

CONTRACT NO. 2010-032936-
PROGRAM ATTACHMENT NO. 001

CONTRACTOR: VALUE OPTIONS

DSHS PROGRAM: NORTHSTAR PROGRAM

TERM: 09/01/2009THRU: 08/31/2011

This risk Contract is entered into between the Department of State Health Services (DSHS) and ValueOptions of Texas, Inc., a behavioral health organization (Contractor). Contractor's selection for this Contract was based upon Contractor's Proposal (the Proposal) submitted in response to DSHS's Request for Proposals for the NorthSTAR Behavioral Health Program Request for Proposal Number NSTARO 3-6-2006 issued on July 26, 2005.

The purpose of this Contract is to set forth the terms and conditions for Contractor's participation as a behavioral health organization (BHO) in NorthSTAR, a managed behavioral health care program administered by the DSHS, implemented on July 1, 1999 (Implementation Date) in the counties of Dallas, Hunt, Kaufman, Rockwall, Ellis, Navarro, and Collin (the Service Area). Under the terms of this Contract, Contractor shall provide prepaid comprehensive behavioral health care services to Enrollees.

ARTICLE I PARTIES AND AUTHORITY TO CONTRACT

1.1 State Authority

The Texas Health and Human Services Commission (HHSC) is the State of Texas single state Medicaid agency. HHSC has delegated the authority to operate the Medicaid behavioral health program in NorthSTAR to DSHS. DSHS has authority to contract with Contractor to carry out the duties and functions of the NorthSTAR program under Texas Government Code, Chapter 533, and Texas Health and Safety Code, Chapters 461, 531 through 535, and 1001.

1.2 Contractor's Authority

Contractor is a corporation with authority to conduct business in the State of Texas. Contractor has a certificate of authority from the Texas Department of Insurance (TDI) to operate as a limited health care service plan under Chapter 843 of the Texas Insurance Code. Contractor is in compliance with all TDI rules and laws that apply to entities licensed as limited health care services plans. Contractor has been authorized to enter into this Contract by its Board of Directors or other governing body. Contractor is an enrolled provider in the Texas Medical Assistance (Medicaid) Program, an entity that is eligible for a risk contract as defined in 42 Code of Federal Regulations (CFR) § 438.2, and a prepaid inpatient health plan (PIHP) as defined in 42 CFR §438.2.

1.3 CMS Approval

- 1.3.1 This Contract is contingent upon approval by the federal Centers for Medicare and Medicaid Services (CMS) and is further contingent upon CMS's approval of any Contract amendments, the State's §1915(b) waiver (Waiver) application for NorthSTAR and any Waiver amendment required by CMS.
- 1.3.2 If CMS does not approve the Waiver, any Waiver amendment, or this Contract or any Contract amendment, the State may, at its sole discretion, terminate this Contract pursuant to §15.8.1 of this Contract.
- 1.3.3 CMS has approved the NorthSTAR 1915(b) waiver beginning 9/1/09. DSHS has provided a copy of the CMS approval letter to Contractor.

ARTICLE II DOCUMENTS CONSTITUTING CONTRACT

The Contract between the parties includes this document and all appendices and amendments to this document, the July 26, 2005 RFP, the application submitted by Contractor in response to the July 26, 2005 RFP (Application), amendments to the Application, interpretation memoranda issued by DSHS for this Contract, and the Waiver, as approved by CMS. All responses, representations and assurances contained in the Application are incorporated into and are enforceable provisions of this Contract. If any conflict exists between provisions in the RFP, the Application, or this Contract, the terms of this Contract and any amendment to this Contract shall prevail.

All appendices referenced in this Contract are attached hereto and made a part of this Contract for all purposes.

Definitions for terms used herein are contained in Appendix 1.

ARTICLE III ADMINISTRATION

3.1 Capacity

Contractor shall maintain the organizational and administrative capacity to carry out all duties and responsibilities under this Contract.

3.2 Primary Business Facility/Local Office

3.2.1 Contractor shall maintain a primary business facility (the "local office") within the service area that meets the Americans with Disabilities Act (ADA) requirements for public buildings. Contractor's local office is located at the following physical and mailing addresses:

Physical: 1199 S. Beltline Rd., Suite 100, Coppell, TX 75019
Mailing: 1199 S. Beltline Rd., Suite 100, Coppell, TX 75019
Telephone: (800) 535-0108
Fax: (972) 906-2789

Contractor shall notify DSHS if the physical or mailing address, or telephone or fax number of the local office changes, within 24 hours of such change.

- 3.2.2 Contractor shall perform all program management and Contract administration functions at the local office, consistent with the Application, including utilization management, customer service, provider relations, quality management, and record retention.

3.3 Records

- 3.3.1 Contractor shall make available to the State upon request all records required to be maintained under this Contract. Copies of requested records shall be produced free of charge.
- 3.3.2 Contractor shall maintain originals of the following records at the local office:
- a) All program enrollment files;
 - b) All Enrollee satisfaction records;
 - c) All Enrollee and provider complaint and appeals records;
 - d) All policies, manuals, and standard operating procedures;
 - e) All provider credentialing records (available via imaging system) ;
 - f) All records relating to insurance policies required in §4.4 of this Contract;
 - g) All employment records;
 - h) All required licenses and certifications, including the TDI certificate of authority;
 - i) All records relating to the Quality Assessment and Performance Improvement Program (QAPI) described in §3.10 of this Contract; and
 - j) All reports required by or submitted to HHSC, DSHS, TDI or CMS.
- 3.3.3 Contractor shall maintain and make available to the State the following records related to this Contract within 10 business days of the State's request or pay all expenses in accordance with the State of Texas travel regulations for State staff to travel to the site where these records are maintained:
- a) Accounting and other financial records;
 - b) General business records;
 - c) Real and personal property leases;
 - d) Computer and data processing systems documentation, including, but not limited to, reports, data flow diagrams, data models, data dictionaries, hardware, software and other subsystems configurations;
 - e) Contracts with service providers, consultants, or other subcontractors performing work related to this Contract;
 - f) Other business records required to be maintained by federal or state laws, rules or regulations, or necessary to meet the requirements of this Contract;
 - g) Records related to matters in litigation for five years following the termination or resolution of the litigation; and

- h) Claims payment histories in an on-line inquiry system.
- 3.3.4 All records required to be maintained under this Contract shall be retained for five years unless otherwise specified in this Contract. Original records shall be kept in the form they were created in the regular course of business for a minimum of two years following the end of this Contract term. Microfilm, digital or electronic records may be substituted for the original records after the first two years, if the retention system is reliable and is supported by a retrieval system that allows reasonable access to the records.

3.4 Organizational Chart

- 3.4.1 Contractor shall submit to DSHS upon request an organizational chart which shall be current at the time of such request and which shows the organization's basic functions, the number of employees performing such functions, and a list of key positions in the organization responsible for the basic functions of the organization, including:
 - a) Chief Executive Officer or equivalent;
 - b) Medical Director;
 - c) Chief Financial Officer or equivalent;
 - d) Senior executive in charge of the QAPI;
 - e) Utilization review manager or equivalent;
 - f) Provider network manager or equivalent;
 - g) Information Services Director;
 - h) Enrollee Services Manager or equivalent; and
 - i) Project director/contract manager for NorthSTAR.
- 3.4.2 The list of key positions shall identify each employee's name, phone number, and include a brief summary of each identified employee's experience in behavioral health management, and/or health services management. Contractor shall ensure that all positions identified in 3.4.1 shall be dedicated full time to NorthSTAR.
- 3.4.3 Contractor shall notify DSHS within 15 business days of any change in key positions listed in 3.4.1. If Contractor fails to notify DSHS in accordance with this requirement, Contractor shall develop and submit a corrective action plan to DSHS .
- 3.4.4 Contractor shall update the organizational chart when there is any significant change in organizational structure or personnel.

3.5 Medical Director

Contractor shall employ a psychiatrist, licensed in Texas, to serve full time as Medical Director. The Medical Director shall be dedicated solely to NorthSTAR and be responsible for the following:

- a) Ensuring that utilization review decisions, including prior authorization protocols and practice guidelines, are rendered by qualified personnel and are based on this Contract's definition of medically necessary services;

- b) Ensuring that a credentialing and oversight process exists to ensure clinical care meets the standards of care accepted in medical practice, including continuity of care;
- c) Ensuring that medical protocols, rules of conduct and standards of public physical and behavioral health are developed, distributed and followed by Contractor's personnel;
- d) Developing and implementing medical policies;
- e) Addressing medically related Enrollee complaints;
- f) Significantly participating in monitoring, investigating and reviewing all complaints; and
- g) Maintaining oversight of Contractor's QAPI.

3.6 Coordination with Local Behavioral Health Authority

Contractor shall cooperate with the North Texas Behavioral Health Authority (NTBHA), the designated local behavioral health authority, which ensures that local communities are given a voice in the delivery of publicly funded managed behavioral health care. NTBHA represents both mental health and chemical dependency interests and concerns.

Reports submitted by Contractor to DSHS will be forwarded to NTBHA.

3.6.1 Contractor shall maintain and comply with its written agreement with NTBHA describing the duties and responsibilities of Contractor and NTBHA for the following:

- a) Identifying problems regarding access to covered services;
- b) Ensuring compliance with all applicable laws, regulations and Contract requirements;
- c) Coordinating with all local entities serving or having frequent contact with adults with serious mental illness (SMI), children with serious emotional disturbance (SED), family members, and other individuals affected by chemical dependency;
- d) Resolving Enrollee complaints received by NTBHA;
- e) Designing service delivery procedures, including special accommodations when needed, that ensure individuals with SMI, SED, or chemical dependency can effectively access and receive covered services;
- f) Providing opportunities for consumers of public behavioral health services and their families to have meaningful involvement in design changes, implementation, operation, and oversight of NorthSTAR;
- g) Coordination and research for county of residence change requests by Contractor; and
- h) Jail match file processing and distribution of information until the alternative process outlined in SB 839 is fully implemented.

3.6.2 NTBHA is responsible, pursuant to Health and Safety Code §533.014, for 1) making recommendations relating to the most appropriate and available treatment alternatives for individuals in need of mental health services, including individuals who are in contact with the criminal justice system

and individuals detained in local jails and juvenile detention facilities; 2) mental health commitments to NTBHA; 3) transfers of patients involving NTBHA, and 4) providing for emergency admissions to a state hospital if obtaining approval from NTBHA could result in a delay that might endanger the patient or others.

NTBHA is responsible for requirements relating to orders of protective custody and commitments for mental health services (Health and Safety Code §§574.012, 574.023, 574.027, 574.041, 575.011) and regulatory requirements found at 25 TAC Chap. 411, Subch. M, Division 2. NTBHA may contract with Contractor to perform certain of these requirements, with DSHS's approval, but NTBHA will retain full responsibility for compliance with such requirements.

Contractor shall work with NTBHA and the local judiciary to ensure that Enrollees who are involuntarily committed to mental health services are served in the most appropriate, safe, and least restrictive environment possible, and have appropriate treatment plans.

- 3.6.3 The written agreement between Contractor and NTBHA shall identify all authority functions to be performed by each party and the procedures NTBHA will use to ensure the performance of any functions delegated by NTBHA to Contractor.
- 3.6.4 Contractor shall provide to NTBHA and DSHS, upon request, all information relating to the status, response to treatment, and service utilization history of Enrollees who are involuntarily committed to a subcontracted hospital.
- 3.6.5 Contractor shall allow NTBHA to have at least one voting representative on Contractor's Quality Improvement Committee in matters pertaining to NorthSTAR. DSHS and NTBHA will inform the Contractor of any problems, complaints, or issues that relate to Contractor's performance. Contractor shall use this information in its QAPI described in §3.10 of this Contract.
- 3.6.6 Contractor shall obtain prior approval from and coordinate with NTBHA, and DSHS for any material changes in the NorthSTAR program including but not limited to: provider payment structures, provider rates, provider network additions/deletions, and utilization management changes.
- 3.6.7 Contractor shall obtain prior approval from, and coordinate, with NTBHA and DSHS for all sub-contracted services referenced in Section 3.8.
- 3.6.8 Contractor shall provide a written (email) bi-monthly summary of programmatic issues to NTBHA executive director and DSHS. This report shall be a status report on current system issues, provider and enrollee issues, as well as any programmatic or systems changes contemplated by Contractor. The format of this report shall be approved by NTBHA.

3.7 Coordination with Texas Medicaid Administrative Systems

HHSC has contracted with several entities to support the Texas Medicaid Administrative System (TMAS) for the state's Medicaid managed care programs. The administrative services provided by the TMAS contractors are intended to complement the efforts of state agency personnel engaged in Medicaid program administration. Contractor must coordinate with the TMAS contractors to produce a system that is as "seamless" as possible from the perspective of Medicaid recipients and their health care providers. Such coordination shall include providing reports to TMAS contractors and participating in meetings as required by DSHS and HHSC.

DSHS will provide operational guidance for interfacing with state-operated information systems that support administration, enrollment and decision support. DSHS's information system will be integrated with Contractor's information system and with TMAS.

The identities and roles of the current TMAS contractors are as follows:

- a) **Maximus:** Maximus is the Enrollment Broker for the NorthSTAR and STAR programs and assists Medicaid eligible individuals enroll in Medicaid managed care and select managed care plans. Maximus's responsibilities include:
 - Receiving a list of Medicaid clients from NorthSTAR who are mandated or otherwise eligible to enroll in a managed care plan;
 - Providing education and enrollment activities to assist clients select a managed care plan;
 - Providing enrollment materials through the mail;
 - Operating the information interfaces required to record enrollment decisions in NorthSTAR, SAVERR and in CMBHS (as it becomes available), the State's Medicaid eligibility system, and to inform managed care plans of their enrolled beneficiaries;
 - Providing services with respect to ongoing enrollment, disenrollment and re-enrollment activity of clients; and
 - Maintaining a client help line that responds to client inquiries regarding the administration of managed care programs.
- b) **ICHP-** The Institute for Child Health Policy (ICHP), contracted in August 2002, provides external reviews to assess Medicaid clients' access to care and the quality of care provided by the Primary Care Case Management (PCCM) network, Medicaid HMOs and CHIP health plans. The quality monitor also collects encounter data and health care claims paid by the HMOs.
- c) **UTMB-340B Drug Pricing Program-** The U.S. Public Health Service 340B discounted drug program offers significant cost savings on outpatient drugs to covered entities, which include community health centers, migrant health centers, public housing facilities, homeless centers, federally qualified health center look-alikes, Title X family planning facilities, HIV grantees, sexually transmitted diseases (STD) and tuberculosis (TB) programs, and publicly-supported disproportionate share hospitals. This program provides substantial

savings on covered outpatient drugs purchased by specified federally funded entities serving the most vulnerable patient populations.

- d) **TMHP-** Texas Medicaid & Healthcare Partnership provides administration of Medicaid claims processing and the Medicaid primary care case management services program.

3.8 Subcontracts

- 3.8.1 Contractor shall maintain written subcontracts with all subcontractors, including providers and other subcontractors, and monitor performance under such subcontracts. For purposes of this Contract, the term "subcontract" shall be used to describe a written agreement between Contractor and another party to fulfill the requirements of this Contract; "provider contract" shall be used to describe subcontracts with providers, and "non-provider contract" shall be used to describe subcontracts with entities or persons other than providers.

All subcontracts are subject to the terms and conditions of this Contract and shall contain the provisions required by Insurance Code §843.309 as well as the provisions contained in §3.8.3 below.

- 3.8.2 Contractor is responsible for monitoring all work performed by its subcontractors and for taking appropriate action as necessary.

- 3.8.3 Contractor shall include the following provisions in each subcontract:

- a) [Subcontractor/provider] shall comply with the applicable statutory and regulatory provisions in §§5.1, 5.3, 5.4, 5.5 and 5.6 of this Contract;
- b) [Subcontractor/provider] understands that services provided under this [sub] contract are funded by state and federal funds under the Texas Medicaid Program. [Subcontractor/provider] understands that any violation by [subcontractor/provider] of a state or federal law relating to the delivery of services under this [sub] contract, or any violation of the NorthSTAR Contract could result in liability for Contract money damages and/or civil and criminal penalties and sanctions under state and federal law;
- c) [Subcontractor/provider] understands and agrees that the Contractor has the sole responsibility for payment of services rendered by the subcontractor under this Contract. In the event of Contractor's insolvency or cessation of operations, provider's sole recourse shall be against the Contractor;
- d) [Subcontractor/provider] understands and agrees that the State is not liable or responsible for payment of any services provided under the [sub] contract;
- e) [Subcontractor/provider] agrees that any modification, addition, or deletion of the provisions of the [sub] contract will become effective no earlier than 30 days after receipt of notification from Contractor;
- f) The [sub] contract is subject to state and federal fraud and abuse statutes and regulations. The [subcontractor/provider] shall cooperate in any investigation of suspected fraud or abuse, allow access to and

provide original records and copies of any and all information free of charge on request to any state or federal agency or their agent(s) with authority to investigate fraud and abuse in NorthSTAR;

- g) [Subcontractor/provider] shall report to HHSC's Office of Inspector General any suspected fraud or abuse including any suspected fraud and abuse committed by Contractor or an Enrollee;
- h) [Subcontractor/provider] shall authorize DSHS, HHSC, and their authorized representatives to have unrestricted access to all buildings, grounds, records, data, information systems, and other information under the control of the [subcontractor/provider] as necessary to enable the State to audit, monitor, and review the financial and program activities and services associated with the [sub] contract;
- i) [Subcontractor/provider] shall retain all records relating to the [sub] contract for five years, except records relating to matters in litigation shall be retained for five years following the termination or resolution of the litigation;
- j) [Subcontractor/provider] understands and agrees that Contractor will remove [Subcontractor/provider] from Contractor's network upon notification by an appropriate licensing or other regulatory entity that [subcontractor/provider] is not in good standing with that entity; and
- k) If [subcontractor/provider] utilizes a subcapitation, case rate, or fixed payment methodology to reimburse provider, then subcontractor shall submit encounter data at a percentage agreeable by NTBHA and DSHS within 90 days of date of service.

3.8.4 Contractor shall maintain in Contractor's local office all written notices to providers regarding provider contracts. Contractor shall submit one copy of each type of NorthSTAR provider contract to DSHS for approval. A provider contract that varies materially from a provider contract approved by DSHS shall contain a provision stating that the provider contract is subject to approval by DSHS and must be submitted to DSHS within five working days after the date of execution of such provider contract. All provider contracts are subject to the terms and conditions of this Contract.

3.8.5 Contractor shall include in each provider contract a description of the provider complaint and appeals process, as described in §8.10, and all requirements applicable to providers regarding third party recovery, as described in §4.9; submission of encounter data, as described in §3.8.3(k); submission of claims data, as described in §4.13; and participation in Department of Family and Protective Services (DFPS) planning, as described in §7.15. Contractor shall further include in each provider contract the following provisions:

- a) The provisions in Texas Insurance Code, §§843.283 and 843.309, relating to physician and provider contracts, and the "hold harmless clause" set forth in 28 Tex. Admin. Code §11.901;
- b) The provisions in §3.8.3 above;

- c) The provider is authorized to collect co-payments for covered services (as described in §4.11) from non-Medicaid adult Enrollees with income over 150% of the Federal Poverty Level (FPL);
 - d) The provider shall accept the specified payment amount from the Contractor and may not seek additional payment from the State or from the Enrollees, except for allowable copayments;
 - e) The provider will be paid within 30 days of receipt of a clean claim. Contractor shall pay interest to the provider on all clean claims not paid within 30 days at a rate of 1.5% per month (18% annual) for each month the claim is not paid;
 - f) A statement that the provider will be a participant in the NorthSTAR program;
 - g) The method by which the provider will be reimbursed and at what rate, the provider's responsibilities for reporting information to the Contractor, the Contractor's process for evaluating the provider's performance, and the Contractor's remedies if the provider does not fulfill its obligations;
 - h) The provider shall obtain a unique Medicaid provider identification number prior to serving Medicaid-eligible NorthSTAR Enrollees;
 - i) The provider shall inform Enrollees of provisions of and comply with 1 Tex. Admin. Code Chapter 353, Subchapter C, Member Bill of Rights and Responsibilities; and
 - j) The provider contract is subject to the terms and conditions of the Contract between Contractor and DSHS, and if any conflict exists between the provisions of the provider contract and the Contract between Contractor and DSHS, the terms and conditions of the Contract between Contractor and DSHS shall prevail; and the provider shall comply with 25 Tex. Admin. Code Chapter 411J, relating to standards of care and treatment in psychiatric hospitals.
- 3.8.6 Contractor shall submit to DSHS for prior approval all non-provider contracts relating to Contractor's obligations under this Contract, including but not limited to:
- a) Pharmacy benefits management;
 - b) Credentialing services;
 - c) Utilization management;
 - d) Intake referral (i.e., call center) services; and
 - e) Data management.
- 3.8.7 Contractor shall continue to seek innovative methods for the most cost effective purchase and distribution of pharmaceuticals.

3.9 Fiscal Management

Contractor shall ensure that health-related decisions are not unduly influenced by fiscal management.

3.10 Quality Assessment and Performance Improvement Program

- 3.10.1 Contractor shall comply with the applicable provisions of DSHS's written strategy described in Appendix 32 for assessing and improving the quality of covered services provided by Contractor pursuant to this Contract. Contractor shall have an ongoing quality assessment and performance improvement program (QAPI) that complies with 42 CFR§438.240. Contractor shall have a process to evaluate the impact and effectiveness of the QAPI.
- 3.10.2 Contractor shall conduct performance improvement projects designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas. Contractor shall have mechanisms to detect both underutilization and over utilization of services and to assess the quality and appropriateness of care furnished to enrollees with special health care needs.
- 3.10.3 Contractor shall further comply with the current QAPI standards and guidelines developed by CMS, with the following exceptions:
- a) Contractor shall develop in collaboration with the external quality monitor, for DSHS approval, two of the Performance Improvement Projects to be performed by Contractor;
 - b) An initial assessment of each Enrollee's health care needs within 90 days of the effective date of enrollment is not required; and
 - c) Contractor shall comply with §3.3.4 of this Contract regarding records retention.
- 3.10.4 Contractor shall report the status and results of each performance improvement project to DSHS as requested. Each performance improvement project shall be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
- 3.10.5 Contractor's QAPI program shall apply to covered services received by all Enrollees regardless of their eligibility type.
- 3.10.6 Contractor shall submit a description of its QAPI for approval by DSHS on or before November 30, 2009.
- 3.10.7 Contractor shall comply with the medical records standards contained in Appendix 2 or the treatment records standards published in the current National Committee for Quality Assurance (NCQA) Standards for Managed Behavioral Health Care Organizations, the Joint Commission, or URAC.

3.11 Participation in Regional Advisory Committee

Contractor shall participate on the Regional Advisory Committee established in the service area pursuant to the Texas Government Code, §§533.021-533.029.

3.12 Conflicts of Interest

Contractor shall not have an employment, consulting, or other agreement with persons who have been excluded from participating in federal contracting if those persons are significant to Contractor's obligations under this Contract.

ARTICLE IV FISCAL, FINANCIAL, CLAIMS AND INSURANCE REQUIREMENTS

4.1 Fiscal Solvency

- 4.1.1 Contractor shall maintain full compliance with all applicable state and federal solvency requirements for limited health maintenance organizations, including but not limited to, all reserve requirements, net worth standards, debt-to-equity ratios, and other debt limitations.
- 4.1.2 If Contractor becomes aware of any impending changes to its financial or business structure that could adversely impact its ability to pay its debts as they come due or provide covered services, Contractor shall notify DSHS immediately in writing.
- 4.1.3 Contractor has not filed for protection under any state or federal bankruptcy laws. None of Contractor's property, plant or equipment has been subject to foreclosure or repossession within the preceding 10-year period. Contractor has not had any debt declared in default and accelerated to maturity within the preceding 10-year period. Contractor represents that these statements are true as of the Contract execution date. Contractor shall inform DSHS within 24 hours of a change in any of the preceding representations.
- 4.1.4 Contractor shall hold harmless and require its providers to hold harmless Enrollees from liability:
 - a) For the Contractor's debts in the event of Contractor's insolvency; and
 - b) For payment, except for allowable co-payments under §4.11 of this Contract, for covered services.

4.2 Minimum Surplus

- 4.2.1 Contractor shall maintain minimum surplus that complies with the Texas Insurance Code and TDI rules. "Surplus" means admitted assets minus uncovered liabilities; "admitted assets" means all assets as defined by generally accepted accounting principles, as permitted and valued in accordance with 28 Tex. Admin. Code §11.803; "liabilities" is defined in 28 Tex. Admin. Code §11.806, which definition is incorporated herein by reference.
- 4.2.2 Contractor shall maintain the minimum surplus during the entire Contract term.

4.3 Performances and Fidelity Bond

- 4.3.1 Contractor shall maintain a performance bond issued by an insurance company licensed by TDI naming DSHS as Obligee, which bond secures Contractor's faithful performance of the terms and conditions of this

Contract and all specifications related to the Texas Medicaid Program. The performance bond covers any expenses, including but not limited to, administrative, personnel and legal expenses incurred by the State resulting from Contractor's non-performance, the additional costs for services rendered after the termination of the Contract for non-performance until other arrangement for service is made, and any costs for services not paid by Contractor under this Contract that ultimately may be the responsibility of DSHS, or the State of Texas. The performance bond shall be issued in the amount of \$250,000 and specify cash payment as the sole remedy.

- 4.3.2 The performance bond shall continue in effect for the greater of 90 days or the closing-out period following the expiration or termination of this Contract.
- 4.3.3 Contractor shall maintain a fidelity bond that meets the requirements of §843.402 of the Texas Insurance Code.

4.4 Insurance

- 4.4.1 Contractor shall maintain or cause to be maintained general liability insurance in the amounts of at least \$1,000,000 per occurrence and \$5,000,000 in the aggregate.
- 4.4.2 Contractor shall maintain or require professional liability insurance on each of the providers in its network in the amount of \$100,000 per occurrence and \$300,000 in the aggregate or the limits required by the hospital at which the network provider has admitting privileges.
- 4.4.3 Contractor shall maintain an umbrella professional liability insurance policy for the greater of \$3,000,000 or an amount (rounded to the next \$100,000) which represents the number of Contractor's Enrollees in the first month of the Contract term multiplied by one hundred fifty dollars (\$150), not to exceed \$10,000,000.
- 4.4.4 Subcontractors and providers that qualify as state or federal units of government and are prohibited by law from purchasing liability insurance are exempt from the insurance requirements of this section. State and federal units of government are required to comply with and are subject to the provisions of the Texas or Federal Tort Claims Act, as applicable.

4.5 Franchise Tax

Contractor certifies that its payment of franchise taxes is current or that it is not subject to the state franchise tax.

4.6 Audit

- 4.6.1 DSHS, the Secretary of Health and Human Services, CMS, HHSC, TDI and their designees have the right to examine and audit books and records of the Contractor and of its subcontractors relating to: (1) Contractor's capacity to bear the risk of potential financial losses; (2) services performed or determination of amounts payable under this Contract; (3) detection of fraud and abuse; (4) evaluation of the quality, appropriateness

and timeliness of services performed under this Contract; and (5) any other purpose these agencies deem necessary to perform their regulatory functions and/or to enforce the provisions of this Contract.

4.6.2 Contractor and its subcontractors shall authorize DSHS, the Secretary of Health and Human Services, CMS, HHSC and their authorized representatives to have unrestricted access to all buildings, grounds, records, data, information systems, and other information under the control of Contractor as necessary to enable these agencies to audit, monitor, and review the financial and program activities and services associated with this Contract.

4.6.3 As required by Government Code, Chapter 2262, contractor acknowledges that the state auditor may conduct an audit or investigation of any entity receiving funds from the state directly under contract or indirectly through subcontract. Contractor further acknowledges that acceptance of funds under this contract acts as acceptance of the authority of the state auditor, under the direction of the legislative audit committee, to conduct an audit or investigation in connection with such funds.

4.7 Pending or Threatened Litigation

Contractor has provided to DSHS in writing, prior to the execution of this Contract, the required disclosure of all pending or potential litigation or administrative actions against Contractor or its subcontractors or network providers. Contractor represents and warrants that it is not aware of any other pending or potential litigation or administrative action against Contractor or its subcontractors or network providers at the time of the execution of this Contract. Contractor shall notify DSHS of any litigation that is initiated or threatened against Contractor related to the NorthSTAR program or its subcontractors or network providers within seven days of receiving service or becoming aware of the threatened litigation. Such notification shall include the names of the parties, nature of the litigation and remedy sought, including amount of damages, if any.

4.8 Misrepresentation and Fraud

4.8.1 Contractor was awarded this Contract based upon the responses, representations and assurances contained in its Proposal. All responses, representations, and assurances upon which scoring was based were material to DSHS's decision of whether to award the Contract to Contractor. Any misrepresentation by Contractor in its responses, representations and assurances is a material misrepresentation.

4.8.2 This Contract was awarded in part based upon Contractor's representation of its current equity and financial ability to bear the risks under this Contract. Any misrepresentation of Contractor with regard to its surplus, equity, or ability to bear financial risks of this Contract, solely for the purpose of being awarded this Contract, is a material misrepresentation and fraud under this Contract.

- 4.8.3 Discovery of any material misrepresentation or fraud on the part of Contractor may cause DSHS to terminate this Contract and may further cause DSHS to take legal action against Contractor.

4.9 Third Party Recovery

- 4.9.1 Third Party Liability. Contractor shall ensure that all Enrollees assign their rights to any benefits to DSHS and agree to cooperate with DSHS in identifying third parties (“third party payors”) who may be liable for all or part of the costs of providing covered services to the Enrollee. Contractor is authorized to act as DSHS’s agent in enforcing DSHS’s rights to third party recovery (TPR) under this Contract.
- 4.9.2 Identification. Contractor shall develop and implement procedures to identify third party payors who may be liable for payment of all or part of the costs for providing covered services to Enrollees under this Contract in accordance with 42 CFR §433.138. Contractor shall coordinate with DSHS to obtain information from other state and federal agencies.
- 4.9.3 Exchange of Identified Resources. Contractor shall coordinate with DSHS to obtain information regarding potential third party payors from other state and federal agencies, including CMS, for Medicare information, and the Child Support Enforcement Division of the Office of the Attorney General, for child support information.
- 4.9.4 Recovery. Contractor shall actively pursue and collect from identified third party payors, except when the cost of pursuing recovery reasonably exceeds the amount that may be recovered by Contractor.

Contractor shall provide third party payor information to network providers. Contractor shall require such providers to seek recovery from potential third party payors prior to seeking payment from Contractor. If network providers are paid capitation, Contractor shall either seek recovery from third party payors or account to DSHS for all amounts received by network providers from third party payors.

Contractor shall prohibit network providers from interfering with or placing liens upon DSHS’s right or the Contractor’s right, acting as DSHS’s agent, to recovery from third party payors.

- 4.9.5 Retention. Contractor may retain all amounts recovered from third party payors if recoveries are obtained in compliance with the Contract and state and federal laws.
- 4.9.6 Accountability. Contractor shall report all TPR efforts and amounts recovered as required in §10.1.9 of this Contract, or as may be additionally required by DSHS. If Contractor fails to pursue and recover from third party payors as required under the Contract, DSHS may pursue TPR and retain all amounts recovered without accounting to Contractor for the amounts recovered. Future capitation rates may be reduced by any amounts recovered by DSHS.

4.10 General Revenue

Contractor may use state general revenues and federal block grant funds only when Contractor has exhausted all other sources of funds, including Medicaid.

4.11 Enrollee Co-payments

4.11.1 Contractor shall comply with the DSHS rules found at 25 Tex. Admin. Code, Chapter 412, Subchapter C (Charges for Community Services) and 25 Tex. Admin. Code, Chapter 417, Subchapter C (Charges for Services in TDMHMR Facilities), as applicable, except as otherwise required in this subsection. Contractor may identify and require co-payments only from non-Medicaid Eligible Adult Enrollees whose income is above 150% of the current FPL on the enrollee's ability-to-pay basis, as defined in 25 Tex. Admin. Code §412.103. Contractor may not charge co-payments from Medicaid Eligible Enrollees or from non-Medicaid Eligible Youth. Contractor may delegate the collection of co-payments to providers or other subcontractors. Contractor shall conduct a financial assessment of the non-Medicaid Eligible Adult Enrollee in accordance with Appendix 15 and with above-referenced rules, as applicable.

4.11.2 Contractor may not require co-payments for emergency behavioral health services.

4.11.3 Contractor may require a co-payment from a non-Medicaid Adult Enrollee who requests a medication that is not on the NorthSTAR Drug Formulary, attached as Appendix 26, or Contractor's preferred medication list when a medication that is on the NorthSTAR Drug Formulary or Contractor's preferred medication list is clinically equivalent or superior to the requested medication, in accordance with the Pharmacy Guidelines described in Appendix 16, or a DSHS-approved variation or substitute of the guidelines. Any co-payments collected for medications fall within 25 Tex. Admin. Code, Chapter 412, Subchapter C (Charges for Community Services).

4.11.4 Contractor shall allow an enrollee to request a waiver of co-payments for non-formulary medications in accordance with Appendix 16.

4.11.5 Contractor may determine whether Contractor or subcontractors retain co-payments permitted under this Contract.

4.11.6 Contractor shall ensure that any co-payments charged each Consumer under this Contract do not exceed the consumer's maximum monthly fee established pursuant to the rules referenced in §4.11.1 of this Contract.

4.11.7 Contractor shall not allow Narcotic Treatment Programs to charge consumers "Patient Fees" related to Provider Permit fees.

4.12 Expenditure of Medicaid Funds and Calculation of Medicaid Premiums

On an annual basis, DSHS will calculate Medicaid expenditures based on allowable Medicaid service costs and other allowable costs as determined by HHSC. Calculation methodology of Medicaid rates are subject to HHSC and CMS approval. These rates will be calculated each year using the previous fiscal year's certified encounter data and Contractor's financial reports.

4.13 Claims Processing Requirements

- 4.13.1 Contractor shall comply with the claims processing procedures described in Insurance Code, §843.341. Contractor shall require its providers to submit claims in accordance with Texas Insurance Code, §843.337.
- 4.13.2 Contractor's providers shall report claims and encounter data using the claims data procedure codes and service codes described in Appendix 22. When a service code described in Appendix 22 differs from a service code described in the procedures referred to §4.13.1 above, then the provider shall use the service codes described in Appendix 22.
- 4.13.3 Contractor shall collect and report claims and encounter data to DSHS in accordance with §9.1 of this Contract.
- 4.13.4 Contractor shall forward claims submitted to Contractor in error to the provider who submitted the claim in error, along with an explanation of why the claim is being returned.
- 4.13.5 Contractor shall not pay any claim submitted by a provider who is under investigation for or has been excluded or suspended from the Medicare or Medicaid programs for fraud and abuse when Contractor is on actual or constructive notice of the investigation, exclusion, or suspension.
- 4.13.6 Contractor shall adjudicate all clean claims submitted by providers in accordance with Texas Insurance Code §§843.338 and 843.3385, except that Contractor shall adjudicate these claims, including prescription claims, within 30 days from the date the clean claim is received by Contractor. Contractor shall send each provider whose claim cannot be adjudicated because the claim is unclean ("unclean claim") a written notice identifying the claim, all reasons the claim is being denied, the date the claim was received by Contractor, all information required from the provider for Contractor to adjudicate the claim, and the date by which information requested must be received from the provider.
- 4.13.7 Contractor shall pay a provider interest on each clean claim that is not adjudicated within 30 days from the date the claim is received by the Contractor at a rate of 1.5% per month (18% annual) for each month the claim remains unadjudicated.
- 4.13.8 Contractor shall inform all network and out-of-network providers of all data fields of each claim form that are required from the provider for Contractor to adjudicate the claim, in accordance with Texas Insurance Code, §843.3385.
- 4.13.9 If Contractor fails to adjudicate a clean claim in accordance with Texas Insurance Code §843.338, Contractor shall pay the provider making the claim in accordance with Texas Insurance Code §843.342.
- 4.13.10 If Contractor intends to audit a claim submitted by a network provider, Contractor shall comply with Texas Insurance Code §843.340.

4.14 Provider Exclusions and Suspensions

Contractor shall develop, maintain and follow procedures for identifying all network providers that are excluded or suspended from the Medicaid or Medicare programs.

4.15 Accounting Records

Contractor shall maintain all accounting records relating to NorthSTAR in compliance with Generally Accepted Accounting Principles (GAAP).

4.16 Minimum Direct Service Claims Target (DSCT)

4.16.1 Contractor's DSCT is 88 percent, which shall be calculated based on Contractor's receipt of premium payments under §11.1 of this Contract and State Hospital Allocation Methodology allocations under §11.2 of this Contract.

4.16.2 DSHS will calculate the DSCT for the contract term using the following methodology: the numerator will include all Contractor's direct service expenditures and the civil portion of the state hospital allocation. For this contract, direct service expenditures will be defined as claims payments made to service providers, invoice payments for direct client services paid by Contractor to service providers, all UTMB expenditures and all medication claims paid by Contractor. The denominator includes all cash premiums and payments made to the Contractor by DSHS for the contract period plus the civil portion of the state hospital allocation. DSCT will be calculated by dividing the numerator by the denominator. DSHS will determine claims expenditures using the DSHS data system. DSHS will use Contractor's behavioral health financial statistical report to determine invoice costs paid by Contractor for direct services.

4.16.3 At the end of each fiscal year DSHS will calculate the DSCT for the previous year. For example, in December DSHS will calculate the DSCT for September–August, the 12-month period of the previous fiscal year. If the calculated DSCT is less than 88 percent level, DSHS will withhold all funds under the 88 percent level from the Contractor. DSHS will hold these funds for any future calculated year for which the DSCT is over 88 percent level and disburse the balance of withheld funds to Contractor up to the 88 percent level.

4.16.4 If Contractor fails to meet the DSCT at the end of the contract term, then Contractor shall develop a reinvestment plan in collaboration with NTBHA and obtain DSHS's approval no later than one month following the end of the Contract term. DSHS has 30 days to approve the plan. Contractor shall complete reinvestment of the unexpended funds within one year following the end of the Contract term, according to the DSHS-approved reinvestment plan. If Contractor does not have an approved reinvestment plan within one month following the end of the Contract term, or has not reinvested the unexpended funds within one year following the end of the Contract term, Contractor shall return all

unexpended funds and the proportionate amount of administrative funds and profit to DSHS.

- 4.16.5 Except as provided in 4.19.2, Contractor accepts full risk for providing or arranging for the provision of all covered services for all Enrollees regardless of whether the actual cost of providing such services reduces Contractor's profits or results in a net loss to Contractor.

4.17 Performance Incentives

- 4.17.1 Contractor, in conjunction with NTBHA and providers, shall develop performance incentives for providers, using the list described in Appendix 4a as a guide and other outcome based performance measures identified by Contractor and NTBHA. If Contractor receives any funds through the American Recovery and Reinvestment Act of 2009 (ARRA) during the term of this Contract, Contractor shall use those funds solely for the provider incentive program for the term of this Contract. After Contractor has developed a written plan for the performance incentives in consultation with NTBHA and providers, Contractor shall submit the incentive plan to DSHS for approval.

4.18 State Hospital Allocation Methodology

Contractor shall comply with the current State Hospital Allocation Methodology as described on the DSHS website.

4.19 New Generation Medication Funds

- 4.19.1 Contractor shall spend the new generation medication funds indicated in Appendix 30 in accordance with the NorthSTAR Pharmacy Manual (Appendix 16), or a DSHS -approved variation or substitute of the practice guidelines developed through the Texas Implementation of Medications Algorithm (TIMA) and the Children's Medication Algorithm Project (CMAP).
- 4.19.2 Contractor shall return to DSHS all new generation medication funds not spent on new generation medications or reinvest those unspent dollars into direct services for clients in accordance with the provisions of Rider 35, page II-114, Special Provisions Relating to All Health and Human Services Agencies, General Appropriations Act, 81st Legislature, Regular Session. Contractor is not obligated to incur expenditures for new generation medications in excess of the new generation medication funds indicated in Appendix 30.
- 4.19.3 Contractor shall develop a formal new generation waiting list protocol if Contractor determines that new generation medication funds may be over spent. Contractor shall report new generation medication waiting list information to DSHS and NTBHA quarterly in a format mutually agreed upon by the DSHS, NTBHA and Contractor.

**ARTICLE V STATUTORY AND REGULATORY COMPLIANCE
REQUIREMENTS**

5.1 Compliance with Federal, State, and Local Laws

5.1.1 Contractor shall know, understand and comply with all state and federal laws and regulations relating to the Texas Medicaid Program which have not been waived by CMS, including all rules relating to the Medicaid managed care program adopted by CMS, HHSC, DSHS, TDH, and TDI, including, but not limited to the following:

- a) 42 USC, §1396a, relating to Medical Assistance Programs;
- b) 42 USC, §1396u-2, relating to Medicaid managed care;
- c) 42 USC, §1395dd, relating to emergency care services;
- d) 42 CFR, Subchapter C, relating to Medical Assistance Programs;
- e) 42 CFR, Subchapter G, relating to Standards and Certifications;
- f) 25 Tex. Admin. Code Chapter 412, Subchapter I, relating to Mental Health Case Management Services;
- g) 1 Tex. Admin. Code Chapter 357, relating to Hearings; and
- h) 25 Tex. Admin. Code Chapter 419, Subchapter L, relating to Medicaid Mental Health Rehabilitative Services.

5.1.2 Contractor shall know, understand and comply with all state and federal laws and regulations relating to mental health, substance abuse, and chemical dependency services, including but not limited to, the following:

- a) Title VII, Subtitle C, Health and Safety Code (Mental Health Code);
- b) Title VII, Subtitle E, Health and Safety Code (Special Provisions Relating to Mental Illness and Mental Retardation);
- c) Title VI, Health and Safety Code, relating to alcohol and substance abuse programs;
- d) Family Code §55.02, relating to children with mental illness;
- e) Applicable rules promulgated by DSHS, including but not limited to the following:
 - (1) 25 Tex. Admin. Code Chapter 417, Subchapter B, relating to Contracts Management;
 - (2) 25 Tex. Admin. Code Chapter 404, Subchapter E, relating to Rights of Persons Receiving Mental Health Services;
 - (3) 25 Tex. Admin. Code Chapter 415, Subchapter A, relating to Prescribing of Psychoactive Medication;
 - (4) 25 Tex. Admin. Code Chapter 405, Subchapter E, relating to electroconvulsive therapy (ECT);
 - (5) 25 Tex. Admin. Code Chapter 415, Subchapter F, relating to interventions in mental health programs;
 - (6) 25 Tex. Admin. Code, Chapter 405, Subchapter K, relating to Deaths of Persons Served by TXMHMR Facilities or Community Mental Health and Mental Retardation Centers;
 - (7) 25 Tex. Admin. Code, Chapter 411, Subchapter N, relating to Standards for Services to Individuals with Co-Occurring Psychiatric and Substance Use Disorders (COPSD);

- (8) 25 Tex. Admin. Code Chapter 412, Subchapter G, relating to Mental Health Community Services Standards;
 - (9) 25 Tex. Admin. Code Chapter 415, Subchapter C, relating to Use and Maintenance of TDMHMR Drug Formulary;
 - (10) 1 Tex. Admin. Code Chapter 354, Subch. A, Division 22, relating to chemical dependency treatment facilities;
 - (11) 25 Tex. Admin. Code Chapter 412, Subchapter D, relating to Mental Health Services – Admission, Continuity, and Discharge; and
 - (12) 25 Tex. Admin. Code Chapter 414, Subchapter I, relating to Consent to Treatment with Psychoactive Medication – Mental Health Services.
- 5.1.3 Contractor shall expand the death reporting and review process outlined in 25 Tex. Admin. Code, Chapter 405, Subchapter K to include providers identified by DSHS. Contractor shall require providers in the NorthSTAR network that have the infrastructure to conduct death reviews to do so and send the death review reports to Contractor. For providers in the NorthSTAR network that do not have the infrastructure to conduct death reviews, Contractor may subcontract clinical death reviews with the written agreement of DSHS. Contractor shall require the subcontracted entity to submit death review reports to Contractor, and Contractor shall send the reports to DSHS. Contractor shall adhere to all timelines and requirements in the above-mentioned TAC, but is not required to enter the data into the CARE system.
- 5.1.4 Contractor shall comply with Chapter 843 of the Insurance Code, and all applicable rules promulgated by TDI at Title 28, Tex. Admin. Code.
- 5.1.5 Contractor shall comply with the Government Code, §533.006, regarding provider networks, as a condition of Contract retention.
- 5.1.6 Contractor shall comply with the provisions of the Clean Air Act and the Federal Water Pollution Control Act, as amended, found at 42 USC 7401, et. seq. and 33 USC 1251, et. seq., respectively.
- 5.1.7 Contractor shall comply with 42 USC §§300x-21 through 300x-35, relating to the Substance Abuse Prevention and Treatment Block Grant, 42 USC §§ 300x-1 through 300x-8, relating to the Federal Community Mental Health Services Block Grant, 42 USC §1397, relating to Block Grants to States for Social Services, and the Government Code, Chapter 2105, relating to Administration of Block Grants.
- 5.1.8 Contractor shall comply with Family Code, Chapter 261, Subchapter B, relating to reporting of abuse or neglect, and 25 Tex. Admin. Code Chapter 414L, relating to Abuse, Neglect, and Exploitation in Local Authorities and Community Centers.
- 5.1.9 Contractor shall require, through contract provision, that all network providers and subcontractors comply with all state and federal laws and regulations relating to the Texas Medicaid Program, the Medicaid managed care program, and mental health, substance abuse and chemical

dependency services, including but not limited to, all of the above-referenced statutes, regulations, and rules.

5.2 Program Integrity

- 5.2.1 Contractor certifies that it has not been excluded, debarred, or suspended from participation in any program under Title XVIII or Title XIX under any of the provisions of Section 1128(a) or (b) of the Social Security Act (42 USC §1320a-7), or Executive Order 12549. Contractor shall notify DSHS within three days of the time it receives notice that any action is being taken against Contractor or any person defined under the provisions of §1128(a) or (b) or any subcontractor, which could result in exclusion, debarment, or suspension of Contractor or a subcontractor from the Medicaid program, or any program listed in Executive Order 12549.
- 5.2.2 Contractor shall comply with the provisions of, and file the certification of compliance required by the Byrd Anti-Lobbying Amendment, found at 31 USC §1352, relating to use of federal funds for lobbying for or obtaining federal contracts.

5.3 Fraud and Abuse Compliance Program

- 5.3.1 This Contract is subject to all state and federal laws and regulations relating to fraud and abuse in health care and the Texas Medicaid Program. Contractor shall cooperate and assist the State and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Contractor shall provide originals of all records and information requested and allow access to premises and provide records to DSHS or its authorized agent(s), HHSC, CMS, the U.S. Department of Health and Human Services, FBI, TDI, and the Texas Office of the Attorney General's Medicaid Fraud Control Unit. All copies of records shall be provided free of charge.
- 5.3.2 Contractor shall comply with Government Code §§531.113 and 533.114 and with Contractor's Corporate Integrity Agreement (Appendix 31) and update the plan as necessary to comply with these statutory provisions. Contractor shall submit to DSHS for approval any updates or modifications to its fraud and abuse compliance plan at least 30 days prior to the effective date of such modifications.
- 5.3.3 The plan shall ensure that all officers, directors, managers, and employees know and understand the provisions of Contractor's fraud and abuse compliance plan. The plan shall contain procedures designed to prevent and detect potential or suspected fraud and abuse in the administration and delivery of services under this Contract. The plan shall contain provisions for the confidential reporting of plan violations to a designated person. The plan shall contain provisions for the investigation and follow-up of any compliance plan reports. The fraud and abuse compliance plan shall ensure that the identity of individuals reporting violations of the plan is protected. The plan shall contain specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting,

and investigating fraud and abuse compliance plan violations. The compliance plan shall require that confirmed violations be reported to the State. The plan shall further require enforcement of the plan through well-publicized disciplinary guidelines.

- 5.3.4 The plan shall require any confirmed or suspected fraud and abuse under state or federal law to be reported to DSHS, the Office of Inspector General of HHSC, and the Medicaid Fraud Control Unit of the Texas Office of the Attorney General. The written plan shall ensure that no individual who reports plan violations or suspected fraud or abuse is retaliated against.
- 5.3.5 Contractor shall comply with the Corporate Integrity Agreement attached hereto as Appendix 31. Contractor shall further comply with the requirements of the Model Compliance Plan for HMOs issued by the U.S. Department of Health and Human Services, the Office of Inspector General (OIG). Contractor shall ensure that executive and essential personnel receive mandatory training in fraud and abuse detection, prevention, and reporting, within the first three months of employment and at least once every two years thereafter.
- 5.3.6 Contractor shall designate an officer or director of the Contractor and a compliance committee who are accountable to senior management to have the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan. Contractor shall ensure effective lines of communication between the compliance officer and Contractor's employees.
- 5.3.7 Contractor's failure to report potential or suspected fraud or abuse may result in sanctions, cancellation of this Contract, or exclusion from participation in the Medicaid program.
- 5.3.8 Contractor shall allow the Texas Medicaid Fraud Control Unit to conduct private interviews of Contractor's and its subcontractors' employees, witnesses, and Enrollees. Contractor shall comply with requests for information in the form and manner requested. Contractor's and its subcontractors' employees shall cooperate fully and be available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials, and any other fraud and abuse investigation processes, at Contractor's and subcontractor's own expense.

5.4 Safeguarding Information

- 5.4.1 Contractor shall only receive and disclose individually identifiable health information ("health information") to carry out Contractor's duties relating to treatment, payment or health care operations, as defined in 45 CFR §164.501, and as required under this Contract. When using or disclosing health information or when requesting health information from another entity, Contractor shall make reasonable efforts to limit the health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

- 5.4.2 Contractor shall inform Enrollees, subcontractors, and providers of the provisions of 42 CFR Part 431, Subpart F, regarding Safeguarding Information on Applicants and Recipients, and Contractor shall ensure that confidential information is protected from disclosure except for authorized purposes.
- 5.4.3 Contractor shall comply and require its subcontractors and providers to comply with all state and federal laws and regulations regarding confidentiality, including but not limited to, the following:
- a) 42 CFR, Part 2;
 - b) 42 CFR, Part 431, Subpart F;
 - c) 45 CFR Parts 160 and 164;
 - d) Chapter 159, Occupations Code;
 - e) Chapter 181, Health and Safety Code;
 - f) Section 576.005, Health and Safety Code;
 - g) Chapter 611, Health and Safety Code;
 - h) Chapter 85, Health and Safety Code; and
 - i) 25 Tex. Admin. Code, Chapter 414, Subchapter A, relating to Protected Health Information.
- 5.4.4 Contractor shall use all confidential information received by Contractor only to carry out duties and responsibilities under this Contract. Contractor shall use at least the same standard of care in the protection of confidential information as Contractor uses to protect its own confidential or proprietary information.
- 5.4.5 Contractor shall take such reasonable measures as are necessary to restrict employees, subcontractors, providers, and agents that are authorized by law to receive confidential information to receive such information on a "need-to-know" basis. Contractor shall advise such employees, subcontractors, providers, and agents of Contractor's obligations under this Contract. Contractor shall ensure that only persons who have signed confidentiality agreements containing the terms set forth in Appendix 28 have access to and enter data into DSHS's enrollment and "look up" system, referred to as the NorthSTAR information System. Contractor shall submit the signed confidentiality agreements to the Contract Manager.
Contractor shall not use confidential information in any way to influence or affect enrollment in Contractor's plan.
- 5.4.6 Contractor shall notify DSHS immediately, in writing, if Contractor determines or has reason to suspect a breach of the requirements of this Section.

5.5 Consent to Treatment

Contractor shall comply, and require its subcontractors and providers to comply, with all statutory and regulatory requirements regarding consent to treatment, including but not limited to:

- a) 42 CFR, Part 2;
- b) Health and Safety Code, §576.025;

- c) Health and Safety Code, §578.003;
- d) Family Code, Chapter 32; and
- e) 25 Tex. Admin. Code, Chapter 415, Subchapter A, relating to Prescribing of Psychoactive Medication

5.6 Nondiscrimination

- 5.6.1 Contractor shall comply with and include in all subcontracts and provider Contracts a provision requiring the subcontractor to comply with each of the following requirements:
 - a) All federal statutes relating to nondiscrimination, including but not limited to Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d, 45 CFR Part 80), Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act of 1990, and Texas Labor Code, Chapter 21, and all requirements imposed by the regulations implementing these acts, and all amendments to the laws and regulations. These statutes and regulations provide, in part, that no person in the United States shall on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion, be excluded from participation in or denied any aid, care, service or other benefits or be subjected to any discrimination under any program or activity receiving federal funds.
 - b) Executive Order 11246, as amended by Executive Order 11375, relating to Equal Employment Opportunity.
 - c) The Drug Abuse Office and Treatment Act of 1972, 21 USC §§1101 *et seq.*, as amended, relating to nondiscrimination on the basis of drug abuse, and with the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, 42 USCS §290dd(b)(1), as amended, relating to the nondiscrimination on the basis of alcohol abuse and alcoholism.
- 5.6.2 Contractor shall ensure that limited English proficient individuals have equal access and participation in NorthSTAR through the provision of bilingual services.

5.7 Historically Underutilized Businesses (HUBs)

- 5.7.1 Contractor shall make a good faith effort to assist HUBs in receiving a portion of the total Contract value of this Contract, pursuant to Texas Government Code, Title 10, Subtitle D, Chapter 2161 and 34 Tex. Admin. Code Chapter 20, Subchapter B, relating to HUB Program.
- 5.7.2 Contractor shall comply with its HUB Subcontracting Plan as approved by DSHS. All modifications to the approved plan must be approved by DSHS prior to implementation. Contractor shall maintain business records documenting its compliance with the HUB Subcontracting Plan and shall submit compliance reports as required in §10.8 of this Contract. DSHS will review Contractor's compliance with its HUB Subcontracting Plan and determine if Contractor is meeting the requirements of this section. If

DSHS determines Contractor has failed to meet these requirements, DSHS will notify Contractor of its deficiencies and give Contractor an opportunity to submit documentation and explain why the failure to fulfill the HUB Subcontracting Plan should not be attributed to a lack of good faith effort by Contractor.

- 5.7.3 Contractor shall submit quarterly reports on HUB activity to the DSHS HUB coordinator and to DSHS NorthSTAR.
- 5.7.4 Contractor shall make any necessary changes to the HUB report as identified by DSHS.

5.8 Buy Texas

Contractor shall purchase Texas products and materials when they are available at a comparable price and in a comparable period of time, as required by §2155.4441, Government Code.

5.9 Child Support Certification

Under §231.006 of the Family Code, the Contractor certifies that the individual or business entity named in this Contract is not ineligible to receive the specified payments and acknowledges that this Contract may be terminated and payment may be withheld if this certification is inaccurate. A child support obligor who is more than 30 days delinquent in paying child support or a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25% is not eligible to receive the specified payments.

If DSHS is informed and verifies that a child support obligor who is more than 30 days delinquent is a partner, shareholder, or owner with at least a 25% ownership interest, DSHS will withhold any payments due under this Contract until DSHS receives satisfactory evidence that the obligation has been satisfied or that the obligor has entered into a written repayment request.

5.10 Requests For Public Information

- 5.10.1 If DSHS receives a public information request under the Public Information Act, Government Code, Chapter 552, relating to information submitted by Contractor to DSHS, DSHS will promptly deliver a copy of the request to the Contractor.
- 5.10.2 If Contractor believes that the requested information qualifies as a trade secret or commercial or financial information that is excepted from disclosure, Contractor shall, within two business days of receipt of request notify DSHS of that belief and identify specific text, or portion of text, which the Contractor claims is excepted from required public disclosure. Contractor shall identify the specific provisions of the Act that Contractor believes are applicable, and include a detailed written explanation of how the exceptions apply to the specific information identified by Contractor as confidential.
- 5.10.3 DSHS may, in its sole discretion, request a decision from the Office of the Attorney General regarding whether the information requested is

excepted from required public disclosure. DSHS may rely on the Contractor's written representations in preparing any request, in accordance with Government Code §552.305. DSHS may not be held liable for failing to request a decision from the Office of the Attorney General or for releasing information that is not deemed confidential by law if the Contractor fails to provide DSHS with specific reasons why the requested information is exempt from the required public disclosure. DSHS will notify the Contractor if decision from the Office of the Attorney General is requested by delivering a copy of the public information opinion request to the Contractor. In the event Contractor disagrees with the option of the Attorney General it shall have three (3) business days to file an appeal in a court of competent jurisdiction.

ARTICLE VI ENROLLEE SERVICES

6.1 Eligibility

6.1.1 Medicaid Eligible Individuals

Individuals in the Medicaid groups listed in Appendix 6, under the column titled "NorthSTAR" who reside in the service area are eligible for covered services and shall be automatically enrolled in NorthSTAR. Individuals in Medicaid Category 2, program type 55 are eligible for enrollment in NorthSTAR only if substance abuse/chemical dependency services are clinically indicated. These individuals are ordinarily excluded from enrollment in NorthSTAR, but shall be enrolled as indigent if the aforementioned services are indicated. All other behavioral health services provided to these Medicaid eligible individuals shall continue to be covered by traditional Medicaid.

6.1.2 Non-Medicaid Eligible Individuals

Individuals who are not eligible for Medicaid under §6.1.1 above may receive covered services if such individuals reside in the service area and meet the following criteria:

- a) Individuals in the DSHS mental health priority population, as described in Appendix 7, and individuals in the DSHS substance abuse/chemical dependency priority population, as described in subsections (b) through (g) below, and who require services outside the scope of any available third party coverage and whose adjusted monthly income does not exceed 200% of the FPL, as determined according to the financial eligibility determination process described in Appendix 15.
- b) Any youth who has a substance abuse or dependency diagnosis is eligible for all covered services as clinically indicated.
- c) Adults with a substance dependency diagnosis are eligible for all covered services as clinically indicated.
- d) Adults with a substance abuse diagnosis are eligible for outpatient treatment programs only.

- e) Pregnant women, women with dependent children, and parents of children in foster care with substance abuse or dependency diagnoses are eligible for all covered services, as clinically indicated.
- f) Persons with HIV with substance abuse or dependency diagnoses are eligible for all covered services, as clinically indicated.
- g) Persons with substance abuse or dependency diagnoses who use needles to take drugs are eligible for all covered services, as clinically indicated.

6.2 Enrollment

- 6.2.1 The Enrollment Broker will enroll and disenroll Medicaid covered lives in the NorthSTAR program and submit enrollment information to DSHS. DSHS will transmit the Medicaid enrollment to Contractor in an automated format. DSHS will confirm the enrollments of non-Medicaid covered lives made by Contractor and submit the enrollment information to Contractor. Contractor will submit disenrollment requests of non-Medicaid covered lives to DSHS for approval in an electronic 834-file format that complies with HIPAA, or in a format approved by DSHS. DSHS will submit the approved disenrollment information to Contractor. Contractor shall accept all covered lives who choose to enroll or who are assigned as Enrollees in the Contractor's plan by DSHS, without regard to the Enrollee's health or behavioral health status or need for health or behavioral health services.
- 6.2.2 DSHS makes no guarantees or representations to Contractor regarding the number of covered lives who will be enrolled in Contractor's plan.
- 6.2.3 Contractor shall participate in all DSHS-sponsored enrollment and marketing activities.
- 6.2.4 Contractor shall accept all eligible covered lives who choose to enroll or who are assigned to Contractor by DSHS in the order in which they apply or are assigned without restriction.
- 6.2.5 Contractor shall not discriminate against individuals eligible to enroll on the basis of race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.
- 6.2.6 Contractor shall be limited to thirty (30) days for purposes of verifying eligibility of non-Medicaid enrollees. If a good faith attempt at eligibility verification and eligibility is not verified within the thirty (30) days, the Contractor may request disenrollment of the Enrollee pursuant to §6.6.1.
- 6.2.7 DSHS will make best efforts to produce enrollment files that contain the following information:
 - a) Medicare Part A coverage information with effective date and term date;
 - b) Medicare Part B coverage information and effective date and term date;
 - c) Medicare Part D coverage information and effective date and term date;

- d) Medicaid segments that identify Qualified Medicare Beneficiaries (QMB), Medicaid Qualified Medicare Beneficiaries (MQMB), and Specified Low Income Beneficiaries (SLMB) effective date and term date;
- e) Medicaid effective date and term date;
- f) Non-Medicaid Indigent effective date and term date; and
- g) Children's Health Insurance Program (CHIP) enrollment information.

6.3 Enrollee Verification

Contractor shall maintain an Enrollee verification telephone system that can be accessed by its subcontractors and providers 24 hours a day/seven days a week.

6.4 Enrollment Period

6.4.1 The enrollment period begins at the point of enrollment and ends when the Contract expires pursuant to Article 16 of this Contract or is terminated pursuant to §15.8.1 of this Contract, or at the time one of the following events occurs:

- a) The Enrollee moves out of the service area;
- b) The Enrollee dies;
- c) The Enrollee is disenrolled pursuant to §6.5 or §6.6 below;
- d) The Enrollee enters a Medicaid Institution for Mental Diseases (IMD) program, an Intermediate Care Facility for the Mentally Retarded (ICF/MR), a nursing home, or DFPS custody; or
- e) The Enrollee no longer meets the eligibility criteria set forth in §6.1.

6.5 Voluntary Disenrollment

6.5.1 Contractor shall ensure that Enrollee requests for disenrollment are not processed through Contractor's complaint procedures but are submitted to DSHS for processing within five business days after the Contractor receives the disenrollment request.

6.6 Involuntary Disenrollment

6.6.1 Contractor may request disenrollment of an Enrollee against his or her will under limited conditions. These conditions include, but are not limited to:

- a) Severe disruptive behavior not caused by a behavioral health condition at a network provider's office;
- b) Fraudulent loaning of the Enrollee's Medicaid identification card to another person; or
- c) The Enrollee no longer meets the eligibility criteria set forth in §6.1.

6.6.2 Contractor may not request a disenrollment based on any of the following:

- a) An adverse change in the Enrollee's health or behavioral health status;
- b) The Enrollee's utilization of services;
- c) Enrollee's race, color, national origin, sex, age, disability, political beliefs, or religion;
- d) Enrollee's diminished mental capacity; or

- e) Enrollee's uncooperative or disruptive behavior due to his or her behavioral health condition.
- 6.6.3 Prior to exercising a right to disenroll an Enrollee under this section, Contractor shall:
- a) Document that necessary steps have been taken to educate the Enrollee regarding the conditions for disenrollment listed in §6.6.1 above; and
 - b) If an Enrollee exhibits disruptive behavior, Contractor shall work with the Enrollee and his family, as appropriate, to develop a plan to address the disruptive behavior prior to requesting disenrollment of the Enrollee.
- 6.6.4 DSHS shall approve all involuntary disenrollments. No involuntary disenrollment will be effective until DSHS has approved the request for disenrollment.
- 6.6.5 Contractor shall notify the Enrollee of the availability of the Enrollee complaint procedures and the Enrollee's right to appeal to DSHS if the Enrollee disagrees that good cause exists for disenrollment.
- 6.6.6 Contractor shall provide DSHS with a written request to disenroll an Enrollee against his or her will. All disenrollment requests shall be either in an electronic 834-file format that complies with HIPAA, or in a DSHS approved format.

6.7 Enrollee Handbook

- 6.7.1 Contractor shall mail to each Enrollee within five working days of enrollment notification a DSHS-approved Enrollee Handbook that meets the cultural and linguistic requirements specified in §6.14 below.
- 6.7.2 The Enrollee Handbook shall include the following information:
- a) The name of the Contractor and the local office address and telephone number, including a toll-free telephone line;
 - b) A description of all services available directly or by referral, including health education and interpretive services and non-English languages spoken by providers, and notification that oral interpretation is available for any language and written information is available in languages for any population group comprising more than 10% of the covered lives;
 - c) The amount, duration and scope of the covered services, an explanation of any service limitations and exclusions from coverage, a description of authorization requirements and how to access the services;
 - d) What constitutes medically necessary services, emergency behavioral health condition, emergency behavioral health services, and post-stabilization care services;
 - e) Procedures for selecting a behavioral health provider; procedures for requesting a change in behavioral health provider; reasons for which a request to change providers may be denied; reasons a behavioral health provider may request a change; and procedures for notifying DSHS if an Enrollee moves out of the service area;

- f) Criteria and procedures for voluntary and involuntary disenrollments;
- g) A statement that only DSHS can approve an involuntary disenrollment;
- h) Procedures for obtaining prescriptions for Medicaid and non-Medicaid Enrollees;
- i) Procedures for obtaining covered services after hours;
- j) The extent to which and how enrollees may obtain benefits from out-of-network providers;
- k) Procedures for obtaining and rules for providing in- and out-of-network emergency behavioral health, including use of the 911 telephone system or its local equivalent, and post stabilization services, the locations of any emergency settings and other locations at which providers and hospitals furnish emergency and post stabilization care services, the fact that the enrollee has a right to use any hospital or other setting for emergency care, and the fact that prior authorization is not required for emergency services;
- l) Procedures for obtaining emergency and non-emergency transportation services;
- m) Description of Enrollee complaint and appeal procedures and timeframes, including the toll-free telephone number for reporting complaints, the title, address, and telephone number of the person(s) responsible for processing and resolving complaints and appeals, and the names and toll-free or local telephone numbers of the Contractor's Enrollee Services Representative, NTBHA Consumer Ombudsman, the DSHS Enrollee and Provider Relations Coordinator, TDI, and the Enrollment Broker;
- n) Information on the Medicaid Enrollee's right to the State's fair hearing process and the non-Medicaid Enrollee's right of appeal to an Independent Review Organization, including the methods for obtaining the hearing or appeal, the rules governing representation at the hearing, the availability of assistance in the filing process, the toll-free numbers the enrollee can use to request a fair hearing or appeal, procedures and timeframes, the continuation of benefits pending appeals and fair hearings filed within the required timeframes, costs that may be incurred by the enrollee if the final decision is adverse to the enrollee, and any other appeal rights made available by the State regarding Contractor's failure to cover a service;
- o) Information on advance directives and the organization's written policies on implementation of the right to advanced directives including the Declaration for Mental Health Treatment, living wills, or durable powers of attorney;
- p) An explanation of the distinction between the non-Medicaid eligible Enrollee's and the Medicaid eligible Enrollee's rights and responsibilities under NorthSTAR;
- q) An address and/or toll-free number for reporting suspected fraud and abuse;

- r) A statement of Member Rights and Responsibilities described in 1 Tex. Admin. Code §§353.202-.203 and 42 CFR §438.100;
- s) Information regarding available educational, prevention, social, and other community services that could benefit Enrollees;
- t) A list of behavioral health providers categorized by individual, group and facility. The list shall be updated quarterly and shall include the provider's name, office address and phone number(s), office hours, qualifications, any specific provider limitations, such as age limitations, the languages each provider and its staff speak, and identification of any specialty areas of practice. The list shall also identify which providers no longer accept new referrals and any restrictions on the enrollees freedom of choice among network providers;
- u) A description of all co-payment requirements;
- v) A description of any benefits available under the State of Texas Medicaid Plan but that are not covered services, including how and when the enrollee may obtain those benefits, any cost sharing, and how transportation is provided;
- w) Notification that information is available in alternative formats and how to access those formats;
- x) Notification of the Medicaid Eligible Enrollee's right to request and obtain any information contained in 42 CFR §438.10(f)(6) at least once a year; and
- y) Additional information that is available upon request, including information on the structure and operation of Contractor and physician incentive plans, and how to request that information.

6.7.3 Contractor shall provide updates to the handbook annually, or as directed by DSHS, explaining changes in the above-required information. All updates to the Enrollee Handbook shall be approved by DSHS. Contractor shall give each enrollee written notice of any significant change in the information described in the handbook at least 30 days before the intended effective date of the change.

6.7.4 Contractor shall make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt of issuance of the termination notice, to each enrollee who received his or her primary care from, or who was seen on a regular basis by the terminated provider.

6.8 Enrollee Information Cards

6.8.1 Contractor shall produce and distribute to Enrollees and providers Enrollee information cards at the time of the Enrollee's enrollment into Contractor's plan or receipt of a covered service.

6.8.2 Contractor's information card shall include the information required by Insurance Code §843.209 and the following information:

- a) The name of Contractor;

- b) The Contractor's 24-hour, 7-day-a-week toll-free telephone number;
and
- c) NTBHA's Consumer Ombudsman's toll-free number.

6.8.3 Contractor shall reissue the information card to Enrollees without cost.

6.9 Enrollee Services Representatives

Contractor shall hire or contract with Enrollee Services Representatives to provide information to Enrollees on enrollment and disenrollment, requirements and benefits of Contractor's plan, plan administration, education and training, access to services, Enrollee rights and responsibilities, and complaint and appeal procedures.

6.10 Marketing

6.10.1 Contractor may recruit Enrollees through acceptable marketing strategies, which include health seminars, health fairs, community outreach programs, multimedia advertisements, mailers, and billboard advertisements.

6.10.2 Contractor shall comply with its DSHS -approved NorthSTAR marketing plan. Modifications to the marketing plan shall be approved by DSHS. Contractor shall not distribute any marketing materials without first obtaining DSHS approval.

6.10.3 Marketing materials shall comply with the information requirements of 42 CFR §438.10 to ensure that, before enrolling, the recipient receives the accurate oral and written information he or she needs to make an informed decision of whether to enroll.

6.10.4 Marketing materials shall be evenly distributed throughout the service area, and shall be accurate and appropriate to the NorthSTAR program and meet the cultural and linguistic requirements specified in §6.14 below.

6.10.5 All Enrollee services representatives and marketing staff shall satisfactorily complete Contractor's marketing orientation and training program prior to engaging in marketing or enrollment activities. Contractor shall provide plan-specific orientation and training programs to its marketing representatives.

6.10.6 Contractor shall require compliance with treatment facilities' marketing and admission requirements in Chapter 164 of the Health and Safety Code.

6.11 Marketing Prohibitions

6.11.1 Contractor shall comply with the marketing requirements contained in 42 CFR §438.104.

6.11.2 A marketing representative may not provide marketing services on behalf of more than one BHO. Marketing representatives may not engage in marketing or enrollment practices that discriminate because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual orientation, physical or mental handicap, health status, or requirements for health care services.

6.11.3 Contractor may not, directly or indirectly, engage in door-to-door marketing, telephonic, or other "cold-call" marketing activities.

- 6.11.4 Contractor's marketing materials and other materials that contain information regarding Medicaid, Medical Assistance, Title XIX or the NorthSTAR program shall be accurate and may not mislead, confuse or defraud enrollees, potential enrollees or the State. Information that will be considered inaccurate, false, or misleading includes, but is not limited to, any assertion or statement, whether written or oral, that:
 - a) The enrollee or potential enrollee must enroll with Contractor to obtain benefits or to not lose benefits; or
 - b) Contractor is endorsed by CMS, the federal or state government, or similar entity.
- 6.11.5 Contractor shall not offer individuals any material or financial gain as an inducement to enroll except:
 - a) Contractor may offer nominal gifts valued at no more than \$10 and free health screenings approved by DSHS to potentially eligible individuals as long as these gifts and free health screenings are offered whether or not the individual enrolls in the Contractor's plan. Free health screenings shall not be used to discourage less healthy individuals from enrolling in Contractor's plan. Distribution of such gifts shall be pre-approved by DSHS; and
 - b) Contractor may, subject to prior approval by DSHS, offer Enrollees incentives to receive covered services or to attend behavioral health educational or preventive sessions.
- 6.11.6 Contractor shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
- 6.11.7 Contractor shall not use marketing agents who are paid solely by commission.
- 6.11.8 Contractor is liable for any and all violations by its marketing representatives of any Contract provisions relating to Contractor's marketing practices.

6.12 Enrollee Complaints

- 6.12.1 Contractor shall ensure that Enrollee requests for disenrollment are not processed through Contractor's complaint procedures but are submitted to DSHS for review and/or processing within five business days after the Contractor receives the disenrollment request.
- 6.12.2 Contractor shall develop, implement, and maintain an internal Enrollee complaint system that provides for the prompt resolution of Enrollee complaints. The Enrollee complaint system shall comply with 42 CFR Part 438 Subpart F and Texas Insurance Code, Chapter 843, Subchapter G.
- 6.12.3 Contractor shall comply with the Enrollee complaint system procedures approved by the DSHS. The Enrollee complaint system procedures shall include the following:
 - a) Written policies and procedures for taking, tracking, reviewing, resolving and reporting all Enrollee complaints. The total time for acknowledgment, investigation, resolution and notice to the enrollee of

the disposition of the complaint or appeal shall not exceed 30 calendar days from receipt of the complaint;

- b) Written policies and procedures for taking, tracking, reviewing, resolving and reporting all Enrollee appeals of adverse determinations, in accordance with Texas Insurance Code §843.261 and Article 21.58A, and actions, in accordance with 42 CFR §438.408;
- c) Written notice to the enrollee and notice to the requesting provider within the timeframes specified in 42 CFR §438.404(c), meeting the linguistic requirements of Section 6.14.3 of this Contract, of any action or adverse action and containing the following information: an explanation of the action the contractor has taken or intends to take; the reasons for the action; the enrollee's or provider's right to file an appeal of the action; the enrollee's right to request an appeal and, for life-threatening conditions: prior to exhausting the Contractor's complaint procedures, the right of the Medicaid enrollee to request a fair hearing and the right of the non-Medicaid enrollee to request a review by an Independent Review Organization; the procedures for exercising the enrollee's rights, and circumstances under which expedited resolution of appeals is available and how to request it; the enrollee's right to have benefits continued pending resolution of the appeal, and the circumstances under which the enrollee may be required to pay the costs of these services;
- d) Written notice to the Enrollee within five business days of receipt of complaints not concerning emergencies or denials of continued stays for hospitalization. The notice shall contain the name of the staff person who may be contacted regarding the complaint, and the toll-free telephone or local telephone numbers of the Enrollee Services Representative and NTBHA's Consumer Ombudsman, and a description of the complaint and appeal procedures;
- e) Participation by individuals with specific responsibility for the complaint process and with authority to require corrective action who were not involved in any previous level of review or decision-making;
- f) Designation of an officer of the Contractor to have primary responsibility for the monitoring and oversight of complaint procedures and for the regular reporting to the Quality Improvement Committee;
- g) Individuals who make decision on grievances and appeals shall be health care professionals who have the appropriate clinical expertise, as determined by the DSHS, in treating the enrollee's condition or disease if the decision is on any of the following: 1) an appeal of a denial based on lack of medical necessity; 2) a grievance regarding denial of expedited resolution of an appeal; 3) a grievance or appeal that involves clinical issues;
- h) Appeals procedures shall provide that oral inquiries seeking to appeal an action are treated as appeals and shall be confirmed in writing, unless the enrollee or the provider requests expedited resolution;

provide the enrollee a reasonable opportunity to present evidence and allegation of fact or law, in person as well as in writing; provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process; include as parties to the appeal the enrollee and his or her representative or the legal representative of a deceased enrollee's estate;

- i) Routine detection of complaint and appeal patterns and involvement of management and supervisory staff in developing policies and procedures to improve the complaint process;
- j) Education of Enrollees, family members, when appropriate, and providers regarding the Enrollee complaint procedures, assistance by an Enrollee Services Representative or other appropriate staff, including interpreters, to Enrollees in filing complaints;
- k) Maintenance of a record of every complaint received in person, by telephone or in writing, which record includes the date of contact, the date complaint was filed, identification of the individual filing the complaint, identification of the Enrollee on whose behalf the complaint was filed, including the Enrollee's name, address and telephone number, identification of the individual recording the complaint, the disposition of the complaint, corrective action required, and date resolved;
- l) Written logs of tabulated complaints and appeals shall be reviewed by the Contractor's Quality Improvement Committee and Contractor's officer charged with complaint system oversight. Contractor shall document the review procedures taken by the Quality Improvement Committee and officer;
- m) Standard resolution of appeals of actions and adverse actions and notification of such resolution shall be completed not later than the 30th calendar day after receipt of written request for appeal. Expedited appeals concerning emergencies, denials of continued stays for hospitalization and emergencies, in accordance with Texas Insurance Code §843.258 and Article 21.58A and expedited resolution of appeals, in accordance with 42 CFR §§ 438.408 and 438.410;
- n) Contractor's management or supervisory staff responsible for the services or operations that are the subject of a complaint shall promptly review Enrollee complaints; and
- o) Continuation of benefits while the IRO review is pending, or while the appeal or fair hearing is pending, pursuant to 42 CFR §438.420.

6.13 Notice of Medicaid Enrollee's Right to State Fair Hearings

6.13.1 Contractor shall develop, implement and maintain procedures to send written notice of an action to Medicaid Enrollees and of the Medicaid Enrollee's right to request a Fair Hearing from the State following the exhaustion of the Contractor's appeal procedures. The procedures shall be

developed, implemented and maintained in accordance with 42 CFR Part 431, Subpart E, applicable provisions of 42 CFR Part 438, Subpart F and 1 TAC Chapter 357.

6.13.2 Contractor's written notices concerning Medicaid hearings shall comply with 42 CFR §431.210, 42 CFR §438.404, and 1 TAC Chapter 357, and shall contain the following information:

- a) An explanation of the Medicaid Enrollee's right to request a Fair Hearing, the procedures and timeframe for making such a request, and the address where the request shall be sent;
- b) A statement of the action Contractor will take or has taken and the date of the action or intended action;
- c) The reasons for the action;
- d) The clinical basis for the action;
- e) A description or the source of the screening criteria supporting the action;
- f) The specific statutory or regulatory authority or the change in federal or state law that supports or requires the action;
- g) A statement that Enrollees may represent themselves, or be represented by the Contractor's Enrollee Services Representative, NTBHA's Consumer Ombudsman, a friend, a relative, legal counsel, the enrollee's provider, or another spokesperson;
- h) The name and phone number of a person who can answer questions regarding the fair hearing process; and
- i) An explanation of the circumstances under which services will be continued, or a transfer or discharge will be deferred, if a Fair Hearing or appeal is requested.

6.13.3 Contractor shall mail the notice within the following timeframes:

- a) For termination, suspension or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action, except as permitted under 42 CFR, Part 431, Subpart E, §§431.213 and 431.214;
- b) For denial of payment, at the time of any action affecting the claim;
- c) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d)(1);
- d) If Contractor extends the timeframe in accordance with §438.210(d)(1), Contractor shall:
 - (1) Give the enrollee a written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and
 - (2) Issue and carry out its determination as expeditiously as the enrollee's behavioral health condition requires and no later than the date the extension expires.
- e) For service authorization decisions not reached within the timeframes specified in §438.210 (d), on the date the timeframes expire; and
- f) For expedited service authorization decisions, within the timeframes specified in §438.210 (d).

6.13.4 If a Fair Hearing is requested, Contractor shall submit to the State copies of all documentation relating to the request.

6.14 Cultural and Linguistic Services

6.14.1 Contractor shall subcontract with and make referrals to providers from different cultural groups so that each Enrollee who needs culturally appropriate services may receive services from a provider who shares his cultural background, values and perspective.

6.14.2 Contractor shall ensure equal access and participation in NorthSTAR for limited English proficient individuals through the provision of bilingual services. Contractor shall coordinate services with community advocates and agencies that assist non-English and limited-English speaking individuals or that provide other culturally appropriate services.

6.14.3 Contractor shall ensure that all marketing and enrollment materials are written at the 4th through 6th grade reading levels and are available in alternative formats and in an appropriate manner that takes into consideration the special needs of enrollees and potential enrollees, including those who are visually limited, disabled, or who have limited reading proficiency, and made available in the language of any population group that comprises more than 10% of the covered lives. Contractor shall ensure that all translated written materials are certified by a professional translator or translation service. Contractor shall provide instruction to enrollees and potential enrollees that information is available in alternative formats and how to obtain those alternative formats.

6.14.4 Contractor shall make oral interpretation services for all non-English languages free of charge. Contractor shall notify enrollees and potential enrollees that oral interpretation services are available for any language and that written information is available in alternative formats and in languages of population groups that comprise more than 10% of the covered lives how to access those services and formats.

6.14.5 Contractor shall provide 24-hour access to interpreter services for Enrollees to access emergency behavioral health services within Contractor's network either through telephone language services or interpreters. Contractor shall:

- a) Provide interpreter services for Enrollees as necessary to ensure effective communication, as well as translated written and video materials, documents, forms and information pamphlets, regarding behavioral health prevention services, assessment, treatment, and education;
- b) Use trained professional interpreters when behavioral health treatment is discussed. Family members or friends may not be used as interpreters in behavioral health treatment;
- c) Have an identified staff member to assist Enrollees who are deaf or hard-of-hearing individuals; and
- d) Maintain a current list of interpreters who are "on-call" to provide interpreter services and make a copy of the list readily available to the

DSHS upon request. This list shall include individuals who can competently translate Spanish and provide Level III interpretive sign language services. Contractor shall comply with the Title III of the ADA and have TDDs in offices where the primary means of offering goods and services is by telephone.

- 6.14.6 For the provision of all covered services, Contractor shall ensure that sign language services are available to enrollees who are deaf or hard-of-hearing individuals. All sign language interpreting services must be requested by a physician and provided by a qualified interpreter to facilitate the communication. A physician's determination of the need for sign language interpreting services must give primary consideration to the needs of the individual who is deaf or hard of hearing. Sign language interpreting services must be provided by an interpreter who possesses one of the following certification levels (i.e., levels A-H) issued by either the Department of Assistive and Rehabilitative Services, Office for Deaf and Hard of Hearing Services, Board for Evaluation of Interpreters (BEI), or the National Registry of Interpreters for the Deaf (RID):

Certification Levels

- A. BEI Level I/Ii and BEI OC:B (Oral Certificate: Basic).
- B. BEI Basic and RID NIC (National Interpreter Certificate) Certified.
- C. BEI Level II/Iii, RID CI (Certificate of Interpretation), RID CT (Certificate of Transliteration), RID IC (Interpretation Certificate), and RID TC (Transliteration Certificate).
- D. BEI Level III/IIIi, BEI OC: C (Oral Certificate: Comprehensive), BEI OC: V (Oral Certificate: Visible), RID CSC (Comprehensive Skills Certificate), RID IC/TC, RID CI/CT, RID RSC (Reverse Skills Certificate), and RID CDI (Certified Deaf Interpreter).
- E. BEI Advanced and RID NIC Advanced.
- F. BEI IV/IVi, RID MCSC (Master Comprehensive Skills Certificate), and RID SC: L (Specialist Certificate: Legal).
- G. BEI V/VI.
- H. BEI Master; and RID NIC Master.

Interpreting services includes the provision of voice-to-sign, sign-to-voice, gestural-to-sign, sign-to-gestural, voice-to-visual, visual-to-voice, sign-to-visual, or visual-to-sign services for communication access provided by a certified interpreter.

The physician requesting interpreting services must maintain documentation verifying the provision of interpreting services. Documentation of the service must be included in the patient's medical record and must include the name of the sign language interpreter and the interpreter's certification level. Documentation must be made available if requested by HHSC or its designee.

6.15 Enrollee Rights

- 6.15.1 Contractor shall comply with the Consumer Protection Bill of Rights directed by Executive Memorandum, signed by the President on February 20, 1998.

- 6.15.2 Contractor shall guarantee each enrollee the following rights:
- a) To receive information in accordance with 42 CFR §438.10 and §6.7 of this Contract;
 - b) To be treated with respect and with due consideration for his or her dignity and privacy;
 - c) To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;
 - d) To participate in decisions regarding his or her health care, including the right to refuse treatment;
 - e) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;
 - f) To be furnished health care services in accordance with 42 CFR §§438.206 through 438.210; and
 - g) To request and receive a copy of his or her medical records and to request that they be amended or corrected, as specified in 45 CFR §§164.524 and 164.526.
- 6.15.3 Contractor shall ensure that each enrollee is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way Contractor treats the enrollee.

6.16 Advance Directives

Contractor shall maintain written policies and procedures that meet the requirements for advance directives under 42 CFR §422.128 and 42 CFR Part 489, Subpart I. Contractor shall inform and distribute written information to enrollees regarding advance directives, including a description of the following state laws:

- a) The individual's rights under the Advance Directives Act of 1999 (Health and Safety Code, Chapter 166) to execute an advance written Directive to Physicians, or to make a non-written directive regarding their right to withhold or withdraw life sustaining procedures in the event of a terminal condition;
- b) The individual's right to execute Statutory Durable Power of Attorney for Health Care under Probate Code Chapter XII, §490, regarding the right to appoint an agent to make medical treatment decisions on their behalf; and
- c) The individual's right to execute a Declaration for Mental Health Treatment, under the Civil Practice and Remedies Code, Chapter 137, regarding the right of an individual who is not incapacitated to document his preference and instructions for certain types of mental health treatment.

Contractor shall inform enrollees of changes in these state laws regarding advance directive as soon as possible, but no later than 90 days after the effective date of the change.

6.17 Choice of Health Professional

Contractor shall allow each enrollee to choose his or her health professional in Contractor's provider network to the extent possible and appropriate.

ARTICLE VII COVERED SERVICES

7.1 Scope of Benefits

- 7.1.1 Appendix 8A describes the scope of mental health benefits. Appendix 8B describes the scope of chemical dependency benefits. Appendix 22 lists the services and service codes covered by the NorthSTAR program. Contractor shall provide medically necessary services to enrollees in the amount, duration and scope that can reasonably be expected to achieve the purpose for which the services are provided. Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required service because of a diagnosis, type of illness, or condition of the enrollee.
- 7.1.2 Contractor shall not deny medically necessary Medicaid State Plan services to Medicaid enrollees. Contractor may provide Medicaid enrollees an alternate service to a Medicaid State Plan service when the alternate service is medically necessary and has equal or superior clinical efficacy to the Medicaid State Plan service. Contractor may provide such alternate services to Medicaid enrollees, when medically necessary, at the discretion of the Contractor with Contractor's savings.
- 7.1.3 Mental health benefits for enrolled youth is not limited. Utilization shall be based on meeting medical necessity criteria.
- 7.1.4 Outpatient visits for the purpose of medication management may not count towards the number of allowed outpatient visits.
- 7.1.5 The decision to discharge from any level of chemical dependency service shall be determined by the treating professional and the Contractor's review professional (i.e., a psychiatrist, physician with experience in addiction medicine, or Qualified Credentialed Counselor (QCC), as defined at 25 Tex. Admin. Code §441.101). The QCC may only determine episode of care in residential or outpatient treatment programs, excluding detoxification services.
- 7.1.6 Contractor shall provide access to pre-test and post-test counseling and anonymous or confidential HIV testing for Enrollees receiving chemical dependency services. Contractor shall make testing available for tuberculosis and sexually transmitted diseases to Enrollees receiving chemical dependency services unless Contractor has access to test results obtained during the past year; and if an Enrollee tests positive for HIV, tuberculosis or sexually transmitted diseases, Contractor shall refer the Enrollee to an appropriate health care provider, coordinate follow-up visits, and develop appropriate treatment goals relating to behavioral healthcare for the Enrollee.
- 7.1.7 Contractor shall ensure that the service capacity of the Specialized Children's Programs in Dallas County, as described in Appendix 9, is not reduced and that service quality is maintained. Contractor shall serve,

through the Specialty Provider Network (SPN), the minimum number of Enrollees for each program as described in the appendix.

- 7.1.8 Contractor shall provide or arrange to have provided to non-Medicaid enrollees all Value Added services, as described in Contractor's Proposal, throughout the term of this Contract. Contractor may provide Value Added services to Medicaid enrollees, when medically necessary, at the discretion of the Contractor with the Contractor's savings.
- 7.1.9 All laboratories providing laboratory services pursuant to a subcontract with Contractor shall either: 1) have an identification number issued pursuant to the Clinical Laboratory Improvement Amendments (CLIA) and a current, unrevoked and unsuspended certificate of waiver, registration certificate, certificate of compliance, certificate for Provider-Performed Microscopy procedures, or certificate of accreditation issued by the U.S. Department of Health and Human Services applicable to the category of examinations or procedures performed by the laboratory; or 2) be CLIA-exempt.

For purposes of this provision, a "laboratory" is defined as any facility that performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, treatment of disease, or impairment of, or assessment of health.

- 7.1.10 Contractor shall spend funds for new generation medications in accordance with the NorthSTAR Pharmacy Manual (Appendix 16) or a DSHS-approved variation or substitute of the practice guidelines developed through the Texas Implementation of Medications Algorithm (TIMA), as negotiated by the parties hereto.
- 7.1.11 Contractor shall participate in Texas Medication Algorithm Project (TMAP) training conducted by DSHS or its designee, and ensure that subcontractors participate in TMAP training. Contractor shall ensure that subcontracted providers comply with TIMA requirements. Contractor shall provide TMAP training if requested or needed by subcontractors.
- 7.1.12 Contractor shall require all subcontracted providers who provide outpatient treatment or substance abuse/dependence to follow treatment guidelines established in the Cannabis Youth Treatment curriculum, promulgated by DSHS, as outlined in Appendix 25 Contractor shall ensure all applicable providers are trained in the curriculum, and provide treatment interventions according to the curriculum. Contractor shall ensure that reimbursement rates for treatment services delivered in accordance to this curriculum are equal to the reimbursement of similar providers outside of the NorthSTAR system, as outlined in Appendix 25.

7.2 Excluded Benefits

The following behavioral health services are excluded from the NorthSTAR benefits for Medicaid individuals, but are covered for Medicaid individuals enrolled in the STAR program:

- a) Screening for behavioral health disorders during well adult checks;

- b) THSteps exams and other ambulatory health exams;
- c) Emergency medical transportation for behavioral health emergencies;
- d) Behavioral health services provided by primary care physicians, other STAR physicians, or other applicable Medicaid physicians within the scope of their licenses;
- e) Behavioral health services provided by federally qualified health centers and rural health clinics;
- f) Ambulatory laboratory services for Medicaid eligible individuals; and
- g) Certain emergency room and inpatient hospital services, as described in Appendix 3.

Medication benefits are also excluded from the NorthSTAR benefits for Medicaid enrollees, but are covered in the Medicaid Vendor Drug Program.

7.3 Behavioral Health Education Services

- 7.3.1 Contractor shall conduct behavioral health education programs to improve the behavioral health status of its Enrollees. Such educational programs may include behavioral health education classes, distribution of health promotion materials, audiovisual programs, health fairs, case management, and one-on-one education. Contractor may provide such education directly or through subcontractors or community agencies.
- 7.3.2 Contractor shall distribute or make available to Enrollees educational materials on the value of preventive care, behavioral health-specific disorder information and self-help or support group information.
- 7.3.3 Contractor's behavioral health education programs shall be designed to attempt to prevent behavioral health problems, educate Enrollees about mental health and substance abuse, assist in the detection of behavioral health problems, and help Enrollees, potential Enrollees, and family members of Enrollees and potential Enrollees learn how to maintain and build upon progress gained in treatment.
- 7.3.4 Contractor shall contract, when appropriate, with community-based health and human services providers and local entities that provide behavioral health education appropriate for NorthSTAR Enrollees to meet the requirements of this section.
- 7.3.5 Contractor shall document behavioral health education services provided to each Enrollee. Contractor shall also maintain attendance records of all Enrollees completing a behavioral health education class. The attendance records shall include the Enrollee's identification number, date(s) of classes, name of class, Enrollee signature, course instructor's signature, and the instructor's agency affiliation, if applicable.
- 7.3.6 Contractor shall establish procedures for promoting preventive services to Enrollees who do not receive health education or health promotion services, e.g., newsletter, reminder cards and mail outs.
- 7.3.7 Contractor shall employ a full-time equivalent qualified professional to oversee the behavioral health education program.

- 7.3.8 Contractor shall provide information regarding Enrollee prevention and behavioral health education services to its providers at least semi-annually.

7.4 Chemical Dependency Civil Court Commitments

- 7.4.1 Contractor shall coordinate care for covered lives who have been civil-court ordered for chemical dependency treatment.
- 7.4.2 Contractor shall implement procedures for compliance with federal and state statutory and regulatory provisions that relate to the care and custody of court-committed clients.
- 7.4.3 Contractor is responsible for all covered chemical dependency inpatient and outpatient services provided to Enrollees pursuant to Chapter 462 of the Health and Safety Code under emergency detention, order of protective custody, or civil court order for chemical dependency services.
- 7.4.4 Contractor is not responsible for criminal commitment conducted pursuant to Chapters 46B and 46C, Texas Code of Criminal Procedure; however, Contractor is responsible for civil commitments conducted pursuant to Texas Code of Criminal Procedure, §42.023 and Health and Safety Code, §462.081.
- 7.4.5 Contractor shall not, under any circumstances, refuse to provide, authorize, or pay for emergency detentions, orders of protective custody, or court-ordered treatment for chemical dependency.
- 7.4.6 Contractor shall establish a working relationship with the judiciary and provide sufficient information in writing on the program design, treatment methods, and admission processes to assist the judiciary in committing appropriate clients.

7.5 Mental Health Commitments

- 7.5.1 Contractor is responsible for all covered mental health inpatient and outpatient services to covered lives pursuant to an emergency detention, order of protective custody or court order for mental health services under the Texas Mental Health Code, Title 7, Subtitle C, Texas Health and Safety Code; Chapter 55, Texas Family Code; and Chapters 46B and 46C, Code of Criminal Procedure. However, Contractor is not responsible for services provided in the maximum-security unit of North Texas State Hospital or for services provided at Waco Center for Youth.
- 7.5.2 Contractor shall not, under any circumstances, refuse to provide, authorize, or pay for emergency detentions, orders of protective custody, or court-ordered mental health services.
- 7.5.3 Contractor shall coordinate admission and discharge with state hospitals and ensure continuity of care for the Enrollee upon discharge. Contractor shall comply with the DSHS State Mental Health Hospitals Fiscal Year (FY) 2010 Over Capacity Plan, attached as Appendix 5.
- 7.5.4 Contractor shall develop written agreements with private psychiatric hospitals and psychiatric units of general hospitals in the service area to ensure that Enrollee's needs for psychiatric hospital beds are met.

- 7.5.5 Contractor shall develop a written agreement with Terrell State Hospital to comply with the State Hospital Allocation Methodology. Contractor shall comply with the Utilization Management Guidelines set forth in the State Hospital Allocation Methodology.
- 7.5.6 Contractor and the state hospital shall submit all disputes regarding discharge and length of stay to the DSHS Director of State Hospitals for final resolution.
- 7.5.7 Contractor shall participate in the commitment process as required in Contractor's agreement with NTBHA.

7.6 Span of Eligibility

- 7.6.1 The entity responsible for payment of an Enrollee's hospital and freestanding psychiatric facility (facility) admissions charges (payor) at the start of an inpatient stay remains responsible for those hospital and facility charges until the time of discharge, or until such time as the Enrollee becomes ineligible for covered services. The payor's responsibility under this section includes hospital and facility admissions charges for Medicaid enrollees who switch to another Medicaid program during the hospital or facility stay.
- 7.6.2 Contractor is responsible for medically necessary and authorized inpatient charges during every month for which Contractor receives a full capitation payment.
- 7.6.3 An Enrollee's discharge from one acute care hospital or facility and readmission to another acute care hospital or facility within 24 hours for continued treatment is not a discharge under this Contract.

7.7 Transportation

- 7.7.1 Non-emergency transportation for Medicaid Enrollees is provided under the Medicaid Transportation Program administered by the Texas Department of Transportation. Emergency transportation for all Medicaid Enrollees is available through either the STAR or the fee-for-service Medicaid programs.
- 7.7.2 Contractor shall provide non-emergency transportation services to non-Medicaid Enrollees who do not have transportation to covered services and as required by 25 TAC §448.910, related to Treatment Services for Women and Children. Contractor shall maintain the same level of transportation as that which is provided to non-Medicaid enrollees by community mental health centers.

7.8 Assertive Community Treatment

- 7.8.1 Contractor shall use Assertive Community Treatment (ACT) teams to provide covered services to Enrollees with serious mental illness (SMI) who qualify for ACT services, subject to the Contractor's DSHS-approved utilization management criteria.
- 7.8.2 Contractor shall use its ACT teams in compliance with the National Alliance for the Mentally Ill Program of Assertive Community Treatment

(PACT) as described in "The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness" by Deborah J. Allness and William H. Knoedler, copyright 1998 by Programs of Assertive Community Treatment, Inc.

7.9 Child Care for Women in Residential Chemical Dependency Treatment

Contractor shall provide child care services and children's therapeutic services, as appropriate, to pregnant, postpartum women, or women who are the primary caretakers of children while receiving treatment when such services are not reasonably available and as required by 25 TAC §448.910.

7.10 Emergency and Post-Stabilization Care Services

7.10.1 Contractor shall promptly arrange for emergency behavioral health services 24 hours a day, seven days a week to all covered lives, when an emergency behavioral health condition is the primary diagnosis. Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Contractor shall be bound by the determination of the attending emergency physician or the provider actually treating the enrollee as to when the enrollee's emergency behavioral health condition is sufficiently stabilized for transfer or discharge.

7.10.2 Contractor shall arrange for conveniently located emergency sites for after-hour emergency behavioral health services throughout the service area.

7.10.3 Contractor shall not require co-payments or prior approvals for emergency behavioral health services.

7.10.4 Contractor shall have a crisis response system and on-call services available 24 hours a day, seven days a week. Such crisis response system shall, at a minimum, include making available by telephone qualified clinical staff who are able to assess the nature of the immediate situation and provide triage, referral, and if necessary, arrange for treatment for the Enrollee. Such staff shall have immediate access throughout the service area to physicians and appropriate behavioral health professionals, which shall include mobile crisis teams. The intake line shall be answered by a live person. Contractor shall enter into written agreements with emergency providers in the service area for coordination of crisis response services.

Contractor requires emergency behavioral health service network providers to notify Contractor within 10 calendar days after emergency behavioral health services are provided as a condition of reimbursement. Contractor requires prior authorizations for post-stabilization care services as a condition of reimbursement.

7.10.5 Contractor shall coordinate with other emergency systems in the community, such as the police, jails, juvenile justice, courts, and child

protective services, to respond appropriately to persons experiencing behavioral health crises.

- 7.10.6 Contractor shall pay for and coordinate emergency behavioral health services rendered by out-of-network providers. Contractor may impose notification requirements in accordance with 42 CFR §438.114 and claim-filing time limitations on out-of-plan providers of emergency services, but the provider's failure to give notice or file claims within this time frame may not be used to deny such claims if the provider shows that notice was in fact given as soon as was reasonable.
- 7.10.7 If an emergency situation results in the voluntary or default enrollment of a covered life into Contractor's plan, Contractor is responsible for all emergency behavioral healthcare services rendered to the individual that resulted in enrollment.
- 7.10.8 Contractor shall cover the following services regardless of whether the enrollee obtains the services within the Contractor's provider network:
- a) Post-stabilization care services that are pre-approved by Contractor;
 - b) Post-stabilization care services that are not pre-approved but administered to maintain the enrollee's stabilized condition within 1 hour of a request for pre-approval for further post-stabilization care services; and
 - c) Post-stabilization care services that are not pre-approved by the Contractor because the Contractor does not respond to the post-stabilization care services provider's request for pre-approval within one hour after being requested to approve such care or could not be contacted for pre-approval.
- 7.10.9 Contractor shall ensure that all funds received under crisis redesign continue to be expended on DSHS-identified crisis services, are provided in accordance with crisis service delivery standards outlined in Appendix 21. Contractor shall ensure that all crisis services can be tracked via service claims or encounters. Contractor shall ensure that this data is transmitted to DSHS via established encounter data transmission processes, as described in Article IX.

DSHS shall allocate funds to Contractor appropriated in the provisions of Article II Section 65 of the General Appropriations Act, 81st Legislature, Regular Session for transitional and on-going services in FY 2010 and FY 2011. The methodology for allocating those funds will be based on a DSHS approved allocation methodology. Contractor shall expend these funds on services using a methodology that will be approved by DSHS and provided to Contractor.

7.11 Services for Enrollees with Co-Occurring Psychiatric and Substance Use Disorders

- 7.11.1 Contractor shall have an organized system to screen, assess, refer, follow-up and monitor Enrollees with co-occurring psychiatric and substance use disorders (COPSD) of mental illness and chemical

dependency. Assessment procedures shall be sufficiently sensitive to detect substance abuse disorders among Enrollees with psychiatric disorders and mental illness symptoms among Enrollees with substance disorders. Contractor shall comply with the standards for services to individuals with COPSD in accordance with 25 TAC Chapter 411, Subchapter N.

- 7.11.2 Staff who serve Enrollees with dual diagnosis shall be trained according to the requirements of 25 TAC Chapter 448 and 25 TAC Chapter 411, Subchapter N.
- 7.11.3 Contractor shall have clearly defined service coordination and integration policies and procedures and ensure that providers follow these guidelines.
- 7.11.4 Contractor shall ensure that Enrollees with co-occurring psychiatric and substance use disorders can access covered services no matter where or how the Enrollee presents.
- 7.11.5 Contractor shall ensure that Enrollees are successfully referred to the most appropriate treatment provider.
- 7.11.6 Contractor's treatment programs for Enrollees with co-occurring psychiatric and substance use disorders shall combine treatment approaches from the mental health and chemical dependency systems and treat both diagnoses as primary unless otherwise documented in the clinical record.

7.12 Accessibility and Continuity of Care

- 7.12.1 Contractor shall make medically necessary covered services available 24 hours a day, seven days a week within the following time periods:
 - a) Emergency behavioral health services: immediately;
 - b) Urgent Care: within 24 hours of request, including transfer between levels of care during a chemical dependency episode;
 - c) Routine Care: within 14 calendar days of request; and
 - d) For telephone services and queries:
 - (1) Telephone callers shall reach a non-recorded voice within a monthly average of 30 seconds or less for each of the following departments: After Hours, Clinical, and Customer Service;
 - (2) Telephone abandonment rates are 5 percent or less for any month for each of the following departments: After Hours, Clinical, and Customer Service; and
 - (3) Contractor shall provide a report of these measures monthly by the 15th of the month following the reported month. The report shall provide a weekly accounting and a monthly average.
- 7.12.2 Contractor shall ensure Enrollee access to covered services by providing flexible hours of operation, including evening and weekend hours, and providing services in alternative settings, such as homes and schools.
- 7.12.3 Contractor shall develop, implement, and maintain procedures to monitor waiting times in providers' offices and obtaining various types of appointments.

- 7.12.4 Contractor shall ensure that a behavioral health assessment and treatment plan is completed within three days of a routine outpatient visit and within 48 hours of an emergency or urgent inpatient or residential placement. Contractor shall update the treatment plan at least weekly for inpatient or residential treatment and after every 10 visits for Enrollees receiving outpatient services, but not less frequently than every three months.
- 7.12.5 Contractor shall ensure the continued availability of behavioral health providers, including specialty providers, programs and services, based on the assessed needs of the Enrollee population.
- 7.12.6 Contractor shall coordinate assessment, treatment, referral, and follow-up for Enrollees who use multiple providers, services sites, and levels of care within Contractor's plan and other health care plans.
- 7.12.7 Contractor shall implement policies and procedures to ensure effective information sharing and monitoring of diagnosis, treatment, follow-up and medication usage between providers and other health care plans.
- 7.12.8 Contractor shall ensure continuity of care for Enrollees who are discharged from an inpatient facility.
- 7.12.9 Contractor shall process requests for initial and continued authorizations of services in accordance with 42 CFR §438.210(b).
- 7.12.10 Contractor shall make standard and expedited authorization decisions in accordance with 42 CFR §438.210(d) and (e).

7.13 Coordination of Care with Physical Health Care Plans and Children's Health Insurance Program (CHIP)

- 7.13.1 Contractor shall coordinate care with physical health care plans participating in STAR according to the Memorandum of Agreement for Coordination of Medicaid Services entered into between STAR MCOs and NorthSTAR BHO (Appendix 3), and in accordance with 42 CFR §438.208(b).
- 7.13.2 Contractor shall comply with any changes to these procedures that are developed by the Care Coordination Workgroup, which is comprised of representatives of DSHS, Contractor, NTBHA, STAR and CHIP Contractors.
- 7.13.3 Contractor shall enter into a DSHS-approved Memorandum of Agreement with CHIP HMOs describing the coordination of care and benefits for children who transition from CHIP-covered services to NorthSTAR-covered services or from NorthSTAR-covered services to CHIP-covered services.
- 7.13.4 Contractor shall submit to DSHS copies of all executed Memoranda of Agreement.

7.14 Coordination with Health and Human Services and Criminal Justice System

- 7.14.1 Contractor shall coordinate with other health and human services and criminal justice systems in the community to ensure effective service planning and better Enrollee care. These systems include education, public

health, child protective services, the courts, juvenile and adult probation departments and homeless shelters.

- 7.14.2 Contractor shall coordinate with existing community-based organizations to meet the following outcomes for children in the community:
 - a) The child has access to the appropriate level of care;
 - b) The child and family are involved in the planning and provision of services;
 - c) The services are individualized to meet each child's treatment needs while allowing the child to remain at home or close to home in the least restrictive environment possible, and
 - d) Services are provided in non-clinic settings such as schools, in home, and in the community.
- 7.14.3 Contractor shall enter into written agreements with Community Resource Coordination Groups (CRCGs) for service planning, as described in Appendix 12.

7.15 Coordination of Services for Children Served by the Department of Family and Protective Services (DFPS)

- 7.15.1 Contractor shall coordinate with DFPS when Enrollees are also clients of DFPS. Children who enter DFPS foster care placement will be disenrolled from Contractor's plan by DSHS.
- 7.15.2 Contractor shall provide all covered services to the child in foster care placement until the child is disenrolled by DSHS.
- 7.15.3 Contractor shall cooperate and coordinate with DSHS, DFPS, THSteps regional program staff and agents to ensure prompt delivery of services to children served by DFPS.
- 7.15.4 Contractor shall designate a full-time liaison that will work with the regional DFPS staff to develop written procedures to address:
 - a) How Contractor and DFPS will coordinate care and services for Enrollees;
 - b) The process for exchanging behavioral health information on Enrollees; and
 - c) Reporting requirements from Contractor to DFPS.
- 7.15.5 Contractor shall require providers that serve Enrollees in DFPS custody to provide periodic written updates on treatment status for Enrollees under the provider's care to DFPS as required by DFPS.
- 7.15.6 Contractor shall require providers to participate, when requested by DFPS, in planning to establish permanent homes for Enrollees in DFPS custody to ensure that behavioral health care needs are accurately and thoroughly addressed in the Enrollee's permanency plan.
- 7.15.7 Contractor shall ensure that children entering DFPS custody also have access, within 14 days of request by DFPS, to any necessary developmental evaluations and behavioral health evaluations to assess the child for out-of-home placement. If Contractor is unable to provide routine care within the network, Contractor shall provide such care out of network in accordance with the Contract.

- 7.15.8 Contractor shall comply with all provisions of a court order or DFPS service plan with respect to a child in the conservatorship of DFPS ("Order") entered by a court of continuing jurisdiction placing a child under the protective custody of DFPS that relates to the behavioral health services to be provided to an Enrollee.
- 7.15.9 Contractor shall not deny, reduce, or controvert the medical necessity of any behavioral health services included in an Order. Any modification or termination of ordered behavioral health services shall be presented and approved by the court with jurisdiction over the matter for decision.
- 7.15.10 Contractor shall include information on working with DFPS in Contractor's provider manuals and training materials, which shall explain the requirements for providing care and treatment to DFPS clients and include information regarding recognition of abuse and neglect and procedures for referring suspected cases of abuse and neglect to DFPS.

7.16 Early Childhood Intervention Services

- 7.16.1 Contractor shall ensure provision of covered services to Medicaid Enrollees under age three with developmental delays all Early Childhood Intervention (ECI) behavioral health services contained in 34 CFR §303.1 et seq. and 40 TAC Chap. 108, which are required in the Enrollee's Individual Family Service Plan (IFSP) and provided by licensed psychologists and social workers.
- 7.16.2 Contractor shall coordinate and cooperate with local ECI programs that perform assessment in the development of the IFSP. Cooperation shall include conducting behavioral health diagnostic procedures and providing records required to perform developmental assessments and develop the IFSP within the time lines established at 34 CFR §303.1 et seq.
- 7.16.3 Contractor shall ensure that all medically necessary behavioral health services contained in the Enrollee's IFSP are provided to the Enrollee in the amount, duration and scope established by the IFSP. Medical necessity for behavioral health services is determined by the interdisciplinary team as approved by the Enrollee's STAR Primary Care Physician (PCP). Contractor shall not modify the plan of care or alter the amount, duration and scope of services required by the Enrollee's IFSP. Contractor shall not create unnecessary barriers for the Enrollee to obtain covered services that are required in the IFSP, such as, requiring prior authorization for the ECI assessment and providing insufficient authorization periods for prior authorized services.

7.17 Initial Screening

- 7.17.1 Contractor shall establish and maintain a 24-hour telephone screening service staffed by sufficient numbers of interviewers to meet the call demand. The interviewers shall be capable of performing clinical screening and provider referral services.

- 7.17.2 Contractor shall identify its NorthSTAR toll-free telephone number as the clinical screening and provider referral contact point in the Enrollee Handbook, marketing materials and the Provider Manual.
- 7.17.3 Contractor shall have sufficient staff that are sufficiently trained available to screen individuals who call their toll-free number, within the timeframes established in §7.12. Contractor's interviewer shall perform the clinical screening as follows:
- a) If the caller is experiencing an emergency medical condition or emergency behavioral health condition, the interviewer stops the interview and assists the caller in accessing emergency medical services or emergency behavioral health services;
 - b) If the interviewer does not have an indication that the caller has a behavioral health problem necessitating a clinical assessment the interviewer refers the caller to the appropriate external behavioral health resource;
 - c) If the interviewer has an indication that the caller has a behavioral health problem necessitating a clinical assessment, the interviewer queries the DSHS enrollment verification system to determine the caller's enrollment status. If the caller is an Enrollee in the NorthSTAR plan, the interviewer shall obtain service authorization. If the caller is not an Enrollee, the Contractor shall schedule the caller for a clinical and eligibility assessment.

7.18 Clinical and Financial Assessments

- 7.18.1 Contractor or designee shall coordinate a clinical assessment on all individuals who present for a behavioral health service and obtain the results of the clinical assessment from the provider.
- 7.18.2 The Contractor shall have a process for financial assessment of all individuals not enrolled who are seeking enrollment in NorthSTAR. This can be done by providers. The Contractor shall have a system for identifying prospective enrollees who are potentially eligible for CHIP, Medicaid or Medicare as identified during the enrollment process or, if already enrolled, at regular intervals. The Contractor or designee shall have a process that provides assistance to non-Medicaid enrollees with applications for CHIP, SSI, TANF or Medicare benefits.
- 7.18.3 If an individual is determined to be eligible for enrollment, the Contractor shall provide the enrollment information to DSHS through the NorthSTAR online enrollment system.
- 7.18.4 For clinical assessments, Contractor's providers shall use the DSHS-approved assessment instruments and the DSM-IV-TR multi-axial classification.
- 7.18.5 Contractor shall comply with utilization review standards for behavioral health as defined in the Insurance Code, Article 21.58A, as well as in the DSHS utilization management criteria. For chemical dependency services, Contractor shall also comply with the utilization review standards for social-medical and social treatment programs, as described in Appendix

19. Contractor and its treatment providers shall use these standards and corresponding criteria to determine reasonable periods of treatment for each level of treatment.

7.18.6 Except as provided in §7.10 of this Contract, Contractor is authorized to require all non-Medicaid eligible adults who are not enrolled in NorthSTAR and who seek services other than inpatient hospitalization and emergency behavioral health services to be assessed for eligibility and enrollment only at a designated enrollment site.

a) Contractor is authorized to require all eligible enrollees who are not enrolled in NorthSTAR and who seek inpatient services to be assessed for eligibility and enrollment only at designated facilities. Designated facilities shall include at least one facility in Dallas County and at least one facility in Collin County. The Contractor shall comply with any agreement between the BHO and county officials in designating facilities in these counties.

b) Contractor is authorized to require all eligible enrollees who are not enrolled in NorthSTAR and who seek outpatient services to be assessed for eligibility and enrollment only at designated enrollment sites. Designated facilities shall include at least one enrollment site in each NorthSTAR County.

7.18.7 Contractor shall comply with any agreements between Contractor and county officials in the service area, in designating enrollment sites in these counties.

7.18.8 Contractor may use an alternative method for conducting mental health assessments if the alternative method is approved by DSHS and if the alternative method enables the Contractor to collect all mental health assessment information required by this Contract.

7.19 Utilization Management

7.19.1 Contractor shall have a Utilization Management (UM) division to authorize all covered services. The UM staff shall be appropriately licensed and credentialed.

7.19.2 Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested shall be reviewed by board certified or board eligible psychiatrists of the same or similar specialty as the services being denied. If the service denials are for children's services, the denial review shall be made by a psychiatrist with appropriate clinical expertise. If circumstances requiring specialty consultation arise regarding service denials for children's services, then Contractor shall consult a board-eligible or board-certified child psychiatrist. If chemical dependency services are denied, the denial shall be made by a physician or psychiatrist who is a certified addictionologist or has American Society for Addiction Medicine (ASAM) certification or a psychiatrist who can demonstrate the equivalence to such certification through training and experience. Contractor shall consult with the requesting provider when appropriate.

- 7.19.3 Contractor shall maintain a comprehensive UM manual, which complies with DSHS-approved UM criteria. Contractor shall ensure that all UM reviewers apply the UM criteria consistently and in compliance with applicable TDI statutes. Any changes must be approved by DSHS.
- 7.19.4 Contractor shall not require prior notification or authorization for emergency behavioral health services before such services are delivered.
- 7.19.5 Contractor shall comply with the verification and preauthorization requirements contained in Insurance Code §§843.347 and 843.348, respectively. Notwithstanding the timeframes for determining preauthorization requests in Insurance Code §843.348(b), however, for all routine care requests, Contractor shall complete the authorization process and communicate a decision to the provider within three (3) calendar days of the provider's request. For urgent service requests, Contractor shall communicate its decision to the provider within five hours of the provider's request.
- 7.19.6 Contractor shall adopt practice guidelines that meet the following requirements:
- a) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the behavioral healthcare field;
 - b) Consider the needs of the enrollees;
 - c) Are adopted in consultation with contracting health care professionals; and
 - d) Are reviewed and updated periodically as appropriate.
- 7.19.7 Contractor shall disseminate the practice guidelines to all affected providers and upon request, to enrollees and potential enrollees.
- 7.19.8 Contractor shall ensure that decisions relating to UM, enrollee education, service coverage, and other areas to which the guidelines apply are consistent with the guidelines. Contractor shall ensure that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.
- 7.19.9 Contractor shall comply with DSHS's Resiliency and Disease Management (RDM) requirements, as developed for the NorthSTAR program. Contractor shall ensure that subcontracted providers comply with RDM requirements, and if needed, make continued training available. Contractor shall comply with any changes to RDM processes that are made by DSHS.
- 7.19.10 Contractor shall continue to ensure provision of jail diversion services, developed in cooperation with NTBHA and the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI), for diversion of individuals with mental illness from the criminal justice system to appropriate community services. Contractor shall continue to ensure provision of adult and juvenile intensive case management services to targeted individuals and jail diversion services, developed in cooperation with TCOOMMI.

- 7.19.11 Contractor shall report to DSHS all Medical Necessity Adverse Determinations and Appeals using the format in Appendix 33. Medical Necessary Adverse Determinations shall include denial of services and or medications.
- 7.19.12 Contractor shall review all requests by NorthSTAR area community centers for RDM service package authorization for Medicaid recipients who are not eligible for enrollment in NorthSTAR. Contractor shall notify requesting providers of authorization or denial decisions promptly. Claims for services provided to these recipients will be paid by TMHP.
- 7.19.13 Contractor shall not make any material changes to the UM guidelines without consultation and approval of NTBHA and DSHS.

7.20 Liability for Ongoing Services at the Time of Enrollment

Contractor shall assume responsibility for all ongoing behavioral health services received by a covered life at the time of enrollment in Contractor’s plan. Contractor’s responsibility for ongoing behavioral health services will continue until a new plan of care is developed. The new plan of care shall indicate the reason for any termination or reduction in the services required under the previous plan of care.

7.21 Services to Individuals Not Enrolled in NorthSTAR

Contractor shall provide the following services to individuals who reside in the NorthSTAR service area but who are not eligible for enrollment in NorthSTAR:

- a) Make recommendations for treatment for the individuals who are in need of involuntary commitment to a state hospital under an order of protective custody or mental health commitment;
- b) Track the individuals who have been involuntarily committed to a state hospital by a court having jurisdiction in the NorthSTAR service area. Contractor is not responsible for authorizing services, managing the care, or prescribing the lengths of stay for the individuals;
- c) Coordinate admissions and discharges with state hospitals and ensure continuity of care for the individuals upon discharge consistent with the continuity of care provided to NorthSTAR enrollees;
- d) Assist with appropriate referrals to service providers outside of NorthSTAR; and
- e) Review treatment requests for Medicaid enrollees not eligible for NorthSTAR, as described in 7.19.13.

7.22 Clinical Criteria for Hospital Placements

Contractor shall submit, for DSHS’s approval, as an addition to Contractor’s DSHS-approved Mental Health Level of Care Criteria, Contractor’s clinical criteria for placing enrollees in state hospitals and in community-based hospitals.

7.23 Offenders with Mental Impairments

Contractor shall ensure the provision of services to adult criminal offenders with mental impairments in Dallas, Hunt, Ellis, and Collin Counties and youth and families in Dallas and Ellis Counties, in accordance with the contract between DSHS and TCOOMMI.

7.24 Continuation of Benefits Pending and Following Contractor Appeals and Fair Hearings

7.24.1 Contractor shall continue an enrollee's benefits while an appeal or fair hearing is pending, in accordance with 42 CFR §438.420.

7.24.2 If the Contractor or State fair hearing officer reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

7.24.3 If the Contractor 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 Contractor shall pay for those services.

7.25 Case Management and Rehabilitative Services

Contractor shall provide case management and rehabilitative services in compliance with the requirements described in Appendix 27.

ARTICLE VIII - PROVIDER NETWORK

8.1 Provider Network

8.1.1 Contractor shall maintain a viable provider network in the service area that is sufficient to provide adequate access to the full scope of covered services to Enrollees and that complies with 42 CFR Part 438, Sections 438.206 through 438.214. Contractor shall ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-services, if the provider serves only Medicaid enrollees.

8.1.2 Contractor shall include the following providers in its network:

- a) Non-Facility Based Providers
 - (1) Psychiatrists.
 - (2) Psychologists.
 - (3) Licensed Professional Counselors, Licensed Master's Social Workers-ACP.
 - (4) Licensed Chemical Dependency Counselors.
 - (5) Other Qualified Credentialed Counselors (QCC).
- b) Facility-Based Providers
 - (1) Freestanding psychiatric facility.
 - (2) General acute facility that delivers behavioral health services.
 - (3) State psychiatric facility.
 - (4) Psychiatric partial hospitalization/day treatment programs.
 - (5) Outpatient chemical dependency treatment programs.

- (6) Inpatient chemical dependency treatment programs.
 - (7) Outpatient chemical dependency detoxification programs.
 - (8) Inpatient chemical dependency detoxification programs.
 - (9) Specialized female chemical dependency treatment programs.
 - (10) Residential chemical dependency detoxification program.
 - (11) Residential chemical dependency treatment programs.
 - (12) Pharmacotherapy programs.
 - (13) Dual diagnosis programs.
 - (14) Mobile Crisis.
 - (15) Specialty providers (SPN).
- c) Community Hospitals
Contractor shall maintain a community hospital bed capacity of 60 beds per day for inpatient services. Notwithstanding the foregoing, Contractor shall ensure the provision of all medically necessary services to enrollees.
- 8.1.3 Contractor shall have a system for monitoring patient load on its provider network so that Contractor can effectively plan for future needs and recruit providers as necessary to assure adequate access to all covered services.
- 8.1.4 Contractor shall not require a provider to agree to contract provisions that the provider cannot agree to by law.
- 8.1.5 Contractor shall not discriminate against providers acting within the scope of their license or state certification with respect to participation, reimbursement, or indemnification, solely on the basis of such licensure or certification. If Contractor decides not to include individual or groups of providers in the provider network, Contractor shall give the affected providers written notice of the reason for such decision.
- 8.1.6 Contractor's provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- 8.1.7 Contractor shall ensure that all requests from providers for network participation shall be reviewed and approved by NTBHA.
- 8.1.8 Contractor shall submit provider network change reports as described in §10.4 of this Contract.
- 8.1.9 Contractor shall not contract with providers who have been excluded from participating in the Medicaid or Medicare programs.
- 8.1.10 Contractor shall include in its provider network rural hospitals, physicians, home and community support service agencies, and other rural health care providers who:
- a) Are sole community providers;
 - b) Agree to accept Contractor's prevailing provider contract rate; and
 - c) Meet Contractor's credentials; however lack of board certification or accreditation by the Joint Commission shall not be the sole ground for exclusion from the provider network.
- 8.1.11 Contractor may not contract with any provider who is not in good standing with the State.

8.1.12 Contractor shall provide for a second opinion from a qualified behavioral health professional within the network, or arrange for the enrollee to obtain a second opinion outside the network, at no cost to the enrollee.

8.2 Out of Network Services

8.2.1 Contractor shall promote and ensure access to covered services within its provider network. If Contractor's provider network is unable to provide medically necessary covered services to an enrollee, Contractor shall adequately and timely cover these services out of network for the enrollee for as long as the Contractor is unable to provide the services through the network. Contractor shall coordinate care with out-of-network providers and provide necessary follow-up services.

8.2.2 Contractor's usage of out-of-network providers or groups of out-of-network providers shall not exceed limits for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions determined by HHSC or DSHS.

8.2.3 If DSHS finds that Contractor has violated Section 8.2.2, Contractor shall reimburse an out-of-network provider for behavioral health services at a rate that is equal to the allowable rate for those services, as determined under §§32.028 and 32.0281, Human Resources Code.

8.3 Payments to Providers

8.3.1 Contractor may offer subcontracted providers any method of payment it determines appropriate, including but not limited to fixed payment, subcapitation, case rate, or fee for service. However, payment arrangements other than fee for service must be reviewed and pre-approved by NTBHA and DSHS. If contractor proposes any provider rate changes, contractor shall allow NTBHA and DSHS 45 days prior to the proposed effective date, to review the proposed revisions, and to assess and/or evaluate the impact such revisions will have on the program.

NTBHA and/or DSHS may prohibit or instruct Contractor to terminate provider payment methodologies that involve subcapitation, case rate, or fixed payment if either NTBHA or DSHS determines that the subcontractor's encounter data or other required data submission requirements are not being fulfilled.

8.3.2 Contractor shall reimburse physicians who practice in rural counties with fewer than 50,000 persons and who participate in a Medicaid managed care program at the Medicaid fee schedule, or in the case of a full-risk managed care contract, at a rate using the current Medicaid fee schedule including negotiated fee for service.

8.3.3 Contractor shall reimburse providers for covered emergency services, and any other services that are needed to determine whether an emergency behavioral health condition exists and whether additional medical examination and treatment is required to stabilize the emergency condition, at the Contractor's prevailing provider rates.

- 8.3.4 If medically necessary covered services are not available through Contractor's provider network, Contractor shall, allow referral to a non-network physician or provider and shall fully reimburse the non-network physician or provider at the Contractor's usual and customary rate or an agreed rate, subject to pre-authorization requirements.
- 8.3.5 Contractor shall only recover an overpayment to a provider in accordance with Insurance Code §843.350.
- 8.3.6 Contractor shall ensure that all additional Medicaid funds received as a result of the Frew Settlement are disbursed to physician and professional providers in the form of a rate increase. Physician and professional services include all medication management, evaluation, and counseling or psychotherapy services provided by physicians, LCSWs, LPCs, LMFTs, and psychologists. Within the NorthSTAR scope of services, these increases shall result in physician and professional rates that are equal to rate increases published by HHSC. Contractor shall maintain evidence of rate increases on file, and shall make that information available to HHSC or DSHS upon request.

8.4 Claims/Encounter Data

Contractor shall comply and require its providers to comply with all claims and encounter data required in §4.13 and as necessary for the Contractor to meet all claims reporting requirements described in §9.1 of this Contract.

8.5 Provide Credentialing

Contractor shall credential all providers in accordance with 42 CFR §438.214 and with Appendix 14.

8.6 Geographic Access

Contractor shall ensure Enrollees are not required to travel in excess of 30 miles to secure covered services, with the exception of psychiatric hospitalization, 24-hour residential rehabilitation and inpatient detoxification services, for which Enrollees may not be required to travel in excess of 75 miles.

8.7 Medicaid Provider Number

- 8.7.1 Contractor shall assist the network providers in obtaining a Medicaid provider number.
- 8.7.2 Contractor shall not initially exclude a provider from their network on the grounds that the provider does not have a Medicaid provider number.
- 8.7.3 A Licensed Chemical Dependency Counselor practicing under his or her own license shall not be excluded from the network on the grounds that he or she cannot obtain a Medicaid provider number.

8.8 Specialty Provider Network (SPN)

8.8.1 Contractor shall contract with a Specialty Provider Network (SPN) to arrange for or provide intensive treatment and case management for adults with SMI or children with SED.

8.8.2 The SPN shall meet all requirements of this Contract for providing services.

8.8.3 In collaboration with Contractor, the SPN shall:

- a) Conduct assessments utilizing DSHS approved assessment instruments, develop treatment plans, and ensure service coordination for each Enrollee for whom the SPN is responsible;
- b) Assess persons referred by the courts for involuntary mental health commitments and provide case management to ensure appropriate coordination of treatment;
- c) Provide specialized mental health services for adults with Serious Mental Illness;
- d) Provide specialty mental health services to children with Serious Emotional Disturbance;
- e) Provide outreach to persons with mental illness in local jails and juvenile facilities; and
- f) Provide information and data as required to Contractor to track services, treatment outcomes and costs.

8.8.4 Individuals who are eligible for services through the SPN are:

- a) Individuals who require multiple services or multiple agency involvement will be assigned to the SPN. For purposes of this subsection, "multiple services" means mental health services, including medication services. Individuals discharged from state psychiatric hospitals will also be referred to the SPN when the need for specialty services is indicated; and
- b) Through the intake and assessment process, Contractor will identify Enrollees eligible for covered services through the SPN and will authorize the Enrollee to receive these services through the SPN. Contractor shall make reasonable efforts to ensure that the Enrollee follows through on the referral and is engaged in treatment. Contractor is also responsible for authorizations, UM, UR and quality oversight of services provided by the SPN.

8.8.5 The SPN shall arrange for Enrollee choice of providers to the extent possible.

8.8.6 DSHS shall approve Contractor's contract termination with the SPN and any substantial changes to such contract.

8.9 Provider Manual and Training

8.9.1 Contractor shall issue each provider a Provider Manual prior to referring any enrollees to the provider. The manual shall inform providers about Enrollee services, all policies and procedures developed for the NorthSTAR program, complaints, appeals and fair hearings, applicable statutes and regulations, Enrollee access to services, enrollment and disenrollment procedures, NTBHA address, phone number and Consumer Ombudsman information, preauthorization requirements, claim and payment information, required forms, provider billing codes and procedures, and provider responsibilities.

- 8.9.2 Contractor shall train providers who are added to the Contractor's network within 30 days of active status.
- 8.9.3 Contractor shall ensure that provider training includes, at a minimum: NorthSTAR scope of benefits and any modifications to the scope of benefits; compliance with 42 CFR §438.208; policies and procedures and any modifications to policies and procedures; complaints, appeals and fair hearings; billing procedures; submission of required clinical information; Enrollee eligibility standards and benefits; enrollment/disenrollment procedures; special needs of Enrollees that affect access to and delivery of services, including cultural and linguistic sensitivity, interpreter services and transportation; rights and responsibilities of Enrollees, health education and prevention; and coordination with other agencies and service providers, including DFPS, health and human service agencies, criminal justice agencies, and the STAR plans.
- 8.9.4 Contractor shall ensure that ongoing provider training is conducted when deemed necessary by either the Contractor or DSHS.
- 8.9.5 Contractor shall maintain on file a copy of provider training attendance rosters dated and signed by each attendee.

8.10 Provider Complaint and Appeal process

- 8.10.1 Contractor shall comply with the DSHS-approved provider complaint and appeal procedures for network providers.
- 8.10.2 The procedures shall be the same for all providers and shall include the activities listed below:
 - a) A process that obligates both parties to make a good faith effort to resolve disputes arising under their agreement;
 - b) If a dispute cannot be resolved through informal discussions, the dissatisfied provider shall submit a written complaint to Contractor that specifically states the basis for the complaint and a proposed resolution;
 - c) Contractor shall respond to any properly submitted complaint within a specified time period, agreed upon by the parties. Contractor's written acceptance, rejection or modification of the provider's proposed resolution will constitute Contractor's final determination; and
 - d) If the parties are still unable to resolve the dispute, the provider may submit the dispute to arbitration in accordance with the rules and regulations of the American Arbitration Association, unless the provider and Contractor mutually agree to another resolution procedure.
- 8.10.3 Contractor shall include the provider complaint and appeal procedure in all network provider Contracts.
- 8.10.4 Contractor shall not refer provider complaints and appeals to the DSHS for resolution. If, through the provider complaint and appeal process, the issue remains unresolved, Contractor shall inform provider that they can refer to DSHS for review.

- 8.10.5 Contractor's provider complaint and appeal process shall comply with Insurance Code, Chapter 843, Subchapter I and all TDI rules relating to provider complaint processes.
- 8.10.6 Contractor shall ensure that network providers have ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and complaint procedures.

8.11 Physician Incentive Plans

- 8.11.1 Contractor shall comply with the physician incentive plan requirements described in 42 CFR §438.6(h), 42 CFR §§422.308 and 422.310. Contractor shall submit to DSHS, within 30 days from the effective date of the Contract, Contractor's physician incentive plan for DSHS's approval. Changes or modifications to the plan shall be submitted to DSHS for approval.
- 8.11.2 Contractor shall not use any financial incentives or payment arrangements to physicians or providers that act directly or indirectly as an inducement to limit medically necessary services.

8.12 Provider communications

- 8.12.1 Contractor shall not restrict a provider's ability to provide opinions or counsel to an Enrollee with respect to health or behavioral health services, Enrollee's health status, medical care or treatment options, any alternative treatment that may be self-administered, information the enrollee needs to decide among all relevant treatment options, risks, benefits, and consequences of treatment or non-treatment, the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions, referral policies, financial incentives, or the provider's network status.
- 8.12.2 Contractor shall require providers to discuss treatment risks, benefits and consequences, with Enrollees in a culturally competent manner.

8.13 Provider Subcontracts

- 8.13.1 Contractor shall enter into subcontracts with its providers and monitor performance of such subcontracts in compliance with §3.8 of the Contract and with 42 CFR §438.230.
- 8.13.2 Contractor shall require its providers to meet DSHS standards for timely access to care and services, taking into account the urgency of the need for services;
- 8.13.3 Contractor shall ensure that the network providers offer hours of operation that are no less than the hours of operations offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves Medicaid enrollees;
- 8.13.4 Contractor shall establish a mechanism to ensure compliance by providers and monitor providers regularly to determine compliance and take corrective action if there is failure to comply.

8.13.5 Contractor shall comply with its provider subcontracts.

8.14 Behavioral Health Integrated Provider System (BHIPS) and Clinical Management of Behavioral Health Services (CMBHS)

Contractor shall require each DSHS-designated provider of substance abuse or chemical dependency services, by provider subcontract, to assess enrollees and enter enrollee assessment information using DSHS's Behavioral Health Integrated Provider System (BHIPS) or (CMBHS) Clinical Management of Behavioral Health Services when it becomes available. Providers must enter intake, discharge and follow-up information in BHIPS on NorthSTAR enrollees receiving substance abuse services. Contractor shall assist DSHS with training the designated providers on using BHIPS/CMBHS if needed. Contractor shall monitor each provider's BHIPS/CMBHS completion rates and ensure compliance, and submit progress reports as requested by DSHS.

8.15 Rehabilitative Services

Contractor shall ensure that all rehabilitative services provided to each enrollee have been recommended by a licensed practitioner of the healing arts (LPHA), practicing within the scope of his or her LPHA license, based on the LPHA's assessment of the enrollee.

8.16 Assurances of Adequate Capacity and Services

If there is a significant change in Contractor's operations that would affect adequate capacity and services, as described in 42 CFR §438.207, Contractor shall submit documentation to DSHS, in a format specified by DSHS, to demonstrate that Contractor meets the following requirements:

- a) Offers an appropriate range of preventive and specialty services that is adequate for the anticipated number of enrollees for the service area; and
- b) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

8.17 340B/University of Texas Medical Branch (UTMB) Telemedicine

8.17.1 Contractor shall require DSHS-designated providers to enter into agreements with UTMB to provide clinic space to UTMB to perform telemedicine services and to receive reimbursement from UTMB for such clinic space.

8.17.2 Contractor shall contract with UTMB describing Contractor's and UTMB's roles under the 340B Medication Program, as approved by the Office of Pharmacy Affairs of the U.S. Department of Health and Human Services. Expenses paid to UTMB for the administration of 340B program may be counted towards the calculation of DSCT. These expenses include clinical services. Contractor shall clearly delineate responsibilities and roles of 340B-eligible enrollees, Pharmacy Benefits Manager (PBM), UTMB and providers under 340B program, and provide training and technical assistance as needed.

ARTICLE IX MANAGEMENT INFORMATION SYSTEM (MIS)

9.1 Management Information System Requirements

9.1.1 Contractor shall maintain a Management Information System (MIS) that supports all functions of the Contractor's processes and procedures for the flow and use of Contractor's data. The Contractor shall have hardware, software, and a network and communications system with the capability and capacity to handle and operate all MIS functionality for the following operational and administrative areas:

- a) Enrollment/Eligibility/Disenrollment Processing
- b) Provider Contracting and Credentialing
- c) Encounter/Claims Processing
- d) Pharmacy
- e) Financial
- f) Coordinated Care
- g) Assessment
- h) Jail Match
- i) Data Warehouse / Data Backup System
- j) Data Recovery / Business Continuity Plan
- k) Two levels of Security on file transfers, i.e. Secure File Transfer Protocol Secure (SFTPS) like FileZilla or Hypertext Transfer Protocol Secure (HTTPS) plus encryption software like MEO by NCH or Pretty Good Privacy (PGP).

9.1.2 The MIS shall enable the Contractor to meet the contract requirements, including all applicable state and federal laws, rules, and regulations. The Contractor shall maintain an MIS that collects, analyzes, integrates and reports data and that enables the Contractor to meet all of its duties and responsibilities under the contract. The MIS shall have the capacity and capability to capture and use various data elements required for contract administration.

9.1.3 The MIS shall ensure that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic and consistency, and collecting service information in standardized formats to the extent feasible and appropriate. As required by 42 CFR §§438.604 and 438.606, the Contractor's CEO, CFO or individual who has delegated authority to sign for, and who reports directly to, the CEO or CFO, shall certify all data and documents submitted to DSHS, including but not limited to, enrollment information, encounter data and all other information required under the Contract.

9.2 Administrative Requirements

9.2.1 Staffing Requirements

9.2.1.1 Staffing levels for system operations shall be adequate to assure that all requirements for data submission are met.

- 9.2.1.2 Contractor shall also maintain a NorthSTAR Information Services Director through the contract period.
- 9.2.1.3 Contractor shall provide DSHS official points-of-contact for MIS and operational issues at least bi-annually (15th of July and January). This document shall include brief functional descriptions of key staff members.
- 9.2.1.4 Contractor shall provide DSHS, including the NorthSTAR Information Systems Coordinator, any updates to the Contractor's organizational chart relating to MIS and the description of MIS responsibilities at least 30 days prior to the effective date of the change.

9.2.2 HHSC Systems Work Group Participation

- 9.2.2.1 Contractor's staff shall participate in the HHSC Systems Work Group. A staff member shall attend the monthly MCO scan call meeting. These calls are run by HHSC and are attended by the HMOs participating in Medicaid managed care.

9.2.3 Change Management

- 9.2.3.1 Contractor shall have a system that can be adapted to changes in business practices/policies within the timeframes negotiated by the Contractor and DSHS. The Contractor is expected to cover the cost of such systems modifications over the life of the Contract.
- 9.2.3.2 Contractor shall provide DSHS, including the NS IS Coordinator, prior written notice of major systems changes, generally within 90 days, and implementations, including any changes relating to subcontractors, in accordance with the requirements of this Contract.

9.2.4 Planning Documents

- 9.2.4.1 Contractor shall create a Joint Interface Plan (JIP), a Disaster Recovery / Business Continuity Plan, and a Systems Quality Assurance Plan.
- 9.2.4.2 At the beginning of each state fiscal year, the Contractor shall submit for DSHS's review and approval any modifications to the following documents:
 - a.) JIP;
 - b.) Disaster Recovery Plan; and
 - c.) Systems Quality Assurance Plan
- 9.2.4.3 The JIP shall include a brief overview of the contractor's internal processing and all transaction layout documentation for files transferred to and from DSHS. JIP will also include all field decodes and validation/edit business rules.
- 9.2.4.4 Contractor shall comply with its Disaster Recovery / Business Continuity Plan described in the proposal, as modified and

approved by DSHS. Any updates or major modifications to the Disaster Recovery Plan shall be submitted to DSHS within 30 days following completion of the update or modification.

9.2.4.5 The Systems Quality Assurance Plan shall include all reports that track Contractor compliance with MIS requirements. The plan shall contain a brief description of each report and who is responsible for providing the report to NorthSTAR.

9.2.5 System Readiness

9.2.5.1 DSHS, or its agent, may conduct a systems readiness review to validate the Contractor's ability to meet the MIS requirements. The system readiness review may include a desk review and/or an onsite review and shall be conducted for the following events:

- a) A new plan is brought into the NorthSTAR program;
- b) An existing plan begins business in a new service area;
- c) An existing plan changes location; and
- d) An existing plan changes its processing system, including changes in subcontractors performing MIS or claims processing functions; and

9.2.5.2 If for any reason Contractor does not fully meet the MIS requirements, then the Contractor shall, upon request by DSHS, either correct such deficiency or submit to DSHS a corrective Action Plan and Risk Mitigation Plan to address such deficiency.

9.2.5.3 Contractor shall provide interface and application flowcharts for all subsystems to DSHS 60 days prior to Systems Readiness Testing. If MIS services are subcontracted, Contractor shall also provide systems documentation.

9.3 Technology Access

9.3.1 Contractor understands that DSHS funds may not be expended in connection with the purchase of an automated information system, unless that system meets certain statutory requirements relating to accessibility by persons with visual impairments. Contractor will engage with DSHS in discussions regarding the purchase of an automated information system or enhancements to best support statutory requirements surrounding accessibility by persons with visual impairments as appropriate. Accordingly, the Contractor represents and warrants to DSHS that the technology provided to DSHS under the Contract is capable, either by virtue of features included within the technology or because it is readily adaptable for use with other technology by: (1) providing equivalent access for effective use by both visual and non-visual means; (2) presenting information, including prompts used for interactive communications, in formats intended for non-visual use; and (3) being integrated into networks for obtaining, retrieving, and disseminating information used by individuals who are not blind or visually impaired.

- 9.3.2 For purposes of this section, the phrase "equivalent access" means a substantially similar ability to communicate with or make use of the technology, either directly by features incorporated within the technology or by other reasonable means such as assistive devices or services which would constitute reasonable accommodations under the ADA or similar state or federal laws. Examples of methods by which equivalent access may be provided include, but are not limited to, keyboard alternatives to mouse commands and other means of navigating graphical displays, and customizable display appearance.

9.4 System-Wide Functions

9.4.1 Processing Requirements

- 9.4.1.1 Software within the MIS shall be capable of performing the data processing functions required under the Contract, including but not limited to:
- a) Performing accounting procedures;
 - b) Maintaining Enrollee demographics, admission, assessment and discharge data, treatment and diagnosis history;
 - c) Tracking services delivered to each Enrollee and payments or denials for services;
 - d) Tracking changes in each Enrollee's eligibility status;
 - e) Assessing Enrollee outcomes;
 - f) Facilitating the reporting to DSHS of all data required to be submitted, in the format prescribed by DSHS; and
 - g) Creating regularly scheduled and specially requested data files.
- 9.4.1.2 Contractor shall send regularly scheduled files that will contain all data elements found in the transaction layouts as defined in Appendix 20. The Contractor shall be able to accept and process/reconcile any and all records rejected by DSHS due to validation failures.
- 9.4.1.3 Contractor shall obtain and maintain access to the TexMedNet BBS, which will handle file transfers and e-mail of some files and data elements. The BBS will post files that the Contractor shall be able to download and process including but not limited to the Coordinated Care NorthSTAR/STAR dual enrollment file.
- 9.4.1.4 Contractor shall comply also with the technical requirements, procedures, file layouts, and processes for the submission of service data and other data interfaces to DSHS described in this Contract.
- 9.4.1.5 Contractor shall comply in a timely manner with the standards for electronic transactions and code sets adopted under Subtitle F, Title II, Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), and 45 CFR Parts 160 and 162, and with any subsequent amendments thereto. DSHS shall supply HIPAA-compliant file layouts for covered transactions for Contractor to use in data submissions to and from DSHS.

- 9.4.1.6 Contractor shall make original records available for inspection by DSHS for validation purposes.
- 9.4.1.7 Contractor's MIS shall provide support for all functions of the Contractor's processes and procedures related to the flow and use of data within the Contract and have the capability to capture and utilize required data elements for the Contractor's administration and management purposes as well as data for DSHS reporting purposes. In addition, the system shall be able to interface with other systems, (e.g., DSHS system, TMHP and those of other BHOs).
- 9.4.1.8 Contractor's MIS system shall include the following key business processing functions and/or features, which shall apply across all operational and administrative areas:
- a) Ability to accept and process files in the format described by DSHS including the ability to pass all edits;
 - b) Process electronic data transmission or media to add, delete, or modify records with accurate begin and end dates;
 - c) Maintain a history of changes and adjustments and audit trails for current and retroactive data;
 - d) Employ industry standard medical billing taxonomies (procedure codes, diagnosis codes) to describe all services and assessments;
 - e) Accommodate the coordination of benefits;
 - f) Ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS;
 - g) Maintain and cross-reference all Enrollee-related activity (i.e. claims, encounters, assessments, etc.) with the most current Medicaid number and/or NorthSTAR ID;
 - h) Update and edit all data in MIS and subsystems via automated processes;
 - i) Maintain historical data available for retrieval and use up to 5 years;
 - j) Relate and extract elements into summary electronic reporting formats;
 - k) Contractor shall ensure MIS contains maintenance functions to correct data errors, such as the ability to merge two NorthSTAR IDs that belong to the same Enrollees as identified by DSHS including associated claims, assessments, and any other associated data; and
 - l) Contractor shall submit regularly scheduled transaction files in electronic format to DSHS as described in Appendix 20. These extracts will be revised as needed and agreed to by the parties.
- 9.4.1.9 Penalties for failing to meet the requirements of §9.4.1 are specified in Appendix 4b.

9.4.2 Systems Reliability

- 9.4.2.1 Contractor shall ensure that computer systems are adequately and reasonably protected against hardware, software, and human error. The systems shall include appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including backup, disaster recovery, and to resume business functions.
- 9.4.2.2 On the fifth (5th) business day of each month, Contractor shall submit a report to DSHS that displays the number of paid claims by service month/year and listed by service code and modifier combination. This report will exclude all denied claims and paid claims that have been subsequently reversed. DSHS must approve the layout and content of the report. This report shall be reviewed by DSHS and Contractor staff by the 10th day of the month looking for any drops in services provided. If DSHS and Contractor staff agree that data at the service code level is missing, the Contractor will have 120 days to correct that data and transmit the data to DSHS. Contractor shall submit the first report to DSHS within 120 days of the signed contract.
- 9.4.2.3 Penalties for failure to meet this requirement are specified in Appendix 4b. Penalties shall apply to failure to transmit daily and weekly files as required in this section, failure to transmit any specially requested files, failure to transmit corrected errors, and failure to create and distribute required reports.

9.5 Operational and Administrative Areas – MIS Functionality

9.5.1 Enrollment/Eligibility/Disenrollment

- 9.5.1.1 Enrollment/Eligibility
 - 9.5.1.1a Contractor's Enrollment/Eligibility Subsystem shall secure all functions that require Enrollee data.
 - 9.5.1.1b Contractor's MIS shall facilitate business processes including accepting and maintaining enrollment data from DSHS. NorthSTAR enrollment and Medicaid eligibility data shall be used for determining payments and benefits including pharmacy benefit.
 - 9.5.1.1c All new enrollments, new disenrollments, and updates to current enrollments shall be sent to Contractor via batch on a daily basis. Contractor shall process the enrollment file through a HIPAA-compliant encrypting process and transmitted using file transfer protocols (FTP) to the Contractor in a HIPAA-compliant 834 format and contain all enrollment history for the client. Contractor shall use a HIPAA-compliant decrypting process for the file. Additionally, an auxiliary file in a proprietary format containing clients' Medicaid eligibility, behavioral

managed care enrollment, and DSHS shall send CHIP enrollment information to Contractor.

- 9.5.1.1d Contractor shall reconcile DSHS's enrollment data file with the Contractor's enrollment subsystem on a daily basis and notify DSHS immediately of any discrepancies or file errors to the NorthSTAR Director of Operations or designate via HIPAA compliant methodology determined by DSHS.
 - 9.5.1.1e Contractor shall generate and retain history of services/treatment and authorization files for Enrollees.
 - 9.5.1.1f Contractor shall have mechanisms for synchronizing files ensuring correct enrollment segments.
 - 9.5.1.1g Contractor shall accept Medicaid data from DSHS in the file format described in Appendix 20.
 - 9.5.1.1h Contractor shall accept DSHS 834 transaction for NorthSTAR Enrollees to replace/update MIS system to reflect current and historic segments.
- 9.5.1.2 Disenrollment
- 9.5.1.2a Contractor shall ensure that Enrollees for whom disenrollment is requested do not have a current Behavioral Managed Care segment open nor paid encounters, including pharmacy encounters, after the disenrollment date. The Enrollees shall also have any open assessment series closed on or prior to the requested disenrollment date.
 - 9.5.1.2b For disenrollment requests, the Contractor shall be able to create an 834 file and send it to DSHS. The 834-file format will be discussed and agreed upon between the Contractor and DSHS.

9.5.2 Provider System

- 9.5.2.1 Contractor's provider system shall support the Contractor's credentialing, re-credentialing, and credential tracking processes. The system shall incorporate or link credentialing information to the provider's record.
- 9.5.2.2 Contractor shall exclude providers from participation that have been identified by DSHS as ineligible or excluded. Files shall be updated to reflect the period and the reason for exclusion.
- 9.5.2.3 Contractor shall accept, process, store and retrieve current and historical data on providers, including demographic information, services provided, payment methodology, and license information.
- 9.5.2.4 Contractor shall obtain and maintain access to the TexMedNet BBS, which will handle file transfers and e-mail of some files and data elements that relate to TPI numbers and decode tables (i.e.: provider specialty, provider type etc.) until NPI is implemented.

- 9.5.2.5 Contractor shall use the TPI number (or DSHS approved number) as the unique identifier for each provider who is eligible to receive a TPI number including any single case agreement providers.
- 9.5.2.6 Contractor shall ensure that all providers have an active NPI (National Provider ID) with associated identifying fields as the unique identifier.
- 9.5.2.7 Contractor shall prepare and send provider data daily in the required file format to DSHS, the file format described in Appendix 20.

9.5.3 Encounter/Claims

- 9.5.3.1 For definitional purposes, the data reflecting services delivered to NorthSTAR Enrollees and submitted to DSHS system by the Contractor are called encounters, because DSHS does not exchange money for services directly with providers, the Contractor does.
- 9.5.3.2 Contractor shall collect and report to DSHS all claims, claim adjustments, and encounter data weekly using DSHS encounter extract file format described in Appendix 20. This extract format will be revised as needed and agreed to by the parties.
- 9.5.3.3 This MIS system may integrate manual and automated systems to validate and adjudicate claims.
- 9.5.3.4 Contractor shall edit for utilization and service criteria, program policy, fee schedules and multiple contract periods.
- 9.5.3.5 Contractor shall provide encounter data to DSHS for all services rendered to NorthSTAR Enrollees including case rate services by procedure code.
- 9.5.3.6 The Contractor shall be able to accommodate an 837 format, or any encounter format mandated by HIPAA, in the future.
- 9.5.3.7 The Contractor shall submit an encounter 837 file to TMHP to TMHP's programming specification which will include all paid, reversed, and denied claims. Submission of the file will meet TMHP submission requirements, and the encounter file shall be sent at least monthly. Contractor shall also accept an 824 and 277 response file and rectify any records determined to be in error at the request of DSHS

9.5.4 Pharmacy

- 9.5.4.1 Contractor shall provide pharmacy data for non-Medicaid NorthSTAR Enrollees. The State's Vendor Drug program will provide pharmacy data for Medicaid enrollees in the NorthSTAR Program.
- 9.5.4.2 Data shall be submitted weekly in the file format described in Appendix 20.
- 9.5.4.3 Penalties for failing to meet the requirements of section 9.5.4 are specified in Appendix 4b.

9.6 Assessment

9.6.1 Resiliency and Disease Management

9.6.1.1 Contractor shall administer DSHS-approved Uniform Assessment instruments to outpatient mental health and dual diagnosis NorthSTAR Enrollees as described in Appendix 13, and Contractor shall follow the data submission requirements described in Appendix 20.

9.6.1.2 The data shall be submitted to DSHS in electronic form regardless of how it is collected from the providers. Contractor may use DSHS's Resiliency and Disease Management online screens to submit the data or FTP the data in DSHS approved layout in Appendix 20.

9.6.2 BHIPS / CMBHS

9.6.2.1 Contractor shall ensure that any provider who serves chemical dependency Enrollees has access to the BHIPS system. Providers must enter intake, discharge and follow up information on enrollees in BHIPS. Upon implementation of the CMBHS system, Contractor shall ensure that any provider serving chemical dependency Enrollees has access to the CMBHS system and completes all required data fields.

9.6.3 Jail Match

9.6.3.1 Contractor shall adhere to the mandate that requires the research and reporting of mental health services for all individuals who are in the NorthSTAR service area's county jail system. Contractor shall enter agreements with each county jail in the NorthSTAR service area to send data to Contractor on a daily basis. Contractor shall accept multiple electronic submission types to accommodate the technology of each county jail.

9.6.3.2 Contractor shall run a match process for the individuals listed on the file and send the result sets to NTBHA. Contractor shall send the data to NTBHA identifying the NorthSTAR ID, provider, last service date, and diagnosis. Contractor shall also distinguish Enrollees who have only had a chemical dependency service and send a separate file to NTBHA to allow NTBHA to contact the chemical dependency provider regarding the incarceration of the Enrollee.

9.6.3.3 Contractor shall collect files from all seven counties and send a concatenated file to NorthSTAR on a daily basis in the specified format found in Appendix 20. NorthSTAR will process the file against the Client Assignment Registration (CARE) system and send results to NTBHA.

9.6.3.4 Contractor shall create a monthly report due on the 5th working day of the month indicating each day that a county jail submitted

a file to Contractor. DSHS and the Contractor shall agree on the format of the file.

9.6.3.5 Penalties for failing to meet the requirements of section 9.6. are specified in Appendix 4b.

9.7 TIMELY CORRECTION OF DATA IN ERROR

9.7.1 For each file submitted to DSHS (encounter, pharmacy, assessment, provider), an error file will be created and sent to Contractor on the same day the file is processed by DSHS. For each error file, Contractor shall correct 90% of all records that have an error within 30 days of receipt of the error file. Ninety eight percent (98%) of all records on the error file shall be corrected within 60 days of receipt of the error file.

9.7.2 By the close of business on the Friday of each week, Contractor shall provide a report to DSHS that indicates the number of records submitted by providers or subcontractors (claims, encounters, pharmacy, assessments) to Contractor and the number of records transmitted to DSHS for the previous month. A brief description of any numerical differences shall be included. The report shall also include the number of records erred by DSHS (including provider errors) and the number of these records that were corrected by Contractor and resubmitted and accepted by DSHS. A brief description must be included for any records that were not corrected and accepted by the 30th and 60th day.

9.8 Financial System

9.8.1 Contractor shall maintain, in accordance with GAAP, accounting records for all claim payments, refunds and adjustments of payments to providers, and all premium payments, interest income and any administrative fees paid to subcontractors for services under the Contract. The Contractor shall report provider payments for services separately from administrative payments.

9.8.2 The financial system shall provide the necessary data for all accounting functions, including cost accounting, inventory, fixed assets, payroll, general ledger, accounts receivable and payable and financial statement presentation.

9.8.3 The financial system shall provide the Contractor's management with information that can demonstrate that the provider or the Contractor is meeting, exceeding, or falling short of fiscal requirements contained in the Contract. This information shall also provide the Contractor's management with the necessary data to spot the early signs of fiscal distress, far enough in advance to allow management to take corrective action where appropriate.

9.8.4 The financial system shall provide information on the Contractor's economic resources, assets, and liabilities and present accurate historical data and projections based on historical performance and current assets and liabilities.

- 9.8.5 Contractor shall provide information to DSHS regarding Third Party Reimbursement (TPR), including potential third party payers, information specific to the Enrollee, claims made against third party payers; collection amounts and dates; denial, if any, and reasons therefore.
- 9.8.6 Contractor shall reduce/increase accounts payable/receivable based on adjustments to claims or recoveries of TPR.
- 9.8.7 Contractor shall produce financial statements in the format prescribed by DSHS.

9.9 Payment Reconciliation

- 9.9.1 The NorthSTAR Payment Process System (PPS) file will transfer premium and Enrollee identifying information to the Contractor. The PPS subsystem will allow the Contractor to reconcile payments made to the Contractor by DSHS. The file will include all Enrollees identified by HHSC as enrolled in Medicaid Behavioral Managed Care (BMC). DSHS will send a monthly file to the Contractor in a format described in Appendix 20.
- 9.9.2 Contractor shall accept the monthly file in the format provided in Appendix 20.
- 9.9.3 Contractor shall maintain a payment history for all NorthSTAR Enrollees.

9.10 Coordinated Care

This file will identify NorthSTAR Enrollees who also are enrolled in STAR. The contractor shall download this file from TexMedCentral monthly, load it to their system, and associate the STAR information with the appropriate client.

9.11 Reporting

- 9.11.1 In addition to any reporting requirements listed in this section, Contractor shall also meet all reporting requirements listing in all other sections of the Contract. Contractor shall demonstrate that its MIS system can provide all reporting data elements.
- 9.11.2 Contractor's MIS shall allow the Contractor to develop reports and data submissions to enable management and DSHS to make informed decisions regarding the Contractor activity.
- 9.11.3 Contractor shall be able to produce standard, DSHS-required reports and ad hoc reports and data extracts for electronic transfer from the data available in the MIS system. All reports and data shall be submitted on hard copy or electronically in a format approved by DSHS.
- 9.11.4 These reports may include but will not be limited to reports regarding:
 - a) Unduplicated counts of Enrollees, providers, payments and units of service unless otherwise specified;
 - b) List of Enrollees by identifying information including: enrollee last name, Texas Medicaid or NorthSTAR identification number;
 - c) List of Enrollee's provider change by reason;
 - d) Lists of providers by Enrollees served; and
 - e) Claims lag report from date of service to date received.

- 9.11.5 Contractor shall collect and report all claims, claim adjustments, and encounter data to TMHP monthly using TMHP encounter extract file format. Records rejected by TMHP shall be corrected and resubmitted to TMHP by the next file submission. This extract format will be revised as needed and agreed to by the parties. Reimbursement for this activity will be outlined in a future amendment.
- 9.11.6 Contractor shall be able to implement and use the NPI (National Provider ID) as the unique identifier for each eligible provider at the application time.

9.12 Clinical Management System for Behavioral Health Services (CMBHS)

Contractor shall implement and utilize CMBHS when it is implemented for the NorthSTAR service delivery area. DSHS will notify Contractor of specific requirements as they become available and will insure that all contracted behavioral health providers submit the CMBHS required data elements.

ARTICLE X REPORTING REQUIREMENTS

In addition to data reporting requirements in Article IX, Contractor shall submit to DSHS accurate and complete reports described below.

10.1 Financial Reports

- 10.1.1 Contractor shall file quarterly and annual Behavioral Health Financial Statistical Reports using the formats contained in Appendix 17, within 30 days from the last day of each quarter. This report shall be submitted in an Excel spreadsheet and in paper format. This report shall depict revenues and expenses on an accrual basis.
- 10.1.2 The first annual report shall reflect expenses incurred through the 90th day after the expiration of the Contract. Contractor shall submit this report on or before the 120th day after the expiration of the Contract. The second annual report shall reflect data completed through the 270th day after the expiration of the Contract and shall be filed on or before the 300th day following the expiration of the Contract.
- 10.1.3 The administrative expenses reported in the Behavioral Health Financial Statistical Reports shall be consistent with TDI requirements and definitions.
- 10.1.4 Contractor shall submit to DSHS a duplicate of the HMO Quarterly Statement and the HMO Annual Statement and supplemental exhibits required by TDI within 10 days of the TDI filing deadlines.
- 10.1.5 Contractor shall submit to DSHS a copy of the annual audited financial report filed with TDI within 10 days after the TDI filing deadline.
- 10.1.6 Contractor shall file an updated Form HCFA-1513 regarding control, ownership, or affiliation of the Contractor within 30 days after the end of the Contract year and within 30 days of any change in control ownership, or affiliation of the Contractor.

- 10.1.7 Contractor shall file an updated CMS Public Health Service (PHS) “Section 1318 Financial Disclosure Report” within 30 days of the end of the Contract year and within 30 days of entering into, renewing, or terminating a relationship with an affiliated party.
- 10.1.8 Contractor shall submit a copy of any TDI Examination Report within 10 days after receipt from TDI.
- 10.1.9 Contractor shall file a quarterly TPR report within 30 days of the last day of each quarter. The report shall include total dollars recovered from third party payors for covered services to Enrollees for each month and the total dollars recovered through coordination of benefits, subrogation, and worker's compensation.

10.2 Disproportionate Share Report

Contractor shall file with HHSC the required disproportionate share reports. The disproportionate share reports shall include the required data elements and be submitted in the form and format specified by HHSC. Contractor shall make this report available to DSHS upon request.

10.3 Provider Complaint and Appeal Reports

Contractor shall submit electronically by the 15th day following the end of each month a provider complaint and appeal report of all provider complaints for that month, including complaints that are in arbitration or litigation. These reports shall include the names of the providers making the complaints and shall be in the format shown in Appendix 23.

10.4 Provider Network Change Reports

Contractor shall maintain an automated standardized provider network change report summarizing changes in the Contractor's provider network. The report shall be submitted electronically to DSHS and to the Enrollment Broker on the 15th day following the end of each month. The report shall identify all provider network changes for that month, including:

- a) The change in providers' HUB status;
- b) The number of providers who have ceased participation in the provider network and the reason(s) the provider ceased such participation; and
- c) The report shall also include the impact of any provider network changes on Enrollees' geographic access and cultural and linguistic services. The report shall be in the format described in Appendix 24A, for individual providers, or Appendix 24B, for facility providers.

10.5 Enrollee Complaint Reports

Contractor shall develop, implement, and maintain an automated standardized system for tracking and reporting Enrollee complaints. Contractor shall submit electronically to DSHS by the 15th day following the end of each month a data report that includes all of the required elements described in Appendix 23 for that month.

10.6 Intake and Referral System

Contractor shall submit by the 15th day following the end of each month and quarter a report for the quarter containing a summary of incoming call traffic, including abandonment rates and average call waiting time, and documentation of referrals made for callers by group referral type.

10.07 QAPI Rep

Contractor shall submit to DSHS, quarterly, quality improvement reports describing all significant changes to the QAPI and all the elements identified in Appendix 29. Contractor shall submit these reports within 30 days following the end of each quarter.

10.8 HUB Reports

Contractor shall submit within 30 days following the end of each quarter a report of HUB program efforts and accomplishments. The report shall include a description of Contractor's HUB efforts and a financial report of payments made to HUBs. These reports shall be submitted directly to the HUB coordinator and copied to NorthSTAR staff. Contractor shall use the format described in Appendix 18 for submitting HUB reports.

10.9 Civil Rights Policies and Complaints

Upon request, Contactor shall provide the Health and Human Services Commission (HHCS) Civil Rights Office with copies of all Contractor's civil rights policies and procedures. Contractor must notify HHSC's Office of Civil Rights of any civil rights complaints received relating to performance under this Contract no more than 10 calendar days after Contractor's receipt of the claim. Notice must be directed to:

HHSC Civil Rights Office
701 W. 51st St., Mail Code W206
Austin, Texas 78751
Toll-free phone (888) 388-6332
Phone (512) 438-4313
TTY Toll-free (877) 432-7232
Fax (512) 438-5885.

ARTICLE XI PAYMENT PROVISIONS

DSHS will pay Contractor premiums monthly, based on the NorthSTAR Budget attached hereto as Appendix 30, no later than the 10th state working day of the month for which payment is made. Contractor shall accept payments by direct deposit into a bank account.

11.1 Premiums

11.1.1 DSHS will pay Contractor, monthly, premiums based on a) all of the Medicaid Enrollees in Contractor's plan for the month in which premiums

are paid and b) the adjusted non-Medicaid covered lives, as determined under Section 11.1.3 of this Contract.

11.1.2 Monthly premiums for Medicaid Enrollees will be paid according to the rates and rate methodologies described in Appendix 11. Monthly premiums for non-Medicaid covered lives will be paid for the rate categories of Adult and Child, as described in Appendix 11.

11.1.3 Non-Medicaid covered lives shall be determined by subtracting Medicaid covered lives from total covered lives. The total number of covered lives shall be based on poverty rate estimates available from HHSC and on census data from the U.S. Department of Commerce, Bureau of the Census.

11.2 State Hospital Allocation Methodology

Contractor shall comply with DSHS's State Hospital Allocation Methodology as described on the DSHS website.

11.3 Performance Incentive Funds

DSHS will pay Contractor performance incentive funds, if applicable, as described in Appendix 4a. Performance incentives paid to Contractor shall be passed through to providers.

11.4 Payment Adjustments

11.4.1 Monthly payments under this Contract are subject to legislative appropriations for this Contract. DSHS will notify Contractor in writing within five business days following DSHS's receipt of actual notice of any proposed legislative reduction in appropriations for this Contract. DSHS and Contractor will work together to determine equitable adjustments to payments, penetration rates, the number of covered lives, and/or the scope of service requirements commensurate with the legislative reduction in appropriations. DSHS shall respond to any programmatic adjustments (i.e., adjustments to penetration rates, number of covered lives or scope of services) proposed by Contractor within 15 business days of receipt of such proposal. Any programmatic adjustments made in response to the legislative reduction in appropriations shall be effective as of the date of any adjustments to monthly payments.

If DSHS receives additional funds for community-based mental health services during the contract term that, within the conditions or requirements of the funding may appropriately be spent on the NorthSTAR Program, DSHS will allocate to the Contractor an equitable proportion of such additional funds. DSHS and Contractor will work together to determine equitable adjustments to payments, penetration rates, number of covered lives, scope of services requirements, or other programmatic adjustments commensurate with the additional funding. Programmatic adjustments made in response to the additional funding shall be effective as of the date of any increase in monthly payments.

This Contract shall be amended pursuant to §12.3 to incorporate any payment or programmatic adjustments to this Contract.

- 11.4.2 DSHS will retroactively adjust monthly premiums for seven months prior to the month for which premiums are paid to insure that premium payments reflect the most current available enrollment information. All adjustments to rates and rate categories shall be made within available funds.
- 11.4.3 If Contractor is reporting disproportionate service costs, DSHS will work with Contractor to identify and address the reasons for such disproportionate costs. The primary concerns of DSHS will be the best interest of the covered lives and the equitable distribution of funds.

11.5 Recoupment of Payments

- 11.5.1 DSHS may recoup premiums paid to Contractor in error. Error may be either human or machine error on the part of DSHS or an agent or entity under contract with DSHS.
- 11.5.2 DSHS may recoup premiums paid to Contractor if an Enrollee for whom the premium is paid moves outside the United States before the first day of the month for which the premium was paid.
- 11.5.3 DSHS may recoup premiums paid to Contractor if an Enrollee for whom premium is paid dies before the first day of the month for which premium is paid.
- 11.5.4 DSHS may recoup or adjust premiums paid to Contractor for an Enrollee if the Enrollee's eligibility status or program type is changed, corrected as a result of error, or is retroactively adjusted.
- 11.5.5 Following expiration or termination of this Contract, DSHS may recoup unexpended new generation medication funds.

ARTICLE XII GENERAL PROVISIONS

12.1 Indemnification

Contractor shall indemnify and hold harmless DSHS, the State of Texas, and their officers, employees and agents for any and all claims, costs, damages and expenses, including court costs and reasonable attorney's fees, which are related to or arise out of:

- a) Any failure, inability, or refusal of Contractor or any of its network providers or other subcontractors to provide covered services pursuant to this Contract;
- b) Claims arising from Contractor's, its network providers' or other subcontractors' negligent or intentional conduct in providing services under this Contract; and
- c) Failure, inability or refusal of Contractor to pay any of its network providers or subcontractors for covered services.

12.2 Independent Contractor

Contractor, its agents, employees, network providers and subcontractors are independent contractors, and do not perform services under this Contract as employees or agents of the State.

12.3 Amendment

12.3.1 This Contract shall be amended if amendment is required to comply with changes in state or federal laws, rules or regulations or to comply with any Contract or waiver changes mandated by CMS.

12.3.2 This Contract may be amended by DSHS and Contractor if reductions in legislative appropriations make full performance of either party impracticable or impossible and amendment could provide a reasonable alternative to termination. If Contractor does not agree to the amendment, the Contract may be terminated under §15.8.1.

12.3.3 Except for amendments to this Contract made pursuant to §11.4.1, §12.3.1 or §12.3.2, DSHS shall give Contractor the opportunity to review for 30 calendar days all Contract amendments proposed by DSHS. If the proposed amendment will have an adverse financial impact on Contractor, the Contractor may propose a reasonable and equitable adjustment to penetration rates, the number of covered lives, or the scope of services to offset such adverse financial impact, and DSHS shall respond to such proposal within 30 calendar days.

12.3.4 This Contract may be amended by mutual agreement at any time.

12.3.5 Except as provided in §12.13, all amendments to this Contract shall be in writing and signed by both parties.

12.3.6 Except as provided in §12.13, no amendment to this Contract is effective unless it is made a part of this Contract by specific reference, and is numbered sequentially by order of its adoption.

12.4 Law, Jurisdiction and Venue

Venue and jurisdiction shall be in the state and federal district courts of Travis County, Texas. The laws of the State of Texas shall be applied in all matters of state law.

12.5 Non-Waiver

Failure to enforce any provision or breach shall not be taken by either party as a waiver of the right to enforce the provision or breach in the future.

12.6 Severability

Any part of this Contract which is found to be unenforceable, invalid, void, or illegal shall be severed from the Contract. The remainder of the Contract shall be effective.

12.7 Assignment

This Contract was awarded to Contractor based on Contractor's qualifications to perform personal and professional services. This Contract may not be assigned by

Contractor without the prior written approval of DSHS. This provision does not prevent the Contractor from subcontracting duties and responsibilities to qualified subcontractors. All subcontracts that would affect the delivery of covered services to Enrollees are subject to the approval of DSHS.

12.8 Non-Exclusive Agreement

This Contract is a non-exclusive agreement. Either party may contract with other entities for similar services in the same service area.

12.9 Notices

Unless specified otherwise in this Contract, all notices, reports, plans, documents, and other information submitted to DSHS shall be addressed to:

Department of State Health Services
ATTN: NorthSTAR Contract Manager
MC 2012
PO Box 149347
Austin, TX 78714-9347

Notices to Contractor shall be addressed to:
Executive Director
ValueOptions, Inc.
1199 S. Beltline Rd., Suite 100
Coppell, Texas, 75019.

With a copy to:

Legal Counsel
ValueOptions, Inc.
240 Corporate Boulevard
Norfolk, Virginia 23502

Notices shall be delivered by any method that confirms receipt.

12.10 Survival

12.10.1 Expiration or termination of this Contract shall not affect the rights and obligations of the parties that accrued prior to the effective date of expiration or termination, and such rights and obligations shall survive and remain enforceable.

12.10.2 The provisions of this Contract relating to the obligations of Contractor to maintain records and reports shall survive the expiration or earlier termination of this Contract for a period not to exceed six years unless another period may be required by record retention policies of DSHS, the State of Texas or CMS.

12.10.3 The provisions of this Contract relating to the obligations of Contractor to safeguard information shall survive the expiration or earlier termination of this Contract in perpetuity.

12.11 Entire Agreement

All oral and written agreements between Contractor and DSHS relating to the subject matter herein that were made prior to the execution of this Contract have been reduced to writing and are contained in this Contract, by direct inclusion or incorporation by reference.

12.12 Ownership of Data

DSHS shall be and remain the sole and exclusive owner of any and all data (the "State's Data") pertaining to the operation of NorthSTAR. The State's Data includes all data entered into Contractor's MIS System, including without limitation, all Covered Lives and Enrollee information, eligibility data, claims reports, utilization reports, and any information from DSHS's present data processing and information system which shall be transferred and converted to operate on Contractor's MIS System. Neither Contractor nor any of its employees, agents, consultants, or assignees shall have any rights in any of the State's Data in any form including, but not limited to, raw data, stripped data, cumulated data, usage information, and statistical information derived from or in connection with the State's Data. The parties agree that Contractor shall promptly download and provide to DSHS, at no cost to DSHS, all State's Data in an electronically accessible form upon the termination of this Contract. Nothing in this section precludes Contractor from maintaining a copy of the data elements listed in this section. This provision shall survive the term or termination of this Contract.

12.13 Appendices

DSHS and Contractor may agree to make revisions to Appendices 13, 16, 20, and 22 by DSHS's issuance of a written notice to Contractor clearly describing the revised provisions and the effective date of the revisions. The revisions will become effective on the effective date and made a part of this Contract without execution of a contract amendment. DSHS may make revisions with 30 days' written notice. Contractor may request a revision to the claims data codes described in Appendix 22. Such request shall be made in writing and submitted to the Contract Manager.

ARTICLE XIII

DEFAULT

DSHS and Contractor shall comply with all applicable provisions of this Contract and any amendments, and shall act in good faith in the performance of these provisions. Contractor acknowledges that its failure to comply with any material provision of this Contract is a default subjecting Contractor to the remedies and sanctions described in Articles XIV and XV.

Prior to imposing remedies or sanctions under Article XIV or XV of this Contract, DSHS shall deliver to Contractor a written notice of default under this Contract. The notice may be delivered by any means that provides confirmation of receipt. The notice of default shall contain a statement of Contractor's conduct constituting a default, the contract provision defaulted, a statement of whether the Contractor will have an opportunity to cure the default, the time period for curing the default, if applicable, and the remedy or sanction DSHS will impose for Contractor's default.

The following is a non-exclusive list of actions that are defaults under this Contract.

13.1 Termination or Suspension of TDI Certificate

Termination or suspension of Contractor's TDI Certificate of Authority or any adverse action taken by TDI that DSHS determines will negatively affect Contractor's ability to provide covered services to Enrollees.

13.2 Failure to Protect Against Fiscal Insolvency

Failure of Contractor to maintain protection against fiscal insolvency as required under State or federal law, or incapacity of Contractor to meet its financial obligations as they come due.

13.3 Exclusion from Participation in Medicaid or Medicare

13.3.1 Exclusion from participation in the Medicaid and/or Medicare programs of Contractor or any of the managing employees of, or persons with an ownership interest in, Contractor whose disclosure is required by §1124(a) or §1128(a) and/or (b) of the Social Security Act.

13.3.2 Exclusion from participation in the Medicaid and/or Medicare programs of any provider or Subcontractor or any of the managing employees of, or persons with an ownership interest in, the provider or Subcontractor whose disclosure is required by §1124(a) or §1128(a) and/or (b) of the Social Security Act, if the exclusion will materially affect the Contractor's performance under this Contract.

13.4 Misrepresentation, Fraud or Abuse

13.4.1 Misrepresentation and fraud, as described in the provisions of §4.8 of this Contract.

13.4.2 Misrepresenting or falsifying information to the Secretary of Health and Human Services, CMS, DSHS or its designee, an Enrollee, potential Enrollee, or provider.

13.4.3 Engaging in fraudulent enrollment and/or marketing activities.

13.4.4 Failure to report potential or suspected fraud or abuse pursuant to §5.3 of this Contract.

13.4.5 Engaging in a fraudulent activity in connection with the enrollment in the Contractor's plan of a Medicaid eligible individual or in connection with marketing the Contractor's services to a Medicaid eligible individual.

13.4.6 Distributing marketing materials that have not been approved by DSHS.

13.5 Failure to Adjudicate or Make Payments

13.5.1 Failure to adjudicate clean claims submitted by providers within 30 days of receipt of such claims.

13.5.2 Failure to pay providers and subcontractors according to the terms of Contractor’s contract with such provider or subcontractor.

13.5.3 Engaging in actions that indicate a pattern of wrongful delays in making payment for covered services.

13.6 Failure to Provide Medically Necessary Services

13.6.1 Failure to provide medically necessary covered services.

13.6.2 Engaging in actions that indicate a pattern of wrongful denial of payment for covered services.

13.7 Failure to Submit Information or Report

Failure to submit to DSHS any data, information, or report required by this Contract.

13.8 Discrimination

Engaging in any practice that discriminates against individuals on the basis of their health status or need for covered services, including termination of enrollment or refusal to enroll or reenroll a covered life or enrollee, or any practice that could reasonably be expected to discourage enrollment by covered lives whose medical or behavioral health conditions or histories indicate a probable need for substantial future behavioral health services.

13.9 Physician Incentive Plan

Failure to comply with the physician incentive plan requirements, as set forth in 42 CFR §§422.208 and 422.210, or failure to submit Contractor’s physician incentive plans to DSHS or to HHSC upon request.

13.10 Failure to Meet DSCT

Failure to meet DSCT requirements, as described in §4.16 of this Contract.

13.11 Enrollee Co-payments

Failure to comply with §4.11 of this Contract, regarding enrollee co-payments.

ARTICLE XIV

INFORMAL REMEDIES

In addition to the sanctions and penalties described in Article XV, DSHS may respond to Contractor’s potential or actual Contract breach by taking any one or more of the following actions:

- a) Sending informal notices to providers and Enrollees;
- b) Conducting telephone and mail inquiries;
- c) Requesting Contractor to respond in writing to identified problems;
- d) Referring DSHS, HHSC, or their designees, for further investigation;
- e) Sending warning letters to Contractor; and

- f) Requiring corrective action.

ARTICLE XV SANCTIONS AND PENALTIES

DSHS may impose any one or more of the sanctions described below, as well as any one or more of the performance sanctions and penalties set forth in Appendix 4b, for Contractor's default under this Contract. If monetary sanctions are imposed, DSHS may reduce the amount of any monthly premium payments otherwise due to the Contractor by the amount of the monetary sanction.

15.1 State and Federal Damages, Penalties and Sanctions

- 15.1.1 DSHS may impose civil money penalties as authorized in 42 USC §1396u-2(e)(2)(A).
- 15.1.2 DSHS may impose civil money penalties in the amounts specified in 42 CFR §438.704, in addition to or in place of withholding payments under §15.4 of this Contract.
- 15.1.3 DSHS may impose sanctions and administrative penalties for Contractor's default under this Contract.

15.2 Suspension of New Enrollment

- 15.2.1 DSHS may suspend Contractor's new enrollment for a default under this Contract.
- 15.2.2 DSHS will give Contractor 30 days' written notice of intent to suspend the new enrollment. The suspension date shall be calculated as 30 days following the date that the notice of intent to suspend new enrollment is received by Contractor. Contractor shall be given an opportunity to cure the default during the 30-day notice period if DSHS determines in its sole discretion that a cure is possible and the right to cure is expressly authorized in the notice letter.
- 15.2.3 The suspension of new enrollment may be for any duration up to the termination date of the Contract. DSHS will impose a duration of suspension that is reasonably proportionate to the type and severity of the default and the Contractor's ability to cure the default.

15.3 State-Initiated Disenrollment

- 15.3.1 DSHS may initiate disenrollment of an Enrollee or reduce the total number of Contractor's Enrollees through disenrollment if Contractor fails to provide medically necessary covered services to an Enrollee or if DSHS determines that Contractor has a pattern or practice of failing to provide medically necessary covered services to Enrollees.
- 15.3.2 DSHS will give Contractor 30 days' written notice of intent to disenroll an Enrollee or reduce the total number of Contractor's Enrollees through disenrollment. The disenrollment date will be calculated as 30 days following the date that the notice of intent to disenroll is received by Contractor. Contractor shall be given an opportunity to cure the default during the 30-day notice period if DSHS determines in its sole discretion

that a cure is possible and the right to cure is expressly authorized in the notice letter.

15.3.3 DSHS may continue to disenroll Contractor's Enrollees until Contractor demonstrates that it will provide covered services as required under this Contract.

15.4 Withholding Payments

15.4.1 DSHS may withhold payments to Contractor until any defaults are cured. The payments withheld will be sufficient to compensate DSHS for the level of effort necessary to resolve the default.

15.4.2 If DSHS has provided or paid for a requested service pending an appeal, including a request for a Fair Hearing, and the determination is adverse to the Contractor, DSHS will withhold the entire amount DSHS paid for the service.

15.5 Liquidated Damages

DSHS may assess liquidated money damages against Contractor for default under this Contract, in addition to other remedies and sanctions provided herein. The liquidated damages referred to in this section are not intended to be penalties but are intended to be reasonable estimates of DSHS's financial loss and damage resulting from Contractor's default. Liquidated damages shall be forfeited by Contractor and will not be subsequently paid to Contractor upon compliance or cure of default.

15.6 Forfeiture of Performance Bond

DSHS may require forfeiture of all or a portion of the face amount of the performance bond required in §4.3 if DSHS determines that a serious event of default has occurred. DSHS will notify Contractor prior to forfeiture of the performance bond. Partial payment of the face amount shall reduce the total bond amount available pro rata consistent with the cost to DSHS to resolve the event of default.

15.7 Temporary Management

Contractor is subject to temporary management by DSHS if DSHS determines that Contractor's performance under this Contract has been chronically substandard. DSHS will provide such temporary management consistent with federal requirements. DSHS shall give Contractor 60 days' written notice prior to imposing temporary management. For purposes of this section, "chronically substandard" shall mean Contractor's repeated failure to perform its responsibilities and obligations under this Contract, which failures have not been corrected by Contractor or cured by the imposition of other sanctions specified in this Article.

15.8 Termination

15.8.1 DSHS may terminate this Contract if:

- a) Contractor defaults under the provisions of Article XIII;

- b) Federal or state funds are no longer available;
- c) DSHS determines that Contractor has placed the health or welfare of enrollees in jeopardy; or
- d) CMS does not approve any waiver or waiver amendment required by CMS, this Contract, or any Contract amendments.

15.8.2 DSHS will give Contractor 90 days written notice of DSHS's intent to terminate this Contract if termination is pursuant to §15.8.1(a). If the reason for termination is covered by §15.8.1(b), (c) or (d), DSHS will give Contractor reasonable written notice under the circumstances. Notice of termination pursuant to §15.8.1(b) shall be subject to the additional notice requirements set forth in §11.6.1, and DSHS will notify Contractor in writing within five business days of DSHS's receipt of actual notice that federal or state funds are not available to fund the Contract.

DSHS may give notice by any means that verifies receipt. The termination date will be calculated from the date that Contractor receives the notice of intent to terminate.

15.8.3 Contractor is entitled to a hearing prior to termination of this Contract pursuant to §15.8.1(a) or (c) of this Contract.

ARTICLE XVI TERM

16.1 Term

16.1.1 This Contract's effective date is September 1, 2009, and its expiration date is August 31, 2011, unless terminated earlier as provided elsewhere in this Contract.

16.1.2 This Contract may be terminated at any time and without cause by either party, upon at least ninety (90) days prior written notice by DSHS and at least one hundred and eighty (180) days prior written notice by Contractor. If notice is given by Contractor, then Contractor shall be at full financial risk for the first 30 days, and for the remaining 150 days of the term the Contractor shall not be at financial risk and shall be compensated on an administrative services only (ASO) rate equivalent to 10% of the budgeted amount set forth in Appendix 30.

ARTICLE XVII DUTIES OF PARTIES UPON TERMINATION OF CONTRACT

17.1 General Duties

When notification of termination of this Contract occurs, the parties shall meet the following obligations:

- a) Contractor will notify all Enrollees of the date of termination or expiration of the Contract and how Enrollees can continue to receive covered services;
- b) If the Contract is terminated pursuant to §15.8.1(a) or (c) or §16.1.4, Contractor shall pay all expenses related to giving notice to Enrollees and implementing the transition plan described in §17.2; and

- c) Contractor shall prepare a transition plan meeting the requirements described in §17.2, which plan shall be acceptable to and approved by DSHS

17.2 Transition Plan

- 17.2.1 Contractor shall develop a transition plan in the event of termination by either party. Contractor shall implement the transition plan, once approved by DSHS, during the 180-day period commencing on the date of receipt of the notice of termination of the Contract. The parties' responsibilities described in the transition plan will survive the expiration of the Contract if it expires prior to the end date of the DSHS approved transition plan.
- 17.2.2 The transition plan shall ensure that Enrollees are transitioned appropriately to another entity designated by DSHS without interruption of enrollees' services. The transition plan shall outline timeframes for critical activities related to transition and outline duties performed by key personnel.
- 17.2.3 The transition plan shall require that Contractor maintain staff reasonably sufficient to perform its responsibilities under this Contract and the transition plan.
- 17.2.4 Contractor shall transfer all data regarding the provision of covered services to enrollees to DSHS or a new BHO, at the sole discretion of DSHS and as directed by DSHS. All transferred data must be compliant with HIPAA. All relevant data must be received and verified by DSHS or the new BHO. If DSHS determines that not all of the data regarding the provision of covered services to enrollees was transferred to DSHS or to the new BHO, as required, or the data is not HIPAA compliant, DSHS reserves the right to hire an independent contractor to assist DSHS in obtaining and transferring all the required data and to ensure that all the data is HIPAA compliant. Contractor shall pay the reasonable costs incurred by DSHS in obtaining these services.
- 17.2.5 Contractor shall provide DSHS with copies of all relevant enrollee and service data, documentation, including correspondence, documentation of ongoing outstanding issues, other operations support documentation, and other pertinent information necessary, as determined by DSHS, for DSHS or a new BHO to assume the operational activities successfully.
- 17.2.6 The transition plan shall describe Contractor's method and schedule for transfer of all data and operational-support information, including the information identified in §§17.2.4 and 17.2.5 of this Contract. This information shall be supplied in the media and format specified by DSHS and according to the schedule approved by DSHS.
- 17.2.7 Contractor shall submit to DSHS any reports reasonably determined by DSHS to be necessary for a successful transition without interruption of enrollee services, including a transition plan results report submitted no later than 30 days after completion of the transition, documenting the completion and results of implementation of the transition plan.