DOCUMENT HISTORY LOG

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| --- | --- | --- | --- |
| **STATUS**1 | **DOCUMENT**  **REVISION**2 | **EFFECTIVE**  **DATE** | **DESCRIPTION**3 |
| Baseline | n/a | January 21, 2008 | Initial version Uniform Managed Care Manual, Chapter 3.15 STAR Health Managed Care Member Handbook Critical Elements |
| Revision | 1.1 | May 20, 2009 | Added language regarding the HHS Office of Civil Rights to end of Attachment H, “Member Rights and Responsibilities.”  Added Attachment O, “What is the Medicaid Limited Program?”  Re-lettered subsequent section. |
| Revision | 1.2 | October 10, 2009 | Chapter 3.15 is revised to conform to the style and preferred terms required by the Consumer Information Tool Kit.  Attachment A “Medicaid Identification Form (Form 3087)” is revised to correct the process for replacing lost forms.  Attachment H, “Member Rights and Responsibilities,” is revised to include additional Member notices.  Attachment K, Fair Hearings, is revised to remove the statement “The Member does not have a right to a fair hearing if Medicaid does not cover the service requested.” |
| Revision | 1.3 | April 1, 2010 | Attachment H “Member Rights and Responsibilities” is revised to conform to comparable language in Chapter 3.14.  Attachment K, “Fair Hearings,” is revised to clarify the requirements for continuing benefits. |
| Revision | 1.4 | July 5, 2010 | Attachment I, “Complaints” is revised to correct the phone number and to add the STAR Health Complaints email address. |
| Revision | 1.5 | March 1, 2011 | Added language as Attachment P, “How many times can I change my/my child’s primary care provider?” Subsequent section is re-lettered. |
| Revision | 2.0 | March 1, 2012 | Revision 2.0 applies to contracts issued as a result of HHSC RFP number 529-06-0293.  Chapter is reformatted to convert the outline narrative to a form and to delete final attachment checklist as redundant.   1. Section III. A. is added and subsequent sections renumbered. 2. Section III. C. is revised to add requirement that Member Services Line include how to access covered services. 3. Section III. D. is revised to replace “Medicaid identification (ID) cards (Form 3087)” with “Your Texas Benefits Medicaid Card.” (Attachment A) 4. Section III. G. is revised to add language regarding prescription drug benefits. 5. Section III. H. is revised to add language regarding prescription drug benefits and birthing centers and to remove language regarding other insurance and the Medicaid Limited Program. 6. Section III. J. is updated to remove the requirement for the MCO to have a local telephone number. 7. Section III. K. is revised to add language regarding prescriptions. 8. All attachments are listed in order of appearance and renumbered appropriately. Spanish translations for required language are provided. 9. Attachment A, “Medicaid Identification Form (Form 3087)” is renamed “Your Texas Benefits Medicaid Card” and the content is revised. 10. Modify required language regarding “Physician Incentive Plans” (Attachment C) 11. Modify required language regarding “What does Medically Necessary mean?” (Attachment D) 12. Add required language regarding “What if I get sick when I am out of town or traveling?” (Attachment G) 13. Add required language regarding “What if I am out of the country?” (Attachment H) 14. Add required language regarding “How do I get my medications?” (Attachment I) 15. Modify required language regarding “What if I can’t get the medication my doctor ordered approved?” (Attachment J) 16. Add required language regarding “Where do I find a family planning services provider?” (Attachment K) 17. Modify required language regarding “What if I need OB/GYN care?” (Attachment L) 18. Remove required language regarding “Medicaid and Private Insurance” (Attachment) 19. Modify required language regarding “Member rights and responsibilities?” (Attachment M) 20. Add required language regarding “Durable Medical Equipment And Other Items Commonly Found In A Pharmacy” (Attachment N) 21. Remove required language regarding “What is the Medicaid Limited Program?” (Attachment) 22. Modify required language regarding “Fraud and Abuse” (Attachment Q) |
| Revision | 2.1 | September 10, 2014 | General Instructions are modified to require availability in the languages of other Major Population Groups if directed by HHSC.  Section III. C. is modified to add language regarding availability of information in English and Spanish, how to access Substance Abuse Services, and to change “TDD” to “TTY”.  Section III. D. is modified to change temporary “ID Cards” to “verification forms”.  Section III. E. is modified to add questions “What is a Primary Care Provider?” and “Can a specialist ever be considered a PCP?” In addition, “my” is changed to “my/my child’s.”  Section III. G. is modified to change “my” to “my/my child’s.”  Section III. H. is modified to add required language for the question “What is urgent medical care?” and to add questions “What should I do if I or my child need urgent medical care?”, “What are mental health rehabilitation services and mental health targeted case management?”, and “What is Early Childhood Intervention (ECI)?” The question “How do I get medical care after my Primary Care Provider’s office is closed?” is moved to Section III. E. “Service Management” is added to the questions “What is Service Coordination?” and “How can I talk with my/my child’s Service Coordinator?” In addition, the question “How does the Patient Protection and Affordable Care Act affect me?” is added.  Attachment A “Your Texas Benefits Medicaid Card” is modified to add “or your child.”  Attachment B “How many times can I change my/my child's primary care provider?” is modified to add “/my child’s.”  Attachment C “Provider Incentive Plans” is modified to remove “This is called a physician incentive plan.”  Attachment D “Medically Necessary” is modified to change “Suehs” to “Janek.”  Attachment F “What is Urgent Medical Care?” is added and all subsequent attachments are re-lettered.  Attachment G “What is post-stabilization?” is modified to add “or your child’s.”  Attachment H “What if I or my child gets sick when I am out town or traveling?” is modified to add “or your child’s.”  Attachment I “What if I or my child are out of the country?” is modified to add “or my child.”  Attachment J “How do I get my/my child's medications?” is modified to add “/my child’s.”  Attachment K “What if I can’t get the medication my doctor ordered approved?” is modified to add “or your child’s.”  Attachment M “What is Case Management for Children and Pregnant Women (CPW)?” is added.  Attachment N “What is HHSC’s Medical Transportation Program?” is added.  Attachment P “Member Rights and Responsibilities” is modified to add compliance with EVV requirements.  Attachment R “Patient Protection and Affordable Care Act” is added.  Attachment V, “Fraud and Abuse” is modified to change “Click Here to Report Waste, Abuse, and Fraud” to “Under the box “I WANT TO” click “Report Waste, Abuse, and Fraud”” to conform to language on the OIG website. |
| Revision | 2.2 | March 15, 2019 | Attachment A “Your Texas Benefits Medicaid Card” is modified to update the phone number for a lost or stolen card and available card information.  Attachment S “Complaints” is modified to update the MCCO Research and Resolution address. |
| Revision | 2.2.1 | April 5, 2019 | Section C - “Phone Numbers” Medicaid Managed Care Helpline is modified to remove a non-working TTY number. |
| Revision | 2.3 | September 1, 2019 | Administrative change made as follows:  Attachment S “Complaints” is modified to change the complaint address and email address for Members to send written complaints to the Ombudsman Managed Care Assistance Team effective September 1, 2019. |
| Revision | 2.4 | September 18, 2020 | Attachment A “Your Texas Benefits Medicaid Card” is modified to revise the phone number for STAR Health members to contact regarding eligibility, change terminology of “pharmacy” to “drug store,” and remove reference regarding the Your Texas Benefits website for questions about a new card.  Administrative change made to Attachment A “Your Texas Benefits Medicaid Card” to modify the contact numbers for questions about a lost or stolen Medicaid card. |
| Revision | 2.5 | April 21, 2021 | Modified “day” and “calendar day” to the Contract term, “Day,” and capitalized “Business Day” where applicable throughout chapter.  Section II. C. is modified to add Non-emergency Medical Transportation (NEMT) Services and “Where’s my Ride” line information and to delete Medical Transportation Services from the other important phone numbers information bullet.  Section II. H. is modified to change the Medical Transportation Program (MTP) information bullet to NEMT.  Attachment N is modified to change MTP required language to NEMT required language.  Attachment P is modified to add member responsibilities while using NEMT services. |
| Revision | 2.5.1 | June 25, 2021 | Chapter modified to add the Spanish translation of the NEMT language in Attachments N and P. |
| Revision | 2.6 | May 1, 2022 | ‘General instructions added explaining the use of terms ‘emergency’ and ‘expedited’ throughout the chapter.  Section II(K)(L) modified to add External Medical Review language.  Attachment X, addition of External Medical Review Required Language  Section II (J): Addition of MDCP/DBMD escalation help line Information  Attachment FF: Added EMR and MDCP-DBMD escalation help line language  Attachment JJ: Revised timeframe guidelines to match policy and language revisions for clarity  Attachment Y: Added to include description of MDCP/DBMD escalation help line and when to utilize |
| Revision | 2.7 | May 2, 2022 | Spanish Language Update |
| Revision | 2.8 | May 3, 2022 | Administrative Update – Language deleted from Attachment X (both English and Spanish versions) that reads: “Go in-person to a local HHSC office”. |
| Revision | 2.9 | September 1, 2022 | Attachment M is modified to update who members can contact to learn about CPW services. |
| Revision | 2.10 | July 17, 2023 | Attachment X is modified to remove the language that the Member may request an IRO be present at the State Fair Hearing.  Attachment X is modified to clarify who the Member must contact for a State Fair Hearing withdrawal. |

**1** Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions

2  Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

3 Brief description of the changes to the document made in the revision.

Web Posting Date (Accessible version): 07/29/19

# Applicability of Chapter 3.15

This chapter applies to Medicaid Managed Care Organizations (MCOs) participating in the STAR Health Program, (formerly referred to as the Comprehensive Healthcare Program for Foster Care).

## GENERAL INSTRUCTIONS TO MCO

As used in this chapter, “emergency appeal” and “emergency State Fair Hearing” have the same meaning as “Expedited MCO Internal Appeal” or “Expedited State Fair Hearing,” respectively.

Member Handbook must be written at or below a 6th grade reading level in English and in Spanish. Additionally, the Member Handbook must be written in the languages of other Major Population Groups if directed by HHSC. The handbook must also be written using the style and preferred terms of the HHS Brand Guide which can be found at [https://hhs.texas.gov/sites/default/files//documents/doing-business-with-hhs/vendor-contract-information/hhs-brand-guide.pdf](https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/vendor-contract-information/hhs-brand-guide.pdf).

This table is to be completed and attached to the Member Handbook when submitted for approval. Include the page number of the location for each required critical element.

The following items must be included in the handbook but not necessarily in this order (unless specified):

| **Required Critical Elements** | **Page Number** |
| --- | --- |
| **I. FRONT COVER** |  |
| The front cover must include, at a minimum: |  |
| * MCO name |  |
| * MCO logo |  |
| * Program name (STAR Health) |  |
| * The words “MEMBER HANDBOOK” |  |
| * Name of MCO’s parent company (if applicable) |  |
| * Member Services Hotline number |  |
| Month/year (may be placed on front or back cover) |  |
| **II. CONTENTS** |  |
| **A. Table of Contents** |  |
| The Member Handbook must include a table of contents. |  |
| 1. **Introduction** |  |
| This includes information the MCO would like to share with its Members about its health plan (benefits and eligibility information). Inform the Member that Member Services is available for help. In addition, explain that the Member Handbook will be made available in audio, larger print, Braille, other language, etc. when a Member requests it or when the health plan identifies a Member who needs it. (This information should be located within the first three pages of the Member Handbook.) |  |
| 1. **Phone Numbers** |  |
| This information should be located within the first three pages of the Member Handbook. |  |
| * Toll-free Member Services Line. Information should include the following explanations:   + regular business hours (8 a.m. to 5 p.m. local time for Service Area, Monday through Friday, excluding state-approved holidays) and   + for after-hours and weekend coverage, an answering service or other similar mechanism, that allows callers to obtain information from a live person, may be used. |  |
| * Requirements of the Members Services Line include: |  |
| * + How to access all covered services – including what to do in an emergency and/or crisis |  |
| * + Availability of information in English and Spanish |  |
| * + Availability of interpreter services through Member Services line |  |
| * + TTY Line for the deaf and hard of hearing |  |
| * Requirements of the Behavioral Health and Substance Abuse Services Line include: |  |
| * + 24 hours a day, 7 day a week, toll-free number |  |
| * + How to access services – including what to do in an emergency and/or crisis |  |
| * + How to access Substance Abuse Services, including information on self-referral. |  |
| * + Availability of information in English and Spanish |  |
| * + Availability of interpreter services |  |
| * Information on the Availability of Service Coordination |  |
| * + Nonemergency Medical Transportation (NEMT) Services and “Where’s My Ride?” line (if separate from other hotlines). Information should include the following explanations: |  |
| * + Hours of the NEMT Services hotline |  |
| * + Hours of the “Where’s My Ride?” line |  |
| * + How to access NEMT Services |  |
| * + Availability of information in English and Spanish |  |
| * + Availability of interpreter services |  |
| * + TTY Line for the deaf and hard of hearing |  |
| * + Other Important health plan quick reference phone numbers and what they are used for: |  |
| * Nurse Line |  |
| * Eye care |  |
| * Dental care |  |
| * Medicaid Managed Care Helpline 1-866-566-8989 |  |
| * STAR Health Program Help Line |  |
| 1. **Member ID Cards:** |  |
| * + Information about (insert MCO name) ID card, including |  |
| * + Sample ID card |  |
| * + How to read it |  |
| * + How to use it |  |
| * + How to replace it if lost |  |
| * Information about the Department of Family and Protective Services (DFPS) (Person) ID – Form 2085-B * Information about the Your Texas Benefits Medicaid Card. (MCO will use HHSC’s provided language – **Attachment A**.) |  |
| * Information about temporary verification form - Form 1027-A (how to use it). |  |
| 1. **Primary Care Providers:** |  |
| The following questions must be included and answered in the handbook: |  |
| * What do I need to bring with me to my/my child's doctor’s appointment? |  |
| * What is a Primary Care Provider? |  |
| * Can a specialist ever be considered a Primary Care Provider? |  |
| * How can I change my/my child's Primary Care Provider? |  |
| * Can a clinic be my/my child's Primary Care Provider? (Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC)) |  |
| * How many times can I change my/my child's Primary Care Provider? (MCO will use HHSC’s provided language – **Attachment B**.) |  |
| * When will my/my child's Primary Care Provider change become effective? |  |
| * Are there any reasons why a request to change a Primary Care Provider may be denied? |  |
| * Can my/my child's Primary Care Provider move me/my child to another Primary Care Provider for non-compliance? |  |
| * What if I choose to go to another doctor who is not my/my child's Primary Care Provider? |  |
| * How do I or my child get medical care after my Primary Care Provider's office is closed? |  |
| 1. **Physician Incentive Plan Information** (MCO will use HHSC’s provided language – **Attachment C**.) |  |
| 1. **Benefits:** |  |
| The following questions must be included and answered in the handbook: |  |
| * What are my/my child's healthcare benefits? |  |
| * + How do I or my child get these services? |  |
| * + Are there any limits to any covered services? |  |
| * What services are not covered benefits? |  |
| * What are my/my child's prescription drug benefits? |  |
| * What extra benefits do I or my child get as a Member of (insert MCO name)? |  |
| * + How can I or my child get these benefits? |  |
| * What health education classes does (insert MCO name) offer? |  |
| * What other services can (insert MCO name) help me/my child get? (non-capitated services) |  |
| **H. Health Care and Other Services:** |  |
| The following questions must be included and answered in the handbook: |  |
| * What does “Medically Necessary” mean? Both Acute Care and Behavioral Health (MCO will use HHSC’s provided language – **Attachment D**.) |  |
| * What is emergency medical care? (MCO will use HHSC’s provided language – **Attachment E**.) |  |
| * + How soon can I or my child expect to be seen? |  |
| * What is urgent medical care? (MCO will use HHSC’s provided language – **Attachment F**). |  |
| * + What should I do if I or my child need urgent medical care? (MCO will use HHSC’s provided language – **Attachment F**.) |  |
| * + How soon can I or my child expect to be seen? (MCO will use HHSC’s provided language – **Attachment F**.) |  |
| * What is post-stabilization? (MCO will use state provided language – **Attachment G**.) |  |
| * What if I or my child get sick when I or my child are out of town or traveling? (MCO will use HHSC’s provided language - **Attachment H**.) |  |
| * + What if I or my child are out of the state? |  |
| * + What if I or my child are out of the country? (MCO will use HHSC’s provided language - **Attachment I**.) |  |
| * What if I or my child need to see a special doctor (specialist)? |  |
| * + What is a referral? |  |
| * + How soon can I or my child expect to be seen by a specialist? |  |
| * What services do not need a referral? |  |
| * + How can I ask for a second opinion? |  |
| * + How do I get help if I or my child have behavioral health (mental) or drug problems? |  |
| * + - Do I need a referral for this? |  |
| * What are mental health rehabilitation services (MHR) and mental health targeted case management (TCM)? |  |
| * + - How do I or my child get these services? |  |
| * How do I get my/my child’s medications? (MCO will use HHSC’s provided language – **Attachment J**.) |  |
| * + - How do I find a network drug store? |  |
| * + - What if I go to a drug store not in the network? |  |
| * + - What do I bring with me to the drug store? |  |
| * + - What if I need my/my child’s medications delivered to me? |  |
| * + - Who do I call if I have problems getting my/my child’s medications? |  |
| * + - What if I can’t get the medication my doctor ordered approved? (MCO will use HHSC’s provided language – **Attachment K**.) |  |
| * + - What if I lose my/my child’s medication(s)? |  |
| * How do I or my child get eye care services? (Include information on access to a Network ophthalmologist or therapeutic optometrist for non-surgical services without a referral from a Primary Care Provider.) |  |
| * How do I or my child get dental services? |  |
| * + - * How do I or my child get family planning services? |  |
| * + - Do I need a referral for this? |  |
| * + - Where do I find a family planning services provider? (MCO will use HHSC’s provided language – ***Attachment L***.) |  |
| * + - * What is Case Management for Children and Pregnant Women (CPW)? (MCO will use HHSC's provided language -- ***Attachment M***.) |  |
| * + - * + What is Early Childhood Intervention (ECI)? |  |
| * + - Do I need a referral for this? |  |
| * + - Where do I find an ECI provider? |  |
| * + - * + What are Service Coordination and Service Management? |  |
| * + - What will a Service Coordinator or Service Manager do for me/my child? |  |
| * + - How can I talk with my/my child's ~~a~~ Service Coordinator or Service Manager? |  |
| **Note:** Include information and phone number for Service Management and Service Coordination |  |
| * What is Texas Health Steps? |  |
| * What services are offered by Texas Health Steps? |  |
| How and when do I get Texas Health Steps medical and dental checkups for my child? |  |
| * Does my doctor have to be part of the (insert MCO name) network? |  |
| Do I have to have a referral for this? |  |
| What if I need to cancel an appointment? |  |
| What if I am out of town and my child is due for a Texas Health Steps checkup? |  |
| * What is the Health Passport? |  |
| * + - * How do I access the Health Passport? |  |
| * What nonemergency medical transportation (NEMT) Services are available to me? (MCO will use HHSC's provided language – ***Attachment N***.) |  |
| * What services are offered? |  |
| * Who do I call for a ride to a medical appointment? |  |
| * Can someone interpret for me when I talk with my doctor? |  |
| Who do I call for an interpreter? |  |
| How far in advance do I need to call? |  |
| How can I get a face-to-face interpreter in the provider’s office? |  |
| * What if I need OB/GYN care? (MCO will use HHSC’s provided language – **Attachment O**.) |  |
| Do I or my child have the right to choose an OB/GYN? |  |
| How do I choose an OB/GYN? |  |
| If I do not choose an OB/GYN, do I or my child have direct access? |  |
| Will I need a referral? |  |
| Can I or my child stay with my OB/GYN if they are not with (insert health plan name)? |  |
| * What if I or my child is pregnant? |  |
| Who do I need to call? |  |
| What other services/activities/education does the health plan offer pregnant women? |  |
| * Where can I find a list of birthing centers? |  |
| How soon can I or my child be seen after contacting my/my child’s OB/GYN for an appointment? (Access requirement for prenatal care is within 2 weeks of request.) |  |
| * Can I pick a Primary Care Provider for my baby before the baby is born? |  |
| How and when can I switch my baby’s Primary Care Provider? |  |
| * How do I sign up my newborn baby? |  |
| How and when do I tell my health plan? |  |
| How and when do I tell my caseworker? |  |
| * Who do I call if I or my child has special healthcare needs and need someone to help? |  |
| * What if I or my child is too sick to make a decision about medical care? |  |
| What are advance directives? |  |
| How do I get an advance directive? |  |
| * What if I get a bill from my/my child’s doctor? |  |
| Who do I call? |  |
| What information will they need? |  |
| * What are my/my child’s rights and responsibilities? (MCO will use HHSC’s provided language – **Attachment P**.) |  |
| * What if I or my child need durable medical equipment (DME) or other products normally found in a pharmacy? (MCO will use HHSC’s provided language – **Attachment Q**.) |  |
| * How does the Patient Protection and Affordable Care Act affect me? (MCO will use HHSC's provided language -- **Attachment R**) |  |
| **I. Medical Consenter** |  |
| * What is a Medical Consenter? |  |
| * What is my role as a Medical Consenter? |  |
| **J. Complaint Process** |  |
| The following questions must be included and answered in the handbook: |  |
| * What should I do if I have a Complaint? (Optional HHSC provided language – **Attachment S**.) |  |
| Who do I call? (Include at least one toll-free telephone number) |  |
| Can someone from (insert MCO name) help me file a Complaint? |  |
| How long will it take to process my Complaint? |  |
| Requirements and timeframes for filing a Complaint. |  |
| * + - Information on how to file a Complaint with HHSC, once I have gone through the (insert MCO name) Complaint process.     - MDCP/DBMD escalation help line (MCO will use HHSC’s provided language) - (Attachment Y) |  |
| **K. Appeal Process** |  |
| The following questions must be included and answered in the handbook: |  |
| * What can I do if my doctor asks for a service or medicine for me that’s covered but the health plan denies it or limits it? |  |
| * How will I find out if services are denied? |  |
| Timeframes for the Appeals process – the MCO must complete the entire standard Appeal process within 30 Days after receipt of the initial written or oral request for Appeal. This deadline may be extended for up to 14 Days at the request of a Member;; or the MCO shows that there is a need for more information and how the delay is in the Member’s interest. If the MCO needs to extend, the Member must receive written notice of the reason for delay.  When does a Member have the right to ask for an Appeal – include option for the request of an Appeal for denial of payment for services in whole or in part. |  |
|  |  |
| Include notification to Member that in order to ensure continuity of current authorized services, the Member must file the Appeal on or before the later of: 10 Days following the MCO’s mailing of the notice of the Action or the intended effective date of the proposed Action. Appeals must be accepted orally or in writing. |  |
|  |  |
| Can someone from (insert MCO name) help me file an Appeal? |  |
| * + Member’s option to request an External Medical Review and State Fair Hearing no later than 120 Days after the MCO mails the appeal decision notice.   + Member’s option to request only a State Fair Hearing no later than 120 Days after the MCO mails the appeal decision notice. |  |
| **L. Expedited MCO Appeal** |  |
| The following questions must be included and answered in the handbook: |  |
| * What is an emergency Appeal? (MCO will use HHSC’s provided language **– Attachment T**.) |  |
| * How to ask for an emergency Appeal (must be accepted orally or in writing) * Does my request have to be in writing? (Must be accepted orally or in writing) |  |
| * What are the timeframes for an emergency Appeal? |  |
| * + What happens if the health plan denies the request for an emergency Appeal? |  |
| * + Who can help me file an emergency Appeal? |  |
| **M. State Fair Hearing** (MCO will use HHSC’s provided language – (**Attachment U**.) |  |
| **N. External Medical Review (MCO will use HHSC’s provided language – (Attachment X).**  **O. Fraud Contacts** |  |
| The following question must be included and answered in the handbook: |  |
| * + How do I report someone who is misusing/abusing the Programs or services? (MCO will use HHSC’s provided language – **Attachment V**.) |  |
| **P. Information That Must Be Available on an Annual Basis** (MCO will use HHSC’s provided language – **Attachment W**.) |  |
| **III. Back Cover** |  |
| Month and year can be on the front or back cover. |  |

REQUIRED LANGUAGE

ATTACHMENT A

## Your Texas Benefits (YTB) Medicaid Card

When you or your child are approved for Medicaid, you will get a YTB Medicaid Card. This plastic card will be your everyday Medicaid card. You should carry and protect it just like your driver’s license or a credit card. Your doctor can use the card to find out if you or your child have Medicaid benefits when you go for a visit.

You will be issued only one card and you will receive a new card only if your card is lost or stolen. If you are currently in Foster Care (FC) and your Medicaid card is lost or stolen, you can get a new one by calling your assigned caseworker. If you are currently receiving Adoption Assistance (AA) or Permanency Care Assistance (PCA) and your Medicaid card is lost or stolen, you can get a new one by calling the Texas Adoption Resource Exchange (TARE) line toll-free at 1-800-233-3405.

If you are not sure if you are covered by Medicaid, you can find out by calling toll-free at 2-1-1 or 877-541-7905. First pick a language and then pick option 2.

The Your Texas Benefits Medicaid card has these facts printed on the front:

* Your name and Medicaid ID number.
* The date the card was sent to you.
* The name of the Medicaid program you’re in. This would be STAR Health.
* Facts your drug store will need to bill Medicaid.

If you forget your card, your doctor, dentist, or drug store can use the phone or the Internet to make sure you get Medicaid benefits.

## Su tarjeta Your Texas Benefits (YTB) de Medicaid

Cuando usted o su hijo obtengan la aprobación para Medicaid, recibirán una tarjeta YTB de Medicaid. Esta tarjeta de plástico será su tarjeta de Medicaid para todos los días. Debe llevarla consigo, debidamente resguardada, tal y como se hace con la licencia de manejar o una tarjeta de crédito. Cuando usted vaya a una cita médica, el médico puede usar la tarjeta para saber si usted o su hijo son beneficiarios de Medicaid.

Se le dará una sola tarjeta, y solo en caso de que la pierda o se la roben recibirá una nueva tarjeta. Si actualmente está en un hogar de acogida y pierde su tarjeta de Medicaid o se la roban, puede obtener una nueva llamando a su trabajador social asignado. Si en la actualidad está recibiendo Asistencia para la Adopción (AA) o Ayuda para el Cuidado de Permanencia (PCA) y ha perdido su tarjeta de Medicaid o se la han robado, puede obtener una nueva llamando a la línea gratuita de Intercambio de Recursos para la Adopción en Texas (TARE), al 800-233-3405.

Si no está seguro de si tiene cobertura de Medicaid, puede averiguarlo llamando a los números gratuitos 2-1-1 o al 877-541-7905. Primero, seleccione el idioma y después oprima el 2.

La tarjeta Your Texas Benefits de Medicaid tiene estos datos impresos en el frente:

* Su nombre y número de identificación de Medicaid.
* La fecha en que se le envió a usted la tarjeta.
* El nombre del programa de Medicaid en el que está inscrito. En este caso sería el programa STAR Health.
* Los datos que su farmacia necesitará para facturarle a Medicaid.

Si olvida su tarjeta, el médico, el dentista o la farmacia pueden asegurarse, ya sea por teléfono o por Internet, de que usted reciba los beneficios de Medicaid.

REQUIRED LANGUAGE

ATTACHMENT B

## How many times can I change my/my child’s primary care provider?

There is no limit on how many times you can change your or your child’s primary care provider.  You can change primary care providers by calling us toll-free at (insert MCO’s toll- free Member Hotline phone number) or writing to (insert MCO’s contact information.)

[**Note**:  if the MCO allows Members to submit primary care provider change requests through its website, please add language regarding this process.]

## ¿Cuántas veces puedo cambiar mi proveedor de cuidado primario o el de mi hijo?

No hay límite en el número de veces que puede cambiar su proveedor de cuidado primario o el de su hijo. Puede cambiar de proveedor de cuidado primario llamándonos gratis al (insert MCO’s toll-free Member Hotline phone number) o escribiendo a (insert MCO’s contact information).

REQUIRED LANGUAGE

ATTACHMENT C

## Physician Incentive Plans (Planes de incentivos para doctores)

**If the MCO offers a physician incentive plan that rewards doctors for treatments that reduce or limit services covered by Medicaid:**

(Insert name of MCO) rewards doctors for treatments that reduce or limit services for people covered by Medicaid. You have the right to know if your primary care provider (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can call (insert toll-free telephone number) to learn more about this.

(Insert name of MCO) premia a los doctores cuyos tratamientos reducen o limitan los servicios prestados a las personas cubiertas por Medicaid. Usted tiene el derecho de saber si su proveedor de cuidado primario (doctor de cabecera) participa en el plan de incentivos para doctores. También tiene el derecho de saber cómo funciona el plan. Puede llamar gratis al (insert toll-free telephone number) para más información.

**If the MCO does not offer a physician incentive plan that rewards doctors for treatments that reduce or limit services covered by Medicaid:**

A physician incentive plan rewards doctors for treatments that reduce or limit services for people covered by Medicaid. Right now, (insert name of MCO) does not have a physician incentive plan.

Un plan de incentivos para doctores premia a los doctores cuyos tratamientos reducen o limitan los servicios prestados a las personas cubiertas por Medicaid. En este momento, (insert name of MCO) no tiene un plan de incentivos para doctores.

REQUIRED LANGUAGE

ATTACHMENT D

**Medically Necessary** means:

1. For Members birth through age 20, the following Texas Health Steps services:
   1. screening, vision, dental, and hearing services; and
   2. other Healthcare Services, including Behavioral Health 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:
      1. must comply with the requirements of the *Alberto N., et al. v. Janek, et al*. partial settlement agreements; and
      2. may include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) and (3)(b-g) of this definition.
2. Acute care services, other than behavioral health services, that are:
   1. reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a member, or endanger life;
   2. provided at appropriate facilities and at the appropriate levels of care for the treatment of a member’s health conditions;
   3. consistent with healthcare practice guidelines and standards that are endorsed by professionally recognized healthcare organizations or governmental agencies;
   4. consistent with the diagnoses of the conditions;
   5. no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
   6. are not experimental or investigative; and
   7. are not primarily for the convenience of the member or provider; and
3. Behavioral health services that are:
   1. are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
   2. are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
   3. are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
   4. are the most appropriate level or supply of service that can safely be provided;
   5. could not be omitted without adversely affecting the member’s mental and/or physical health or the quality of care rendered;
   6. are not experimental or investigative; and
   7. are not primarily for the convenience of the member or provider.

**Médicamente necesario** significa:

1. Para los miembros desde nacimiento hasta los 20 años, los siguientes servicios de Pasos Sanos de Texas:
   1. servicios de detección para la vista, dental y la audición; y
   2. otros servicios de atención médica, entre ellos, servicios de salud mental y abuso de sustancias, que son necesarios para corregir o eliminar un defecto o una enfermedad o un padecimiento físico o mental. La determinación de que un servicio es necesario para corregir o eliminar un defecto o una enfermedad o un padecimiento físico o mental:
      1. tiene que cumplir con los requisitos del acuerdo conciliatorio parcial de *Alberto N., et al. v. Janek, et al*.; y
      2. puede incluir la consideración de otros factores relevantes, como los criterios descritos en las partes (2)(b-g) y (3)(b-g) de esta definición.
2. Los servicios de atención de casos agudos, aparte de los de salud mental y abuso de sustancias que:
   1. son razonables y necesarios para evitar enfermedades o padecimientos médicos, detectar a tiempo enfermedades, hacer intervenciones o para tratar padecimientos médicos que provoquen dolor o sufrimiento, para prevenir enfermedades que causen deformaciones del cuerpo o que limiten el movimiento, que causen o empeoren una discapacidad, que provoquen enfermedad o pongan en riesgo la vida del miembro;
   2. se prestan en instalaciones adecuadas y al nivel de atención adecuado para el tratamiento del padecimiento médico del miembro;
   3. cumplen con las pautas y normas de calidad de atención médica aprobadas por organizaciones profesionales de atención médica o por departamentos del gobierno;
   4. son acordes con el diagnóstico del padecimiento;
   5. son lo menos invasivos o restrictivos posible para permitir un equilibrio de seguridad, efectividad y eficacia;
   6. no son experimentales ni de estudio; Y
   7. no son principalmente para la conveniencia del miembro o proveedor; y
3. Servicios de salud mental y abuso de sustancias que:
   1. son razonables y se necesitan para diagnosticar o tratar los problemas de salud mental o de abuso de sustancias, o para mejorar o mantener el funcionamiento o para evitar que los problemas de salud mental empeoren;
   2. cumplen con las pautas y normas clínicas aceptadas en el campo de la salud mental y el abuso de sustancias;
   3. se prestan en el lugar más adecuado y menos restrictivo y en donde hay un ambiente seguro;
   4. se prestan al nivel más adecuado de servicios que puedan prestarse sin riesgos;
   5. no se pueden negar sin verse afectada la salud mental o física del miembro o la calidad de la atención prestada;
   6. no son experimentales ni de estudio; Y
   7. no son principalmente para la conveniencia del miembro o proveedor.

REQUIRED LANGUAGE

ATTACHMENT E

**Emergency Medical Condition** means:

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 could result in:

1. placing the patient’s health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.

**Padecimiento médico de emergencia** significa:

Un padecimiento médico que se manifiesta con síntomas agudos de tal severidad (incluso dolor muy fuerte) que la persona prudente, que tenga conocimientos promedio sobre la salud y la medicina, podría deducir que la falta de atención médica inmediata podría tener como resultado lo siguiente:

1. poner en grave peligro la salud del paciente;
2. ocasionar problemas graves en las funciones corporales;
3. ocasionar disfunción grave de algún órgano vital o parte del cuerpo;
4. causar desfiguración grave; O
5. en el caso de una mujer embarazada, poner en grave peligro la salud de la mujer o del feto.

REQUIRED LANGUAGE

ATTACHMENT F

## What Is Urgent Medical Care?

Another type of care is **urgent care**. There are some injuries and illnesses that are probably not emergencies but can turn into emergencies if they are not treated within 24 hours. Some examples are:

* Minor burns or cuts
* Earaches
* Sore throat
* Muscle sprains/strains

## What should I do if my child or I need urgent medical care?

For urgent care, you should call your doctor’s office even on nights and weekends. Your doctor will tell you what to do. In some cases, your doctor may tell you to go to an urgent care clinic. If your doctor tells you to go to an urgent care clinic, you don’t need to call the clinic before going. You need to go to a clinic that takes (insert name of MCO) Medicaid. For help, call us toll-free at (insert MCO’s toll-free Member Hotline phone number). *If health plan has a 24-hour nurse helpline, insert the following language* -- You also can call our 24-hour Nurse HelpLine at 1-xxx-xxx-xxxx for help with getting the care you need.

## How Soon Can I Expect to Be Seen?

You should be able to see your doctor within 24 hours for an urgent care appointment. If your doctor tells you to go to an urgent care clinic, you do not need to call the clinic before going. The urgent care clinic must take (insert name of MCO) Medicaid.

## ¿Qué es la atención médica urgente?

La **atención urgente** es otro tipo de atención. Hay algunas enfermedades y lesiones que quizás no sean emergencias pero pueden convertirse en una emergencia si no se tratan dentro de 24 horas. Algunos ejemplos son:

* Quemaduras o cortadas pequeñas
* Dolores de oído
* Dolores de garganta
* Torceduras o esguinces musculares

## ¿Qué debo hacer si mi hijo o yo necesitamos atención médica urgente?

Para la atención urgente, debe llamar al consultorio de su doctor incluso por la noche y los fines de semana. El doctor le dirá qué hacer. En algunos casos, el doctor quizás le diga que vaya a la clínica de atención urgente. Si el doctor le dice que vaya a una clínica de atención urgente, no tiene que llamar a la clínica antes de ir. Tiene que ir a una clínica que acepte Medicaid de (insert name of MCO). Para recibir ayuda, llámenos gratis al (insert MCO’s toll-free Member Hotline phone number). *If health plan has a 24 hour nurse helpline, insert the following language* -- También puede llamar a nuestra Línea de Ayuda de Enfermeras las 24 horas al 1-xxx-xxx-xxxx para que le ayuden a obtener la atención que necesita.

## ¿Cuánto tiempo esperaré para que me vean?

Podrá ver su doctor dentro de 24 horas para una cita de cuidado urgente. Si su doctor le dice que vaya a una clínica de cuidado urgente, no necesita llamar a la clínica antes de ir. La clínica de cuidado urgente tiene que aceptar (insert name of MCO) Medicaid.

REQUIRED LANGUAGE

ATTACHMENT G

## What is post-stabilization?

Post-stabilization care services are services covered by Medicaid that keep your or your child’s condition stable following emergency medical care.

## ¿Que es la posestabilización?

Los servicios de atención de posestabilización son servicios cubiertos por Medicaid que mantienen a usted o a su hijo en un estado estable después de recibir atención médica de emergencia.

REQUIRED LANGUAGE

ATTACHMENT H

## What if I or my child gets sick when I or my child are out town or traveling?

If you or your child need medical care when traveling, call us toll-free at (insert MCO’s toll-free Member Hotline phone number) and we will help you find a doctor.

If you or your child need emergency services while travelling, go to a nearby hospital, then call us toll-free at (insert MCO’s toll-free Member Hotline phone number).

## ¿Qué hago si mi hijo o yo nos enfermamos cuando estamos fuera de la ciudad o de viaje?

Si usted o su hijo necesitan atención médica cuando está de viaje, llámenos gratis al (insert MCO's toll-free Member Hotline phone number) y le ayudaremos a encontrar a un doctor.

Si usted o su hijo necesitan servicios de emergencia cuando está de viaje, vaya a un hospital cercano, luego llámenos gratis al (insert MCO’s toll-free Member Hotline phone number).

REQUIRED LANGUAGE

ATTACHMENT I

## What if I or my child are out of the country?

Medical services performed out of the country are not covered by Medicaid.

## ¿Qué hago si mi hijo o yo estamos del país?

Medicaid no cubre los servicios médicos prestados fuera del país.

REQUIRED LANGUAGE

ATTACHMENT J

## How do I get my/my child’s medications?

Medicaid pays for most medicine your doctor says you or your child need. Your doctor will write a prescription so you can take it to the drug store, or may be able to send the prescription for you.

## ¿Cómo obtengo mis medicamentos o los de mi hijo?

Medicaid paga la mayoría de los medicamentos que el doctor dice que usted o su hijo necesitan. El doctor le dará una receta para que la lleve a la farmacia o tal vez pida el medicamento recetado por usted.

REQUIRED LANGUAGE

ATTACHMENT K

## What if I can’t get the medication my doctor ordered approved?

If your doctor cannot be reached to approve a prescription, you may be able to get a three-day emergency supply of your or your child’s medication.

Call [insert MCO name] at [insert toll-free number] for help with your medications and refills.

## ¿Qué pasa si no me aprueban la receta que el doctor pidió?

Si no se puede localizar al doctor para que apruebe un medicamento recetado para usted o su hijo, es posible que reciba un suministro de emergencia para 3 días.

Llame a [insert MCO name] al [insert toll-free number] para que le ayuden a obtener o volver a surtir los medicamentos.

REQUIRED LANGUAGE

ATTACHMENT L

## Where do I find a family planning services provider?

You can find the locations of family planning providers near you online at <http://www.dshs.state.tx.us/famplan/locator.shtm>, or you can call [insert MCO’s name] at [insert MCO’s toll-free number] for help in finding a family planning provider.

## ¿Cómo encuentro a un proveedor de servicios de planificación familiar?

Puede encontrar en Internet la dirección de los proveedores de planificación familiar cercanos en <http://www.dshs.state.tx.us/famplan/locator.shtm>, o puede llamar a [insert MCO’s name] al [insert MCO’s toll-free number] para recibir ayuda para encontrar a un proveedor de planificación familiar.

REQUIRED LANGUAGE

ATTACHMENT M

## Case Management for Children and Pregnant Women

Need help finding and getting services? You might be able to get a case manager to help you.

### Who can get a case manager?

Children, teens, young adults (birth through age 20) and pregnant women who get Medicaid and:

* have health problems, or
* are at a high risk for getting health problems.

Note: Only for STAR Health Members in categories 3, 4, 5 and 6 of the Target Population

### What do case managers do?

A case manager will visit with you and then:

* Find out what services you need.
* Find services near where you live.
* Teach you how to find and get other services.
* Make sure you are getting the services you need.

### What kind of help can you get?

Case managers can help you:

* Get medical and dental services.
* Get medical supplies or equipment.
* Work on school or education issues.
* Work on other problems.

### How can you get a case manager?

Contact your <MCO name> for more information or call Texas Health Steps at 1-877-847-8377 (toll-free), Monday to Friday, 8 a.m. to 8 p.m.

*[MCOs may include the following optional information:]*

* <MCO name> Case Management phone:
* <MCO name> Website:

## Administración de Casos para Mujeres Embarazadas y Niños

¿Necesita ayuda para encontrar y recibir servicios? Quizás un administrador de casos pueda ayudarle.

### ¿Quién puede obtener un administrador de casos?

Los niños, adolescentes, adultos jóvenes, desde el nacimiento hasta los 20 años, y las mujeres embarazadas que reciben Medicaid y:

* Tienen problemas de salud, o
* Corren un alto riesgo de desarrollar problemas de salud.

### Nota: Solo para Miembros de STAR Health en las categorías 3, 4, 5 y 6 de la Población objetivo

### ¿Qué hacen los administradores de casos?

Un administrador de casos se reunirá con usted y entonces:

* Se enterará de qué servicios necesita usted.
* Encontrará servicios cerca de donde vive.
* Le enseñará cómo encontrar y recibir otros servicios.
* Se asegurará de que usted está recibiendo los servicios que necesita.

### ¿Qué tipo de ayuda puede recibir?

Los administradores de casos pueden ayudarle a:

* Recibir servicios médicos y dentales.
* Obtener artículos o equipo médicos.
* Trabajar en asuntos escolares o educativos.
* Tratar otros problemas.

### ¿Cómo puede usted obtener un administrador de casos?

Comuníquese con su <nombre de la MCO> para obtener más información o llame a Pasos Sanos de Texas al 1-877-847-8377 (llamada gratuita), de lunes a viernes, de 8 a. m. a 8 p. m.

[MCOs may include the following optional information:]

* <Nombre de la MCO> Teléfono de administración de casos:
* • Sitio web de <nombre de la MCO>.

REQUIRED LANGUAGE

ATTACHMENT N

## NONEMERGENCY MEDICAL TRANSPORTATION (NEMT) SERVICES

**(<MCO name of transportation program>, if applicable)**

### What <are NEMT services or is MCO name of transportation program>?

<NEMT services provide or MCO name of transportation program provides> transportation to nonemergency health care appointments for Members who have no other transportation options. These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get Medicaid services. These trips do NOT include ambulance trips.

### What services are part of <NEMT services or MCO name of transportation program>?

* Passes or tickets for transportation such as mass transit within and between cities or states including by rail or bus.
* Commercial airline transportation services.
* Demand response transportation services, which is curb-to-curb transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
* Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be you, a responsible party, a family member, a friend, or a neighbor.
* If you are 20 years old or younger, you may be able to receive the cost of meals associated with a long-distance trip to obtain health care services. The daily rate for meals is $25 per day for you and $25 per day for an approved attendant.
* If you are 20 years old or younger, you may be able to receive the cost of lodging associated with a long-distance trip to obtain health care services. Lodging services are limited to the overnight stay and do not include any amenities used during your stay, such as phone calls, room service, or laundry service.
* If you are 20 years old or younger, you may be able to receive funds in advance of a trip to cover authorized NEMT services.

If you need an attendant to travel to your appointment with you, <NEMT services> or <MCO name of transportation program> will cover the transportation costs of your attendant.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years old must be accompanied by a parent, guardian, or other authorized adult or have the consent of a parent, guardian, or other authorized adult on file to travel alone. Parental consent is not required if the health care service is confidential in nature.

**How to get a ride?**

Your MCO will provide you with information on how to request <NEMT services or MCO name of transportation program>. You should request NEMT services as early as possible, and at least two business days before you need the NEMT service. In certain circumstances you may request the NEMT service with less notice. These circumstances include being picked up after being discharged from a hospital; trips to the pharmacy to pick up medication or approved medical supplies; and trips for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.

You must notify your MCO as soon as possible prior to the approved and scheduled trip if your medical appointment is cancelled.

## SERVICIOS DE TRANSPORTE MÉDICO QUE NO ES DE EMERGENCIA (NEMT)

**(<Nombre del programa de transporte de la Organización de atención médica administrada (MCO)>, si corresponde)**

### ¿Qué <son los servicios de NEMT o cuál es el nombre del programa de transporte de la Organización de atención médica administrada (MCO)>?

<Los servicios de NEMT proporcionan o el [nombre del programa de transporte] de la MCO proporciona> transporte a las citas médicas que no son de emergencia para los miembros que no tienen otras opciones de transporte. Estos viajes incluyen los traslados al médico, al dentista, al hospital, a la farmacia y a otros lugares en los que usted recibe servicios de Medicaid. Estos viajes NO incluyen los viajes en ambulancia.

### ¿Qué servicios forman parte de <los servicios de NEMT o el nombre del programa de transporte de la Organización de atención médica administrada (MCO)>?

* Pases o boletos para transporte, como el transporte público en y entre ciudades o estados, incluyendo el tren o el autobús.
* Servicios de transporte aéreo comercial.
* Servicios de transporte a la demanda, que es el transporte desde su casa al lugar de la cita en autobús privado, minivan o automóvil, incluidos los vehículos accesibles para sillas de ruedas, si es necesario.
* Reembolso del millaje para un participante a cargo del transporte individual (ITP) por un viaje verificado y completo a un servicio médico cubierto. El ITP puede ser usted, un responsable, un familiar, un amigo o un vecino.
* Si tiene 20 años o menos, podría recibir el costo de las comidas relacionadas con un viaje de larga distancia para obtener servicios médicos. La tarifa diaria de las comidas es de $25 por día para usted y $25 por día para un acompañante aprobado.
* Si tiene 20 años o menos, podría recibir el costo del alojamiento relacionado con un viaje de larga distancia para obtener servicios médicos. Los servicios de alojamiento se limitan a la estancia de una noche y no incluyen los servicios utilizados durante la estancia, como llamadas telefónicas, servicio de habitaciones o servicio de lavandería.
* Si tiene 20 años o menos, podría recibir fondos antes de un viaje para cubrir los servicios de NEMT autorizados.

Si necesita que un acompañante viaje a su cita con usted, <servicios de NEMT> o <nombre del programa de transporte de la MCO> cubrirá los gastos de transporte de su acompañante.

Los niños de 14 años o menos deben ir acompañados por un padre, tutor u otro adulto autorizado. Los jóvenes de 15 a 17 años deben ir acompañados por un padre, tutor u otro adulto autorizado o tener el consentimiento de un padre, tutor u otro adulto autorizado en los archivos para viajar solos. El consentimiento de los padres no es necesario si el servicio médico es de carácter confidencial.

**Cómo obtener transporte**

Su MCO le proporcionará información sobre cómo solicitar <servicios de NEMT o nombre del programa de transporte de la MCO>. Debe solicitar los servicios NEMT con la mayor anticipación posible, y al menos dos días hábiles antes de necesitar el servicio de NEMT. Solo en determinadas circunstancias, podrá solicitar el servicio NEMT con menos anticipación. Estas circunstancias incluyen la recogida después de recibir el alta de un hospital; los viajes a la farmacia para recoger medicamentos o suministros médicos aprobados; y los viajes por problemas de salud urgentes. Un problema de salud urgente es aquel que no es una emergencia, pero que es lo suficientemente grave o doloroso como para requerir tratamiento en un plazo de 24 horas.

En caso de cancelación de la cita médica, deberá notificar a su MCO tan pronto como sea posible antes del viaje aprobado y programado.

REQUIRED LANGUAGE

ATTACHMENT O

MCO has a choice of language in Attachment O, depending on whether or not the selection of an OB/GYN is limited to the Primary Care Provider’s network.

## Select the language that applies to your Health Plan

OPtion 1: MCO DOES NOT LIMIT TO PCP’S NETWORK

#### ATTENTION FEMALE MEMBERS

(Insert Name of MCO) allows you to pick any OB/GYN, whether that doctor is in the same network as your Primary Care Provider or not.

You have the right to pick an OB/GYN without a referral from your Primary Care Provider. An OB/GYN can give you:

* One well-woman checkup each year.
* Care related to pregnancy.
* Care for any female medical condition.
* Referral to special doctor within the network.

#### AVISO IMPORTANTE PARA LA MUJER

(Insert Name of MCO) le permite escoger a cualquier ginecoobstetra, esté o no en la misma red que su proveedor de cuidado primario.

Usted tiene el derecho de escoger a un ginecoobstetra sin un envío a servicios del proveedor de cuidado primario. Un ginecoobstetra le puede brindar:

* Un examen preventivo para la mujer cada año.
* Atención relacionada con el embarazo.
* Tratamiento de los problemas médicos de la mujer.
* Envíos para ver a un especialista de la red.

oPTION 2: mco LIMITS SELECTION TO PCP’S NETWORK

#### ATTENTION FEMALE MEMBERS

(Insert Name of MCO) allows you to pick an OB/GYN but this doctor must be in the same network as your Primary Care Provider.

You have the right to pick an OB/GYN without a referral from your Primary Care Provider. An OB/GYN can give you:

* One well-woman checkup each year.
* Care related to pregnancy.
* Care for any female medical condition.
* Referral to special doctor within the network.

#### AVISO IMPORTANTE PARA LA MUJER

(Insert Name of MCO) le permite escoger a un ginecoobstetra, pero este doctor tiene que estar en la misma red que su proveedor de cuidado primario.

Usted tiene el derecho de escoger a un ginecoobstetra sin un envío a servicios del proveedor de cuidado primario. Un ginecoobstetra le puede brindar:

* Un examen preventivo para la mujer cada año.
* Atención relacionada con el embarazo.
* Tratamiento de los problemas médicos de la mujer.
* Envíos para ver a un especialista de la red.

REQUIRED LANGUAGE

ATTACHMENT P

## MEMBER RIGHTS and RESPONSIBILITIES

**MEMBER RIGHTS:**

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
   1. Be treated fairly and with respect.
   2. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a primary care provider. This is the doctor or healthcare provider you will see most of the time and who will coordinate your care. You have the right to change to another provider in a reasonably easy manner. That includes the right to:
   1. Be told how to choose and change your primary care provider
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   1. Have your provider explain your healthcare needs to you and talk to you about the different ways your healthcare problems can be treated.
   2. Be told why care or services were denied and not given.
   3. Be given information about your health plan, services, and providers.

d. Be told about your rights and responsibilities.

1. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   1. Work as part of a team with your provider in deciding what healthcare is best for you.
   2. Say yes or no to the care recommended by your provider.
2. You have the right to use each complaint and appeal process available through the STAR Health health plan and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
   1. Make a complaint to the STAR Health health plan or to the state Medicaid Program about your healthcare, your provider, or the STAR Health health plan.
   2. MDCP/DBMD escalation help line for Members receiving Waiver services via the Medically Dependent Children Program or Deaf/Blind Multi-Disability Program. (Attachment Y)
   3. Get a timely answer to your complaint.
   4. Use the HHSC claims administrator’s and STAR Health plan’s appeal process and be told how to use it.
   5. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   6. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.
3. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   1. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   2. Get medical care in a timely manner.
   3. Be able to get in and out of a healthcare provider’s office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   4. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   5. Be given information you can understand about your health plan rules, including the healthcare services you can get and how to get them.
4. You have the right to not be restrained or secluded when doing so is for someone else’s convenience, is meant to force you to do something you do not want to do, or to punish you.
5. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child’s health status, medical care, and treatment.  Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
6. You have a right to know that you are not responsible for paying for covered services provided to your child.  Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.
7. 10. You have a right to make recommendations to your health plan’s member rights and responsibilities policy

**MEMBER RESPONSIBILITIES:**

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   1. Learn and understand your rights under the Medicaid program.
   2. Ask questions if you do not understand your rights.
2. You must abide by the STAR Health health plan’s policies and procedures and Medicaid policies and procedures. That includes the responsibility to:
   1. Learn and follow the STAR Health health plan’s rules and Medicaid rules.
   2. Choose a primary care provider quickly.
   3. Make any changes in your primary care provider in the ways established by Medicaid and by the STAR Health health plan.
   4. Keep your scheduled appointments.
   5. Cancel appointments in advance when you can not keep them.
   6. Always contact your primary care provider first for your non-emergency medical needs.
   7. Be sure you have approval from your primary care provider before going to a specialist.
   8. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
   1. Tell your primary care provider about your health.
   2. Talk to your providers about your healthcare needs and ask questions about the different ways your healthcare problems can be treated.
   3. Help your providers get your medical records.
4. You must comply with Electronic Visit Verification requirements if you receive services delivered by an attendant or nursing services by allowing the attendant to use your telephone to call a toll-free number when he or she starts and ends work, or allow the attendant to use alternate devices when he or she starts and ends work.
5. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:
   1. Work as a team with your provider in deciding what healthcare is best for you.
   2. Understand how the things you do can affect your health.
   3. Do the best you can to stay healthy.
   4. Treat providers and staff with respect.
   5. Talk to your provider about all of your medications.

6. Additional Member Responsibilities while using <NEMT services> or <MCO name of transportation program>:

1. When requesting NEMT services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT services to travel to and from your medical appointments.
7. If you have arranged for an NEMT service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at [www.hhs.gov/ocr](http://www.hhs.gov/ocr)

## DERECHOS y RESPONSABILIDADES DEL MIEMBRO

**DERECHOS DEL MIEMBRO:**

1. Tiene el derecho de ser respetado, conservar la dignidad, la privacidad, la confidencialidad y de no ser discriminado. Esto incluye el derecho de:
   1. Ser tratado justa y respetuosamente.
   2. Saber que se respetarán la privacidad y la confidencialidad de sus expedientes médicos y las discusiones que sostenga con los proveedores.
2. Tiene el derecho a una oportunidad razonable de escoger un plan de salud y un proveedor de cuidado primario. Este es el doctor o proveedor de atención médica que usted verá la mayoría de las veces y que coordinará su atención. Usted tiene el derecho de cambiar a otro plan o proveedor de una manera razonablemente sencilla. Esto incluye el derecho de:
   1. Ser informado de cómo elegir y cambiar de proveedor de atención primaria
3. Tiene el derecho de hacer preguntas y obtener respuestas sobre cualquier cosa que no entienda. Esto incluye el derecho de:
   1. Recibir explicaciones del proveedor sobre sus necesidades de atención médica y a que le hable de las diferentes opciones que tiene para tratar sus problemas médicos.
   2. Recibir explicaciones de por qué se le negó y no se le dio la atención o el servicio.
   3. Recibir información sobre su plan médico, servicios y proveedores.
   4. Ser informado de sus derechos y responsabilidades.
4. Tiene el derecho de aceptar tratamiento o rechazarlo, y de tomar parte activa en las decisiones sobre el tratamiento. Esto incluye el derecho de:
   1. Colaborar como parte del equipo con su proveedor y decidir cuál atención médica es mejor para usted.
   2. Aceptar o rechazar el tratamiento recomendado por su proveedor.
5. Tiene el derecho de utilizar todos los trámites de quejas y apelación disponibles mediante el plan médico STAR Health y Medicaid, y de recibir una respuesta oportuna a las quejas, apelaciones, revisiones médicas externas y audiencias imparciales estatales. Esto incluye el derecho de:
   1. Presentar una queja ante su plan médico STAR Health o el programa estatal de Medicaid con respecto a la atención médica, el proveedor o el plan médico STAR Health.
   2. Usar la línea de ayuda de escalación de los programas MDCP/DBMD para los miembros que reciben servicios opcionales a través del Programa para Menores Médicamente Dependientes o del Programa para Personas Sordociegas o con Discapacidades Múltiples (MDCP/DBMD). (Anexo Y)
   3. Recibir una respuesta oportuna a su queja.
   4. Usar el trámite de apelaciones del administrador de reclamaciones de la HHSC y del plan médico STAR Health y recibir información sobre cómo usarlo.
   5. Pedir una revisión médica externa y una audiencia imparcial estatal del programa estatal de Medicaid y recibir información sobre cómo funciona ese proceso.
   6. Pedir una audiencia imparcial estatal sin una revisión médica externa del programa estatal de Medicaid y recibir información sobre cómo funciona ese proceso.
6. Tiene derecho a acceso oportuno a servicios de atención médica sin obstáculos físicos ni de comunicación. Esto incluye el derecho de:
   1. Tener acceso telefónico a un profesional médico las 24 horas del día, los 7 días de la semana para recibir cualquier atención de emergencia o urgente que necesite.
   2. Recibir atención médica de manera oportuna.
   3. Poder entrar y salir del consultorio de cualquier proveedor de atención médica. Si tiene alguna discapacidad o padecimiento que le dificulte la movilidad, esto incluye el acceso sin barreras de acuerdo con la Ley para Estadounidenses con Discapacidades.
   4. Obtener los servicios de un intérprete, si son necesarios, durante las citas con sus proveedores o cuando se comunique con el personal del plan médico. Los intérpretes son personas que hablan la lengua materna del cliente, ayudan a alguien que tiene una discapacidad o le ayuda a entender la información.
   5. Recibir información clara sobre las reglas del plan médico, incluso cuáles son los servicios de salud que se ofrecen y cómo obtenerlos.
7. Tiene el derecho de no ser sujetado a la fuerza ni aislado si es por conveniencia de otra persona, o para forzarlo a hacer algo que usted no quiere hacer o para castigarlo.
8. Tiene el derecho de saber que los médicos, hospitales y otras personas que atienden a su hijo pueden aconsejarle sobre el estado de salud, la atención médica y el tratamiento de su hijo. El plan médico no puede impedir que ellos le den esta información, aunque la atención o tratamiento no sea un servicio cubierto.
9. Tiene el derecho de saber que no es responsable de pagar los servicios cubiertos que se le ofrecieron a su hijo. Los médicos, hospitales y otros proveedores no pueden exigirle a hacer copagos ni pagar ninguna otra suma adicional por los servicios cubiertos.
10. Tiene el derecho de hacer sugerencias sobre las normas de derechos y responsabilidades de los miembros de su plan médico.

**RESPONSABILIDADES DEL MIEMBRO:**

1. Tiene que aprender y entender cada uno de los derechos que tiene con el programa de Medicaid. Es decir, tiene la responsabilidad de:
   1. Aprender y entender sus derechos con el programa de Medicaid.
   2. Preguntar, si no entiende cuáles son sus derechos.
   3. Saber qué otras opciones de planes de salud hay en su área.
2. Tiene que respetar las normas y los procedimientos del STAR Health plan de salud y de Medicaid. Es decir, tiene la responsabilidad de:
   1. Aprender y seguir las normas del plan de salud y de Medicaid.
   2. Escoger su STAR Health plan de salud y su proveedor de cuidado primario sin demora.
   3. hacer cualquier cambio de STAR Health plan de salud y de proveedor de cuidado primario, según lo indiquen Medicaid y el STAR Health plan de salud.
   4. Acudir a las citas programadas.
   5. Cancelar las citas con anticipación cuando no pueda asistir.
   6. siempre llamar primero a su proveedor de cuidado primario para sus necesidades médicas que no sean de emergencia;
   7. Estar seguro de que tiene la aprobación de su proveedor de cuidado primario antes de consultar a un especialista;
   8. Entender cuándo debe ir a la sala de emergencias y cuándo no.
3. Tiene que compartir con su proveedor de cuidado primario toda información sobre su salud y aprender sobre las opciones de servicio y tratamiento. Es decir, tiene la responsabilidad de:
   1. Informar a su proveedor de cuidado primario sobre su salud.
   2. Hablar con sus proveedores de sus necesidades de atención médica y preguntarles sobre las diferentes maneras de tratar sus problemas médicos.
   3. Ayudar a los proveedores a obtener su historia clínica.
   4. Si recibe servicios de un ayudante o de enfermería, tiene que cumplir con los requisitos de verificación electrónica de visita permitiéndole al ayudante o enfermera usar su teléfono para llamar gratis o usar otro aparato, cuando entre y salga del trabajo.
4. Tiene que participar en las decisiones que tengan que ver con las opciones de servicio y tratamiento, y tomar decisiones y acciones personales para estar saludable. Es decir, tiene la responsabilidad de:
   1. Trabajar en equipo con su proveedor para decidir cuál atención médica es la mejor para usted.
   2. Entender cómo pueden afectar su salud las cosas que usted hace.
   3. Hacer lo mejor que pueda para mantenerse saludable.
   4. Tratar a los proveedores y al personal con respeto.
   5. Hablar con su proveedor acerca de todos sus medicamentos.

5. Responsabilidades adicionales del miembro mientras usa <servicios de NEMT> o <nombre del programa de transporte de la MCO>:

1. Cuando solicite servicios de NEMT, debe proporcionar la información solicitada por la persona que organiza o verifica su transporte.
2. Debe seguir todas las normas y reglamentos que afectan a sus servicios de NEMT.
3. Debe devolver los fondos anticipados que no haya utilizado. Debe proporcionar un comprobante de que acudió a su cita médica antes de recibir futuros fondos anticipados.
4. No debe agredir o acosar verbal, sexual o físicamente a nadie mientras solicite o reciba servicios de NEMT.
5. No debe perder los boletos de autobús o las fichas y debe devolver los boletos de autobús o las fichas que no utilizó. Debe utilizar los boletos o las fichas de autobús únicamente para acudir a su cita médica.
6. Solo debe utilizar los servicios de NEMT para ir y volver de sus citas médicas.
7. Si ha hecho arreglos para un servicio de NEMT, pero algo cambia y ya no necesita el servicio, debe comunicarse lo antes posible con la persona que le ayudó a programar el transporte.

Si usted cree que lo han tratado injustamente o lo han discriminado, llame gratis al Departamento de Salud y Servicios Humanos (HHS) de EE. UU. al 1-800-368-1019. También puede ver información sobre la Oficina de Derechos Civiles del HHS en Internet en [www.hhs.gov/ocr](http://www.hhs.gov/ocr).

REQUIRED LANGUAGE

ATTACHMENT Q

## Durable Medical Equipment and Other Items Commonly Found in a Pharmacy:

Some durable medical equipment (DME) and products normally found in a pharmacy are covered by Medicaid. For all members, [Insert MCO name] pays for nebulizers, ostomy supplies, and other covered supplies and equipment if they are medically necessary. For children (birth through age 20), [insert MCO name] also pays for medically necessary prescribed over-the-counter drugs, diapers, formula, and some vitamins and minerals.

Call [insert MCO member hotline number] for more information about these benefits.

## Equipo médico duradero y otros artículos que se encuentran comúnmente en una farmacia:

Ciertos equipos médicos duraderos (DME) y productos que se encuentran normalmente en una farmacia están cubiertos por Medicaid. Para todos los miembros, [Insert MCO name] paga por nebulizadores, artículos para la ostomía y otros artículos y equipo si son médicamente necesarios. Para niños (desde el nacimiento hasta los 20 años), [insert MCO name] también paga artículos médicamente necesarios, como medicamentos recetados por un doctor que se compran sin receta, pañales, fórmula para bebés y algunas vitaminas y minerales.

Llame a [insert MCO member hotline number] para más información sobre estos beneficios.

REQUIRED LANGUAGE

ATTACHMENT R

## The Patient Protection and Affordable Care Act

Texas will provide Medicaid benefits to adults under age 26 who were in foster care and receiving Medicaid when they aged out. This program is called the Former Foster Care Children Program (FFCC).

FFCC Members will receive health care benefits in one of two programs. These are based on their age:

* Members who are 18-20 years old will continue to get their benefits in the STAR Health program, unless they want to change to a STAR plan.
* Members 21-25 years old will get their Medicaid benefits through a STAR plan of their choice.

The Medicaid for Transitioning Foster Care Youth (MTFCY) and Former Foster Care in Higher Education (FFCHE) programs are still available, but only for those that were *not* receiving Medicaid when they aged out of foster care.

For questions on eligibility requirements for youth aging out of foster care, please call 2-1-1. If you are calling from outside of Texas, you can also, dial the toll-free number at 1-877-541-7905. For TTY access, call 1-877-833-4211.

## Ley de Protección al Paciente y Cuidado de Salud a Bajo Costo

Texas brindará beneficios de Medicaid a adultos menores de 26 años que estaban bajo cuidado temporal y recibían Medicaid cuando llegaron a la edad límite. Este programa se llama Programa para Niños que Estaban en Cuidado Temporal (FFCC).

Las personas inscritas en el FFCC recibirán beneficios de atención médica por medio de uno de dos programas. Esto se basa en la edad:

* Las personas que tienen de 18 a 20 años seguirán recibiendo sus beneficios en el programa STAR Health, a menos que quieran cambiar a un plan de STAR.
* Las personas de 21 a 25 años recibirán sus beneficios de Medicaid a través de un plan STAR que ellos escogen.

Los programas Medicaid para Jóvenes que Salen del Cuidado Temporal (MTFCY) y Former Foster Care in Higher Education (FFCHE) están todavía disponibles, pero solo para aquellos que *no* recibían Medicaid cuando salieron del cuidado temporal a la edad límite.

Si tiene preguntas sobre los requisitos de elegibilidad para jóvenes que salen de cuidado temporal debido a su edad, por favor, llame al 211. Si llama desde fuera de Texas, marque el número gratis: 1-877-541-7905. Para tener acceso a TTY, llame al 1-877-833-4211.

REQUIRED LANGUAGE

ATTACHMENT S

## COMPLAINTS

### What should I do if I have a complaint?

We want to help. If you have a complaint, please call us toll-free at (insert Member Services hotline number) to tell us about your problem. A (insert MCO’s name) Member Services Advocate can help you file a complaint. Just call (insert Member Services hotline number). Most of the time, we can help you right away or at the most within a few days.

Once you have gone through the (insert MCO name) complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free at 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission

Ombudsman Managed Care Assistance Team

P.O. Box 13247

Austin, Texas 78711-3247

If you can get on the Internet, you can submit your complaint at: hhs.texas.gov/managed-care-help.

## QUEJAS

### ¿Qué hago si tengo una queja?

Queremos ayudar. Si tiene una queja, por favor, llámenos gratis al (insert Member Services hotline number) para explicarnos el problema. Un Defensor de Servicios para Miembros de (insert MCO's name) puede ayudarle a presentar una queja. Solo llame al (insert Member Services hotline number). Por lo general, podemos ayudarle de inmediato o, a más tardar, en unos días.

Una vez que haya agotado el trámite de quejas de (insert MCO name), puede quejarse ante la Comisión de Salud y Servicios Humanos (HHSC) de Texas llamando gratis al 1-866-566-8989. Si quiere hacer su queja por escrito, por favor, envíela a la siguiente dirección:

Texas Health and Human Services Commission

Ombudsman Managed Care Assistance Team

P.O. Box 13247

Austin, Texas 78711-3247

Si tiene acceso a Internet, puede enviar la queja a:

hhs.texas.gov/managed-care-help.

REQUIRED LANGUAGE

ATTACHMENT T

## What is an Emergency Appeal?

An Emergency Appeal is when the health plan has to make a decision quickly based on the condition of your health, and taking the time for a standard appeal could jeopardize your life or health.

## ¿Qué es una apelación de emergencia?

Una apelación de emergencia ocurre cuando el plan de salud tiene que tomar rápidamente una decisión debido a su estado de salud, y el proceso normal de apelación podría poner en peligro su vida o salud.

ATTACHMENT U

## STATE FAIR HEARING

### Can I ask for a State Fair Hearing?

If you, as a member of the health plan, disagree with the health plan’s decision, you have the right to ask for a State Fair Hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want representing you. A provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the State Fair hearing within 120 days of the date on the health plan’s letter with the decision. If you do not ask for the State Fair Hearing within 120 days, you may lose your right to a State Fair Hearing. To ask for a State Fair Hearing, you or your representative should either send a letter to the health plan at (address for health plan) or call (number for health plan).

If you ask for a State Fair Hearing within 10 days from the time you get the hearing notice from the health plan, you have the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final hearing decision is made. If you do not request a State Fair Hearing within 10 days from the time you get the hearing notice, the service the health plan denied will be stopped.

If you ask for a State Fair Hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most State Fair Hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

HHSC will give you a final decision within 90 days from the date you asked for the hearing.

**Can I ask for an emergency State Fair Hearing?**

If you believe that waiting for a State Fair Hearing will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you or your representative may ask for an emergency State Fair Hearing by writing or calling [insert MCO’s name]. To qualify for an emergency State Fair Hearing through HHSC, you must first complete [insert MCO’s name]’s internal appeals process.

REQUIRED LANGUAGE

## AUDIENCIA IMPARCIAL ESTATAL

### ¿Puedo pedir una audiencia imparcial estatal?

Si como miembro del plan médico, usted no está de acuerdo con la decisión del plan, tiene el derecho de pedir una audiencia imparcial estatal. Puede nombrar a alguien para que lo represente escribiendo una carta al plan médico con el nombre de la persona que usted quiere que lo represente. Un proveedor puede ser su representante. Si quiere cuestionar una decisión tomada por el plan de salud, usted o su representante tiene que pedir la audiencia imparcial estatal en un plazo de 120 días de la fecha de la carta de decisión del plan médico. Si no pide la audiencia imparcial estatal dentro de los 120 días, puede perder el derecho a una audiencia imparcial estatal. Para pedir una audiencia imparcial estatal, usted o su representante debe enviar una carta al plan médico (address for health plan) o llamar al (number for health plan).

Si solicita una audiencia imparcial estatal en un plazo de 10 días a partir del recibo del aviso de la audiencia del plan médico, tiene derecho a seguir recibiendo cualquier servicio que el plan médico haya denegado, basándose en los servicios previamente autorizados, al menos hasta que se tome la decisión final de la audiencia. Si no solicita una audiencia imparcial estatal en un plazo de 10 días a partir del momento en que reciba el aviso de audiencia, el servicio que el plan médico denegó se cancelará.

Si pide una audiencia imparcial estatal, recibirá un paquete de información con la fecha, la hora y el lugar de la audiencia. La mayoría de las audiencias imparciales estatales se hacen por teléfono. En la audiencia, usted o su representante puede explicar por qué necesita el servicio que el plan médico le denegó.

La HHSC le dará la decisión final dentro de 90 días de la fecha en que pidió la audiencia.

**¿Puedo pedir una audiencia imparcial estatal de emergencia?**

Si cree que esperar hasta que se llegue la fecha de la audiencia imparcial estatal pondría en grave peligro su vida o salud, o su capacidad de lograr, mantener o recuperar el máximo funcionamiento, usted o su representante puede solicitar una audiencia imparcial estatal de emergencia escribiendo o llamando al [insert MCO’s name]. Para llenar los requisitos para una audiencia imparcial estatal de emergencia por medio de la HHSC, primero tiene que completar el proceso de apelación interna de [insert MCO’s name].

ATTACHMENT V

## FRAUD AND ABUSE

### Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other healthcare providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

* Getting paid for services that weren’t given or necessary.
* Not telling the truth about a medical condition to get medical treatment.
* Letting someone else use their Medicaid ID.
* Using someone else’s Medicaid ID.
* Not telling the truth about the amount of money or resources he or she has to get benefits.

**To report waste, abuse, or fraud, choose one of the following:**

* Call the OIG Hotline at 1-800-436-6184;
* Visit https://oig.hhs.texas.gov/ and click on “Report Fraud” to complete the online form; or
* You can report directly to your health plan:
  + [*MCO’s name*]
  + [*MCO’s office/director address*]
  + [*MCO’s toll free phone number*]

**To report waste, abuse or fraud, gather as much information as possible.**

* When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  + Name, address, and phone number of provider
  + Name and address of the facility (hospital, nursing home, home health agency, etc.)
  + Medicaid number of the provider and facility, if you have it
  + Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  + Names and phone numbers of other witnesses who can help in the investigation
  + Dates of events
  + Summary of what happened
* When reporting about someone who gets benefits, include:
  + The person’s name
  + The person’s date of birth, Social Security Number, or case number if you have it
  + The city where the person lives
  + Specific details about the waste, abuse or fraud.

## FRAUDE Y ABUSO

### ¿Quiere denunciar malgasto, abuso o fraude?

Avísenos si cree que un doctor, dentista, farmacéutico, otros proveedores de atención médica o una persona que recibe beneficios está cometiendo una infracción. Cometer una infracción puede incluir malgasto, abuso o fraude, lo cual va contra la ley. Por ejemplo, díganos si cree que alguien:

* Está recibiendo pago por servicios que no se prestaron o no eran necesarios.
* No está diciendo la verdad sobre su padecimiento médico para recibir tratamiento médico.
* Está dejando que otra persona use una tarjeta de identificación de Medicaid.
* Está usando la tarjeta de identificación de Medicaid de otra persona.
* Está diciendo mentiras sobre la cantidad de dinero o recursos que tiene para recibir beneficios.

**Para denunciar malgasto, abuso o fraude, escoja uno de los siguientes:**

* Llame a la Línea Directa de la Fiscalía General (OIG) al 1-800-436-6184;
* Visite <https://oig.hhsc.state.tx.us/> y haga clic en “Report Waste” para llenar una forma en línea; O
* Denúncielo directamente al plan de salud:
  + [*MCO’s name*]
  + [*MCO’s office/director address*]
  + [*MCO’s toll free phone number*]

**Para denunciar el malgasto, abuso o fraude, reúna toda la información posible.**

* Al denunciar a un proveedor (un doctor, dentista, terapeuta, etc.) incluya:
  + El nombre, la dirección y el teléfono del proveedor
  + El nombre y la dirección del centro (hospital, centro para convalecientes, agencia de servicios de salud en casa, etc.)
  + El número de Medicaid del proveedor o centro, si lo sabe
  + El tipo de proveedor (doctor, dentista, terapeuta, farmacéutico, etc.)
  + El nombre y teléfono de otros testigos que puedan ayudar en la investigación
  + Las fechas de los sucesos
  + Un resumen de lo ocurrido
* Al denunciar a una persona que recibe beneficios, incluya:
  + El nombre de la persona
  + La fecha de nacimiento de la persona, su número de Seguro Social o su número de caso, si los sabe
  + La ciudad donde vive la persona
  + Los detalles específicos sobre el malgasto, abuso o fraude.

REQUIRED LANGUAGE

ATTACHMENT W

The following information must be made available to Members on an annual basis (Balanced Budget Act requirement). This should be stated as below:

As a member of (insert MCO name) you can ask for and get the following information each year:

* Information about network providers – at a minimum primary care doctors, specialists, pharmacies and hospitals in our service area. This information will include names, addresses, telephone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients, and, when applicable, professional qualifications, specialty, medical school attended, residency completion and board certification status
* Any limits on your freedom of choice among network providers.
* Your rights and responsibilities.
* Information on complaint, appeal, External Medical Review and State Fair Hearing procedures.
* Information about benefits available under the Medicaid program, including amount, duration and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
* How you get benefits including authorization requirements.
* How you get benefits, including family planning services, from out-of-network providers and/or limits to those benefits.
* How you get after hours and emergency coverage and/or limits to those kinds of benefits, including:
  + What makes up emergency medical conditions, emergency services and post-stabilization services.
  + The fact that you do not need prior authorization from your Primary Care Provider for emergency care services.
  + How to get emergency services, including instructions on how to use the 911 telephone system or its local equivalent.
  + The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
  + A statement saying you have a right to use any hospital or other settings for emergency care.
  + Post-stabilization rules.
* Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider.
* (Insert MCO name)’s practice guidelines.

La siguiente información debe ponerse a disposición de los miembros anualmente (Balanced Budget Act requirement). Debe declararse como se indica a continuación:

Como miembro de (insert MCO name), usted puede pedir y recibir la siguiente información cada año:

* Información sobre los proveedores de la red; por lo menos los doctores de cuidado primario, los especialistas y los hospitales en nuestra área de servicio. Esta información incluirá el nombre, la dirección, los teléfonos de cada proveedor de la red y los idiomas que habla (aparte del inglés), así como los nombres de aquellos proveedores que no están aceptando a nuevos pacientes, y, cuando corresponda, las cualificaciones profesionales, la especialidad, la escuela de medicina a la que asistió, la finalización de la residencia y el estado de la certificación de la junta.
* Cualquier restricción de su libertad de escoger entre los proveedores de la red.
* Sus derechos y responsabilidades.
* Información sobre los trámites de queja, apelación, revisión médica externa y audiencia imparcial estatal.
* Información sobre los beneficios disponibles bajo el programa de Medicaid, incluso la cantidad, la duración y el alcance de los beneficios. Se hizo así para asegurar que usted entienda los beneficios a los que tiene derecho.
* Cómo obtener beneficios, entre ellos, los requisitos de autorización.
* Cómo obtener beneficios, entre ellos, servicios de planificación familiar, de proveedores que no pertenecen a la red y los límites a dichos beneficios.
* Cómo recibir cobertura de emergencia y después de las horas normales de consulta, y los límites a dichos beneficios, entre ellos:
  + La explicación de un estado médico de emergencia, y de los servicios de emergencia y de posestabilización.
  + El hecho de que no necesita la autorización previa de su proveedor de cuidado primario para recibir atención de emergencia.
  + Cómo obtener servicios de emergencia, incluso cómo usar el sistema telefónico de 911 o su equivalente local.
  + Las direcciones de los lugares donde proveedores y hospitales prestan servicios de emergencia cubiertos por Medicaid.
  + Una declaración sobre su derecho de usar cualquier hospital u otro lugar para recibir atención de emergencia
  + Las reglas sobre la posestabilización.
* Las normas sobre envíos a especialistas y a otros servicios que el proveedor de cuidado primario no presta.

Las pautas de práctica de (Insert MCO name).

**ATTACHMENT X**

**EXTERNAL MEDICAL REVIEW INFORMATION**

* **Can a Member ask for an External Medical Review?**

If a Member, as a member of the health plan, disagrees with the health plan’s internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed before the State Fair Hearing. The Member may name someone to represent them by contacting the health plan giving the name of the person the Member wants to represent him or her. A provider may be the Member’s representative. The Member or the Member’s representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member’s representative may either:

* Fill out the ‘State Fair Hearing and External Medical Review Request Form’ provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to <MCO name> by using the address or fax number at the top of the form.;
* Call the MCO at <MCO telephone number>;
* Email the MCO at <MCO email address>, or;

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The Member may withdraw the Member’s request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member’s External Medical Review request. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The Member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, it is the State Fair Hearing decision that is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

**Can a Member ask for an emergency External Medical Review?**

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member’s life or health or the Member’s ability to attain, maintain, or regain maximum function, the Member or Member’s representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling <insert MCO’s name>. To qualify for an emergency External Medical Review and emergency State Fair Hearing , the Member must first complete <insert MCO’s name>’s internal appeals process.

**ANEXO X**

**INFORMACIÓN SOBRE LA REVISIÓN MÉDICA EXTERNA**

* **¿Puede un miembro solicitar una revisión médica externa?**

Si como miembro del plan médico, usted no está de acuerdo con la decisión de la apelación interna del plan, tiene el derecho de pedir una revisión médica externa. La revisión médica externa es un paso opcional y adicional que el miembro puede tomar para que se revise el caso antes de que se celebre la audiencia imparcial estatal. El miembro puede nombrar a alguien para que lo represente comunicándose con el plan médico y dando el nombre de la persona que el miembro quiere que lo represente. Un proveedor puede ser el representante del miembro. El miembro o su representante debe solicitar la revisión médica externa en un plazo de 120 días a partir de la fecha en que el plan de salud envíe la carta con la decisión de la apelación interna. Si el miembro no solicita la revisión médica externa en un plazo de 120 días, puede perder su derecho a una revisión médica externa. Para solicitar una revisión médica externa, el miembro o su representante pueden:

* Llenar la "Solicitud de una audiencia imparcial estatal y una revisión médica externa" que se adjunta a la carta de notificación al miembro de la decisión de apelación interna de la MCO y enviarlo por correo o por fax a <MCO name> usando la dirección o el número de fax que aparecen en la parte superior de la solicitud;
* Llamar a la MCO al <MCO telephone number>;
* Enviar un correo electrónico a la MCO a <MCO email address>, o bien,

Si el miembro solicita una revisión médica externa en un plazo de 10 días de haber recibido la decisión de la apelación del plan médico, el miembro tiene el derecho de seguir recibiendo cualquier servicio que el plan médico denegó o redujo, basándose en los servicios previamente autorizados, al menos hasta que se tome una decisión final sobre la audiencia imparcial estatal. Si el miembro no solicita una revisión médica externa en un plazo de 10 días de haber recibido la decisión de la apelación del plan médico, el servicio que el plan médico le denegó se cancelará.

El miembro puede retirar su solicitud de una revisión médica externa antes de que se asigne a una Organización de Revisión Independiente o mientras esta organización esté evaluando la solicitud de la revisión médica externa del miembro. Una Organización de Revisión Independiente es una organización de terceros contratada por la HHSC que realiza las revisiones médicas externas durante los trámites de apelación de los miembros relacionados con las determinaciones adversas de beneficios basadas en las necesidades funcionales o médicas.Una revisión médica externa no se puede retirar si una Organización de Revisión Independiente ya terminó la revisión y tomó una decisión.

Una vez recibida la decisión de la revisión médica externa, el miembro tiene derecho a retirar la solicitud de una audiencia imparcial estatal. Si prosigue con el trámite de la audiencia imparcial estatal, el miembro también puede pedir que la Organización de Revisión Independiente esté presente en la audiencia imparcial estatal. El miembro puede hacer estas dos solicitudes al comunicarse con su MCO en (specify MCO information) o con el equipo de admisión de la HHSC en [EMR\_Intake\_Team@hhsc.state.tx.us](mailto:EMR_Intake_Team@hhsc.state.tx.us).

Si el miembro prosigue con el trámite de la audiencia imparcial estatal y la decisión que se toma es diferente a la decisión de la Organización de Revisión Independiente, la decisión de la audiencia imparcial estatal es la definitiva. La decisión de la audiencia imparcial estatal solo puede exigir que los beneficios sigan al mismo nivel o aumenten con respecto a la decisión de la Organización de Revisión Independiente.

**¿Puede un miembro pedir una revisión médica externa de emergencia?**

Si un miembro cree que esperar hasta que se llegue la fecha de la revisión médica externa pondría en grave peligro su vida o salud, o la capacidad del miembro de lograr, mantener o recuperar el máximo funcionamiento, el miembro o su representante puede solicitar una revisión médica externa de emergencia y una audiencia imparcial estatal de emergencia escribiendo o llamando al [insert MCO’s name]. Para llenar los requisitos para una audiencia imparcial estatal de emergencia, el miembro primero tiene que completar el proceso de apelación interna de [insert MCO’s name].

REQUIRED LANGUAGE

ATTACHMENT Y

**MDCP/DBMD Escalation Help Line**

**What is the MDCP/DBMD escalation help line?**

The MDCP/DBMD escalation help line assists people with Medicaid who get benefits through the Medically Dependent Children Program (MDCP) or the Deaf-Blind with Multiple Disabilities (DBMD) program.

The escalation help line can help solve issues related to the STAR Kids managed care program. Help can include answering questions about State Fair Hearings and continuing services during the appeal process.

**When should Members call the escalation help line?**

Call when you have tried to get help but have not been able to get the help you need. If you don’t know who to call, can call **844-999-9543** and they will work to connect you with the right people.

**Is the escalation help line the same as the HHS Office of the Ombudsman?**

No. The MDCP/DBMD Escalation Help Line is part of the Medicaid program. The Ombudsman offers an independent review of concerns and can be reached at 866-566-8989 or go on the Internet (hhs.texas.gov/managed-care-help). The MDCP/DBMD escalation help line is dedicated to individuals and families that receive benefits from the MDCP or DBMD program.

**Who can call the help line?**

You, your authorized representatives or your legal representative can call.

**Can members call any time?**

The escalation help line is available Monday through Friday from 8 a.m.–8 p. After these hours, please leave a message and one of our trained on-call staff will call you back.

**¿Qué es la línea de escalamiento del MDCP/DBMD?**

**La línea de escalamiento del MDCP/DBMD** ayuda a las personas con Medicaid que reciben beneficios del Programa para Niños Médicamente Dependientes (MDCP) o del Programa para Personas Sordociegas con Discapacidades Múltiples (DBMD).

La línea de escalamiento le ayuda a resolver problemas relacionados con el programa de atención médica administrada STAR Kids. Esa ayuda puede consistir en darle respuesta a las dudas que pueda tener sobre las audiencias imparciales de Medicaid o sobre la continuación de los servicios mientras se lleva a cabo la apelación.

**¿Cuándo puedo llamar a la línea de escalamiento?**

Llámenos si ha tratado de obtener ayuda y no ha recibido el tipo de ayuda que necesitaba. Si no sabe a quién recurrir, puede llamarnos al **844-999-9543** y nosotros nos encargaremos de ponerlo en contacto con el personal adecuado.

**¿Es esta la misma oficina que la Oficina del Ombudsman de HHS?**

No. La línea de escalamiento del MDCP/DBMD forma parte del programa Medicaid. El Ombudsman le ofrece una revisión independiente de sus inquietudes. Para obtener ayuda del Ombudsman comuníquese al 866-566-8989, o visite el sitio de internet hhs.texas.gov/managed-care-help. La línea de escalamiento del MDCP/DBMD está dirigida a individuos y familias que reciben beneficios del programa MDCP o DBMD.

**¿Quiénes pueden llamar a la línea de ayuda?**

Usted, su representante autorizado o su representante legal.

**¿Puedo llamar a cualquier hora?**

La línea de escalamiento está disponible de lunes a viernes de 8:00 a.m. a 8:00 p.m. Si llama después de este horario, deje un mensaje y uno de nuestros empleados de guardia capacitado se comunicará con usted.