose to non-renew the contract as of December 31, 2015 provided the STAR+PLUS MMP gives notice before August 1, 2015, and may terminate the contract by mutual consent of CMS and HHSC at any time pursuant to 42 C.F.R. § 422.508. In considering requests for termination under 42 C.F.R. § 422.508, CMS and HHSC consider, among other factors, financial performance and stability in granting consent for termination. Any written communications or oral scripts developed to implement the requirements of 42 C.F.R. § 422.506(a) must be submitted to and approved by CMS and HHSC prior to their use.

5.6.3.2. Pursuant to 42 C.F.R. §§ 422.506(a)(4) and 422.508(c), CMS considers STAR+PLUS MMP termination of this Contract with prior notice as described in Section 5.6.3 and non-renewal of this Contract as described in Section 5.8 to be circumstances warranting special consideration, and will not prohibit the STAR+PLUS MMP from applying for new Medicare Advantage contracts or Service Area expansions for a period of two years due to termination.

5.6.4. Termination pursuant to Social Security Act § 1115A(b)(3)(B).

5.6.5. Termination for Cause

5.6.5.1. Any party may terminate this Agreement upon ninety (90) days' notice due to a material breach of a provision of this Contract unless CMS or HHSC determines that a delay in termination would pose an imminent and serious risk to the health of the individuals enrolled with the STAR+PLUS MMP or the STAR+PLUS MMP experiences financial difficulties so severe that its ability make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Enrollees, whereby CMS or HHSC may expedite the termination.

5.6.5.2. Pre-termination Procedures: Before terminating a Contract for cause under 42 C.F.R. §422.510 and §438.708, the STAR+PLUS MMP may request a pre-termination hearing or develop and implement a corrective action plan. CMS or HHSC must:

5.6.5.2.1. Give the STAR+PLUS MMP written notice of its intent to terminate, the reason for termination, and a reasonable opportunity of at least thirty (30) calendar days to develop and implement a corrective action plan to correct the deficiencies; and/or

5.6.5.2.2. Notify the STAR+PLUS MMP of its Appeal rights as provided in 42 C.F.R. § 422 Subpart N and § 438.710.

5.6.6. Termination due to a Change in Law

5.6.6.1. In addition, CMS or HHSC may terminate this Contract upon thirty (30) days' notice due to a material change in law, or with less or no notice if required by law.

5.6.7. Continued Obligations of the Parties

5.6.7.1. In the event of termination, expiration, or non-renewal of this Contract, or if the STAR+PLUS MMP otherwise withdraws from the Medicare or Texas Medicaid programs, the STAR+PLUS MMP shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the STAR+PLUS MMP; provided, however, that CMS and HHSC will exercise best efforts to complete all disenrollment activities within six (6) months from the date of termination or withdrawal.

5.6.7.2. In the event that this Contract is terminated, expires, or is not renewed for any reason:

5.6.7.2.1. If CMS or HHSC, or both, elect to terminate or not renew the Contract, CMS and HHSC will be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive care. If the STAR+PLUS MMP elects to terminate or not renew the Contract, the STAR+PLUS MMP will be responsible for notifying all Enrollees and the general public, in accordance with federal and State requirements;

5.6.7.2.2. The STAR+PLUS MMP must promptly return to CMS and HHSC all payments advanced to the STAR+PLUS MMP for Enrollees after the effective date of their disenrollment; and

5.6.7.2.3. The STAR+PLUS MMP must supply to CMS and HHSC all information necessary for the payment of any outstanding Claims determined by CMS and HHSC to be due to the STAR+PLUS MMP, and any such Claims will be paid in accordance with the terms of this Contract.

5.7. Order of Precedence

5.7.1. Order of Precedence Rules

5.7.1.1. The following documents are incorporated into and made a part of this Contract, including all appendices. In the event of any conflict among the documents that are a part of this Contract, including all appendices, the order of priority to interpret the Contract shall be as follows:

5.7.1.1.1. The Contract terms and conditions, including all appendices;

5.7.1.1.2. Capitated Financial Alignment Application, a document issued by CMS and subject to modification each program year;

5.7.1.1.3. Memorandum of Understanding, a document between CMS and the State of Texas Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (May 23, 2014);

5.7.1.1.4. HHSC Uniform Managed Care Manual (UMCM).

5.7.1.1.5. Any state or federal requirements or instructions released to Medicare-Medicaid Plans. Examples include the annual rate report, Medicare-Medicaid Marketing Guidance, Enrollment Guidance, and Reporting Requirements.

5.7.1.2. In the event of any conflict between this Contract and the MOU, the Contract shall prevail.

5.8. Contract Term

5.8.1. Contract Effective Date

5.8.1.1. This Contract shall be in effect through December 31, 2016, and, so long as the STAR+PLUS MMP has not provided CMS with a notice of intention not to renew, and CMS/HHSC have not provided the STAR+PLUS MMP with a notice of intention not to renew, pursuant to 42 C.F.R. § 422.506, shall be renewed in one year terms, through December 31, 2018.

5.8.1.2. At the discretion of CMS and upon notice to the parties, this Contract may be terminated, or the effectuation of the Contract Operational Start Date may be delayed, if Texas has not received all necessary approvals from CMS or, as provided in Section 2.2.1 of this Contract, if the STAR+PLUS MMP is determined not to be ready to participate in the Demonstration.

5.8.1.3. Texas may not expend federal funds for, or award federal funds to, the STAR+PLUS MMP until Texas has received all necessary approvals from CMS. Texas may not make payments to STAR+PLUS MMP by using federal funds, or draw Federal Medical Assistance Payment (FMAP) funds, for any services provided, or costs incurred, by STAR+PLUS MMP prior to the later of the approval date for any necessary State Plan and waiver authority, the Readiness Review approval, or the Contract Operational Start Date.

5.9. Amendments

5.9.1. Amendment Process

5.9.1.1. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein.

5.9.1.2. By mutual agreement, the parties may amend this Contract where such amendment does not violate federal or state statutory, regulatory, or waiver provisions, provided that such

amendment is in writing, signed by authorized representatives of all parties, and attached hereto.

5.10. Written Notices

5.10.1. Contacts

5.10.1.1. Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to the contacts in this Section. Copies may be delivered to the designated entities by email at the discretion of the sender.

5.10.1.2. CMS:

To	Centers for Medicare and Medicaid Services Medicare-Medicaid Coordination Office 7500 Security Boulevard, S3-13-23 Baltimore, MD 21244

5.10.1.3. Texas Health and Human Services Commission:

To	Sandra Faske 4900 North Lamar Blvd Mail Code H340 Austin, Texas 78751 Sandra.faske@hhsc.state.tx.us
Copies to:	Carey Smith, Senior Counsel 4900 North Lamar Blvd 4th Floor Austin, Texas 78751 Carey.Smith@hhs.state.tx.us

5.10.1.4. The STAR+PLUS MMP (<Entity>):

To	
Copies to:	

Section 6. **Signatures**

In Witness Whereof, CMS, HHSC, and the STAR+PLUS MMP have caused this Agreement to be executed by their respective authorized officers:

_____ _____

Date

<Entity>

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In Witness Whereof, CMS, HHSC, and the STAR+PLUS MMP have caused this Agreement to be executed by their respective authorized officers:

Charles Smith Chief Deputy Executive Commissioner Texas Health and Human Services Commission	Date

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In Witness Whereof, CMS, HHSC, and the STAR+PLUS MMP have caused this Agreement to be executed by their respective authorized officers:

Bill Brooks Associate Regional Administrator Centers for Medicare & Medicaid Services United States Department of Health and Human Services	Date
Kathryn Coleman Director Medicare Drug & Health Plan Contract Administration Group Centers for Medicare & Medicaid Services United States Department of Health and Human Services	Date

Appendix A. Covered Services

A.1 Medical Necessity: The STAR+PLUS MMP shall provide services to Enrollees as follows:

A.1.1 Authorize, arrange, coordinate, and provide to Enrollees all Medically Necessary Covered Services as specified in Section 2.4, in accordance with the requirements of the Contract.

A.1.2 Provide all Covered Services that are Medically Necessary, including but not limited to, those Covered Services that:

A.1.2.1 Prevent, diagnose, or treat health impairments; and/or

A.1.2.2 Attain, maintain, or regain functional capacity.

A.1.3 Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee.

A.1.4 Not deny authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary.

A.1.5 The STAR+PLUS MMP may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of utilization management, provided that the furnished services can reasonably be expected to achieve their purpose. The STAR+PLUS MMP's Medical Necessity guidelines must, at a minimum, be:

A.1.5.1 Developed with input from practicing physicians in the STAR+PLUS MMP's Service Area;

A.1.5.2 Developed in accordance with standards adopted by national accreditation organizations;

A.1.5.3 Developed in accordance with the definition of Medical Necessity in Section 1;

A.1.5.4 Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

A.1.5.5 Evidence-based, if practicable; and,

A.1.5.6 Applied in a manner that considers the individual health care needs of the Enrollee.

A.1.6 The STAR+PLUS MMP's Medical Necessity guidelines, program specifications and service components for Behavioral Health services must, at

a minimum, be submitted to HHSC annually for approval no later than thirty (30) days prior to the start of a new Contract Year, and no later than thirty (30) days prior to any change.

A.1.7 Offer and provide to all Enrollees any and all non-medical programs and services specific to Enrollees for which the STAR+PLUS MMP has received HHSC approval.

A.2 Covered Services: The STAR+PLUS MMP agrees to provide Enrollees access to the following Covered Services:

A.2.1 All services provided under Texas State Plan Services or THTQIP section 1115(a) demonstration, excluding those services otherwise excluded or limited in A.4 or A.5 of this Appendix.

A.2.2 All services provided under Medicare Part A

A.2.3 All services provided under Medicare Part B

A.2.4 All services provided under Medicare Part D

A.2.5 Pharmacy products that are covered by HHSC and may not be covered under Medicare Part D, including:

A.2.5.1 Over-the-counter (OTC) drugs as specified at http://www.txvendordrug.com/index.shtml.

A.2.5.2 Barbiturates for indications not covered by Part D (butalbital, mephobarbital, phenobarbital secobarbital);

A.2.5.3 "Miscellaneous" drugs for indications that may not be covered by Part D (dronabinol, megestrol, oxandrolone, somatropin); and

A.2.5.4 Prescription vitamins and minerals.

A.2.6 STAR+PLUS MMPs are encouraged to offer a broader drug formulary than minimum requirements for Part D covered drugs.

A.3 Cost Sharing for Covered Services

A.3.1 Except as described in Section 4.4.1 and A.3.2, Cost Sharing of any kind is not permitted in this Demonstration.

A.3.2 Cost Sharing for Part D drugs:

A.3.2.1 Co-pays charged by the STAR+PLUS MMP for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D LIS.

A.3.2.2 The STAR+PLUS MMP may establish lower Cost Sharing for prescription drugs than the maximum allowed.

A.4 Limitations on Covered Services. The following services and benefits shall be limited as Covered Services:

A.4.1 Termination of pregnancy may be provided only as allowed by applicable state and federal law and regulation (42 C.F.R. Part 441, Subpart E).

A.4.2 Sterilization services may be provided only as allowed by state and federal law (see 42 C.F.R. Part 441, Subpart F).

A.5 Carved-out Services:

A.5.1 The following Texas Medicaid programs, services, or benefits have been excluded from STAR+PLUS MMP Covered Services. Enrollees are eligible to receive these Non-Capitated Services on a FFS basis (STAR+PLUS MMPs should refer to relevant chapters in the Texas Medicaid Provider Procedures Manual for more information: http://www.tmhp.com/HTMLmanuals/TMPPM/Current/toc.html):

A.5.1.1 Hospice services
A.5.1.2 PASRR specialized services
A.5.1.3 Medical Transportation Program

A.5.2 Although STAR+PLUS MMPs are not responsible for paying or reimbursing for Non-Capitated Services, STAR+PLUS MMPs are responsible for educating Enrollees about the availability of Non-Capitated Services, and for providing appropriate referrals for Enrollees to obtain or access these services. The STAR+PLUS MMPs is responsible for informing Providers that bills for all Non-Capitated Services must be submitted to HHSC's Claims Administrator for reimbursement.

A.6 The following is a non-exhaustive, high-level listing of Community-Based LTSS included under the STAR+PLUS MMP.

A.6.1 Community Based LTSS for all Enrollee
A.6.2 Personal Attendant Services (PAS) – All Enrollee of a STAR+PLUS MMP may receive medically and Functionally Necessary Personal Attendant Services (PAS).
A.6.3 Day Activity and Health Services (DAHS) – All Enrollees of a STAR+PLUS MMP may receive medically and Functionally Necessary Day Activity and Health Care Services (DAHS).
A.6.4 HCBS STAR+PLUS Waiver Services for those Enrollees who qualify for these services
A.6.4.1 The state provides an enriched array of services to Enrollees who would otherwise qualify for nursing facility care through a Home and Community Based Medicaid Waiver. In traditional Medicaid,

this is known as the Community Based Alternatives (CBA) waiver. The STAR+PLUS MMP must also provide medically necessary services that are available to Enrollees through the CBA waiver in traditional Medicaid to those Enrollees that meet the functional and financial eligibility for the HCBS STAR+PLUS Waiver.

A.6.4.2 PAS (including the three (3) service delivery options: Self-Directed; Agency Model, Self-Directed; and Agency Model)

A.6.4.3 In-Home or Out-of-Home Respite Services

A.6.4.4 Nursing Services (in home)

A.6.4.5 Emergency Response Services (Emergency call button)

A.6.4.6 Home Delivered Meals

A.6.4.7 Minor Home Modifications

A.6.4.8 Adaptive Aids and Medical Equipment

A.6.4.9 Medical Supplies not available under the Texas Medicaid State Plan/ Texas Healthcare Transformation and Quality Improvement Program (THTQIP) section 1115(a) demonstration

A.6.4.10 Physical Therapy, Occupational Therapy, Speech Therapy

A.6.4.11 DAHS (for Enrollees in 217-Like STAR+PLUS eligibility group, as identified in the THTQIP section 1115(a) demonstration, whose income exceeds 150% FPL)

A.6.4.12 Adult Foster Care

A.6.4.13 Assisted Living

A.6.4.14 Transition Assistance Services (These services are limited to a maximum of $2,500.00. If the STAR+PLUS MMP determines that no other resources are available to pay for the basic services/items needed to assist a Enrollee, who is leaving a nursing facility, with setting up a household, the STAR+PLUS MMP may authorize up to $2,500.00 for Transition Assistance Services (TAS). The $2,500.00 TAS benefit is part of the expense ceiling when determining the Total Annual Individual Service Plan (ISP) Cost.)

A.6.4.15 Dental Services (The annual cost cap of this service is $5,000 per waiver plan year. The $5,000 cap may be waived by the STAR+PLUS MMP upon request of the Enrollee only when the services of an oral surgeon are required. Exceptions to the $5,000 cap may be made up to an additional $5,000 per waiver plan year when the services of an oral surgeon are required.)

A.6.4.16 Cognitive Rehabilitation Therapy

A.6.4.17 Financial Management Services

A.6.4.18 Support Consultation

A.6.4.19 Employment Assistance

A.6.4.20 Supported Employment

A.6.5 Community First Choice services for those Enrollees who qualify for these services

Appendix B. Enrollee Rights

B.1 The STAR+PLUS MMP must have written policies regarding the Enrollee rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollees. Enrollees must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, functional status, and language needs. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and the Texas Memorandum of Understanding (MOU).

B.2 Specifically, Enrollees must be guaranteed:

B.2.1 The right to be treated with dignity and respect.

B.2.2 The right to be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.

B.2.3 The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.

B.2.4 The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or Claims history, mental or physical Disability, genetic information, or source of payment.

B.2.5 The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.

B.2.6 Access to an adequate network of primary and specialty Providers who are capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.

B.2.7 The right to choose a plan and Provider at any time, including a plan outside of the Demonstration, and have that choice be effective the first calendar day of the following month.

B.2.8 The right to have a voice in the governance and operation of the integrated system, Provider, or health plan, as detailed in this Contract.

B.2.9 The right to participate in all aspects of care and to exercise all rights of Appeal.

B.2.10 Enrollees have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, Enrollees must:

B.2.10.1 Receive a Comprehensive Health Risk Assessment upon Enrollment in a plan and to participate in the development and implementation of a Plan of Care. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Enrollee's strengths and weaknesses, and a plan for managing and coordination Enrollee's care. Enrollees, or their LAR, also have the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment.

B.2.10.2 Receive complete and accurate information on his or her health and functional status by the Service Coordination Team.

B.2.10.3 Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in to consideration Enrollee's condition and ability to understand. An Enrollee who is unable to participate fully in treatment decisions has the right to designate a LAR. This includes the right to have translation services available to make information appropriately accessible. Information must be available:

B.2.10.3.1 Before Enrollment;

B.2.10.3.2 At Enrollment; and

B.2.10.3.3 At the time as Enrollee's needs necessitate the disclosure and delivery of such information in order to allow the Enrollee to make an informed choice.

B.2.10.4 Be encouraged to involve caregivers or family members in treatment discussions and decisions.

B.2.10.5 Have advance directives explained and to establish them, if the Enrollee so desires, in accordance with 42 C.F.R. §§489.100 and 489.102.

B.2.10.6 Receive reasonable advance notice, in writing, of any Transfer to another treatment setting and the justification for the Transfer.

B.2.10.7 Be afforded the opportunity file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.

B.2.10.8 The right to receive medical and non-medical care from a team that meets the Enrollee's needs, in a manner that is sensitive to the

Enrollee's language and culture, and in an appropriate care setting, including the home and community.

B.2.10.9 The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

B.2.10.10 Each Enrollee is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the STAR+PLUS MMP and its Providers, CMS, and/or HHSC treat the Enrollee.

B.2.10.11 The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in Section 2.15.4.3 at least once per year, and the right to receive notice of any significant change in the information provided at least thirty (30) days prior to the intended effective date of the change. See 438.10 for G and H.

B.2.10.12 The right to be protected from liability for payment of any fees that are the obligation of the STAR+PLUS MMP.

B.2.10.13 The right not to be charged any Cost Sharing for Medicare Parts A and B services.

Appendix C. Relationship With First Tier, Downstream, or Related Entities

C.1 STAR+PLUS MMP shall ensure that any contracts or agreements with First Tier, Downstream, or Related Entities performing functions on STAR+PLUS MMP's behalf related to the operation of the Medicare-Medicaid Plan (MMP) are in compliance with 42 C.F.R. §§422.504, 423.505, 438.6(l), and 438.230(b)(1).

C.2 STAR+PLUS MMP shall specifically ensure:

C.2.1 HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect and books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream, and Related Entities; and

C.2.2 HHS's, the Comptroller General's, or their designees right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.

C.3 STAR+PLUS MMP shall ensure that all contracts or arrangements with First Tier, Downstream, and Related Entities contain the following:

C.3.1 Enrollee protections that include prohibiting Providers from holding an Enrollee liable for payment of any fees that are the obligation of the STAR+PLUS MMP;

C.3.2 Language that any services or other activity performed by a First Tier, Downstream, or Related Entity is in accordance with the STAR+PLUS MMP's contractual obligations to CMS and HHSC;

C.3.3 Language that specifies the delegated activities and reporting requirements;

C.3.4 Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, HHSC or the STAR+PLUS MMP determine that First Tier, Downstream, and Related Entities have not performed satisfactorily;

C.3.5 Language that specifies the performance of the First Tier, Downstream, and Related Entities is monitored by the STAR+PLUS MMP on an ongoing basis and the STAR+PLUS MMP may impose corrective action as necessary;

C.3.6 Language that specifies the First Tier, Downstream, and Related Entities agree to safeguard Enrollee Privacy and confidentiality of Enrollee health records; and

C.3.7 Language that specifies the First Tier, Downstream, and Related Entities must comply with all federal and state laws, regulations, and CMS instructions.

C.4 STAR+PLUS MMP shall ensure that all contracts or arrangements with First Tier, Downstream, and Related Entities that are for credentialing of medical Providers contains the following language:

C.4.1 The credentials of medical professionals affiliated with the party or parties will be either reviewed by the STAR+PLUS MMP; or

C.4.2 The credentialing process will be reviewed and approved by the STAR+PLUS MMP and the STAR+PLUS MMP must audit the credentialing process on an ongoing basis.

C.5 STAR+PLUS MMP shall ensure that all contracts or arrangements with First Tier, Downstream, and Related Entities that delegate the selection of medical Providers must include language that the STAR+PLUS MMP retains the right to approve, suspend, or terminate any such arrangement.

C.6 Provider Contracts

C.6.1 STAR+PLUS MMP shall ensure that all contracts or arrangements with First Tier, Downstream, and Related Entities for Providers include additional provisions. Such contracts or arrangements must contain the following:

C.6.1.1 The minimum requirements specified in the Uniform Managed Care Manual Chapter 8.1 "Provider Contract Checklist," as applicable.

C.6.1.2 Language that all contracts or arrangements with First Tier, Downstream, and Related Entities shall state that the STAR+PLUS MMP shall provide a written statement to a Provider of the reason or reasons for termination with cause.

C.6.1.3 Language that the STAR+PLUS MMP is obligated to pay contracted Providers under the terms of the contract between the STAR+PLUS MMP and the Provider. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the STAR+PLUS MMP and the relevant Provider and are compliant with state and federal law;

C.6.1.4 Language that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;

C.6.1.5 Language that Providers abide by all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, and other health and Enrollment information;

C.6.1.6 Language that Providers ensure that medical information is released in accordance with applicable federal or state law, and pursuant to court orders and subpoenas;

C.6.1.7 Language that Providers maintain Enrollee Medical Records and information in an accurate and timely manner;

C.6.1.8 Language that Providers ensure timely access by Enrollees to the records and information that pertain to them; and

C.6.1.9 Language that Enrollees will not be held liable for Medicare Part A and B Cost Sharing. Specifically, Medicare Parts A and B services must be provided at zero Cost Sharing to Enrollees.

C.6.1.10 Language that clearly state the Provider's EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.

C.6.1.11 Language prohibiting Providers, including, but not limited to PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.

C.6.1.12 Language that prohibits the STAR+PLUS MMP from refusing to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has in good faith:

C.6.1.12.1 Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the STAR+PLUS MMP's health benefit plans as they relate to the needs of such Provider's patients; or

C.6.1.12.2 Communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the STAR+PLUS MMP for services provided to the patient.

C.6.1.13 Language that states the Provider is not required to indemnify the STAR+PLUS MMP for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any Claim or action brought against the STAR+PLUS MMP based on the STAR+PLUS MMP's management decisions, utilization review provisions or other policies, guidelines or actions.

C.6.1.14 Language that states the STAR+PLUS MMP shall require Providers to comply with the STAR+PLUS MMP's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.

C.6.1.15 Language that states the STAR+PLUS MMP shall notify Providers in writing of modifications in payments, modifications in Covered Services or modifications in the STAR+PLUS MMP's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the Providers, and the effective date of the modifications. The notice shall be provided thirty (30) days before the effective date of such modification unless such other date for notice is mutually agreed upon between the STAR+PLUS MMP and the Provider or unless such change is mandated by CMS or HHSC without thirty (30) days prior notice.

C.6.1.16 Language that states that Providers shall not bill patients for charges for Covered Services other than Part D pharmacy co-payments, if applicable.

C.6.1.17 Language that states that no payment shall be made by the STAR+PLUS MMP to a Provider for a Provider Preventable Condition; and

C.6.1.18 As a condition of payment, the Provider shall comply with the reporting requirements as set forth in 42 C.F.R. § 447.26(d) and as may be specified by the STAR+PLUS MMP. The Provider shall comply with such reporting requirements to the extent the Provider directly furnishes services.

C.6.2 STAR+PLUS MMP shall ensure that contracts or arrangements with First Tier, Downstream, and Related Entities for medical Providers do not include incentive plans that include a specific payment to a Provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services and;

C.6.2.1 The Provider shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate.

C.6.2.2 The STAR+PLUS MMP shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate.

C.6.3 STAR+PLUS MMP shall ensure that all contracts or arrangements with First Tier, Downstream, and Related Entities for PCPs include additional provisions. Such contracts or arrangements must contain the following:

C.6.3.1 Language that requires that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected Behavioral Health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice.

C.6.3.2 Language that the STAR+PLUS MMP must provide training on how to screen for and identify behavioral health disorders, on the STAR+PLUS MMP's referral process for Behavioral Health Services, and on clinical coordination requirements for such services.

C.6.3.3 Language that The STAR+PLUS MMP must include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.

C.6.3.4 Language that the STAR+PLUS MMP must develop and disseminate policies regarding clinical coordination between Behavioral Health Service Providers and PCPs.

C.6.4 STAR+PLUS MMP shall ensure that all contracts or arrangements with First Tier, Downstream, and Related Entities for Behavioral Health Service Providers include additional provisions. Such contracts or arrangements must contain the following:

C.6.4.1 Language that Behavioral Health Service Providers refer Enrollees with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Enrollee's or the Enrollee's LAR's consent. Behavioral Health Service Providers may only provide physical Health Care Services if they are licensed to do so.

C.6.4.2 Language that the STAR+PLUS MMP require that Behavioral Health Service Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of an Enrollees' behavioral health status to the PCP, with the Enrollee's or the Enrollee's LAR's consent.

C.6.4.3 Language that the STAR+PLUS MMP must require that all Enrollees receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to Discharge. The outpatient treatment must occur within seven (7) days from the date of Discharge.

C.6.4.4 Language that ensures Behavioral Health Service Providers contact Enrollees who have missed appointments within one (1) business day to reschedule appointments.

C.6.5 STAR+PLUS MMP shall ensure that all contracts or arrangements with First Tier, Downstream, and Related Entities for Nursing Facility Providers include additional provisions. Such contracts or arrangements must contain the following:

C.6.5.1 Language that requires that the Nursing Facility use the state and federally-required assessment instrument, as amended or modified, to assess Enrollees and to supply current medical information for Medical Necessity determinations.

C.6.5.2 Language that requires the Nursing Facility to supply these assessments to the STAR+PLUS MMP.

C.6.6 The STAR+PLUS MMP's Provider Contracts must specify that program violations arising out of performance of the contract are subject to administrative enforcement by the HHSC Office of Inspector General (OIG) as specified in 1 T.A.C., Chapter 371, Subchapter G.

C.7 The STAR+PLUS MMP shall ensure that contracts or arrangements with First Tier, Downstream, and Related Entities for Providers includes language that prohibits the STAR+PLUS MMP from imposing a financial risk on Providers for the costs of care, services or equipment provided or authorized by another physician or health care Provider unless such contract includes specific provisions with respect to the following:

C.7.1 Stop-loss protection;

C.7.2 Minimum patient population size for the Provider or Provider group; and

C.7.3 Identification of the health care services for which the Provider or Provider group is at risk.

C.8 The STAR+PLUS MMP shall ensure that all contracts or arrangements with First Tier, Downstream, and Related Entities for laboratory testing sites providing services include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

C.9 Nothing in this section shall be construed to restrict or limit the rights of the STAR+PLUS MMP to include as Providers religious non-medical Providers or to utilize medically based eligibility standards or criteria in deciding Provider status for religious non-medical Providers.

Appendix D. Part D Addendum

ADDENDUM TO CAPITATED FINANCIAL ALIGNMENT CONTRACT PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and Texas, acting by and through the Health and Human Services Commission (HHSC), and a Medicare-Medicaid managed care organization (hereinafter referred to as STAR+PLUS MMP) agree to amend the contract <Contract Number> governing STAR+PLUS MMP's operation of a Medicare-Medicaid Plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as "the Act") to include this addendum under which STAR+PLUS MMP shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

ARTICLE I
VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

A. STAR+PLUS MMP agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this addendum, which incorporates in its entirety the *2013 Capitated Financial Alignment Application* , released on March 29, 2012 (hereinafter collectively referred to as "the addendum"). STAR+PLUS MMP also agrees to operate in accordance with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable Federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. CMS agrees to perform its obligations to STAR+PLUS MMP consistent with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable Federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 C.F.R. Part 423 that impose new, significant regulatory requirements on STAR+PLUS MMP. This provision does not apply to new requirements mandated by statute.

D. This addendum is in no way intended to supersede or modify 42 C.F.R., Parts 417, 422 423, 431 or 438. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to STAR+PLUS MMP, HHSC, and CMS.

ARTICLE II
FUNCTIONS TO BE PERFORMED BY STAR+PLUS MMP

A. ENROLLMENT

STAR+PLUS MMP agrees to enroll in its Medicare-Medicaid plan only Eligible Beneficiaries as they are defined in 42 C.F.R. §423.30(a) and who have met the Texas Demonstration requirements and have elected to or have been passively enrolled in STAR+PLUS MMP's Capitated Financial Alignment benefit.

A. PRESCRIPTION DRUG BENEFIT

1. STAR+PLUS MMP agrees to provide the required prescription drug coverage as defined under 42 C.F.R. §423.100 and, to the extent applicable, supplemental benefits as defined in 42 C.F.R. §423.100 and in accordance with Subpart C of 42 C.F.R. Part 423. STAR+PLUS MMP also agrees to provide Part D benefits as described in STAR+PLUS MMP's Part D plan benefit package(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. STAR+PLUS MMP agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 C.F.R. §423.505(b)(25).

B. DISSEMINATION OF PLAN INFORMATION

1. STAR+PLUS MMP agrees to provide the information required in 42 C.F.R. §423.48.

2. STAR+PLUS MMP acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part D Payments for the contract year as provided in 42 C.F.R. §423.505(o).

3. STAR+PLUS MMP certifies that all materials it submits to CMS under the File and Use Certification authority described in the Medicare Marketing Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.

C. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. STAR+PLUS MMP agrees to operate quality assurance, drug utilization management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 C.F.R. Part 423.

2. STAR+PLUS MMP agrees to address complaints received by CMS against the STAR+PLUS MMP as required in 42 C.F.R. §423.505(b)(22) by:

   (a) Addressing and resolving complaints in the CMS complaint tracking system; and

   (b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

D. APPEALS AND GRIEVANCES

STAR+PLUS MMP agrees to comply with all requirements in Subpart M of 42 C.F.R. Part 423 governing coverage determinations, Grievances and Appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. STAR+PLUS MMP acknowledges that these requirements are separate and distinct from the Appeals and Grievances requirements applicable to STAR+PLUS MMP through the operation of its Medicare Parts A and B and Medicaid benefits.

E. PAYMENT TO STAR+PLUS MMP

STAR+PLUS MMP and CMS and HHSC agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 C.F.R. Part 423.

F. PLAN BENEFIT SUBMISSION AND REVIEW

If STAR+PLUS MMP intends to participate in the Part D program for the next program year, STAR+PLUS MMP agrees to submit the next year's Part D plan benefit package including all required information on benefits and Cost Sharing, by the applicable due date, as provided in Subpart F of 42 C.F.R. Part 423 so that CMS, HHSC and STAR+PLUS MMP may conduct negotiations regarding the terms and conditions of the proposed benefit plan renewal. STAR+PLUS MMP acknowledges that failure to submit a timely plan benefit package under this section may affect the STAR+PLUS MMP's ability to offer a plan, pursuant to the provisions of 42 C.F.R. §422.4(c).

G. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. STAR+PLUS MMP agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 C.F.R. Part 423.

2. STAR+PLUS MMP agrees to comply with Medicare Secondary Payer procedures as stated in 42 C.F.R. §423.462.

H. SERVICE AREA AND PHARMACY ACCESS

1. STAR+PLUS MMP agrees to provide Part D benefits in the Service Area for which it has been approved by CMS and HHSC (as defined in Appendix H) to offer Medicare Parts A and B benefits and Medicaid benefits utilizing a pharmacy network and formulary approved by CMS and HHSC that meet the requirements of 42 C.F.R. §423.120.

2. STAR+PLUS MMP agrees to provide Part D benefits through out-of-network pharmacies according to 42 C.F.R. §423.124.

3. STAR+PLUS MMP agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug Claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 C.F.R. §423.100), and long-term care pharmacies (as defined in 42 C.F.R. §423.100) according to 42 C.F.R. §423.505(b)(17).

4. STAR+PLUS MMP agrees to contract with any pharmacy that meets STAR+PLUS MMP's reasonable and relevant standard terms and conditions according to 42 C.F.R. §423.505(b)(18).

I. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

STAR+PLUS MMP agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 C.F.R. §423.504(b)(4)(vi).

J. LOW-INCOME SUBSIDY

STAR+PLUS MMP agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 C.F.R. Part 423.

K. Enrollee Financial Protections

STAR+PLUS MMP agrees to afford its Enrollees protection from liability for payment of fees that are the obligation of STAR+PLUS MMP in accordance with 42 C.F.R. §423.505(g).

L. Relationship with First Tier, Downstream, or Related Entities

1. STAR+PLUS MMP agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.

2. STAR+PLUS MMP shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on STAR+PLUS MMP's behalf related to the operation of the Part D benefit are in compliance with 42 C.F.R. §423.505(i).

M. Certification of Data That Determine Payment

1. STAR+PLUS MMP must provide certifications in accordance with 42 C.F.R. § 423.505(k).

N. STAR+PLUS MMP REIMBURSEMENT TO PHARMACIES

1. If STAR+PLUS MMP uses a standard for reimbursement of pharmacies based on the cost of a drug, STAR+PLUS MMP will update such standard not less frequently than once every seven days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. STAR+PLUS MMP will issue, mail, or otherwise transmit payment with respect to all Claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of an electronically submitted Claim or within 21 calendar days of receipt of a Claim submitted otherwise.

3. STAR+PLUS MMP must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than thirty (30) days (but not more than ninety (90) days) to submit Claims to STAR+PLUS MMP for reimbursement.

ARTICLE III
RECORD RETENTION AND REPORTING REQUIREMENTS

A. Record Maintenance and access

STAR+PLUS MMP agrees to maintain records and provide access in accordance with 42 C.F.R. §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

STAR+PLUS MMP agrees to submit information to CMS according to 42 C.F.R. §§423.505(f) and 423.514, and the "Final Medicare Part D Reporting Requirements," a document issued by CMS and subject to modification each program year.

C. CMS and Texas License For Use of STAR+PLUS MMP Formulary

STAR+PLUS MMP agrees to submit to CMS and HHSC the STAR+PLUS MMP's formulary information, including any changes to its formularies, and hereby grants to the Government, and any person or entity who might receive the formulary from the Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

ARTICLE IV
HIPAA PROVISIONS

A. STAR+PLUS MMP agrees to comply with the confidentiality and Enrollee Medical Record accuracy requirements specified in 42 C.F.R. §423.136.

B. STAR+PLUS MMP agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

ARTICLE V
ADDENDUM TERM AND RENEWAL

A. Term of ADDENDUM

1. This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2016. This addendum shall be renewable for successive one-year periods thereafter according to 42 C.F.R. §423.506.

B. Qualification to renew ADDENDUM

1. In accordance with 42 C.F.R. §423.507, STAR+PLUS MMP will be determined qualified to renew this addendum annually only if—

   (a) STAR+PLUS MMP has not provided CMS or HHSC with a notice of intention not to renew in accordance with Article VII of this addendum, and

(b) CMS or HHSC has not provided STAR+PLUS MMP with a notice of intention not to renew.

2. Although STAR+PLUS MMP may be determined qualified to renew its addendum under this Article, if STAR+PLUS MMP, CMS, and HHSC cannot reach agreement on the Part D plan benefit package under Subpart F of 42 C.F.R. Part 423, no renewal takes place, and the failure to reach agreement is not subject to the appeals provisions in Subpart N of 42 C.F.R. Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE VI
NONRENEWAL OF ADDENDUM

A. Nonrenewal by STAR+PLUS MMP

STAR+PLUS MMP may non-renew this addendum in accordance with 42 C.F.R. 423.507(a).

B. NONRENEWAL BY CMS

CMS may non-renew this addendum under the rules of 42 C.F.R. 423.507(b). (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE VII
MODIFICATION OR TERMINATION OF ADDENDUM BY MUTUAL CONSENT

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 C.F.R. 423.508. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE VIII
TERMINATION OF ADDENDUM BY CMS

CMS may terminate this addendum in accordance with 42 C.F.R. 423.509. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE IX
TERMINATION OF ADDENDUM BY STAR+PLUS MMP

A. STAR+PLUS MMP may terminate this addendum only in accordance with 42 C.F.R. 423.510.

B. If the addendum is terminated under Section A of this Article, STAR+PLUS MMP must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE X
RELATIONSHIP BETWEEN ADDENDUM AND CAPITATED FINANCIAL ALIGNMENT CONTRACT

A. STAR+PLUS MMP acknowledges that, if it is a Capitated Financial Alignment STAR+PLUS MMP, the termination or nonrenewal of this addendum by any party may require CMS to terminate or non-renew the STAR+PLUS MMP's Capitated Financial Alignment contract in the event that such non-renewal or termination prevents STAR+PLUS MMP from meeting the requirements of 42 C.F.R. §422.4(c), in which case the STAR+PLUS MMP must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 C.F.R. Part 422.

B. The termination of this addendum by any party shall not, by itself, relieve the parties from their obligations under the Capitated Financial Alignment contract to which this document is an addendum.

C. In the event that the STAR+PLUS MMP's Capitated Financial Alignment contract is terminated or nonrenewed by any party, the provisions of this addendum shall also terminate. In such an event, STAR+PLUS MMP, HHSC and CMS shall provide notice to Enrollees and the public as described in this contract as well as 42 C.F.R. Part 422, Subpart K or 42 C.F.R. Part 417, Subpart K, as applicable.

ARTICLE XI
INTERMEDIATE SANCTIONS

Consistent with Subpart O of 42 C.F.R. Part 423, STAR+PLUS MMP shall be subject to sanctions and civil money penalties.

ARTICLE XII
SEVERABILITY

Severability of the addendum shall be in accordance with 42 C.F.R. §423.504(e).

ARTICLE XIII
MISCELLANEOUS

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 C.F.R. Part 423 or, as applicable, 42 C.F.R. Parts 417, 422, 431 or Part 438.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

STAR+PLUS MMP agrees that it has not altered in any way the terms of the STAR+PLUS MMP addendum presented for signature by CMS. STAR+PLUS MMP agrees that any alterations to the original text STAR+PLUS MMP may make to this addendum shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS

STAR+PLUS MMP agrees to include in this addendum other terms and conditions in accordance with 42 C.F.R. §423.505(j).

D. CMS AND HHSC APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES

STAR+PLUS MMP agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS and HHSC' approval to begin STAR+PLUS MMP marketing activities relating to its Part D benefit. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS and HHSC systems to process Enrollment applications (or contracting with an entity qualified to perform such functions on STAR+PLUS MMP's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, STAR+PLUS MMP must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to send and receive transactions to and from CMS, and 4) check and receive transaction status information.

E. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), STAR+PLUS MMP agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

F. STAR+PLUS MMP agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 C.F.R. §423.505(b)(23).

Appendix E. Data Use Attestation

The STAR+PLUS MMP shall restrict its use and disclosure of Medicare data obtained from CMS and HHSC information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare/Medicaid managed care and/or outpatient prescription drug benefits for which it has contracted with the CMS and HHSC to administer. The STAR+PLUS MMP shall only maintain data obtained from CMS and HHSC information systems that are needed to administer the Medicare/Medicaid managed care and/or outpatient prescription drug benefits that it has contracted with CMS and HHSC to administer. The STAR+PLUS MMP (or its First Tier, Downstream or other Related Entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system or HHSC, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the STAR+PLUS MMP contracted with CMS and HHSC.

The STAR+PLUS MMP further attests that it shall limit the use of information it obtains from its Enrollees to those purposes directly related to the administration of such plan. The STAR+PLUS MMP acknowledges two exceptions to this limitation. First, the STAR+PLUS MMP may provide its Enrollees information about non-health related services after obtaining consent from the Enrollees. Second, the STAR+PLUS MMP may provide information about health-related services without obtaining prior Enrollee consent, as long as the STAR+PLUS MMP affords the Enrollee an opportunity to elect not to receive such information.

CMS may terminate the STAR+PLUS MMP's access to the CMS data systems immediately upon determining that the STAR+PLUS MMP has used its access to a data system, data obtained from such systems, or data supplied by its Enrollees beyond the scope for which CMS and the HHSC have authorized under this agreement. A termination of this data use agreement may result in CMS or HHSC terminating the STAR+PLUS MMP's Medicare-Medicaid contract(s) on the basis that it is no longer qualified as an STAR+PLUS MMP. This agreement shall remain in effect as long as the STAR+PLUS MMP remains an STAR+PLUS MMP sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS or HHSC make available to the general public on their websites.

Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

- Automated Plan Payment System (APPS)
- Common Medicare Environment (CME)
- Common Working File (CWF)
- Coordination of Benefits Contractor (COBC)
- Drug Data Processing System (DDPS)
- Electronic Correspondence Referral System (ECRS)
- Enrollment Database (EDB)
- Financial Accounting and Control System (FACS)
- Front End Risk Adjustment System (FERAS)

- Health Plan Management System (HPMS), including Complaints Tracking and all other modules
- HI Master Record (HIMR)
- Individuals Authorized Access to CMS Computer Services (IACS)
- Integrated User Interface (IUI)
- Medicare Advantage Prescription Drug System (MARx)
- Medicare Appeals System (MAS)
- Medicare Beneficiary Database (MBD)
- Payment Reconciliation System (PRS)
- Premium Withholding System (PWS)
- Prescription Drug Event Front End System (PDFS)
- Retiree Drug System (RDS)
- Risk Adjustments Processing Systems (RAPS)

Appendix F. Model File & Use Certification Form

Pursuant to the contract between the Centers for Medicare & Medicaid Services (CMS), the State of Texas, acting by and through Health and Human Services Commission (HHSC), and <Entity>, hereafter referred to as the STAR+PLUS MMP, governing the operations of the following health plan: <Entity> (<Contract Number>), the STAR+PLUS MMP hereby certifies that all qualified materials for the Demonstration is accurate, truthful and not misleading. Organizations using File & Use Certification agree to retract and revise any materials (without cost to the government) that are determined by CMS or HHSC to be misleading or inaccurate or that do not follow established Medicare Marketing Guidelines, Regulations, and sub-regulatory guidance. In addition, organizations may be held accountable for any beneficiary financial loss as a result of mistakes in marketing materials or for misleading information that results in uninformed decision by a beneficiary to elect the plan. Compliance criteria include, without limitation, the requirements in 42 CFR §422.2260 – §422.2276 and 42 CFR §422.111 for STAR+PLUS MMPs and the Medicare Marketing Guidelines.

I agree that CMS or HHSC may inspect any and all information including those held at the premises of the STAR+PLUS MMP to ensure compliance with these requirements. I further agree to notify CMS and HHSC immediately if I become aware of any circumstances that indicate noncompliance with the requirements described above.

I possess the requisite authority to make this certification on behalf of the STAR+PLUS MMP

_____ _____

Date

On behalf of <Entity>

Appendix G. Medicare Mark License Agreement

THIS AGREEMENT is made and entered into on December 15, 2015

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),

with offices located at 7500 Security Blvd., Baltimore, MD 21244

and

<Entity> (hereinafter "Licensee"),

with offices located at <Principal Place of Business>.

CMS Contract ID: <Contract Number>

WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning February 1, 2015.

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.

2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.

3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.

4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.

5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.

6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2015, concurrent with the execution of the Part D addendum to the three-way contract. This Agreement may be terminated by either party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting December 31, 2015, this agreement shall be renewable for successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Capitated Financial Alignment Demonstration contract).

7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.

8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.

9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.

10. Federal law shall govern this Agreement.

Appendix H. Service Area

The Service Area outlined below is contingent upon the STAR+PLUS MMP meeting all Readiness Review requirements in each county. CMS and HHSC reserve the right to amend this Appendix to revise the Service Area based on final Readiness Review results or subsequent determinations made by CMS and HHSC. The Service Area consists of the following Counties: Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant.