Contract Crosswalk: Georgia Families 360° and Texas STAR Health Contracts

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Key Takeaways

Sellers Dorsey developed a crosswalk comparison of the Georgia Families 360° contract and Texas's STAR Health contract to identify opportunities to strengthen the next iteration of the Georgia Families 360° program. Both programs are specialty managed care programs that serve similar populations. Georgia Families 360° serves children, youth, and young adults in foster care, those receiving adoption assistance, and select youth involved in the juvenile justice system. The Texas STAR Health program provides health care and long-term care services to children and young adults in foster care with the Texas Department of Family and Protective Services. Specifically, these populations include children in conservatorship, children in the adoption assistance or permanency care assistance program, youth aged 21 years and younger in extended foster care, and youth aged 20 and younger in former foster care children. The Georgia Families 360 program serves around 27,000 children and youth while the STAR Health program serves approximately 45,000 children and youth in Texas. The crosswalk summarizes contract language pertaining to core elements of the provision of health care to children and youth in foster care, adoption agencies, or the juvenile justice system. In general, our review noted Texas uses much more specific contractual language around several key topic areas, such as care coordination and electronic medical records (EMRs). We recommend Georgia consider adopting more prescriptive requirements across these and other key functional areas to provide opportunities for better state control and oversight and to clarify and codify state expectations to the care management organization (CMO).

Sellers Dorsey identified several areas in which Georgia can strengthen and improve future Georgia Families 360° contract language:

1. *Coordination with the child protection agency.* Texas's STAR Health contract has numerous specific requirements around how the managed care organization (MCO) must coordinate with the state's child protection agency. The Georgia Families 360° program would benefit from implementing similar, prescriptive contract language to define the CMO's 's roles and responsibilities vis a vis the Georgia Division of Family & Children Services (DFCS).
2. *Care coordination/case management.* Texas's STAR Health contract care coordination language ensures that plans are sufficiently staffed to meet members' needs, requires, to the extent feasible, co-location of physical and behavioral health staff, and requires warm transfers. The Georgia Families 360° program may benefit from incorporating contract language holding plans accountable for its care

coordination/case management staffing model and operational processes, as members will gain the support required for effective care coordination.

3. *Electronic Medical Records (EMRs).* The Texas STAR Health program requires its MCOs, the equivalent to CMOs in Georgia, to develop and maintain a Health Passport for its members. The STAR Health contract language provides specific, extensive details on the state's expectations of plans regarding EMR security, features, and reporting requirements. The Georgia Families 360° program may benefit from setting specific, detailed expectations pertaining to EMRs in its contract language moving forward.
4. *Substance Use Disorder (SUD) and residential treatment facilities.* Both the STAR Health contract and the Georgia Families 360° contract demonstrate room for improvement in their expectations regarding SUD and residential treatment facilities, as neither provides detailed protocols in either of these fields. The Georgia Families 360° program may benefit from setting detailed expectations regarding SUD and residential treatment facilities in its contract language.
5. *Trauma-informed care.* Texas' STAR Health contract contains numerous requirements related to trauma-informed care, including requirements related to MCO staff training and provider network development. Using trauma-informed care as a lens for these and other managed care functions may help strengthen the Georgia Families 360° contract.
6. While not directly related to the contract crosswalk, we recommend updating the 2015 Interagency Cooperative Agreement[1] (last signed and updated in 2015) to formalize the interagency agreement between DCH and sister agencies to provide for more coordinated and collaborative Georgia Families 360 CMO° contract oversight between DCH and these sister agencies in accordance with the CMO contract goals that builds on the previous DCH Joint Taskforce structure and processes.
7. The Georgia Families 360° contract language should also more clearly define the CMO's role and responsibility vis a vis the Georgia Division of Family and Children Services (DFCS), Department of Behavioral Health and Developmental Disabilities (DBHDD), Department of Juvenile Justice (DJJ), Department of Public Health (DPH), Department of Early Care and Learning (DECAL), and Department of Education (DOE). The Georgia Families 360° program could benefit from more specificity in these program requirements and should specify requirements on the CMO's responsibility in coordinating with these sister agencies.

[1] Attachment: Interagency Cooperative Agreement from 2015 "Cooperative Agreement Between the Georgia Department of Behavioral Health and Developmental Disabilities, Georgia Department of Human Services, Georgia Department of Juvenile Justice, Georgia Department of Community Health, Georgia Department of Public Health, Georgia Department of Education, Georgia Department of Early Care and Learning, and Georgia Vocational Rehabilitation Agency"

Contract Crosswalk

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Contract Link	Georgia Families 360˚ Contract[2]	Texas STAR Health Contract[3]
Coordination with child protection agency	**Section 4.11.9.8** "The Contractor shall have documented Member Care Coordination policies and procedures for coordinating care and creating linkages with external organizations, including but not limited to school districts, child protective service agencies, early intervention agencies, behavioral health, and developmental disabilities service organizations. Such policies and procedures must include details on the Contractor's approach for documenting care coordination activities and creating linkages with external organizations for each Member. The Contractor shall submit the policies and procedures to Department of Community Health (DCH) for review within one hundred twenty (120) Calendar Days of the Operational Start Date and within ten (10) Calendar Days of any subsequent updates. In all instances, DCH shall have at least fourteen (14) Calendar Days to review the materials and the Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH."	**Section 8.1.11** "The MCO must cooperate and coordinate with the Texas Department of Family and Protective Services (DFPS) for the care of a child or young adult who is receiving services from or has been placed in DFPS conservatorship. The MCO Service Coordinators and Service Managers must be available to provide information to and assist Members, Medical Consenters and DFPS Staff with access to care and coordination of services as required in Sections 8.1.13.2, "Access to Care and Service Management," and 8.1.14, "Service Coordination," including development of the Case Plan. The MCO will also provide training opportunities including web-based and trainings at the regional level to DFPS staff." "If there is a dispute over the Medical Necessity of any Covered Services for any Member, the Member, the Member's Medical Consenter, or DFPS Staff, as appropriate, will use the Texas Health and Human Services Commission (HHSC) MCO Complaint and Appeal processes or the Fair Hearing process as described in Sections 8.1.33, "Member Complaint and Appeal Process," and 8.1.33.5, "Access to Fair Hearing for Members." The MCO, DFPS, and HHSC will meet on a schedule determined by HHSC to address issues and concerns that arise during the

[2] Copy of Georgia Families 360˚ generic contract
[3] Copy of STAR Health generic contract

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		Transition and Operations Phases. HHSC may require the MCO to revise processes and procedures, modify trainings or educational materials, or make other Program changes as a result of these meetings. The meetings will provide an ongoing opportunity to improve communication and share information between HHSC, DFPS Staff, Members, Providers, Caregivers and Medical Consenters, and the MCO. These meetings may also serve to update STAR Health Program requirements and streamline processes as necessary."
Assessments	**Section 4.7.7.3** "The Comprehensive Child & Family Assessment (CCFA) is used by DFCS to assist in developing case plans, making placement decisions, expediting permanency and planning for effective service intervention. The Contractor shall be responsible for ensuring that the Medical and Trauma Assessments required for the foster care (FC) Members as part of the CCFA are conducted and reported in a timely manner as set forth herein. Each instance of failure to meet a timeframe specified in this Section shall constitute a Category 4 event as set forth in Section 25.5. The Contractor shall ensure Providers conducting the Medical Assessment provide outcomes of the Assessment to the Contractor within twenty (20) Calendar Days of the Contractor's receipt of the eligibility file from DCH or electronic notification from DFCS or DCH. The Contractor must provide outcomes of the Medical Assessments to the DFCS-contracted CCFA Provider within twenty (20) Calendar Days of the Contractor's receipt of the	**Section 8.1.11.3** "The MCO must ensure that all Members in category 1 of the Target Population age 3 through 17 are assessed by a behavioral health (BH) provider using the Texas Comprehensive Child and Adolescent Needs and Strengths (CANS) 2.0 (child welfare) tool within 30 days of receipt of the daily notification file (DNF). For Members enrolled in Service Management, the results of the assessment must be used to inform the Member's Healthcare Service Plan."

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	eligibility file from DCH or electronic notification from DFCS or DCH." "The Contractor shall provide a Health Risk Screening within thirty (30) days of receipt of the eligibility file from DCH. The Health Risk Screening is used to develop a comprehensive understanding of the Members' health status and will be used by the Contractor to develop the Health Care Service Plan and used by the Care Coordination Team to determine the Member's Care Coordination needs. The Contractor must assess the need to complete a new Health Risk Screening each time a Member moves to a new placement or based on a change in the Member's medical or behavioral health as identified by Providers. The Contractor shall submit policies and procedures for conducting the Health Risk Screening and the tools that will be used to conduct the screenings to DCH for review and approval within one hundred twenty (120) Calendar Days of the Operational Start Date." See section 4.7.7.3.1.2 for Trauma Assessment Screening details.	
Care coordination	**Section 4.11.8** "The Contractor is responsible for developing and implementing a System of Care approach to Care Coordination and Continuity of Care. Care Coordination includes Case Management, Disease Management, Transition of Care and Discharge	**Section 8.1.14** "The MCO must implement a systematic administrative process to coordinate access to services, including Non-capitated Services, and information at the request of a Member, DFPS Staff, Caregiver, Medical Consenter, or primary care provider (PCP). The MCO must also

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	Planning. Policies and procedures are designed to accommodate the specific cultural and linguistic needs of the Contractor's Members and include, at a minimum, the following elements: • An individual needs assessment and diagnostic assessment; the development of an individualized treatment plan, as necessary, based on the needs assessment; the establishment of treatment objectives; the monitoring of outcomes; and a process to ensure that treatment plans are revised as necessary; • A patient-centered approach to meet the needs of Members, addressing both developmental and chronic conditions; • A treatment plan for Members who are determined to need a course of treatment or regular care monitoring, developed by the Member's primary care provider (PCP) with Member participation, and in consultation with any specialists caring for the Member. The Contractor will develop a care plan for all members with a treatment plan who are actively enrolled in case management. The Contractor's medical officer responsible for oversight of the care management function shall follow up with the treating physician when the actively case managed member is not achieving his/her care plan goals that align with the treating physician's treatment plan;	coordinate with DFPS Case Management Services, whose function is to enlist the involvement of community organizations that may not be providing Covered Services but are otherwise important resources to help Members in maintaining health and well-being. The MCO will contact all Members, Caregivers, and Medical Consenters upon enrollment to notify them of the availability of Service Coordination and its functions. The MCO will provide additional outreach about the availability of Service Coordination (such as additional phone calls or mailings) to Caregivers and Medical Consenters of Members identified by DFPS as having special healthcare needs, to parents of children in their own home, and to Caregivers and Medical Consenters of Members in relative placements. The MCO will also encourage Caregivers and Medical Consenters to use Service Coordination services." "Members, DFPS Staff, Caregivers, Medical Consenters, or PCPs may request Service Coordination from the MCO. A Service Coordinator will contact the Member, DFPS Staff, Caregiver, Medical Consenter, or PCP by the next Business Day upon receipt of a request for Service Coordination. The MCO will maintain an adequate number of Service Management and Service Coordination personnel and management having expertise in physical health, BH, and the STAR Health population to meet the needs of the population. The MCO will continue to assess the staff's ability to complete these functions in a timely nature and will take corrective action as necessary." "The MCO's Service Management and Coordination model will offer specialized teams having additional expertise to

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	• A strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning or regular Care Management; • A strategy to ensure the timely provision of services; • A strategy to ensure that the Contractor works with Members and Providers to implement an integrated approach to meeting physical health and behavioral health needs of the Member; • Use of data analytics to identify patterns of care. DCH encourages the use of predictive modeling to identify high risk Members; • Procedures and criteria for making Referrals to specialists and sub-specialists; • Procedures and criteria for maintaining treatment plans and Referral Services when the Member changes PCPs; • Capacity to implement, when indicated, Case Management functions such as individual needs assessment, including e stablishing treatment objectives, treatment follow-up, monitoring of outcomes, or revision of the treatment plan; • Be patient-centered: Should meet the needs of Members, addressing both developmental and chronic conditions; and • Include actively linking the Member, in a timely manner, to Providers, medical services, residential, social and other support services or resources appropriate to	assist those experiencing acute episodes or severe complex conditions. The MCO will maintain a sufficient number of regional offices in which Service Management and Service Coordination teams will be housed. Regional offices will be located in areas throughout the state that are determined by agreement between the MCO and HHSC to have the greatest member density. In accordance with the requirements in Uniform Managed Care Manual (UMCM) Chapter 16 the MCO must share and integrate care coordination and services authorization data internally and, if applicable, between the MCO and the third party or subsidiary contracted with the MCO to manage Behavioral Health Services. MCOs must implement joint rounds for physical health and Behavioral Health Services Network Providers or implement another effective means for sharing clinical information. MCOs must, to the extent feasible, co-locate physical health and behavioral health care coordination staff and ensure warm call transfers between physical health and behavioral health care coordination staff.”

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	the needs and goals identified in the plan of care. Care Coordination should ensure that services are delivered appropriately and that information flows among care Providers and back to the PCP." "The Contractor must consider the role of non-medical factors that may create challenges to Coordination of Care when developing Coordination and Continuity of Care policies. The Contractor shall submit Care Coordination and continuity of care Policies and Procedures to DCH for review and approval within ninety (90) Calendar Days of Contract Award and as updated thereafter. The Contractor is encouraged to use Community Health Workers in the engagement of Members in Care Coordination activities."	
Case management	**Section 4.11.11** "The Contractor's Case Management program shall emphasize prevention, Continuity of Care, and coordination and integration of care. Case Management functions include, but are not limited to: • Early identification of Members who have or may potentially have special needs by receiving referrals, reviewing medical records, claims and/or administrative data, or by conducting interviews, while gaining consent when appropriate. An initial assessment of pregnant women may be performed by a local public health agency at	**Section 8.1.13.2** "The MCO must provide Service Management to facilitate the provision of integrated Covered Services to meet the special preventive, primary Acute Care, Community-Based Services, long term support services (LTSS), and specialty healthcare needs appropriate for treatment of the individual Member's condition(s). The MCO Service Managers must identify Members who may benefit from Service Management, conduct a screening and provide Service Management when appropriate. The MCO must contact the identified Member, Caregiver, DFPS Staff or Medical Consenter to communicate the benefits of Service Management and encourage the Member's participation in Service Management. The MCO will complete Service

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	the time of the presumptive eligibility determination. This completed assessment will be forwarded to the woman's selected CMO; • Assessment of a Member's risk factors such as an over- or under-utilization of services, inappropriate use of services, non-adherence to established plan of care or lack thereof, lack of education or understanding of current condition, lack of support system, financial barriers that impede adherence to plan of care, compromised patient safety, cultural or linguistic challenges, and physical, mental, or cognitive disabilities; • Development of a personalized, patient-centered plan of care which is consistent with evidence-based guidelines and includes established goals that are specific and measurable, with emphasis on Member education of disease or condition to facilitate shared decision making and self-management; • Coordination of Care, as previously described; • Monitoring to ensure the plan of care and interventions continue to be appropriate or revised as needed based on changes in the Member's condition or lack of positive response to the plan of care; • Continuity of care which includes collaboration and communication with other Providers involved in the Member's	Management screenings for all new Members to establish the degree to which Service Management is needed." "The MCO will complete a new Service Management screening each time a Member moves to a new placement. If the screening indicates the need for Service Management, a healthcare service plan (HCSP) must be completed or updated by the MCO within 30 Days of notification of the Member's move to a new placement."

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	transition to another level of care to optimize outcomes and resources while eliminating fragmentation of care; • Follow up which includes assessing the achievement of established goals and identifying the overall impact of the plan of care; • Documentation which includes adherence to Member privacy and confidentiality standards, evidence of Member's progress and effectiveness of the plan of care, evaluation of Member satisfaction; and • When appropriate, Disenrollment from Case Management when the goals have been achieved and the Member is able to self-manage, or the needs and desires of the Member change." "Levels of Case Management for the Georgia Families 360°° Program include: • Level I – Services that ensure Members have received area specific information about public assistance programs for health and social services to which they may be entitled, have received an assessment related to their health problem and a plan of care that has been developed which provides for health and social problem follow-up as indicated. • Level II - Services that ensure necessary Member services are available. Case managers will arrange for appointments and	

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	transportation to the Member's appointments and referrals and verify that the referral site is available and appropriate for the Member's needs. • Level III - Services defined in Level I and Level II plus assisting the Member to complete forms, accompanying the Member to their appointments to provide introductions and support as well as contacting the Member to schedule additional appointments. Visits to the Member's residence are included in Level III Case Management. This level of Case Management services ensures the Member successfully negotiates any transitions in care. Level III Case Management may be reserved for certain high-risk Members who require special assistance to negotiate complex or highly structured health or social systems." "The Contractor shall be responsible for the Case Management of their Members and shall make special effort to identify Members who have the greatest need for Case Management, including those who have catastrophic or other high-cost or high-risk Conditions including pregnant women under twenty-one (21) years of age, high risk pregnancies and infants and toddlers with established risk for developmental delays. The Contractor must notify DCH of the specific Case Management programs it initiates (i.e. OB case	

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	management, Behavioral Health case management, etc.) and terminates and provide evidence, on an annual basis, of the effectiveness of such programs for its enrolled Members. The Contractor will submit quarterly reports to DCH which include specified Case Management Program data as listed in Section 5.71 in addition to the annual report."	
Service/care plans	**Section 4.11.8.16** "The Contractor shall use the results of all assessments and screenings to develop a Health Care Service Plan which identified the Member's Care Coordination needs for all new Members within thirty (30) Calendar Days of Member Enrollment. The Contractor must document the involvement of the Member's PCP, dentist, Behavioral Health Providers, specialists or other providers in the development of the Health Care Service Plan and provide evidence of such documentation to DCH, DFCS and Department of Juvenile Justice (DJJ). The Contractor shall develop a process by which the Contractor will regularly review and update the Members' Health Care Service Plans, which shall include: • The detailed description of the involvement of the Member's PCP, dentist, Behavioral Health Providers, specialists or other providers in the development of the Health Care Service Plan; • The approach for updating or revising the Health Services Plan; and	**Section 8.1.13.2** "To ensure Continuity of Care for MSHCN receiving services authorized in a treatment plan, transition plan, or Individual Service Plan (ISP) by their prior health plan, the MCO and Service Managers will work with the Member's current PCP and specialists to ensure the Member's condition remains stable and services are consistent to meet the Members ongoing needs. The Service Manager will authorize the transitioning Member's out of network (OON) providers to continue with the current treatment plan authorized by the Member's prior health plan until the initial HCSP is completed or the MCO can provide comparable services to transition the Member to a Provider who will be able to meet the Member's complex needs." "The MCO will complete Service Management screenings for all new Members to establish the degree to which Service Management is needed. During this telephonic screening, the MCO must ensure that the Medical Consenter is aware that Members in category 1 of the Target Population age 3 through 17 must receive the Texas Comprehensive CANS 2.0 (child welfare) assessment within

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	• Details on the monitoring and follow-up activities conducted by the Contractor with the Members' Providers." "Such process shall be submitted to DCH for review and approval within ninety (90) Calendar Days of the Operational Start Date. DCH shall have at least ten (10) Calendar Days to review the materials and the Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH. The Contractor is responsible for ensuring that the Health Care Service Plan for Members with Severe Emotional Disturbance (SED) shall include a safety and contingency Crisis plan. The development of such a plan will be coordinated between the Contractor, Core Services Providers and/or Intensive Family Intervention (IFI) Providers."	30 days of receipt on the DNF. The MCO must assist in scheduling this assessment with a BH Provider that is trained and certified in the administration of the CANS assessment tool. An initial HCSP must be completed within 45 Days of receipt of the Member on the DNF for each new Member whose screening indicates a need for Service Management. The initial HCSP must include recommended services indicated on the results page of the Texas Comprehensive CANS 2.0 (child welfare) assessment. Service Management or Service Coordination must be offered to the Member or the Member's Caregiver if the results of the Service Management screening or the Texas Comprehensive CANS 2.0 (child welfare) assessment indicate a need for either of these services." "The MCO will develop a process by which Members' HCSPs are reviewed and updated on a regular basis. The HCSP must be updated each time an annual Texas Comprehensive CANS 2.0 (child welfare) assessment is completed. The HCSP for Members with an SED must include a contingency crisis plan. The MCO Service Managers may request and review DFPS case plans, safety plans and permanency plans during the HCSP development and monitoring process."
Electronic medical records	**Section 4.17.2.1** "The Contractor shall have in place or develop initiatives towards implementing electronic health information exchange and health care transparency to encourage the use of Qualified Electronic Health Records and make available to Providers and	**Section 8.1.12** "The MCO must develop and maintain a web-based Health Passport system to provide an Electronic Health Record (EHR) for all Members. The Health Passport will facilitate Service Management and Continuity of Care for Members, as well as streamline data sharing and coordination

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	Members increased information on cost and Quality of care through health information technology." "The Contractor shall develop an incentive program for the adoption and utilization of electronic health records that result in improvements in the Quality and cost of health care services. This incentive program shall be submitted to DCH initially and as revised thereafter. The Contractor shall provide to DCH quarterly reports illustrating adoption of electronic health records by Providers."	between the Members' Providers and DFPS. The Health Passport will function as an easily accessible, paperless repository of information related to each Member, his or her Providers, demographics, medical services rendered, and pertinent administrative documentation." "The Health Passport must be maintained in a web-based electronic format with the following minimum system functions and features: 1. Advanced security capabilities to protect Member confidentiality and comply with security and privacy rules adopted by the U.S. Department of Health and Human Services (HHS) under HIPAA, 45 C.F.R. §§ 164.302–.318; 164.500–.534, the HITECH Act, all applicable state and federal laws, including Texas Administrative Code Chapter 390, and current Information Security Controls (Enterprise Information Security Standards and Guidelines (EISSG), which can be found at https://hhs.texas.gov/sites/default/files/documents/doing-business-withhhs/contracting/information-security-controls.pdf; 2. retention of records until the Member reaches age 26 or the timeframe prescribed in Attachment A, Section 9.01, "Financial record retention and audit," (whichever occurs later); 3. role-based access to Health Passport data by designated parties as defined by HHSC, in which the Member's designated PCP and additional Providers must be clearly identifiable by role in the Health Passport; 4. additional security layer for the following cases; a. cases deemed sensitive by DFPS to allow access only by personnel as designated by DFPS; and b. cases regarding Members who are not in DFPS conservatorship, including newborn Members, adoption assistance (AA) Members, permanency care assistance (PCA) Members,

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		and former foster care child (FFCC) Members; 5. secure user access to prevent unauthorized use of data, data loss, tampering and destruction; 6. audit trail functionality to include security audits (logging of Health Passport access attempts) and data audits (logging when, and by whom, records are created, viewed, updated, extracted, or deleted), in which the MCO must report any security breach in the Health Passport system to HHSC and DFPS within 24 hours of the breach; 7. integration of the Health Passport with the 24-hour Nurse Hotline and BH Hotline to allow case-specific access to Health Passport records by designated Hotline staff; 8. integration of the Health Passport with the MCO's Provider portal; 9. sorting and printing capacity supported at a record and data category basis; 10. ad hoc reporting functionality; 11. transferability and exportability of the complete Health Passport database in a file format designated by HHSC; and 12. export of Member clinical data to a portable, electronic format that can be imported into Certified Electronic Health Record Technology (CEHRT) to allow providers to maximize their use of electronic Member data. Implementation of this functionality should carefully follow up-to-date guidance of the Office of the National Coordinator for Health IT, which specifies the standards and criteria for interoperability of software involved in Member care. Current criteria call for the use of Consolidated Clinical Document Architecture (CCDA) to describe clinical data elements and the use of the XML-based Continuity of Care Document (CCD) template as the format by which the data elements are organized."

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		"The MCO is required to include the following data items in the Health Passport: 1. Member-specific information including name, address of record, date of birth, race/ethnicity, gender, and other demographic information, as appropriate, for each Member; 2. name and address of each Member's Primary Care Physician, Caregiver and Medical Consenter with clear designation of Member's authorized Medical Consenter; 3. name and contact information of each Member's DFPS caseworker as well as non-medical personnel such as Service Coordinator and Service Manager, as appropriate; 4. acquisition and retention of the Member's Medicaid ID and DFPS personal identification number ("Person ID"), when available, are required; 5. the initial HCSP, as well as any updates, for each Member who is receiving Service Management, including the plan of treatment to address the Member's physical, psychological, and emotional healthcare problems and needs, and identification of enrollment in a Disease Management (DM) program, the Transitioning Youth Program (TYP) or other type of specialized assistance the Member is receiving; 6. record of all Psychotropic Medication Utilization Reviews (PMUR), to include the outcome of each review and any actions taken to address identified concerns with the Member's medication regimen; 7. provider-specific information including, name of Provider, professional group, or facility, Provider's address and phone number, and Provider type including any specialist designations and credentials; 8. record of each service event with a physician or other Provider, including routine checkups conducted in accordance with the Texas Health Steps program, that include the date of the service event, location, Provider name, the associated

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		problem(s) or diagnosis, and treatment given, including drugs prescribed; 9. record of future scheduled service appointments and referrals, when known; 10. record of all diagnoses applicable to the Member, with emphasis on BH diagnoses utilizing either the applicable Diagnostic and Statistical Manual of Mental Disorders (DSM) or ICD national code sets as based on claims submitted; 11. record of current and past medications and doses (including psychotropic medications), interaction alerts, and where available, the prescribing physician, date of prescription(s) and target symptoms; 12. record and results of all Texas Health Steps medical, dental, and BH exams, including all required information from Texas Health Steps forms; 13. monthly progress notes from BH exams or treatments, submitted more frequently if necessary, to document significant changes in a Member's treatment or progress. Notes must include the following: a. Primary and secondary (if present) diagnosis; b. assessment information; c. brief narrative summary of Member's progress or status; d. scores on each outcome rating form(s); e. referrals to other Providers or community resources; and f. any other relevant care information; 14. Family Strengths and Needs Assessment (FSNA) assessment, as submitted by DFPS; 15. The Texas Comprehensive CANS 2.0 (child welfare) assessment, including: a. scores from the rating sheet; and b. the results page, including narrative and recommendation fields; 16. listing of Member's known health problems and allergies; 17. complete record of all immunizations, supplemented by and exchangeable with data from ImmTrac2, the Texas Immunization Registry that meets the requirements of Texas Health & Safety Code Chapter 161

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		as well as the recommended immunization schedules for Members age birth through 18 years, and the catch-up immunization schedule as posted on the Centers for Disease Control and Prevention (CDC) website; 18. listing of Member's DME must be reflected in the claims or "Visits" module, and in the Member's HCSP, if Member is in Service Management; 19. any utilization of an informational code set, such as ICD-10, should provide the used code value as well as an appropriate and understandable code description (this is applicable to codes pertaining to a service event, healthcare Provider, and Member records.); 20. laboratory test results; and 21. functionality that assists DFPS Caseworkers."
Continuity of care	**Section 4.11.8.6** "Contractors shall identify and facilitate transitions for Members that are moving from the Contractor's GF 360°° Plan to another CMO or from the Contractor's GF 360°° Plan to a Fee-for Service (FFS) provider or to private insurance and require additional or distinctive assistance during a period of transition. When relinquishing Members, the Contractor shall cooperate with the receiving CMO or FFS Medicaid regarding the course of on-going care with a specialist or other Provider. Priority will be given to Members with select medical conditions or circumstances (see contract for details)." "The Contractor will monitor Providers to ensure transition of care from one entity to another to include Discharge Planning as appropriate. Members with Procedures that are scheduled to occur after	**Section 8.1.27** "The MCO must ensure continuity of care such that the care of newly enrolled Members and Members who disenroll from the MCO is not disrupted or interrupted. The MCO must ensure that the care to newly enrolled Members and Members who disenroll from the MCO whose health or BH condition has been treated by specialty care providers or whose health could be placed in jeopardy if Medically Necessary Covered Services is disrupted or interrupted." "Upon notification from a Member or Provider of the existence of a prior authorization, the new MCO must ensure Members receiving services through a prior authorization (PA) from either another MCO or FFS receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following: 1. 90 Days after the transition to a new

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	the transition effective date, but that have been authorized by either DCH or the Member's original CMO prior to their new CMO transition effective date will be covered by the Member's new CMO for thirty (30) Calendar Days; and members that are in ongoing outpatient treatment or that are receiving medication that has been covered by DCH or another entity prior to their new CMO effective date will be covered by the new CMO for at least thirty (30) Calendar Days to allow time for clinical review, and if necessary transition of care. The Contractor will not be obligated to cover services beyond thirty (30) Calendar Days, even if the DCH authorization was for a period greater than thirty (30) Calendar Days." "The Contractor shall employ System of Care principles in the coordination and delivery of services to ensure coordinated planning across and between multiple child-serving agencies which also serve the Members. The Contractor will coordinate with DCH, DFCS, Department of Public Health) DPH, DJJ, Department of Education (DOE), Department of Behavioral Health and Developmental Disabilities (DBHDD) and Department of Early Care and Learning (DECAL) as needed when a Member transitions into or out of the CMO to maintain continuity of care and services and minimize disruptions to the Member including: When a foster care (FC) Member or DJJ Member is transitioning from another CMO or from private insurance, the Contractor shall contact the FC Member's or DJJ Member's prior CMO or other	MCO; 2. until the end of the current authorization period; or 3. until the MCO has evaluated and assessed the Member and issued or denied a new authorization. " "For instances in which a newly enrolled Member transitioning from FFS to managed care was receiving a service that did not require a prior authorization in FFS, but does require one by the new MCO, the MCO must ensure Members receive services for the same amount, duration, and scope for the shortest period of one of the following: (1) 90 Days after the transition to a new MCO, or (2) until the MCO has evaluated and assessed the Member and issued or denied a new authorization. The MCO must make every effort to outreach to and recruit providers providing services to Members, including individual BH providers providing services in residential treatment cetnters (RTCs)."

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	insurer and request information about the FC Member's or DJJ Member's needs, current Medical Necessity determinations, authorized care and treatment plans within two (2) Business Days of receipt of the eligibility file from DCH or electronic notification from DFCS, DCH or DJJ and receipt of a signed release of information form from DFCS or DJJ." "When an AA Member is transitioning from another CMO or from private insurance, the Contractor shall contact the AA Member's prior CMO or other insurer and request information about the AA Member's needs, current medical necessity determinations, authorized care and treatment plans within two (2) Business Days of receipt of the eligibility file from DCH and receipt of a signed release of information form from the Adoptive Parent." "When a Member is transitioning from Fee-for-Service Medicaid, the Contractor shall coordinate with DCH staff designated to coordinate administrative services for the Member, and contact the FC Member's or DJJ Member's prior Service Providers including but not limited to PCPs, specialists and dental providers, and request information about the FC Member's or DJJ Member's needs, current Medical Necessity determinations, and authorized care and treatment plans within two (2) Business Days of the receipt of the eligibility file from DCH or electronic notification	

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	from DFCS, DJJ or DCH and receipt of a signed release of information form from DFCS or DJJ." "When an AA Member is transitioning from Fee-for-Service Medicaid, the Contractor shall coordinate with DCH staff designated to coordinate administrative services for the AA Member, and contact the AA Member's prior Service Providers including but not limited to PCPs, specialists and dental providers, and request information about the AA Member's needs, current Medical Necessity determinations, authorized care and treatment plans within two (2) Business Days of the receipt of the eligibility file from DCH and receipt of a signed release of information form from the Adoptive Parent." "The Contractor must authorize all services included in treatment plans by prior CMOs, private insurers or Fee-for-Service Medicaid for Members transitioning from another CMO, private insurance or Fee-for-Service Medicaid. The Contractor must authorize the Member to continue care with his or her providers and current services, including the issuance of an Out-of-Network authorization to ensure the Member's condition remains stable and services are consistent to meet the Member's needs. All such authorizations or allowances will continue for the later of a period of at least thirty (30) Calendar Days or until the Contractor's authorized Health Care Service Plan is completed. The Contractor shall provide additional coordination	

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	to ensure continuity of care for Members with Special Health Care Needs as detailed in Section 4.11.4. When Members disenroll from the GF 360°° program, the Contractor is responsible for transferring to the DCH the Member's Care Management history, six (6) months of claims history, and pertinent information related to any special needs of transitioning Members.	
SUD/residential treatment facilities	**Section 4.6.11** "The Contractor shall provide a full range of recovery-based services and engage non-medical services and supports as indicated to provide holistic care focused on whole-health wellness, long-term independence, and skills building. This includes access to Certified Peer Supports for youth, adults and parents of youth with mental illness. The Contractor shall have written Mental Health and Substance Abuse Policies and Procedures that explain how they will arrange or provide for covered mental health and substance abuse services. Such policies and procedures shall include Advance Directives. The Contractor shall assure timely delivery of mental health and substance abuse services and coordination with other acute care services. Mental Health and Substance Abuse Policies and Procedures shall be submitted to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date and as updated thereafter. The Contractor shall permit	**Section 8.1.17.6** "The MCO must comply with 28 Tex. Admin. Code §§ 3.8001 et seq., regarding Utilization Review for Substance use disorder and Chemical Dependency Treatment. Substance use disorder and Chemical Dependency Treatment must conform to the standards set forth in 28 Tex. Admin. Code Chapter 3, Subchapter HH. Substance use disorder includes substance use disorder and dependence as defined by the current DSM."

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	Members to self-refer to an In-Network Provider for an initial mental health or substance abuse assessment. The Contractor shall permit all initial outpatient behavioral health (mental health and substance abuse) evaluation, diagnostic testing, and assessment services to be provided without Prior Authorization. The Contractor shall permit up to three (3) initial evaluations per year for Members younger than twenty-two (22) years of age without requiring additional Prior Authorization. Following an initial evaluation, the Contractor shall permit up to twelve (12) outpatient counseling/therapy visits to be provided without Prior Authorization." "The Contractor shall promote the delivery of behavioral health services in the most integrated and person-centered setting including in the home, school or community, for example, when identified through care planning as the preferred setting by the Member. The delivery of home and community based behavioral health services shall be incentivized by the Contractor for Providers who engage in this person-centered service delivery. The Contractor shall provide emergency services diversion techniques and interventions (including but not limited to SBIRT (Screening, Brief Intervention and Referral to Treatment) for Members with mental illness and/or substance use. The Contractor shall provide scalable intensity of Care Management, disease management, Care	

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	Coordination, and Complex Care Coordination based on the intensity of the Members need, as described in Section 4.11.8."	
Behavioral health	**Section 4.8.4.5** "The Contractor will include Behavioral Health Homes in its Medical Home network. Behavioral Health Home providers do not need to provide all the services of a traditional Medical Home themselves, but must ensure that the full array of primary and Behavioral Health Care services is available, integrated and coordinated. The number of Behavioral Health Homes proposed in the network should be responsive to the prevalence of members with severe and persistent mental illness or chronic behavioral health conditions. The proposed algorithm along with assignment of Behavioral Health Homes shall be included in a Medical Home implementation plan." **Section 4.11.9.9** "The Contractor shall develop an innovative approach to encourage PCPs, Behavioral Health Providers, and dental Providers to effectively and efficiently share behavioral and physical health clinical Member information, including how the Contractor will notify Behavioral Health Providers and PCPs after an inpatient mental health stay. The Contractor must require Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of a Member's	**Section 8.1.17** "The MCO must provide or arrange for the delivery of all Medically Necessary community-based, rehabilitative, and inpatient Hospital BH Services. The MCO must cover up to three five-day extensions in a Psychiatric Hospital after treatment is completed if DFPS Staff is in the process of finalizing the Member's placement. The MCO will encourage all contracted Psychiatric Hospitals that have psychiatric bed capacity to expand their inpatient BH service capacity. The MCO will not require a PA for all outpatient medication management services, and a PA will not be required for the first ten outpatient BH sessions, to include the initial evaluation." "The MCO may provide BH Services not only in offices and clinics, but also in schools, homes, and other locations as appropriate. A continuum of services, as indicated by the BH needs of Members, must be available. The MCO must include Providers in its Network who utilize evidence-based practices (EBPs) and promote Provider use of EBPs. BH assessments must include a primary and secondary (if present) diagnosis using the Diagnostic and Statistical Manual (DSM) multi-axial classification. Because BH and substance use disorder problems commonly occur in Members, the MCO must screen all such Members for both types of problems. Diagnostic information and outcome measurement information must be documented in the Member's Health Passport."

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	behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Handbooks. The Contractor shall submit an annual Health Coordination and Integration Report to the Department due June 30th of each calendar year for the prior calendar year beginning 2017. This report is subject to approval by the Department."	"The MCO must contract with BH Providers specializing in treatment of issues that are common to children and young adults in the STAR Health population such as abuse, neglect, sexual offender behavior, and exposure to complex and multiple traumas, in order to meet the BH needs of the STAR Health population. To the extent available, the Network must include Providers that utilize EBPs and promising practices specific to the diagnoses of the STAR Health population. The Network must also include Providers that are trained and certified in the administration of the CANS assessment."