

## **Request for Comment on Managed Care Rules Due by January 29, 2016**

HHSC proposes new and amended rules in Chapter 353, Medicaid Managed Care, as a result of laws passed during the 84<sup>th</sup> Texas Legislative Session. Additionally, HHSC proposes added definitions to §353.2 to clarify terms used in this chapter of rule. HHSC also proposes to amend §370.303, concerning CHIP Completion of Enrollment. These rules would be effective in September 2016 and are attached for your review.

HHSC invites all Medicaid and CHIP MCOs to provide comments by close of business on January 29, 2016 to Amanda Woodall via email at [Amanda.woodall@hhsc.state.tx.us](mailto:Amanda.woodall@hhsc.state.tx.us).

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### TITLE 1 ADMINISTRATION

#### PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION

#### CHAPTER 353 MEDICAID MANAGED CARE

#### SUBCHAPTER A GENERAL PROVISIONS

#### RULE §353.2 Definitions

The following words and terms, when used in this chapter, have the following meanings, unless the content clearly indicates otherwise.

(1) Action--

(A) An action is defined as:

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

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

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

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

(v) the failure of a managed care organization (MCO) to act within the timeframes set forth by the Health and Human Services Commission (HHSC) and state and federal law; or

(vi) for a resident of a rural area with only one MCO, the denial of a member's request to obtain services outside the network.

(B) "Action" does not include expiration of a time-limited service.

(2) Acute care--Preventive care, primary care, and other medical or behavioral health care provided by the provider or under the direction of a provider for a condition having a relatively short duration.

(3) Acute care hospital--A hospital that provides acute care services.

(4) Agreement or Contract--The formal, written, and legally enforceable contract and amendments thereto between HHSC and an MCO.

(5) Allowable revenue--All managed care revenue received by the MCO pursuant to the contract during the contract period, including retroactive adjustments made by HHSC. This would include any revenue earned on Medicaid managed care funds such as investment income, earned interest, or third party administrator earnings from services to delegated networks.

(6) Appeal--The formal process by which a member or his or her representative requests a review of the MCO's action.

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(7) Applicant Provider--A physician or other health care provider applying for expedited credentialing as defined in Texas Government Code §533.0064.

(8) [(7)] Behavioral health service--A covered service for the treatment of mental, emotional, or substance use disorders.

- (9) [(8)] Capitated service--A benefit available to members under the Texas Medicaid program for which an MCO is responsible for payment.
- (10) [(9)] Capitation rate--A fixed predetermined fee paid by HHSC to the MCO each month, in accordance with the contract, for each enrolled member in exchange for which the MCO arranges for or provides a defined set of covered services to the member, regardless of the amount of covered services used by the enrolled member.
- (11) [(10)] Children's Medicaid Dental Services--The dental services provided through a dental MCO to a client birth through age 20.
- (12) [(11)] Clean claim--A claim submitted by a physician or provider for health care services rendered to a member, with the data necessary for the MCO or subcontracted claims processor to adjudicate and accurately report the claim. A clean claim must meet all requirements for accurate and complete data as further defined under the terms of the contract executed between the MCO and HHSC.
- (13) [(12)] Client--Any Medicaid-eligible recipient.
- (14) [(13)] CMS--The Centers for Medicare and Medicaid Services, which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid.
- (15) [(14)] Complainant--A member, or a treating provider or other individual designated to act on behalf of the member, who files a complaint.
- (16) [(15)] Complaint--Any dissatisfaction expressed by a complainant, orally or in writing, to the MCO about any matter related to the MCO other than an action. Subjects for complaints may include:
- (A) the quality of care of services provided;
  - (B) aspects of interpersonal relationships such as rudeness of a provider or employee; and
  - (C) failure to respect the member's rights.
- (17) [(16)] Covered services--Unless a service or item is specifically excluded under the terms of the state plan, a federal waiver, a managed care services contract, or an amendment to any of these, the phrase "covered services" means all health care or dental services or items that
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- the MCO must arrange to provide and pay for on a member's behalf under the terms of the contract executed between the MCO and HHSC, including:
- (A) all services or items comprising "medical assistance" as defined in §32.003 of the Human Resources Code; and
  - (B) all value-added services under such contract.
- (18) Credentialing--The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a Medicaid enrolled health care provider to determine eligibility to deliver covered services.
- (19) [(17)] Cultural competency--The ability of individuals and systems to provide services effectively to people of various cultures, races, ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves their dignity.
- (20) [(18)] Day--A calendar day, unless specified otherwise.
- (21) [(19)] Default enrollment--The process established by HHSC to assign a Medicaid managed care enrollee to an MCO when the enrollee has not selected an MCO.
- (22) [(20)] Dental managed care organization (dental MCO)--A dental indemnity(22) [(20)] Dental managed care organization (dental MCO)--A dental indemnity insurance provider or dental health maintenance organization licensed or approved by the Texas Department of Insurance.

- (23) [(21)] Dental contractor--A dental MCO that is under contract with HHSC for the delivery of dental services.
- (24) [(22)] Dental home--A provider who has contracted with a dental MCO to serve as a dental home to a member and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as dental homes are federally qualified health centers and individuals who are general dentists or pediatric dentists.
- (25) [(23)] Dental service--The routine preventive, diagnostic, urgent, therapeutic, initial, and primary care provided to a member and included within the scope of HHSC's agreement with a dental contractor. For purposes of this chapter, "dental service" does not include dental devices for craniofacial anomalies; treatment rendered in a hospital, urgent care center, or ambulatory surgical center setting for craniofacial anomalies; or emergency services provided in a hospital, urgent care center, or ambulatory surgical center setting involving dental trauma. These types of services are treated as health care services in this chapter.
- (26) [(24)] Disability--A physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, socializing, or working.
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- (27) [(25)] Disproportionate Share Hospital (DSH)--A hospital that serves a higher than average number of Medicaid and other low-income patients and receives additional reimbursement from the State.
- (28) [(26)] Dual eligible--A Medicaid recipient who is also eligible for Medicare.
- (29) [(27)] Elective enrollment--Selection of a primary care provider (PCP) and MCO by a client during the enrollment period established by HHSC.
- (30) [(28)] Emergency behavioral health condition--Any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine:
- (A) requires immediate intervention and/or medical attention without which the client would present an immediate danger to themselves or others; or
  - (B) renders the client incapable of controlling, knowing, or understanding the consequences of his or her actions.
- (31) [(29)] Emergency medical condition--A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care to result in:
- (A) placing the patient's health in serious jeopardy;
  - (B) serious impairment to bodily functions;
  - (C) serious dysfunction of any bodily organ or part;
  - (D) serious disfigurement; or
  - (E) serious jeopardy to the health of a pregnant woman or her unborn child.
- (32) [(30)] Emergency service--A covered inpatient and outpatient service, furnished by a network provider or out-of-network provider that is qualified to furnish such service, that is needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition. For health care MCOs, the term "emergency service" includes post-stabilization care services.
- (33) [(31)] Encounter--A covered service or group of covered services delivered by a

provider to a member during a visit between the member and provider. This also includes value-added services.

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(34) [(32)] Enrollment--The process by which an individual determined to be eligible for Medicaid is enrolled in a Medicaid MCO serving the service area in which the individual resides.

(35) Expedited Credentialing--The process under Government Code §533.0064 in which an MCO allows an applicant provider to provide Medicaid services to members on a provisional basis.

(36) [(33)] EPSDT--The federally mandated Early and Periodic Screening, Diagnosis and Treatment program defined in 25 TAC Chapter 33. The State of Texas has adopted the name Texas Health Steps (THSteps) for its EPSDT program.

(37) [(34)] EPSDT-CCP--The Early and Periodic Screening, Diagnosis and Treatment-Comprehensive Care Program described in Chapter 363 of this title (relating to Texas Health Steps Comprehensive Care Program).

(38) [(35)] Exclusive provider benefit plan (EPBP)--An MCO that complies with 28 TAC §§3.9201 - 3.9212, relating to the Texas Department of Insurance's requirements for EPBPs, and contracts with HHSC to provide Medicaid coverage.

(39) [(36)] Experience rebate--The portion of the MCO's net income before taxes that is returned to the State in accordance with the MCO's contract with HHSC.

(40) [(37)] Fair hearing--The process adopted and implemented by HHSC in Chapter 357, Subchapter A of this title (relating to Uniform Fair Hearing Rules) in compliance with federal regulations and state rules relating to Medicaid fair hearings.

(41) [(38)] Federally Qualified Health Center (FQHC)--An entity that is certified by CMS to meet the requirements of 42 U.S.C. §1395x(aa)(3) as a Federally Qualified Health Center and is enrolled as a provider in the Texas Medicaid program.

(42) [(39)] Federal Poverty Level (FPL)--The household income guidelines issued annually and published in the *Federal Register* by the United States Department of Health and Human Services under the authority of 42 U.S.C. §9902(2) and as in effect for the applicable budget period determined in accordance with 42 C.F.R. §435.603(h). HHSC uses the FPL to determine an individual's eligibility for Medicaid.

(43) [(40)] Federal waiver--Any waiver permitted under federal law and approved by CMS that allows states to implement Medicaid managed care.

(44) [(41)] Former Foster Care Children (FFCC) program--The Medicaid program for young adults who aged out of the conservatorship of Texas Department of Family and Protective Services (DFPS), administered in accordance with Chapter 366, Subchapter J of this title (relating to Former Foster Care Children's Program).

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(45) [(42)] Functional necessity--A member's need for services and supports with activities of daily living or instrumental activities of daily living to be healthy and safe in the most integrated setting possible. This determination is based on the results of a functional assessment.

(46) [(43)] Health care managed care organization (health care MCO)--An entity that is licensed or approved by the Texas Department of Insurance to operate as a health maintenance organization or to issue an EPBP.

(47) Health care provider group – a group of providers providing health care items or services certified or licensed in Texas under the auspices of a legal entity, such as a partnership, corporation, limited liability company, or professional association with at least one enrolling

performing provider.

(48 ) [(44)] Health care services--The acute care, behavioral health care, and health-related services that an enrolled population might reasonably require in order to be maintained in good health, including, at a minimum, emergency services and inpatient and outpatient services.

(49 ) [(45)] Health and Human Services Commission (HHSC)--The single state agency charged with administration and oversight of the Texas Medicaid program or its designee.

(50 ) [(46)] Health maintenance organization (HMO)--An organization that holds a certificate of authority from the Texas Department of Insurance to operate as an HMO under Chapter 843 of the Texas Insurance Code, or a certified Approved Non-Profit Health Corporation formed in compliance with Chapter 844 of the Texas Insurance Code.

(51) [(47)] Hospital--A licensed public or private institution as defined in the Texas Health and Safety Code at Chapter 241, relating to hospitals, or Chapter 261, relating to municipal hospitals.

(52) [(48)] Intermediate care facility for individuals with an intellectual disability or related condition (ICF-IID)--A facility providing care and services to individuals with intellectual disabilities or related conditions as defined in §1905(d) of the Social Security Act (42 U.S.C. 1396(d)).

(53) [(49)] Long term service and support (LTSS)--A service provided to a qualified member in his or her home or other community-based settings necessary to provide assistance with activities of daily living to allow the member to remain in the most integrated setting possible. LTSS includes services provided to all SSI recipients under the Texas State Plan as well as services available only to persons who qualify for STAR+PLUS Home and Community-Based Waiver Services.

(54) [(50)] Main dental home provider--See definition of "dental home" in this section.

(55) [(51)] Main dentist--See definition of "dental home" in this section.

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(56) [(52)] Managed care--A health care delivery system or dental services delivery system in which the overall care of a patient is coordinated by or through a single provider or organization.

(57) [(53)] Managed care organization (MCO)--A dental MCO or a health care MCO.

(58) [(54)] Marketing--Any communication from an MCO to a client who is not enrolled with the MCO that can reasonably be interpreted as intended to influence the client's decision to enroll, not to enroll, or to disenroll from a particular MCO.

(59) [(55)] Marketing materials--Materials that are produced in any medium by or on behalf of the MCO that can reasonably be interpreted as intending to market to potential members. Materials relating to the prevention, diagnosis or treatment of a medical or dental condition are not marketing materials.

(60) [(56)] Medicaid--The medical assistance program authorized and funded pursuant to Title XIX of the Social Security Act (42 U.S.C. §1396 et seq) and administered by HHSC.

(61) [(57)] Medical Assistance Only (MAO)--A person who qualifies financially and functionally for Medicaid assistance but does not receive Supplemental Security Income (SSI) benefits.

(62) [(58)] Medicaid for transitioning foster care youth (MTFCY) program--The Medicaid program for young adults who aged out of the conservatorship of Texas Department of Family and Protective Services (DFPS), administered in accordance with Chapter 366, Subchapter F of this title (relating to Medicaid for Transitioning Foster Care Youth).

(63) [(59)] Medical home--A PCP or specialty care provider who has accepted the

responsibility for providing accessible, continuous, comprehensive, and coordinated care to members participating in an MCO contracted with HHSC.

(64) [(60)] Medically necessary--

(A) For Medicaid members birth through age 20, the following Texas Health Steps services:

(i) screening, vision, dental, and hearing services; and

(ii) other health care services or dental services that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:

(I) must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid managed care program as a whole; and  
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(II) may include consideration of other relevant factors, such as the criteria described in subparagraphs (B)(ii) - (vii) and (C)(ii) - (vii) of this paragraph.

(B) For Medicaid members over age 20, non-behavioral health services that are:

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

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

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

(iv) consistent with the member's diagnoses;

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

(vi) not experimental or investigative; and

(vii) not primarily for the convenience of the member or provider.

(C) For Medicaid members over age 20, behavioral health services that:

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

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

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

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

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

(vi) are not experimental or investigative; and

(vii) are not primarily for the convenience of the member or provider.

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(65) [(61)] Member--A person who is eligible for benefits under Title XIX of the Social Security Act and Medicaid, is in a Medicaid eligibility category included in the Medicaid managed care program, and is enrolled in a Medicaid MCO.

(66) [(62)] Member education program--A planned program of education:

(A) concerning access to health care services or dental services through the MCO and

about specific health or dental topics;

(B) that is approved by HHSC; and

(C) that is provided to members through a variety of mechanisms that must include, at a minimum, written materials and face-to-face or audiovisual communications.

(67) [(63)] Member materials--All written materials produced or authorized by the MCO and distributed to members or potential members containing information concerning the managed care program. Member materials include member ID cards, member handbooks, provider directories, and marketing materials.

(68) [(64)] Non-capitated service--A benefit available to members under the Texas Medicaid program for which an MCO is not responsible for payment.

(69) Nursing Facility Add-on Services--Services that are provided in a nursing facility setting but are not included in the Nursing Facility Unit Rate, including emergency dental services, physician-ordered rehabilitative services, customized power wheel chairs, and augmentative communication devices.

(70) Nursing Facility Unit Rate--Services included in the Texas Department of Aging and Disability Services, or its successor agency, daily rate for nursing facility providers. These services include room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The nursing facility unit rate also includes applicable nursing facility rate enhancements and professional and general liability insurance. The nursing facility unit rate excludes nursing facility add-on services.

(71) [(65)] Outside regular business hours--As applied to FQHCs and rural health clinics (RHCs), means before 8 a.m. and after 5 p.m. Monday through Friday, weekends, and federal holidays.

(72) [(66)] Participating MCO--An MCO that has a contract with HHSC to provide services to members.

(73) [(67)] Post-stabilization care service--A covered service, related to an emergency medical condition, that is provided after a Medicaid member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. §438.114(b) and (e) and 42 C.F.R. §422.113(c)(iii) to improve or resolve the Medicaid member's condition.

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(74) [(68)] Primary care provider (PCP)--A physician or other provider who has agreed with the health care MCO to provide a medical home to members and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

(75) [(69)] Provider--A credentialed and licensed individual, facility, agency, institution, organization, or other entity, and its employees and subcontractors, that have a contract with the MCO for the delivery of covered services to the MCO's members.

(76) [(70)] Provider education program--Program of education about the Medicaid managed care program and about specific health or dental care issues presented by the MCO to its providers through written materials and training events.

(77) [(71)] Provider network or Network--All providers that have contracted with the MCO for the applicable managed care program.

(78) [(72)] Quality improvement--A system to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

(79) [(73)] Rural Health Clinic (RHC)--An entity that meets all of the requirements for designation as a rural health clinic under §1861(aa)(1) of the Social Security Act (42 U.S.C. §1395x(aa)(1)) and is approved for participation in the Texas Medicaid program.

(80) [(74)] Service area--The counties included in any HHSC-defined service area as applicable to each MCO.

(81) [(75)] Significant traditional provider (STP)--A provider identified by HHSC as having provided a significant level of care to the target population, including a DSH.

(82) [(76)] STAR--The State of Texas Access Reform (STAR) managed care program that operates under a federal waiver and primarily provides, arranges for, and coordinates preventive, primary, acute care, and pharmacy services for low-income families, children, and pregnant women.

(83) [(77)] STAR Health--The managed care program that operates under the Medicaid state plan and primarily serves:

(A) children and youth in Texas Department of Family and Protective Services (DFPS) conservatorship;

(B) young adults who voluntarily agree to continue in a foster care placement (if the state as conservator elects to place the child in managed care); and

(C) young adults who are eligible for Medicaid as a result of their former foster care status through the month of their 21st birthday.

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(84) [(78)] STAR+PLUS--The managed care program that operates under a federal waiver and primarily provides, arranges, and coordinates preventive, primary, acute care, and long-term services and supports to persons with disabilities and elderly persons age 65 and over who qualify for Medicaid by virtue of their SSI or MAO status.

(85) [(79)] STAR+PLUS Home and Community-Based Services Waiver--The program that provides person-centered care services that are delivered in the home or in a community setting, as authorized through a federal waiver under §1115 of the Social Security Act, to qualified clients who are 65 years of age or older, are blind, or have a disability as cost-effective alternatives to institutional care in nursing facilities.

(86) [(80)] State plan--The agreement between the CMS and HHSC regarding the operation of the Texas Medicaid program, in accordance with the requirements of Title XIX of the Social Security Act.

(87) [(81)] Supplemental Security Income (SSI)--The federal cash assistance program of direct financial payments to people who are 65 years of age or older, are blind, or have a disability administered by the Social Security Administration (SSA) under Title XVI of the Social Security Act. All persons who are certified as eligible for SSI in Texas are eligible for Medicaid. Local SSA claims representatives make SSI eligibility determinations. The transactions are forwarded to the SSA in Baltimore, which then notifies the states through the State Data Exchange (SDX).

(88) [(82)] Texas Health Steps (THSteps)--The name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, described at 42 U.S.C. §1396d(r) and 42 CFR §440.40 and §§441.40 - 441.62.

(89) [(83)] Value-added service--A service provided by an MCO that is not "medical assistance," as defined by §32.003 of the Texas Human Resources Code.

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#### RULE §353.4 Managed Care Organization Requirements Concerning Out-of-Network Providers

(a) Network adequacy. HHSC is the state agency responsible for overseeing and monitoring the Medicaid managed care program. Each MCO participating in the Medicaid managed care program must offer a network of providers that is sufficient to meet the needs of the Medicaid

population who are MCO members. HHSC monitors MCO members' access to an adequate provider network through reports from the MCOs and complaints received from providers and members. Certain reporting requirements are discussed in subsection (e) of this section.

(b) MCO requirements concerning coverage for treatment of members by out-of-network providers for non-emergency services.

(1) Nursing facility services. A health care MCO must reimburse an out-of-network nursing facility for medically necessary services using the reasonable reimbursement methodology in subsection (d) of this section. Nursing facility add-on services are considered "other authorized services" under paragraph (2) of this subsection.

(2) Other authorized services. The MCO must allow referral of its member(s) to an out-of-network

provider, must timely issue the proper authorization for such referral, and must timely reimburse the out-of-network provider for authorized services provided if the criteria in this paragraph are met. If all of the following criteria are not met, an out-of-network provider is not entitled to Medicaid reimbursement for non-emergency services:

(A) Medicaid covered services are medically necessary and these services are not available through an in-network provider;

(B) a participating provider currently providing authorized services to the member requests authorization for such services to be provided to the member by an out-of-network provider; and

(C) the authorized services are provided within the time period specified in the MCO's authorization. If the services are not provided within the required time period, a new request for referral from the requesting provider must be submitted to the MCO prior to the provision of services.

(3) School-based telemedicine services. The health care MCO must reimburse an out-of-network distant site physician providing school-based telemedicine without prior authorization, even if the physician is not the member's PCP, using the reasonable reimbursement methodology in subsection (d) of this section if the following conditions are met:

(A) the physician is enrolled as a provider in the Texas Medicaid program;

(B) the service is provided in a primary or secondary school-based setting to a member who is a child;

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(C) the parent or legal guardian of the member provides consent before the service is provided; and

(D) a health professional as defined by Government Code 531.0217(a)(1) is present with the member during the treatment

(c) MCO requirements concerning coverage for treatment of members by out-of-network providers for emergency services.

(1) An MCO may not refuse to reimburse an out-of-network provider for medically necessary emergency services.

(2) Health care MCO requirements concerning emergency services.

(A) A health care MCO may not refuse to reimburse an out-of-network provider for poststabilization

care services provided as a result of the MCO's failure to authorize a timely transfer of a member.

(B) A health care MCO must allow its members to be treated by any emergency services provider for emergency services, and services to determine if an emergency condition exists. The

health care MCO must pay for such services.

(C) A health care MCO must reimburse for transport provided by an ambulance provider for a Medicaid recipient whose condition meets the definition of an emergency medical condition. Facility-to-facility transports are considered emergencies if the required treatment for the emergency medical condition, as defined in §353.2 of this subchapter (relating to Definitions), is not available at the first facility and the MCO has not included payment for such transports in the hospital reimbursement.

(D) A health care MCO is prohibited from requiring an authorization for emergency services or for services to determine if an emergency condition exists.

(3) Dental MCO requirements concerning emergency services.

(A) A dental MCO must allow its members to be treated for covered emergency services that are provided outside of a hospital or ambulatory surgical center setting, and for covered services provided outside of such settings to determine if an emergency condition exists. The dental MCO must pay for such services.

(B) A dental MCO is prohibited from requiring an authorization for the services described in subparagraph (A) of this paragraph.

(C) A dental MCO is not responsible for payment of non-capitated emergency services and post-stabilization care provided in a hospital or ambulatory surgical center setting, or devices for craniofacial anomalies. A dental MCO is not responsible for hospital and physician services, anesthesia, drugs related to treatment, and post-stabilization care for:

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(i) a dislocated jaw, traumatic damage to a tooth, and removal of a cyst;

(ii) an oral abscess of tooth or gum origin; and

(iii) craniofacial anomalies.

(D) The services and benefits described in subparagraph (C) of this paragraph are reimbursed:

(i) by a health care MCO, if the member is enrolled in a managed care program; or

(ii) by HHSC's claims administrator, if the member is not enrolled in a managed care program.

(4) An MCO may be required by contract with HHSC to allow members to obtain services from out-of-network providers in circumstances other than those described in subsections (b) - (c) of this section.

(d) Reasonable reimbursement methodology.

(1) Out-of-network nursing facilities.

[(A)] Out-of-network nursing facilities must be reimbursed at:

(A) [(i)] at or above ninety-five percent of the nursing facility unit rate established by HHSC for the date of services for services provided inside of the MCO's service area; and

(B) [(ii)] at or above one hundred percent of the nursing facility unit rate for the date of services for services provided outside of the MCO's service area.

[(B) The nursing facility unit rate refers to the services included in the Texas Department of Aging and Disability Services daily rate for nursing facility providers, such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The nursing facility unit rate also includes professional and general liability insurance and applicable nursing facility rate enhancements. The nursing facility unit rate excludes nursing facility add-on services.]

(2) Emergency and authorized services performed by out-of-network providers.

(A) Except as provided in §353.913 of this chapter (relating to Managed Care

Organization Requirements Concerning Out-of-Network Outpatient Pharmacy Services) or subsection (h)(2) of this section, the MCO must reimburse an out-of-network, in-area service provider the Medicaid FFS rate in effect on the date of service less five percent, unless the parties agree to a different reimbursement amount.

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(B) Except as provided in §353.913 of this chapter, an MCO must reimburse an out-of-network, out-of-area service provider at 100 percent of the Medicaid FFS rate in effect on the date of service, unless the parties agree to a different reimbursement amount until the MCO arranges for the timely transfer of the member, as determined by the member's attending physician, to a provider in the MCO's network.

(3) For purposes of this subsection, the Medicaid FFS rates are defined as those rates for providers of services in the Texas Medicaid program for which reimbursement methodologies are specified in Chapter 355 of this title (relating to Reimbursement Rates), exclusive of the rates(e) Reporting requirements.

(1) Each MCO that contracts with HHSC to provide health care services or dental services to members in a service area must submit quarterly information in its Out-of-Network quarterly report to HHSC.

(2) Each report submitted by an MCO must contain information about members enrolled in each HHSC Medicaid managed care program provided by the MCO. The report must include the following information:

(A) the types of services provided by out-of-network providers for the MCO's members;

(B) the scope of services provided by out-of-network providers to the MCO's members;

(C) for a health care MCO, the total number of hospital admissions, as well as the number of admissions that occur at each out-of-network hospital. Each out-of-network hospital must be identified;

(D) for a health care MCO, the total number of emergency room visits, as well as the total number of emergency room visits that occur at each out-of-network hospital. Each out-of-network

hospital must be identified;

(E) total dollars for paid claims by MCOs, other than those described in subparagraphs

(C) and (D) of this paragraph, as well as total dollars billed by out-of-network providers for other services; and

(F) any additional information required by HHSC.

(3) HHSC determines the specific form of the report described in this subsection and includes the report form as part of the Medicaid managed care contract between HHSC and the MCOs.

(f) Utilization.

(1) Upon review of the reports described in subsection (e) of this section that are submitted to HHSC by the MCOs, HHSC may determine that an MCO exceeded maximum out-of-network

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usage standards set by HHSC for out-of-network access to health care services and dental services during the reporting period.

(2) Out-of-network usage standards.

(A) Inpatient admissions: No more than 15 percent of a health care MCO's total hospital admissions, by service area, may occur in out-of-network facilities.

(B) Emergency room visits: No more than 20 percent of a health care MCO's total emergency room visits, by service area, may occur in out-of-network facilities.

(C) Other services: For services that are not included in subparagraph (A) or (B) of this

paragraph, no more than 20 percent of total dollars for paid claims by the MCO for services provided may be provided by out-of-network providers.

(3) Special considerations in calculating a health care MCO's out-of-network usage of inpatient admissions and emergency room visits.

(A) In the event that a health care MCO exceeds the maximum out-of-network usage standard set by HHSC for inpatient admissions or emergency room visits, HHSC may modify the calculation of that health care MCO's out-of-network usage for that standard if:

(i) the admissions or visits to a single out-of-network facility account for 25 percent or more of the health care MCO's admissions or visits in a reporting period; and

(ii) HHSC determines that the health care MCO has made all reasonable efforts to contract with that out-of-network facility as a network provider without success.

(B) In determining whether the health care MCO has made all reasonable efforts to contract with the single out-of-network facility described in subparagraph (A) of this paragraph, HHSC considers at least the following information:

(i) how long the health care MCO has been trying to negotiate a contract with the out-of-network facility;

(ii) the in-network payment rates the health care MCO has offered to the out-of-network facility;

(iii) the other, non-financial contractual terms the health care MCO has offered to the out-of-network facility, particularly those relating to prior authorization and other utilization management policies and procedures;

(iv) the health care MCO's history with respect to claims payment timeliness, overturned claims denials, and provider complaints;

(v) the health care MCO's solvency status; and

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(vi) the out-of-network facility's reasons for not contracting with the health care MCO.

(C) If the conditions described in subparagraph (A) of this paragraph are met, HHSC may modify the calculation of the health care MCO's out-of-network usage for the relevant reporting period and standard by excluding from the calculation the inpatient admissions or emergency room visits to that single out-of-network facility.

(g) Provider complaints.

(1) HHSC accepts provider complaints regarding reimbursement for or overuse of out-of-network providers and conducts investigations into any such complaints.

(2) When a provider files a complaint regarding out-of-network payment, HHSC requires the relevant MCO to submit data to support its position on the adequacy of the payment to the provider. The data includes a copy of the claim for services rendered and an explanation of the amount paid and of any amounts denied.

(3) Not later than the 60th day after HHSC receives a provider complaint, HHSC notifies the provider who initiated the complaint of the conclusions of HHSC's investigation regarding the complaint. The notification to the complaining provider includes:

(A) a description of the corrective actions, if any, required of the MCO in order to resolve the complaint; and

(B) if applicable, a conclusion regarding the amount of reimbursement owed to an out-of-network provider.

(4) If HHSC determines through investigation that an MCO did not reimburse an out-of-network provider based on a reasonable reimbursement methodology as described in subsection

(d) of this section, HHSC initiates a corrective action plan. Refer to subsection (h) of this section for information about the contents of the corrective action plan.

(5) If, after an investigation, HHSC determines that additional reimbursement is owed to an out-of-network provider, the MCO must:

(A) pay the additional reimbursement owed to the out-of-network provider within 90 days from the date the complaint was received by HHSC or 30 days from the date the clean claim, or information required that makes the claim clean, is received by the MCO, whichever comes first; or

(B) submit a reimbursement payment plan to the out-of-network provider within 90 days from the date the complaint was received by HHSC. The reimbursement payment plan provided by the MCO must provide for the entire amount of the additional reimbursement to be paid within 120 days from the date the complaint was received by HHSC.

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(6) If the MCO does not pay the entire amount of the additional reimbursement within 90 days from the date the complaint was received by HHSC, HHSC may require the MCO to pay interest on the unpaid amount. If required by HHSC, interest accrues at a rate of 18 percent simple interest per year on the unpaid amount from the 90th day after the date the complaint was received by HHSC, until the date the entire amount of the additional reimbursement is paid.

(7) HHSC pursues any appropriate remedy authorized in the contract between the MCO and HHSC if the MCO fails to comply with a corrective action plan under subsection (h) of this section.

(h) Corrective action plan.

(1) HHSC requires a corrective action plan in the following situations:

(A) the MCO exceeds a maximum standard established by HHSC for out-of-network access to health care services and dental services described in subsection (f) of this section; or

(B) the MCO does not reimburse an out-of-network provider based on a reasonable reimbursement methodology as described in subsection (d) of this section.

(2) A corrective action plan imposed by HHSC requires one of the following:

(A) reimbursements by the MCO to out-of-network providers at rates that equal the allowable rates for the health care services as determined under §32.028 and §32.0281, Texas Human Resources Code, for all health care services provided during the period:

(i) the MCO is not in compliance with a utilization standard established by HHSC; or

(ii) the MCO is not reimbursing out-of-network providers based on a reasonable reimbursement methodology, as described in subsection (d) of this section;

(B) initiation of an immediate freeze by HHSC on the enrollment of additional recipients in the MCO's managed care plan until HHSC determines that the provider network under the managed care plan can adequately meet the needs of the additional recipients;

(C) education by the MCO of members enrolled in the MCO regarding the proper use of the MCO's provider network; or

(D) any other actions HHSC determines are necessary to ensure that Medicaid recipients enrolled in managed care plans provided by the MCO have access to appropriate health care services or dental services, and that providers are properly reimbursed by the MCO for providing medically necessary health care services or dental services to those recipients.

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(i) Application to Pharmacy Providers. The requirements of this section do not apply to providers of outpatient pharmacy benefits, except as noted in §353.913 of this chapter (relating to Managed Care Organization Requirements Concerning Out-of-Network Outpatient Pharmacy Services).

TITLE 1 ADMINISTRATION

PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 353 MEDICAID MANAGED CARE

SUBCHAPTER E STANDARDS FOR MEDICAID MANAGED CARE

RULE §353.411 Accessibility of Services

(a) Requirements for health care managed care organizations (health care MCOs).

(1) A health care MCO must provide a broad-based and accessible primary care provider (PCP) network within the service area to ensure member accessibility to providers in time, distance, cultural competency, and language.

(2) A health care MCO must have pediatric and family practitioner PCPs in their network of providers in sufficient numbers to provide regular and preventive pediatric care and Texas Health Steps (THSteps) services to all eligible children enrolled in the service area.

(3) A health care MCO must have PCPs and acute care hospitals available throughout the service area to ensure that no member must travel more than 30 miles from his or her residence to access the PCP, unless the Health and Human Services Commission (HHSC) has made an exception.

(4) A health care MCO must have PCPs in sufficient numbers to ensure that no member must wait an unreasonable amount of time for an appointment, and that no member must wait an unreasonable amount of time to be seen at their appointed time.

(5) A health care MCO must ensure the reasonable availability and accessibility of specialists for all covered services requiring specialty care. Specialists must also be reasonably accessible to members in time, distance, cultural competency, and language.

(6) A member of a health care MCO must not be required to travel in excess of 75 miles from his or her residence to secure initial contact with referral specialists; special hospitals; psychiatric hospitals; diagnostic and therapeutic services; and single service health care physicians, dentists, or providers, except as provided in subsections (c) and (d) of this section.

(7) For applicable managed care programs, a healthcare MCO must ensure the reasonable availability and accessibility of providers of long-term services and supports and specialty pediatric care providers of home and community-based services as determined by HHSC. These providers must be reasonably accessible to members in number, time, distance, cultural competency, and language.

(b) Requirements for dental managed care organizations (MCOs).

(1) A dental MCO must provide a broad-based and accessible main dentist network within the service area to ensure member accessibility to providers in time, distance, cultural competency, and language.

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(2) A dental MCO must have main dentist providers in their network in sufficient numbers to provide regular and preventive dental care and THSteps services to all eligible children enrolled in the service area.

(3) A dental MCO must have general dental providers throughout the service area to ensure that no member must travel more than 30 miles to access such providers in urban counties and 75 miles in rural counties, unless HHSC has made an exception.

(4) A dental MCO must have general dental providers in sufficient numbers to ensure that no member must wait an unreasonable amount of time for an appointment, and that no member must wait an unreasonable amount of time to be seen at their appointed time.

(5) A dental MCO must ensure the reasonable availability and accessibility of dental

specialists for all covered services. Dental specialists must also be reasonably accessible to members in time, distance, cultural competency, and language.

(6) A member of a dental MCO must not be required to travel in excess of 75 miles from his or her residence to secure initial contact with referral dental specialists, unless HHSC has made an exception.

(c) Service or provider not available. If any service or provider is not available to a member within the mileage radius specified in subsections (a)(3), (a)(6), (b)(3), or (b)(6) of this section, the MCO must submit to HHSC for approval data that indicates covered health care services or dental services are not available to the member within the required distance.

(d) Service or provider outside the service area. The provisions in subsections (a)(3), (a)(6), (b)(3), and (b)(6) of this section do not preclude an MCO from making arrangements with another source outside the service area for members to receive a higher level of skill or specialty than the level that is available within the MCO service area. For health care MCOs, this can include treatment of cancer, burns, and cardiac diseases.

(e) Provider education and training.

(1) A health care MCO must provide education and training to providers on the specific health and behavioral health problems and needs of members.

(2) A dental MCO must provide education and training to providers on the specific dental health problems and needs of members.

(3) All MCOs must provide education and training regarding the contract and rule requirements for accessibility and availability. MCOs and HHSC will cooperate and coordinate education and training activities for providers.

(f) Cultural competency plan. An MCO must develop a written cultural competency plan describing how the MCO will effectively provide health care services or dental services to members from varying cultures, races, ethnic backgrounds, and religions to ensure those  
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characteristics do not pose barriers to gaining access to needed services. As part of the requirement to develop the cultural competency plan, the MCO must at a minimum:

(1) employ multi-cultural and multi-lingual staff;

(2) make available interpreter services for members as necessary to ensure availability of effective communication regarding treatment, medical history, or health education;

(3) display to HHSC through the written plan a method for incorporating the plan into the MCO's policy-making process, administration, and daily practices; and

(4) submit the written plan to HHSC for review and approval at intervals specified by HHSC.

(g) Verbal and physical barriers. An MCO must ensure that communication and physical access barriers do not deter members' timely access to health care services or dental services. The MCO must provide information in appropriate communication formats, including formats accessible to people with disabilities.

(h) Significant traditional providers. An MCO must not exclude Significant Traditional Providers from its network for a period of time and under conditions determined by HHSC and specified in the contract.

(i) Provider manual. An MCO must develop a written provider manual clearly stating the policies and procedures adopted by the MCO to meet the provider's duties and obligations required by these and other agency rules and the contract.

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TITLE 1 ADMINISTRATION

PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 353 MEDICAID MANAGED CARE  
SUBCHAPTER E STANDARDS FOR MEDICAID MANAGED CARE  
Rule §353.423 Expedited Credentialing

- (a) HHSC identifies applicant provider types for which an expedited credentialing process must be established and implemented.
- (b) Each MCO must establish and implement an expedited credentialing process that allows applicant providers to provide services to members on a provisional basis.
- (c) To qualify for expedited credentialing under this section and payment under subsection (d) of this section, an applicant provider must:
- (1) be a member of an established health care provider group that has a current contract with an MCO;
  - (2) be a Medicaid-enrolled provider;
  - (3) agree to comply with the terms of the contract described in paragraph (1) of this subsection; and
  - (4) submit all documentation and information required by the MCO as necessary for the MCO to begin the credentialing process.
- (d) On submission by the applicant provider of the information required by the MCO under subsection (c) of this section, and for Medicaid reimbursement purposes only, the MCO must treat the provider as if the provider were in the MCO's provider network when the provider provides services to recipients, subject to subsections (e) and (f) of this section.
- (e) Except as provided by subsection (f) of this section, if, on completion of the credentialing process, an MCO determines that the applicant provider does not meet the MCO's credentialing requirements, the MCO may recover from the provider the difference between payments for innetwork benefits and out-of-network benefits.
- (f) If an MCO determines on completion of the credentialing process that the applicant provider does not meet the MCO's credentialing requirements and that the provider made fraudulent claims in the provider's application for credentialing, the MCO may recover from the provider the entire amount of any payment paid to the provider.

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TITLE 1 ADMINISTRATION

PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
CHAPTER 370 STATE CHILDREN'S HEALTH INSURANCE PROGRAM  
SUBCHAPTER C ENROLLMENT, RENEWAL, DISENROLLMENT, AND COST SHARING

DIVISION 1 ENROLLMENT AND DISENROLLMENT

RULE §370.303 Completion of Enrollment

§370.303 Completion of Enrollment

- (a) To complete CHIP enrollment, an applicant must:
- (1) select and indicate on the enrollment form[,] a health care managed care organization (MCO) and a dental MCO for all eligible children;
  - (2) select a PCP [primary care provider (PCP)] and a dental home, and place the names on the enrollment form;
  - (3) indicate if an eligible child has special health care needs based on criteria in the member guide; [and]
  - (4) sign and return the enrollment form; and
  - (5) pay any applicable enrollment fee on or before the due date.

(b) If a child enrolled in Medicaid transitions to CHIP after being determined ineligible for Medicaid before the end of the child's Medicaid certification period, the applicant must do the following to complete CHIP enrollment:

- (1) select and indicate on the enrollment form a health care MCO and dental MCO;
- (2) select a PCP and dental home, and place the names on the enrollment form; and
- (3) pay any applicable enrollment fee on or before the due date.

(c) If an applicant or member does not pay an applicable enrollment fee as described in subsections (a) and (b) of this section, the applicant or member is not enrolled in CHIP or is disenrolled from CHIP.

(d) [(b)] An applicant may select a PCP, dental home, health care MCO, and dental MCO by mail, telephone, or facsimile. Unless the applicant is a perinate receiving expedited enrollment in accordance with §370.401 of this chapter (relating to Perinates), he or she will have 30 calendar days from the date the enrollment packet is mailed to choose a health care MCO, dental MCO, PCP, and dental home. If the applicant does not choose a health care MCO, dental MCO, PCP, or dental home within the time period established by HHSC, HHSC or its designee will assign one using the default assignment methodologies described in this section.

(e) [(c)] PCP assignment. If an applicant has not selected a PCP, the health care MCO will assign one using an algorithm that considers:

- (1) the applicant's established history with a PCP, as demonstrated by the health care MCO's encounter history with the provider in the preceding year;
- (2) the geographic proximity of the applicant's home address to the PCP;
- (3) whether the provider serves as a PCP to other members of the applicant's household;
- (4) limitations on default assignment, such as PCP restrictions on age, gender, and capacity; and
- (5) other criteria approved by HHSC.

(f) [(d)] Dental home assignment. If an applicant has not selected a dental home, the dental MCO will assign one using an algorithm that considers:

- (1) the applicant's established history with a dental home, as demonstrated by the dental MCO's encounter history with the provider in the preceding year;
- (2) the geographic proximity of the applicant's home address to the dental home;
- (3) whether the provider serves as the dental home to other members of the applicant's household;
- (4) limitations on default assignment, such as dental home restrictions on age and capacity; and
- (5) other criteria approved by HHSC.

(g) [(e)] MCO assignment. If a beneficiary has not selected a health care MCO or dental MCO, HHSC or its administrative services contractor will assign one using an algorithm that considers the beneficiary's history, including [with a] PCP or dental home when possible. If this is not possible, HHSC or its administrative services contractor will equitably distribute beneficiaries among qualified MCOs, using an algorithm that considers one or more of the following factors:

- (1) whether the member was previously enrolled in the MCO in Medicaid or CHIP;
- (2) [(1)] whether other members of the beneficiary's household are enrolled in the MCO in Medicaid or CHIP;
- (3) [(2)] MCO performance;
- (4) [(3)] the greatest variance between the percentage of elective and default enrollments (with the percentage of default enrollments subtracted from the percentage of elective

enrollments);

(5) [(4)] capitation rates;

(6) [(5)] market share; and

(7) [(6)] other criteria determined by HHSC.

(h) [(f)] Modified default enrollment process. HHSC has the option to implement a modified default enrollment process for MCOs when contracting with a new MCO or implementing managed care in a new service area, or when it has placed an MCO on full or partial enrollment suspension.

(i) [(g)] Request to change dental home or PCP. There is no limit on the number of times a member can request to change his or her dental home or PCP. A member can request a change in writing or by calling the MCO's toll-free member hotline.