**DOCUMENT HISTORY LOG**

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| --- | --- | --- | --- |
| **STATUS1** | **DOCUMENT**  **REVISION2** | **EFFECTIVE**  **DATE** | **DESCRIPTION3** |
| Baseline | 1.0 | November 15, 2005 | Initial version Uniform Managed Care Manual, Chapter 3.3 Medicaid Managed Care/CHIP Provider Manual Combined Required Critical Elements |
| Revision | 1.1 | September 1, 2006 | Chapter 3.3, Attachment F, revised to update the mailing address for State Fair Hearing Requests. |
| Revision | 1.2 | September 30, 2006 | Chapter 3.3 modified to include STAR+PLUS requirements. |
| Revision | 1.3 | October 20, 2006 | All provisions of Chapter 3.3 are modified to include CHIP Perinatal Program requirements. |
| Revision | 1.4 | April 30, 2007 | All provisions of Chapter 3.3 are modified to include the Foster Care Model.  Section VI General Responsibilities Electronic Medical Records has been updated to include conforming to the requirements of HIPAA and other federal and state laws  Attachment C: Version 2: was added to reflect the Foster Care Model  Attachment H was added to include State language regarding residential placement for children. |
| Revision | 1.5 | January 8, 2008 | All provisions of Chapter 3.3 are modified to remove the Foster Care Model. Information regarding the Foster Care Model can be found in Chapter 3.14 Foster Care Provider Manual Critical Elements.  Chapter 3.3 modified to change CHIP eligibility period from 6 months to 12 months.  Attachment F revised to reflect changes to the Fair Hearings process.  Attachment H replaced with required language for “Emergency Prescription Supply”.  Added required language Attachment I for “Children of Migrant Farmworkers” |
| Revision | 1.6 | August 1, 2009 | Chapter 3.3 is revised to conform to the style and preferred terms required by the Consumer Information Tool Kit.  Attachment B, “MMC Member Rights and Responsibilities,” is revised to include additional Member notices.  Attachment C, “CHIP Member Rights and Responsibilities,” is revised to include additional Member notices.  Attachment F, “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 | 1.7 | September 1, 2010 | Chapter 3.3 is revised to update eligibility rules for CHIP Perinatal newborns and to correct reference from “TexMedNet” to “TXMedConnect”. |
| Revision | 1.8 | July 10, 2011 | Section X. A. is updated to remove the requirement for the MCO to have a local telephone number.  Section XI. B. is updated to replace “Medicaid identification (ID) cards (Form 3087)” with “Your Texas Benefits Medicaid Card.”  Attachment E, “Fraud and Abuse” is updated. |
| Revision | 2.0 | March 1, 2012 | Revision 2.0 applies to contracts issued as a result of HHSC RFP numbers 529-08-0001, 529-10-0020, and 529-12-0002.  Chapter is reformatted to convert the outline narrative to a form and to delete final attachment checklist as redundant.  All references to a separate CHIP Perinatal Program are removed.  Section III. is modified to add the role of pharmacy.  Section IV.E. is modified to remove Vendor Drugs as a non-capitated service.  Section VI.A. is modified to add requirement to provide updates to contact information to HHSC’s administrative services contractor and to add access to ophthalmologists and therapeutic optometrists without a referral and access to network pharmacies.  Section VI.C. “Pharmacy Provider Responsibilities” is added and subsequent sections re-lettered.  Sections X.A., X.B., and X.C. are modified to clarify the language.  All attachments are listed in order of appearance and re-lettered appropriately.  Attachment F “Emergency Dental Services” is modified to add Medicaid Emergency Dental Services.  Attachment I “Member Rights and Responsibilities” is modified to conform to language in Chapter 3.5.  Attachment K, “Span of Eligibility” is deleted. |
| Revision | 2.1 | September 15, 2012 | Section IV. C. is modified to change “1915 (c) Nursing Facility” Waiver Services to “HCBS STAR+PLUS” Waiver Services.  Section IV. E. is modified to clarify non-capitated primary and preventative dental services.  Section VI. A. is modified to conform to the question in Attachment C.  Section VI. E. is modified to add “Non-emergency Dental Services” and “Durable Medical Equipment.”  Section XII is modified to clarify CHIP Perinatal eligibility.  Section XIV is modified to clarify co-payment requirements and to require MCOs to include a copy of the CHIP Cost Sharing Table found in UMCM Chapter 6.3.  Section XVI is modified to clarify disenrollment requirements.  Section XVII is modified to clarify Perinatal enrollment, plan change, and disenrollment requirements.  Attachment A, “Children of Migrant Farmworkers” is modified to clarify that accelerated checkups are not an exception to periodicity and should be billed as a checkup.  Attachment C, “How to Help a Member Find Dental Care” is added.  All subsequent attachments re-lettered.  Attachment D, “Emergency Prescription Supply” is modified to add reimbursement language for 72-hour emergency prescriptions.  Attachment E, “Emergency Dental Services” is modified to remove treatment of craniofacial abnormalities.  Attachment F, “Non-Emergency Dental Services” is added.  Attachment G, “Durable Medical Equipment and Other Products Normally Found in a Pharmacy” is added.  Attachment H, “State Fair Hearing Information” is modified to change all references from “you” to “the Member.”  Attachment L, “Member’s Right to Designate an OB/GYN” is modified to match the heading in Section XIII, D, and to change all references from “you” to “the Member.” |
| Revision | 2.2 | November 28, 2012 | Section III is modified to add “Role of Main Dental Home.”  Attachment A, “Role of Main Dental Home,” is added.  All subsequent attachments are relettered.  Attachment D, “How to Help a Member Find Dental Care,” is modified. |
| Revision | 2.3 | October 15, 2013 | Section XI B is modified to add “Verifying Member Medicaid Eligibility.”  Section XI C is modified to remove the waiver of spell of illness for STAR+PLUS Members.  Attachment D, “How to Help a Member Find Dental Care” is modified to remove the separate phone number for CHIP.  Attachment J, “Verifying Member Medicaid Eligibility,” is added.  All subsequent attachments are re-lettered.  Attachment O, “Fraud Information” 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 | 2.4 | May 15, 2014 | Revision 2.4 applies to contracts issued as a result of HHSC RFP numbers 529-08-0001, 529-10-0020, 529-12-0002, 529-13-0042.  Section III. is modified to add the roles of MCO Service Coordinators.  Section IV.B. is modified to require inclusion of training materials pertaining to ADHD.  Section IV.C. is modified to include Employment Assistance, Supported Employment, Cognitive Rehabilitation Therapy, Adult Foster Care, Financial Management Services, Support Consultation, Medical Supplies, Dental Services, Targeted Case Management, and Mental Health Rehabilitative Services.  Section IV.D. is modified to require explanations or descriptions for Service Coordinator, Service Coordination, and Service Coordination services, Level 1 Members, Level 2 Members, Level 3 Members, Discharge Planning, and Transition Plan.  Section IV.E. is modified to add require a reference to the TMPPM and to update the list of Non-Capitated Services.  Section IV.F. is modified to clarify the requirement.  Section IV.H. is modified to clarify coordination with LMHAs, to add ADHD as a behavioral health service, and to add Mental Health Rehabilitative Services and Targeted Case Management requirements.  Section VI.A. is modified to add right of Members with disabilities, special health care needs, and Chronic or Complex conditions, to designate a specialist as their Primary Care Provider.  Section VI.B. is modified to add Employment Assistance, and Supported Employment Responsibilities.  Section VI.C. is modified to clarify that adherence to the PDL is required of MCOs serving MMC Members.  Section VI.E. is modified to add transportation Value-added Services.  Sections VII. is modified to clarify Provider Complaint and Appeal processes and to add Provider Portal. (Effective date 9/1/14)  Section IX. is modified to clarify Provider Complaint and Appeal processes and to add Provider Portal. (Effective date 9/1/14)  Section XI.B. is modified to add Provider Portal. (Effective date 9/1/14)  Section XII.A. is modified to conform to contract language.  Section XII.B. is modified to add Provider Portal. (Effective date 9/1/14)  Section XIV. is modified to add Provider Portal Functionality, timeframes for claims payment, and clarifications to the process for requesting a PA. (Effective date 9/1/14)  Section XVII.A. is deleted and subsequent subsections are re-lettered.  Section XVII.A. is modified to remove the enrollment of all traditional CHIP Members in the household into the CHIP Perinatal Member’s plan.  Section XVII.C. is modified to conform to contract language. |
| Revision | 2.5 | November 1, 2014 | Attachment F is modified to remove remaining language regarding devices for craniofacial anomalies. |
| Revision | 2.6 | July 1, 2016 | Revision 2.6 applies to contracts issued as a result of HHSC RFP numbers 529-08-0001, 529-10-0020, 529-12-0002, 529-13-0042; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.  Applicability is modified to include applicability to Medicare-Medicaid Plans (MMPs).  Section III is modified to include applicability to Medicare-Medicaid Plans (MMPs).  Section IV. is modified to include applicability to Medicare-Medicaid Plans (MMPs).  Section IV.C. is modified to add Electronic Visit Verification and Community First Choice services, and to remove past effective dates.  Section VI. is modified to include applicability to Medicare-Medicaid Plans (MMPs).  Section VI.A. is modified to add Abuse, Neglect, and Exploitation and Community First Choice requirements.  Section VI.B. is modified to add Community First Choice services and Abuse, Neglect, and Exploitation requirements.  Section VI.F. “Electronic Visit Verification” is added.  Section VII. is modified to include applicability to Medicare-Medicaid Plans (MMPs) and to clarify the Provider complaints and Provider appeals process.  Section VII. “Medicaid Managed Care Provider Complaint/Appeal Process” is modified to add “Provider Appeal Process to HHSC” and “Payment responsibility for Medicaid enrollment changes that occur during Continuous Inpatient Stay in a Hospital.”  Section VIII. is modified to include applicability to Medicare-Medicaid Plans (MMPs).  Section XIV. is modified to add “Payment/accrual of interest by MCO” and to add “How to find a list of PA required services and codes.”  Section XI. is modified to include applicability to Medicare-Medicaid Plans (MMPs).  Section XV. is modified to include applicability to Medicare-Medicaid Plans (MMPs).  Section XIX. “Additional MMP Specific Critical Elements” is added.  Attachment E “Reporting Abuse, Neglect, or Exploitation (ANE)” is added and all subsequent attachments re-lettered.  Attachment F “Community First Choice” is added.  Attachment K “Electronic Visit Verification” is added.  Attachment L “Provider Appeal Process to HHSC” is added.  Attachment M “Payment responsibility for Medicaid enrollment changes that occur during Continuous Inpatient Stay in a Hospital” is added.  Attachment O “Verifying Member Medicaid Eligibility” is modified to require Providers to keep copies of Form H1027 when presented by a Member. |
| Revision | 2.7 | December 1, 2016 | Applicability is modified to add language regarding combined program manuals.  Section IV. A. is modified to add "Documentation of completed Texas Health Steps components and elements" and a reference to required language in Attachment B. All subsequent Attachment references are re-lettered.  Section IV. E. is modified to add a reference to required language in Attachment D and to remove items 11.a. and 11.b. as redundant.  Section IV. H. is modified to reference the discontinuation of NorthSTAR.  Section VI. F. is modified to clarify it is not applicable to CHIP and STAR MCOs.  Section VII. 8. regarding payment responsibility for Medicaid enrollment changes that occur during Continuous Inpatient Stay in a Hospital is deleted.  Attachment B "Documentation of completed Texas Health Steps components and elements" is added and all subsequent attachments are re-lettered.  Attachment D "Medical Transportation Program (MTP)" is added and all subsequent attachments are re-lettered.  Attachment O "Span of Coverage (Hospital) - Responsibility during a Continuous Inpatient Stay" is deleted and all subsequent attachments are re-lettered.  Attachment P "Verifying Member Eligibility" is modified to add section on Your Texas Benefits, a system that gives providers access to Medicaid health information. |
| Revision | 2.8 | March 1, 2017 | Section IV. A. is modified to add Comprehensive Care Program services including private duty nursing, PPECCs, and therapies.  Section IV. B. is modified to add PPECCs.  Section IV. H. is modified to remove the reference to NorthSTAR.  Attachment D "Prescribed Pediatric Extended Care Centers and Private Duty Nursing" is added and all subsequent attachments are re-lettered. |
| Revision | 2.9 | March 15, 2019 | Attachment Q “Verifying Member Medicaid Eligibility” is modified to update the ways to verify eligibility and remove reference to the Your Texas Benefits Card provider portal. |
| Revision | 2.10 | May 29, 2019 | Attachment W **“**Breast Pump Coverage in Medicaid and CHIP” added to clarify coverage for breast pumps in Medicaid and CHIP. |
| Revision | 2.10.1 | February 21, 2020 | Corrected the last version number from 3.0 to 2.10.  Accessibility approved version. |
| Revision | 2.11 | April 21, 2021 | Modified “day” and “calendar day” to the Contract term, “Day,” and capitalized “Business Day” where applicable throughout chapter.  Section IV.B. is modified to add reference to NEMT services.  Section IV.E. deletes the reference to HHSC’s Medical Transportation Program.  Section VI. E. deletes nonemergency transportation information.  Section XIV. is modified to add NEMT Services as a special billing example.  Section XVIII. modifies the general transportation and ambulance/wheelchair van bullet to emergency and nonemergency transportation.  Section XIX. adds NEMT Services under Section 4.  Attachment E is modified to provide required language on NEMT and remove the language on MTP.  Attachment R is modified to add additional member responsibilities when using NEMT services. |
| Revision | 2.12 | May 1, 2022 | Added section titled, “GENERAL INSTRUCTIONS TO MCO” to provide guidance to MCOs on the use of the term ‘emergency’.  Revised to include information on the Medicaid External Medical Review process.  Section VIII(B). Adds Member option to request an External Medical Review.  Added required language Attachment X for “External Medical Review” Information.  Amended the term “fair hearing” to contract-defined term “State Fair Hearing” throughout the document.  Attachment P: Revised timeframes to match current policy.  .  Section VIII.B. page 12 - removal of requirement to confirm an internal appeal request in writing.  Attachment J – Revisions made to Member Rights, item 5. Pages 29-30 adding external medical review information. |
| Revision | 2.13 | May 2, 2022 | Administrative Change |
| Revision | 2.14 | May 3, 2022 | Administrative Update – Language deleted from ATTACHMENT X that reads, “Go in person to a local HHSC office”. |
| Revision | 2.15 | September 1, 2022 | Section IV.C. is modified to add reference to Case Management for Children and Pregnant Women (CPW).  Section IV.D. is modified to add STAR and CHIP as programs that have Service Coordination.  Section IV.E. is modified to remove CPW from Medicaid Non-capitated Services list. |
| Revision | 2.16 | September 16, 2022 | Section VI.F revised because the 21st Century Cures Act, Section 12006, required Texas to expand Electronic Visit Verification to all personal care services including Consumer Directed Services (CDS). This revision includes the following:  Added: questions and answers pertaining to clarify who uses the EVV System; the process to select an EVV System; requirements to meet before using the system; and process to change to another EVV System  Added: questions and answers pertaining to clocking in and out of the EVV System  Added: questions and answers to clarify Visit Maintenance requirements  Added: questions and answers pertaining to EVV training  Added: questions and answers to clarify compliance reviews  Added: questions and answers pertaining to claims submission; claims matching; and claims payment  Attachment N is modified to provide required language on EVV. |
| Revision | 2.17 | 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.

## Applicability of Chapter 3.3

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR Program, the STAR+PLUS Program (including the Medicare-Medicaid Dual Demonstration), or the CHIP Program. The requirements in this chapter apply to all Programs, except where noted.

MCOs may develop a distinct STAR, STAR+PLUS, CHIP, or STAR Kids provider manual or choose to develop a combined manual to include STAR, STAR+PLUS, CHIP, and STAR Kids. If MCOs choose to develop a combined provider manual, the manual must include distinctions between each program. For instance, program information that pertains to all managed care programs may be provided in a more generalized section of the manual. Any program information specific to STAR, STAR+PLUS, CHIP, or STAR Kids must be contained in a specific section for that particular program, or the MCO may reference the program in the section title (ex. For STAR Only).

MCOs participating in the CHIP Program must add provisions relating to CHIP Perinatal to the CHIP Program Provider Manual that: (i) clearly indicate that the CHIP Program portion of the Provider Manual also applies to CHIP Perinate Newborn Members, with noted exceptions; and (ii) include separate provisions for CHIP Perinate Members.

MCOs participating in the Dual Demonstration must add provisions to the MMP Provider Manual that clearly differentiates the MMP and STAR+PLUS Programs. Please refer to Section XIX for additional requirements.

**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.

| Required Element | Page Number |
| --- | --- |
| The following items must be included in the Provider Manual, but not necessarily in this order (unless specified). |  |
| This table is to be completed and attached to the Provider Manual when submitted for approval. Include the page number of the location for each required critical element. |  |
| **I. FRONT COVER** |  |
| The front cover must include, at a minimum: |  |
| 1. MCO name |  |
| 1. MCO logo |  |
| 1. STAR, STAR+PLUS, or CHIP logo |  |
| 1. Service Area |  |
| 1. The words “PROVIDER MANUAL” |  |
| 1. Provider services number |  |
| 1. Date of current publication |  |
| 1. Website address |  |
| **II. TABLE OF CONTENTS** |  |
| The Provider Manual must include a Table of Contents. |  |
| **III. INTRODUCTION** |  |
| 1. Background |  |
| 1. Quick reference phone list |  |
| 1. Objectives of Program(s) |  |
| 1. Role of Primary Care Provider (or “Medical Home”) (for MCOs serving Medicaid Managed Care (MMC) Members, CHIP Program, or CHIP Perinate Newborn Members) |  |
| 1. Role of specialty care provider (for MCOs serving MMC Members, CHIP Program Members, or CHIP Perinate Newborn Members) |  |
| 1. Role of long-term services and supports (LTSS) Providers (for MCOs serving STAR+PLUS Members and MMP Enrollees) |  |
| 1. Role of MCO Service Coordinator (for MCOs serving STAR+PLUS Members and MMP Enrollees) |  |
| 1. Role of CHIP Perinatal Provider (for MCOs serving CHIP Perinate Members) |  |
| 1. Role of Pharmacy |  |
| 1. Role of Main Dental Home (MCO will use HHSC’s provided language – **Attachment A.**) |  |
| 1. Network limitations (e.g., Primary Care Providers, Specialists, OB/GYN) |  |
| **IV. COVERED SERVICES** |  |
| 1. Texas Health Steps Services (for MCOs serving MMC Members) |  |
| 1. Refer provider to the *Texas Medicaid Provider Procedures Manual* for information regarding Texas Health Steps and Comprehensive Care Program services, including private duty nursing, prescribed pediatric extended care centers, and therapies. |  |
| 1. Documentation of completed Texas Health Steps components and elements (MCO will use HHSC's provided language - **Attachment B**.) |  |
| 1. Children of Migrant Farmworkers (MCO will use HHSC’s provided language – **Attachment C**.) |  |
| 1. **Medicaid Managed Care Covered Services** (for MCOs serving MMC Members) |  |
| At a minimum, the participating MCO must provide a benefit package to MMC Members that includes Fee-for-Service (FFS) services currently covered under the Medicaid program. Please refer to the current *Texas Medicaid Provider Procedures Manual* for listing of limitations and exclusions. |  |
| At a minimum, the participating MCO must include specific information pertaining to Attention Deficit Hyperactivity Disorder (ADHD) Covered Services for children including reimbursement for ADHD and availability of follow-up care for children who have been prescribed ADHD medications. |  |
| Prescribed Pediatric Extended Care Centers (for STAR Members only) (MCO will use HHSC’s provided language – **Attachment D**.) |  |
| Breast pump coverage (MCO will use HHSC’s provided language – **Attachment W**.) |  |
| Nonemergency Medical Transportation (NEMT) Services (MCO will use HHSC’s provided language – **Attachment E**.) |  |
| 1. **STAR+PLUS Covered Services** (for MCOs serving STAR+PLUS Members and MMP Enrollees) |  |
| At a minimum, the participating MCO must provide a benefit package to Members that includes Fee-for-Service services currently covered under the Medicaid program. Please refer to the current HHSC Provider Manuals for a more inclusive listing of limitations and exclusions that apply to each benefit category. |  |
| MCO must include a description of the following: |  |
| 1. Day Activity and Health Services (DAHS) |  |
| 1. Personal Assistance Services (PAS) |  |
| 1. Home and Community Based Services (HCBS) STAR+PLUS Waiver Services |  |
| 1. Employment Assistance |  |
| 1. Supported Employment |  |
| 1. Cognitive Rehabilitation Therapy |  |
| 1. Adult Foster Care |  |
| 1. Financial Management Services |  |
| 1. Support Consultation |  |
| 1. Medical Supplies |  |
| 1. Dental Services |  |
| 1. Targeted Case Management (TCM) |  |
| 1. Mental Health Rehabilitative Services (MHR) |  |
| 1. Electronic Visit Verification (EVV) |  |
| 1. Community First Choice services 2. Case Management for Children and Pregnant Women (CPW) services |  |
| 1. **Service Coordination Services** (for MCOs serving STAR, CHIP, STAR+PLUS Members and MMP Enrollees) |  |
| MCOs must include an explanation/description of Service Coordination, including the following: |  |
| 1. The role of the Service Coordinator |  |
| 1. Service Coordination services 2. How to contact a Service Coordinator |  |
| 1. Service Coordination for Level 1, 2, and 3 Members (STAR+PLUS and MMP only) |  |
| 1. Discharge Planning (STAR+PLUS and MMP only) |  |
| 1. Transition Plan (STAR+PLUS and MMP only) |  |
| 1. **Coordination with Non-Medicaid Managed Care Covered Services *(Non-Capitated Services)*** (for MCOs serving MMC Members and MMP Enrollees as applicable) |  |
| MCO must include the following references to Texas Medicaid Provider Procedures Manual (TMPPM). |  |
| 1. Texas Health Steps dental (including orthodontia) |  |
| 1. Texas Health Steps environmental lead investigation (ELI) |  |
| 1. Early Childhood Intervention (ECI) case management/service coordination |  |
| 1. Early Childhood Intervention Specialized Skills Training |  |
| 1. Mental Health Targeted Case Management (MMP only) |  |
| 1. Mental health rehabilitation (MMP only) |  |
|  |  |
| 1. Texas School Health and Related Services (SHARS) |  |
| 1. Department of Assistive and Rehabilitative Services (DARS) Blind Children’s Vocational Discovery and Development Program |  |
| 1. Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation) |  |
| 1. Health and Human Services Commission (HHSC) hospice services |  |
| 1. Admissions to inpatient mental health facilities as a condition of probation |  |
| 1. for STAR, Texas Health Steps Personal Care Services for Members birth through age 20 |  |
| 1. for STAR+PLUS, Nursing Facility services (Non-capitated until February 28, 2015) |  |
| 1. for STAR+PLUS, PASRR screenings, evaluations, and specialized services |  |
| 1. HHSC contracted providers of long-term services and supports (LTSS) for individuals who have intellectual or developmental disabilities. |  |
| 1. HHSC contracted providers of case management or service coordination services for individuals who have intellectual or developmental disabilities. |  |
| * + - 1. **CHIP Covered Services** (for MCOs serving CHIP and CHIP Perinate Members) |  |
| At a minimum, the participating MCO must provide a benefit package that includes the services currently covered in the CHIP, CHIP Perinate, and CHIP Perinate Newborn Evidence of Coverage (EOC) or Certificate of Coverage (COC).  The MCO must attach benefit information from the EOC/COC. |  |
| Breast pump coverage (MCO will use HHSC’s provided language – **Attachment W**.) |  |
| * + - 1. **Coordination with Non-CHIP Covered Services *(Non-Capitated Services)*** (for MCOs serving CHIP and CHIP Perinate Members) |  |
| 1. Texas agency administered programs and case management services |  |
| 1. Essential public health services |  |
| **H. Behavioral Health** (for MCOs serving MMC Members, MMP Enrollees, or CHIP Members and CHIP Perinate Newborn Members) |  |
| 1. Definition of behavioral health |  |
| 1. List behavioral health Covered Services (services may differ between MMC and CHIP) |  |
| 1. MCO responsible for authorized inpatient Hospital services, this includes services provided in Freestanding Psychiatric Facilities for children in STAR and STAR+PLUS, and for adults in STAR+PLUS (for MCOs serving STAR+PLUS Members) |  |
| 1. Primary Care Provider requirements for behavioral health: |  |
| 1. Primary Care Provider may provide behavioral health services within the scope of its practice |  |
| 1. Behavioral Health Services: |  |
| 1. Member access to behavioral health services |  |
| 1. Attention Deficit Hyperactivity Disorder (ADHD) |  |
| 1. Self-referral (any Network behavioral health provider) |  |
| 1. Primary Care Provider referral |  |
| 1. Coordination between behavioral health and physical health services |  |
| 1. Medical records documentation and referral information (required to document using the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) multi-axial classifications) |  |
| 1. Consent for disclosure of information |  |
| 1. Court-Ordered Commitments |  |
| 1. Coordination with the Local Mental Health Authority (LMHA) and state psychiatric facilities |  |
| 1. Assessment instruments for behavioral health available for use by a Primary Care Provider |  |
| 1. Focus studies |  |
| 1. Utilization management reporting requirements (specify by individual mental health service type) |  |
| 1. Procedures for follow-up on missed appointments |  |
| 1. Member discharged from inpatient psychiatric facilities need to have follow-up within 7 Days from the date of discharge |  |
| 1. Behavioral Health Value-Added Services, if any |  |
| 1. Mental Health Rehabilitative (MHR) Services and Targeted Case Management(TCM) (for MCO's serving MMC Members) |  |
| 1. Definition of severe and persistent mental illness (SPMI) |  |
| 1. Definition of severe emotional disturbance (SED) |  |
| 1. Member access to and benefits of MHR Services and TCM |  |
| 1. Provider Requirements |  |
| * + 1. Training and certification to administer Adult Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) assessment tools |  |
| * + 1. Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG) |  |
| * + 1. Attestation from Provider entity to MCO that organization has the ability to provide, either directly or through sub-contract, the Members with the full array of MHR and TCM services as outlined in the RRUMG |  |
| * + 1. HHSC-established qualification and supervisory protocols |  |
| **I. CHIP Member Prescriptions** (MCO will use HHSC’s provided language – **Attachment F.**) |  |
| 1. **QUALITY MANAGEMENT** |  |
| 1. Include practice guidelines |  |
| 1. Focus studies |  |
| 1. Utilization management reporting requirements |  |
| 1. **PROVIDER RESPONSIBILITIES** |  |
| 1. **General Responsibilities** |  |
| 1. Primary Care Provider (Medical Home) responsibilities (for MCOs serving MMC Members or CHIP Members and CHIP Perinate Newborn Members) |  |
| 1. Availability and accessibility |  |
| 1. 24-hour availability |  |
| 1. **Updates to contact information.** Network providers must inform both the MCO and HHSC’s administrative services contractor of any changes to the provider’s address, telephone number, group affiliation, etc. |  |
| 1. Plan termination |  |
| 1. Member’s right to designate an OB/GYN as their Primary Care Provider (for MCOs serving MMC Members or CHIP Members and CHIP Perinate Newborn Members) |  |
| 1. For Members with disabilities, special health care needs, and ~~or~~ Chronic or Complex conditions, the right to designate a specialist as their Primary Care Provider as long as the specialist agrees. |  |
| 1. Member’s right to select and have access to, without a Primary Care Provider referral, a Network ophthalmologist or therapeutic optometrist to provide eye Health Care Services other than surgery |  |
| 1. Member’s right to obtain medication from any Network pharmacy |  |
| 1. Member information on advance directive (for MCOs serving MMC Members) |  |
| 1. Referral to specialists and health-related services (documentation of coordination of referrals and services provided between Primary Care Provider and specialist) (for MCOs serving MMC Members or CHIP Members and CHIP Perinate Newborn Members) |  |
| 1. How to Help a Member Find Dental Care (MCO will use HHSC’s provided language – **Attachment G.**) |  |
| 1. Primary Care Provider may provide behavioral health-related services within the scope of its practice (for MCOs serving MMC Members or CHIP Members and CHIP Perinate Newborn Members) |  |
| 1. Referral to Network facilities and contractors |  |
| 1. Access to second opinion (for MCOs serving MMC Members or CHIP Members and CHIP Perinate Newborn Members) |  |
| 1. Specialty Care Provider responsibilities (must include availability and accessibility standards) (for MCOs serving MMC Members or CHIP Members and CHIP Perinate Newborn Members) |  |
| 1. Verify Member eligibility or authorizations for service |  |
| 1. Continuity of Care related to: |  |
| 1. Pregnant woman information (for MCOs serving MMC Members or CHIP Members and CHIP Perinate Newborn Members) |  |
| 1. Member moves out of Service Area |  |
| 1. Preexisting condition not imposed (for MCOs serving MMC Members or CHIP Members and CHIP Perinate Newborn Members) |  |
| 1. Medical records: standards that medical records must reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws. |  |
| 1. Required to inform Members on how to report Abuse, Neglect, and Exploitation, as defined in Attachment A of the Contract. (MCO will use HHSC’s provided language – **Attachment H.**) |  |
| 1. Required to train staff on how to recognize and report Abuse, Neglect, and Exploitation, as defined in Attachment A of the Contract. (MCO will use HHSC’s provided language – **Attachment H.**) |  |
| 1. The Provider must provide the MCO with a copy of the abuse, neglect, and exploitation report findings within one Business Day of receipt of the findings from the Department of Family and Protective Services (DFPS). |  |
| 1. Justification to MCO regarding Out-of-Network referrals, including partners not contracted with MCO (for MCOs serving MMC Members or CHIP Members and CHIP Perinate Newborn Members) |  |
| 1. Community First Choice (MCO will use HHSC’s provided language – **Attachment I.**) |  |
| 1. **Long-Term Services and Supports Provider Responsibilities** (for MCOs serving STAR+PLUS Members and MMP Enrollees) |  |
| 1. Responsibility to contact Health Plan to verify Member eligibility or authorizations for service |  |
| 1. Continuity of Care |  |
| 1. Medicaid/Medicare coordination |  |
| 1. Coordination of benefits for Dual Eligibles as applicable |  |
| 1. Notification to MCO of change in Member’s physical condition or eligibility |  |
| 1. Community First Choice services |  |
| 1. Employment Assistance Responsibilities |  |
| 1. Providers must develop and update quarterly a plan for delivering employment assistance services. |  |
| 1. Supported Employment Responsibilities |  |
| 1. Providers must develop and update quarterly a plan for delivering supported employment services. |  |
| 1. The Provider must provide the MCO with a copy of the abuse, neglect, and exploitation report findings within one Business Day of receipt of the findings from the Department of Family and Protective Services (DFPS). |  |
| 1. **Pharmacy Provider Responsibilities** |  |
| * + - * 1. Adhere to the Formulary |  |
| * + - * 1. Adhere to the Preferred Drug List (PDL) (for MCOs serving MMC Members) |  |
| * + - * 1. Coordinate with the prescribing physician |  |
| * + - * 1. Ensure Members receive all medications for which they are eligible |  |
| * + - * 1. Coordination of benefits when a Member also receives Medicare Part D services or other insurance benefits |  |
| 1. Coordination With Texas Department of Family And Protective Services (DFPS) |  |
| 1. Provider must coordinate with DFPS and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of DFPS and must respond to requests from DFPS, including: |  |
| * + 1. Providing medical records |  |
| * + 1. Recognition of abuse and neglect, and appropriate referral to DFPS |  |
| 1. Routine, Urgent, and Emergency Services |  |
| 1. Definitions |  |
| 1. Requirements for scheduling appointments |  |
| 1. Emergency prescription supply (MCO will use HHSC’s provided language – **Attachment J.**) |  |
| 1. Emergency transportation (explanation) |  |
| 1. Emergency Dental Services (MCO will use HHSC’s provided language – **Attachment K.**) |  |
| 1. Non-emergency Dental Services (MCO will use HHSC’s provided language – **Attachment L.**) |  |
| 1. Durable Medical Equipment and Other Products Normally Found in a Pharmacy (for MCOs serving MMC Members) (MCO will use HHSC’s provided language – **Attachment M.**) |  |
| 1. Electronic Visit Verification |  |
| **General Information about EVV** |  |
| 1. What is EVV? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. Is there a law that requires the use of EVV? (MCO will use HHSC's provided language - **Attachment N.)** |  |
| 1. Which services must a Service Provider or CDS Employee electronically document and verify using EVV? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. Who must use EVV? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| **EVV Systems** |  |
| 1. Do Providers and FMSAs have a choice of EVV Systems? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. Does a CDS Employer have a choice of EVV Systems? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. What is the process for a Provider or FMSA to select an EVV System? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. What requirements must a Provider or FMSA meet before using the selected EVV System? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. Does a Provider or FMSA pay to use the selected EVV System? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. Can a Provider or FMSA change EVV Systems? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. What is the process to change from one EVV System to another EVV System? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. Are the EVV Systems accessible for people with disabilities? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| **EVV Service Authorizations** |  |
| 1. What responsibilities does a Provider or FMSA have regarding service authorizations issued by an MCO for an EVV required service? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| **EVV Clock In and Clock Out Methods** |  |
| 1. What are the approved methods a Service Provider or CDS Employee may use to clock in and clock out of the EVV System to begin and to end service delivery when providing services to a member in the home or in the community? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. What actions must the Provider or FMSA take if a Service Provider or CDS Employee does not clock in or clock out or enters inaccurate information in the EVV System while clocking in or clocking out? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| **EVV Visit Maintenance** |  |
| 1. Is there a timeframe in which Providers, FMSAs, and CDS Employers must perform Visit Maintenance? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. Are Providers, FMSAs, and CDS Employers required to include information in the EVV System to explain why they ~~have performed~~ are performing Visit Maintenance? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| **EVV Training** |  |
| 1. What are the EVV training requirements for each EVV System user? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| **Compliance Reviews** |  |
| 1. What are EVV Compliance Reviews? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| **EVV Claims** |  |
| 1. Are Providers and FMSAs required to use an EVV System to receive payment for EVV required services? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. Where does a Provider or FMSA submit an EVV claim? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. What happens if a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. What happens after the HHSC Claims Administrator receives an EVV claim from a Provider or FMSA? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. How does the automated EVV claims matching process work? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. How can a Provider and FMSA see the results of the EVV claims matching process? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| 1. Could an MCO deny payment of an EVV claim even if the EVV claim successfully matches the EVV visit transaction? (MCO will use HHSC’s provided language – **Attachment N**.) |  |
| * + 1. **MEDICAID MANAGED CARE PROVIDER COMPLAINT/APPEAL PROCESS** (for MCOs serving MMC Members and MMP Enrollees) |  |
| 1. Provider Complaints process to MCO |  |
| 1. How to submit complaints online |  |
| 1. How to submit complaints via fax or paper |  |
| 1. Documentation |  |
| * + 1. Retention of fax cover pages |  |
| * + 1. Retention of emails to and from MCO |  |
| * + 1. Maintain log of telephone communication |  |
| 1. Provider Appeals process to MCO |  |
| * 1. Provider Portal |  |
| * 1. How to submit appeals via fax or paper |  |
| * 1. Documentation |  |
| * 1. Retention of fax cover pages |  |
| * 1. Retention of emails to and from MCO |  |
| * 1. Maintain log of telephone communication |  |
| 1. Provider Complaint process to HHSC |  |
| 1. Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment) (MCO will use HHSC’s provided language – **Attachment O**.) |  |
| * + 1. **MEDICAID MANAGED CARE MEMBER COMPLAINT/APPEAL PROCESS** (for MCOs serving MMC Members and MMP Enrollees) |  |
| * + - 1. **Member Complaint Process** |  |
| 1. The Member’s right to file Complaints to MCO and HHSC |  |
| 1. The requirements and timeframes for filing a Complaint |  |
| 1. The availability of assistance in the filing process |  |
| 1. The toll-free numbers that the Member can use to file a Complaint |  |
| * 1. **Member Appeal Process** |  |
| 1. What can I do if the MCO denies or limits my Member’s request for a Covered Service? |  |
| 1. How will I find out if services are denied? |  |
| 1. 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 additional information and how the delay is in the Member’s interest. If MCO needs to extend, Member must receive written notice of the reason for delay. |  |
| 1. When does Member have the right to request an Appeal – include option for the request of an Appeal for denial of payment for services in whole or in part. |  |
| 1. 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. |  |
| 1. The Member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the Member. |  |
| 1. Appeals must be accepted orally or in writing. |  |
| 8. Can someone from (insert MCO name) help me file an Appeal? 9.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. |  |
| 10.Member’s option to request only a State Fair Hearing, no later than 120 days after the MCO mails the appeal decision notice. at any time during or after the MCO’s Appeals process. |  |
| * 1. **Member Expedited MCO Appeal** |  |
| 1. How to request an emergency Appeal (must be accepted orally or in writing) |  |
| 1. Timeframes |  |
| 1. What happens if the MCO denies the request for an emergency Appeal? |  |
| 1. Who can help me file an emergency Appeal? |  |
| * 1. **Member request for State Fair Hearing only** (MCO will use HHSC’s provided language – **Attachment P.**)   2. **Member request for an External Medical Review and State Fair Hearing (MCO will use HHSC’s provided language – Attachment X.)** |  |
| **IX. CHIP PROVIDER COMPLAINT AND APPEAL PROCESSES** (for MCOs serving CHIP Members and CHIP Perinatal Members) |  |
| 1. Provider Complaint process to MCO |  |
| 1. Provider Complaint process to Texas Department of Insurance (TDI) |  |
| 1. Provider Appeal process to MCO |  |
| * + 1. Provider Portal |  |
| 1. Provider Appeal process to TDI |  |
| 1. **CHIP MEMBER COMPLAINT PROCESS** (for MCOs serving CHIP Members and CHIP Perinatal Members) |  |
| 1. **CHIP Member Complaint Process** |  |
| 1. What should I do if I have a Complaint? |  |
| 1. Who do I call? (Include at least one toll-free telephone number.) |  |
| 1. Can someone from (insert MCO name) help me file a Complaint? |  |
| 1. How long will it take to investigate and resolve my Complaint? |  |
| 1. If I am not satisfied with the outcome, who else can I call? (file complaint with TDI) |  |
| * 1. **CHIP Member Appeal Process** |  |
| 1. What can I do if the MCO denies or limits my patient’s request for a Covered Service? |  |
| 1. How will I find out if the Appeal is denied? |  |
| 1. Timeframes for the Appeal process |  |
| 1. When does a Member have the right to request an Appeal? |  |
| 1. Appeals must be accepted orally or in writing. |  |
| 1. Can someone from (insert MCO name) help me file an Appeal? |  |
| * 1. **Member Expedited MCO Appeal** |  |
| 1. How to request an Expedited Appeal (must be accepted orally or in writing) |  |
| 1. Timeframes |  |
| 1. What happens if the MCO denies the request for an Expedited Appeal? |  |
| 1. Who can help me file an Expedited Appeal? |  |
| * 1. **Member Independent Review Organization Process** |  |
| 1. What is an Independent Review Organization (IRO)? |  |
| 1. How do I request a review by an IRO? |  |
| 1. Timeframes |  |
| * + 1. **MEDICAID MANAGED CARE MEMBER ELIGIBILITY AND ADDED BENEFITS** (for MCOs serving MMC Members and MMP Enrollees) |  |
| * + 1. **Eligibility** |  |
| Determination by HHSC |  |
| 1. **Verifying Eligibility** |  |
| 1. Verifying Member Medicaid Eligibility (MCO will use HHSC’s provided language – **Attachment Q.**) |  |
| 1. Your Texas Benefits Medicaid Card |  |
| 1. Temporary ID (Form 1027-A) |  |
| 1. MCO ID card |  |
| 1. If the Member gets Medicare, Medicare is responsible for most primary, acute, and behavioral health services; therefore, the Primary Care Provider’s name, address, and telephone number are not listed on the Member’s ID card. The Member receives long-term services and supports through (Insert Name of MCO)*.* (STAR+PLUS Dual Eligibilities) |  |
| 1. Call MCO |  |
| 1. AIS line/TXMedConnect |  |
| 1. Provider Portal |  |
| 1. Electronic eligibility verification, e.g., NCPDP E1 Transaction (for Pharmacies only) |  |
| * 1. **Added Benefits** |  |
| 1. Spell-of-illness limitation does not apply for STAR Members. |  |
| 1. $200,000 annual limit on inpatient services does not apply for STAR and STAR+PLUS Members. |  |
| 1. Unlimited prescriptions for adults (For MCOs serving STAR+PLUS Members: Benefit is only available for Members who are NOT covered by Medicare.) |  |
| 1. Value-Added Services |  |
| **XII. CHIP** **MEMBER ELIGIBILITY AND ADDED BENEFITS** |  |
| 1. **Eligibility** |  |
| * 12-month eligibility for CHIP Program Members |  |
| * A CHIP Perinate (unborn child) who lives in a family with an income at or below Medicaid Eligibility Threshold (an unborn child who will qualify for Medicaid once born) will be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage (effective on the date of birth) after the birth is reported to HHSC’s enrollment broker. |  |
| * A CHIP Perinate mother in a family with an income at or below Medicaid Eligibility Threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under Medicaid Eligibility Threshold will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the Doctor at the time of birth and returned to HHSC’s enrollment broker. |  |
| * A CHIP Perinate will continue to receive coverage through the CHIP Program as a “CHIP Perinate Newborn” if born to a family with an income above Medicaid Eligibility Threshold and the birth is reported to HHSC’s enrollment broker. |  |
| * A CHIP Perinate Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan. |  |
| * Determination by the Administrative Services Contractor |  |
| * 1. **Verifying Eligibility** |  |
| * MCO ID card |  |
| * Call MCO |  |
| * Provider Portal |  |
| * Electronic eligibility verification, e.g., NCPDP E1 Transaction (for Pharmacies only) |  |
| 1. **Pregnant Teens** (does not apply to CHIP Perinatal Members) |  |
| Include language that requires Providers to contact the MCO immediately when a pregnant CHIP or Medicaid Member is identified (see EOC/COC language). |  |
| 1. **Added Benefits** |  |
| * There is no spell-of-illness limitation for CHIP Members and CHIP Perinate Newborn Members. |  |
| * Value-Added Services, if applicable |  |
| * 1. **MEMBER RIGHTS AND RESPONSIBILITES** |  |
| 1. **Medicaid Managed Care Member Rights and Responsibilities** (MCO will use HHSC’s provided language – **Attachment R.**) |  |
| 1. **CHIP Member Rights and Responsibilities** (MCO will use HHSC’s provided language – **Attachment S.**) |  |
| 1. **CHIP Perinate Member Rights and Responsibilities** (MCO will use HHSC’s provided language – **Attachment T.**) |  |
| 1. **Member’s Right to Designate an OB/GYN** (MCO will use HHSC’s provided language – **Attachment U.**) (for MCOs serving MMC Members or CHIP Members) |  |
| 1. **Fraud Reporting** (MCO will use HHSC’s provided language – **Attachment V.**) |  |
| **XIV. MEDICAID MANAGED CARE/CHIP ENCOUNTER DATA, BILLING AND CLAIMS ADMINISTRATION** |  |
| * Where to send claims/Encounter Data |  |
| * Provider Portal Functionality |  |
| * Online and batch claims processing |  |
| * Form/Format to use |  |
| * What services are included in the monthly capitation (Include note to call MCO for information or questions) |  |
| * Emergency services claims |  |
| * Cost sharing schedule (for MCOs serving CHIP Program Members) (MCOs should include a copy of the cost sharing table found in UMCM Chapter 6.3) |  |
| * No co-payments for MMC Members, CHIP Perinate Members, CHIP Perinate Newborn Members, and CHIP Members who are Native Americans or Alaskan Natives. Additionally, for CHIP Members there is no cost-sharing on benefits for well-baby and well-child services, preventive services, or pregnancy-related assistance. |  |
| * Billing Members: |  |
| * Member acknowledgment statement (explanation of use) |  |
| * Private pay form agreement (provide sample and explanation of use) (for MCOs serving MMC Members or CHIP Members and CHIP Perinate Newborn Members) |  |
| * Time limit for submission of claims/Encounter Data/claims Appeals |  |
| * Claims payment: |  |
| * 30-Day Clean Claim payment for professional and institutional claim submission |  |
| * 18-Day Clean Claim payment for electronic pharmacy claim submission |  |
| * 21-Day Clean Claim payment for non-electronic Pharmacy Claims submission |  |
| * Claim submission requirement (within 95 Days) |  |
| * Approved claim forms |  |
| * Payment/accrual of interest by MCO |  |
| * Allowable billing methods (e.g., electronic billing) |  |
| * Special billing (newborns, Value-Added Services, SSI, compounded medications, NEMT Services, etc.) |  |
| * Claims questions/Appeals (see Section VII - included in the complaint and appeals processes) |  |
| * How to find a list of covered drugs |  |
| * How to find a list of preferred drugs |  |
| * Process for requesting a prior authorization (PA) |  |
| * How to find a list of PA required services and codes |  |
| * + Meaning of “PA Not Required” on returned PA request form |  |
| * “PA Not Required” does not mean that service is approved |  |
| * + Provider Portal |  |
| * + Continuity of Care and Out of Network Provider Requirements |  |
| **XV. MEDICAID MANAGED CARE MEMBER ENROLLMENT AND DISENROLLMENT FROM MCO** (for MCOs serving MMC Members and MMP Enrollees) |  |
| * 1. **Enrollment** |  |
| * Newborn process |  |
| 1. **Automatic Re-enrollment** |  |
| * Six months (include information that Member may choose to switch plans) |  |
| 1. **Disenrollment** |  |
| * Inform the Provider that he or she cannot take retaliatory action against a Member. |  |
| * Member’s disenrollment request from managed care will require medical documentation from Primary Care Provider or documentation that indicates sufficiently compelling circumstances that merit disenrollment. |  |
| * HHSC will make the final decision. |  |
| **XVI. CHIP MEMBER ENROLLMENT AND DISENROLLMENT FROM MCO** (for MCOs serving CHIP Members) |  |
| * Enrollment (12 month eligibility) |  |
| * Reenrollment |  |
| * Disenrollment |  |
| * + Inform the Provider that he or she cannot take retaliatory action against a Member. |  |
| * Plan Changes: |  |
| * + Members are allowed to make health plan changes under the following circumstances: |  |
| * for any reason within 90 Days of enrollment in CHIP; |  |
| * for cause at any time; |  |
| * if the client moves to a different service delivery area; and |  |
| * during the annual re-enrollment period. |  |
| * HHSC will make the final decision. |  |
| **XVII. CHIP PERINATAL MEMBER ENROLLMENT AND DISENROLLMENT FROM HEALTH PLAN** (for MCOs serving CHIP Perinate Members and CHIP Perinate Newborn Members) |  |
| 1. **Newborn Process** |  |
| * In the 10th month of the CHIP Perinate Newborn’s coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn’s and the CHIP members’ information. Once the child’s CHIP Perinatal coverage expires, the child will be added to his or her siblings’ existing CHIP case. |  |
| 1. **Disenrollment** |  |
| * Inform the Provider that he or she cannot take retaliatory action against a Member. |  |
| * HHSC will make the final decision. |  |
| 1. **Plan Changes** |  |
| * A CHIP Perinate (unborn child) who lives in a family with an income at or below Medicaid Eligibility Threshold (an unborn child who will qualify for Medicaid once born) will be deemed eligible for Medicaid and will receive 12 months of continuous Medicaid coverage (effective on the date of birth) after the birth is reported to HHSC’s enrollment broker. |  |
| * + A CHIP Perinate mother in a family with an income at or below Medicaid Eligibility Threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under Medicaid Eligibility Threshold will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the Doctor at the time of birth and returned to HHSC’s enrollment broker. |  |
| * A CHIP Perinate will continue to receive coverage through the CHIP Program as a “CHIP Perinate Newborn” if born to a family with an income above Medicaid Eligibility Threshold and the birth is reported to HHSC’s enrollment broker. |  |
| * A CHIP Perinate Newborn is eligible for 12 months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan. |  |
| * CHIP Perinate mothers must select an MCO within 15 Days of receiving the enrollment packet or the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has 90 Days to select another MCO. |  |
| * When a member of a household enrolls in CHIP Perinatal, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal member’s health plan if the plan is different. All members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinatal member’s enrollment period, or (2) the end of the traditional CHIP members’ enrollment period. In the 10th month of the CHIP Perinate Newborn’s coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn’s and the CHIP members’ information. Once the child’s CHIP Perinatal coverage expires, the child will be added to his or her siblings’ existing CHIP case. |  |
| * CHIP Perinatal Members may request to change health plans under the following circumstances: |  |
| * for any reason within 90 Days of enrollment in CHIP Perinatal; |  |
| * if the member moves into a different service delivery area; and |  |
| * for cause at any time. |  |
| * 1. **MEDICAID MANAGED CARE/CHIP SPECIAL ACCESS REQUIREMENTS** |  |
| * Emergency and non-emergency ambulance transportation(for MCOs serving MMC Members) |  |
| * Interpreter/translation services |  |
| * MCO/Provider coordination |  |
| * Reading/grade level consideration |  |
| * Cultural sensitivity |  |
| * The MCO must have a mechanism in place to allow Members with Special Health Care Needs to have direct access to a specialist as appropriate for the Member’s condition and identified needs, such as a standing referral to a specialty physician. (for MCOs serving MMC Members or CHIP Members and CHIP Perinate Newborn Members). |  |
| * 1. **ADDITIONAL MMP SPECIFIC CRITICAL ELEMENTS** |  |
| MMPs may incorporate Dual Demonstration critical elements into their existing Provider Manuals or may develop a Provider Manual specific to MMP. The following are elements MMPs must include in addition to the elements referenced in Sections I through XVIII (where applicable): |  |
| **Section I Front Cover** |  |
| * 1. MMP Logo |  |
| * 1. County/Counties |  |
| **Section III Introduction** |  |
| 1. Role of long-term services and supports (LTSS) Providers (for MCOs serving MMP Enrollees) |  |
| 1. Service Coordination for Level 1 and Level 2 |  |
| **Section IV Covered Services** |  |
| 1. STAR+PLUS Covered Services (Wrap Services) |  |
| 1. Acute Covered Services (Medicare) |  |
| 1. NEMT Services |  |
| **Section V Quality Management for STAR+PLUS** |  |
| 1. Quarterly, submit the number of critical incident and abuse report for members receiving LTSS |  |
| 1. Quarterly, submit the number of MCO service coordinators receiving CDS training |  |
| **Section XI Member Eligibility and Added Benefits** |  |
| 1. Description of Flexible Benefits |  |
| 1. Description of Rewards and Incentives |  |
| 1. Description of Nominal Gifts |  |

REQUIRED LANGUAGE

## ATTACHMENT A

Dental plan Members may choose their Main Dental Homes. Dental plans will assign each Member to a Main Dental Home if he/she does not timely choose one. Whether chosen or assigned, each Member who is 6 months or older must have a designated Main Dental Home.

### Role of Main Dental Home

A Main Dental Home serves as the Member’s main dentist for all aspects of oral health care. The Main Dental Home has an ongoing relationship with that Member, to provide comprehensive, continuously accessible, coordinated, and family-centered care. The Main Dental Home provider also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers and individuals who are general dentists and pediatric dentists can serve as Main Dental Homes.

REQUIRED LANGUAGE

## ATTACHMENT B

### Documentation of completed Texas Health Steps components and elements

Each of the six components and their individual elements according to the recommendations established by the Texas Health Steps periodicity schedule for children as described in the Texas Medicaid Provider Procedures Manual must be completed and documented in the medical record.

Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element.  The medical record must contain documentation on all screening tools used for TB, growth and development, autism, and mental health screenings.  The results of these screenings and any necessary referrals must be documented in the medical record.  THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation.

THSteps checkups are made up of six primary components. Many of the primary components include individual elements. These are outlined on the Texas Health Steps Periodicity Schedule based on age and include:

1. **Comprehensive health and developmental history** which includes nutrition screening, developmental and mental health screening and TB screening

* A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social and emotional screening. The Texas Health Steps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.

1. **Comprehensive unclothed physical examination** which includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening

* A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (0-2 years), and blood pressure (3-20 years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.

1. **Immunizations**, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.

* Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza and HPV must be administered at the time of the checkup and according to the current ACIP “Recommended Childhood and Adolescent Immunization Schedule-United States,” unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
* The screening provider is responsible for administration of the immunization and are not to refer children to other immunizers, including Local Health Departments, to receive immunizations.
* Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
* Providers may enroll, as applicable, as Texas Vaccines for Children providers.  For information, please visit <https://www.dshs.texas.gov/immunize/tvfc/>.

1. **Laboratory tests**, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia

* Newborn Screening:   Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn Members and the Member’s mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.
* Anemia screening at 12 months.
* Dyslipidemia Screening at 9 to 12 years of age and again 18-20 years of age
* HIV screening at 16-18 years
* Risk-based screenings include:
  + dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis and gonorrhea/chlamydia.

1. **Health education** (including anticipatory guidance), is a federally mandated component of the medical checkup and is required in order to assist parents, caregivers and clients in understanding what to expect in terms of growth and development. Health education and counseling includes healthy lifestyle practices as well as prevention of lead poisoning, accidents and disease.
2. **Dental referral** every 6 months until the parent or caregiver reports a dental home is established.

* Clients must be referred to establish a dental home beginning at 6 months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self-refer for dental care at any age.

Use of the THSteps Child Health Record Forms can assist with performing and documenting checkups completely, including laboratory screening and immunization components. Their use is optional and recommended.  Each checkup form includes all checkup components, screenings that are required at the checkup and suggested age appropriate anticipatory guidance topics.  They are available online in the resources section at [www.txhealthsteps.com](http://www.txhealthsteps.com).

REQUIRED LANGUAGE

## ATTACHMENT C

### Children of Migrant Farmworkers

Children of Migrant Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service but should be billed as a checkup.

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

REQUIRED LANGUAGE

## ATTACHMENT D

### Prescribed Pediatric Extended Care Centers and Private Duty Nursing

A Member has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services and must be coordinated to prevent duplication. A Member may receive both in the same day, but not simultaneously (e.g., PDN may be provided before or after PPECC services are provided.) The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the Member's medical condition or the authorized hours are not commensurate with the Member's medical needs. Per 1 Tex. Admin. Code §363.209 (c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary.

REQUIRED LANGUAGE

## ATTACHMENT E

### NONEMERGENCY MEDICAL TRANSPORTATION (NEMT) SERVICES

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

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

<MCO Name of Program provides or NEMT services provide> transportation to covered health care services for Medicaid Members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. <MCO Name of Program does or NEMT services 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 service 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 the Member, the Member’s family member, friend, or neighbor.
* Members 20 years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain covered health care service. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
* Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
* Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

If you have a Member needing assistance while traveling to and from his or her appointment with you, <MCO Name of Program or NEMT services> will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health care services are being provided but may remain in the waiting room during the Member’s appointment.

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

If you have a Member you think would benefit from receiving <MCO Name of Program or NEMT services>, please refer him or her to <MCO Name> at <contact information for NEMT services> for more information.

REQUIRED LANGUAGE

## ATTACHMENT F

### CHIP Member Prescriptions

CHIP members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-Day supply of a drug.

REQUIRED LANGUAGE

## ATTACHMENT G

### How to Help a Member Find Dental Care

The Dental Plan Member ID card lists the name and phone number of a Member’s Main Dental Home provider. The Member can contact the dental plan to select a different Main Dental Home provider at any time. If the Member selects a different Main Dental Home provider, the change is reflected immediately in the dental plan’s system, and the Member is mailed a new ID card within 5 Business Days.

If a Member does not have a dental plan assigned or is missing a card from a dental plan, the Member can contact the Medicaid/CHIP Enrollment Broker’s toll-free telephone number at 1-800-964-2777.

REQUIRED LANGUAGE

## ATTACHMENT H (for MCOs serving MMC Members)

### REPORTING ABUSE, NEGLECT, OR EXPLOITATION (ANE)

**MEDICAID MANAGED CARE**

#### Report suspected Abuse, Neglect, and Exploitation:

MCOs and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

#### Report to the Health and Human Services Commissions (HHSC) if the victim is an adult or child who resides in or receives services from:

* Nursing facilities;
* Assisted living facilities;
* Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and HHSC;
* Adult day care centers; or
* Licensed adult foster care providers

Contact HHSC at 1-800-458-9858.

#### Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

* An adult who is elderly or has a disability, receiving services from:
  + Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to HHSC;
  + Unlicensed adult foster care provider with three or fewer beds
* An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
  + Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services;
  + a person who contracts with a Medicaid managed care organization to provide behavioral health services;
  + a managed care organization;
  + an officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
* An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at [www.txabusehotline.org](http://www.txabusehotline.org)

#### Report to Local Law Enforcement:

* If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

#### Failure to Report or False Reporting:

* It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, HHSC, or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
* It is a criminal offense to knowingly or intentionally report false information to DFPS, HHSC, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
* Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

REQUIRED LANGUAGE

## ATTACHMENT I (for MCOs serving MMC Members)

### Community First Choice:

#### Program Provider Responsibilities

* The CFC services must be delivered in accordance with the Member’s service plan.
* The program provider must have current documentation which includes the member’s service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable)
* The HCS or TxHmL program provider must ensure that the rights of the Members are protected (ex. e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
* The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the Member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the Member that are required to ensure the Member’s health, safety, and welfare. The program provider must maintain documentation of this training in the Member’s record.
* The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (ex. e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the Member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline. (1-800-647-7418).
* The program provider must address any complaints received from a Member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the Member/LAR with the appropriate contact information for filing a complaint.
* The program provider must not retaliate against a staff member, service provider, Member (or someone on behalf of a Member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
* The program provider must ensure that the service providers meet all the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver’s license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.
* For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
* Per the CFR §441.565 for CFC, the program provider must ensure that any additional training requested by the Member/LAR of CFC PAS or habilitation (HAB) service providers is procured.
* The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
* The program provider must adhere to the MCO financial accountability standards.
* The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a Member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.
* The program provider must prevent financial impropriety toward a Member, including unauthorized disclosure of information related to a Member’s finances and the purchase of goods that a Member cannot use with the Member’s funds.

REQUIRED LANGUAGE

## ATTACHMENT J

### Emergency Prescription Supply

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member’s medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information: [*MCO inserts claim submission process here*].

Call [*insert the appropriate MCO provider hotline number*] for more information about the 72-hour emergency prescription supply policy.

REQUIRED LANGUAGE

## ATTACHMENT K

### EMERGENCY DENTAL SERVICES

#### Medicaid Emergency Dental Services:

(Insert MCO’s name) is responsible for emergency dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

* treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts; and
* treatment of oral abscess of tooth or gum origin.

#### CHIP Emergency Dental Services:

(Insert MCO’s name) is responsible for emergency dental services provided to CHIP Members and CHIP Perinate Newborn Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

* treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts; and
* treatment of oral abscess of tooth or gum origin.

REQUIRED LANGUAGE

## ATTACHMENT L

### NON-EMERGENCY DENTAL SERVICES

#### Medicaid Non-Emergency Dental Services:

(Insert MCO’s name) is **not responsible** for paying for routine dental services provided to Medicaid Members. These services are paid through Dental Managed Care Organizations.

(Insert MCO’s name) is **responsible** for paying for treatment and devices for craniofacial anomalies, and of Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for Members aged 6 through 35 months.

[MCO must explain in detail OEFV billing guidelines and documentation criteria].

OEFV benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a Main Dental Home choice.

* OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.
* OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
* Documentation must include all components of the OEFV. [MCO may describe components].
* Texas Health Steps providers must assist Members with establishing a Main Dental Home (see Attachment D) and document Member’s Main Dental Home choice in the Members’ file.

#### CHIP Non-Emergency Dental Services:

(Insert MCO’s name) is **not responsible** for paying for routine dental services provided to CHIP and CHIP Perinate Members. These services are paid through Dental Managed Care Organizations.

(Insert MCO’s name) is **responsible** for paying for treatment and devices for craniofacial anomalies**.**

REQUIRED LANGUAGE

## ATTACHMENT M (for MCOs serving MMC Members)

### Durable Medical Equipment and Other Products Normally Found in a Pharmacy

[Insert MCO name] reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bed pans, and other supplies and equipment. For children (birth through age 20), [insert MCO name] also reimburses for items typically covered under the Texas Health Steps Program, such as prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies, and some nutritional products.

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must [describe the MCO’s enrollment process and claims submission process].

Call [insert the appropriate MCO provider hotline number] for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

**Note:** The MCO may elaborate on the scope of DME/other products for children (birth through age 20) provided by the MCO. The above language must be included at a minimum.

REQUIRED LANGUAGE

## ATTACHMENT N (for MCOs serving MMC Members)

### ELECTRONIC VISIT VERIFICATION

### GENERAL INFORMATION ABOUT EVV

**1. What is EVV?**

EVV is a computer-based system that electronically documents and verifies the occurrence of a visit by a Service Provider or CDS Employee, as defined in Chapter 8.7.1 of the UMCM, to provide certain services to a member. The EVV System documents the following:

* Type of service provided (Service Authorization Data);
* Name of the Member to whom the service is provided (Member Data);
* Date and times the visit began and ended;
* Service delivery location;
* Name of the Service Provider or CDS Employee who provided the service (Service Provider Data); and
* Other information HHSC determines is necessary to ensure the accurate adjudication of Medicaid claims.

**2.** **Is there a law that requires the use of EVV?**

Yes. In December of 2016, the federal 21st Century Cures Act added Section 1903(l) to the Social Security Act (42 USC. § 1396b(l)) to require all states to implement the use of EVV. Texas Government Code, Section 531.024172, requires HHSC to implement an EVV System to electronically verify certain Medicaid services in accordance with federal law. To comply with these statutes, HHSC required the use of EVV for all Medicaid personal care services requiring an in-home visit, effective January 1, 2021. HHSC plans to require the use of EVV for Medicaid home health care services requiring an in-home visit, effective January 1, 2023.

**3.** **Which services must a Service Provider or CDS Employee electronically document and verify using EVV?**

The EVV required services that must be electronically documented and verified through EVV are listed on the HHSC EVV website. Refer to the Programs, Services and Service Delivery Options Required to Use Electronic Visit Verification.

Check the EVV Service Bill Codes Table on the HHSC EVV website for up-to-date information and specific HCPCS code(s) and modifiers for EVV-required services.

[MCO will provide the link to the HHSC EVV website for the EVV Service Bill Codes Table.]

**4.** **Who must use EVV?**

The following must use EVV:

* Provider: An entity that contracts with an MCO to provide an EVV service.
* Service Provider: A person who provides an EVV required service and who is employed or contracted by a Provider or a CDS Employer.
* CDS Employee: A person who provides an EVV required service and who is employed by a CDS Employer.
* Financial Management Services Agency (FMSA): An entity that contracts with an MCO to provide financial management services to a CDS Employeras described in Texas Administrative Code, Title 40, Part 1, Chapter 41, Subchapter A, § 41.103(25), Consumer Directed Services Option.
* CDS Employer: A Member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining a service provider who delivers a service.

**EVV SYSTEMS**

**5.** **Do Providers and FMSAs have a choice of EVV Systems?**

Yes. A Provider or FMSA must select one of the following two EVV Systems:

* EVV vendor system. An EVV vendor system is an EVV System provided by an EVV vendor selected by the HHSC Claims Administrator, on behalf of HHSC, that a Provider or FMSA may opt to use instead of an EVV proprietary system.

[MCO must provide a link to the TMHP vendor page for additional information]

* EVV proprietary system. An EVV proprietary system is an HHSC-approved EVV System that a Provider or FMSA may choose to use instead of an EVV vendor system. An EVV proprietary system:
  + Is purchased or developed by a Provider or an FMSA.
  + Is used to exchange EVV information with HHSC or an MCO; and
  + Complies with the requirements of Texas Government Code Section 531.024172 or its successors.

[The MCO must provide a link to the TMHP Proprietary System page for additional information].

**6****. Does a CDS Employer have a choice of EVV Systems?**

No. A CDS Employer must use the EVV System selected by the CDS Employer’s FMSA.

**7. What is the process for a Provider or FMSA to select an EVV System?**

* To select an EVV vendor from the state vendor pool, a Provider or FMSA, signature authority and the agency’s appointed EVV System administrator must complete, sign, and date the EVV Provider Onboarding Form located on the EVV vendor’s website.
* [MCO must provide a link to the TMHP web page to access state approved vendors and contact information]. To use an EVV proprietary system, a Provider or FMSA, signature authority, and the agency’s appointed EVV System administrator, must visit the TMHP Proprietary System webpage to review the EVV PSO Onboarding process and HHSC EVV Proprietary System approval process.

[MCO must provide a link to TMHP’s EVV website for more information about the EVV proprietary system onboarding process.]

**8.** **What requirements must a Provider or FMSA meet before using the selected EVV System?**

Before using a selected EVV System:

* The Provider or FMSA must submit an accurate and complete form directly to the selected EVV vendor.

(MCO must provide a link to the TMHP website for state approved vendor information);

* Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:
  + An EVV Proprietary System Request Form
  + EVV PSO Detailed Questionnaire (DQ)
  + TMHP Interface Access Request
* A program provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHSC to use an EVV proprietary system to comply with HHSC EVV requirements.
* If selecting either an EVV vendor or an EVV Proprietary System, a Provider or FMSA must:
  + Complete all required EVV training as described in the answer to Question #18; and
  + Complete the EVV System onboarding activities:
    - Manually enter or electronically import identification data;
    - Enter or verify Member service authorizations;
    - Setup member schedules (if required); and
    - Create the CDS Employer profile for CDS Employer credentials to the EVV System.

**9. Does a Provider or FMSA pay to use the selected EVV System?**

* If a Provider or FMSA selects an EVV vendor system, the Provider or FMSA uses the system free of charge.
* If a Provider or FMSA elects to use an EVV proprietary system, the Provider or FMSA is responsible for all costs for development, operation, and maintenance of the system.

**10. Can a Provider or FMSA change EVV Systems?**

Yes. A Provider or FMSA may:

* Transfer from an EVV vendor to another EVV vendor within the state vendor pool;
* Transfer from an EVV vendor to an EVV Proprietary System;
* Transfer from an EVV Proprietary System to an EVV vendor; or
* Transfer from one EVV Proprietary system to another EVV Proprietary system.

**11. What is the process to change from one EVV System to another EVV System?**

To change EVV Systems, a Provider or FMSA must request a transfer as follows:

* To request a transfer to an EVV vendor, a Provider or FMSA must submit an EVV Provider Onboarding Form to the new EVV vendor.
* To request a transfer to an EVV proprietary system, a Provider or FMSA must submit the PSO Request packet and complete the EVV PSO Onboarding Process.
* A Provider or FMSA must submit an EVV Provider Onboarding Form to the newly selected EVV vendor or an EVV PSO Request packet to TMHP at least 120 Days before the desired effective date of the transfer.
* If a Provider or FMSA is transferring to an EVV vendor, the effective date of the transfer may be earlier than the desired effective date of the transfer if the Provider or FMSA and the newly selected EVV vendor agree on an earlier date.
* If a Provider or FMSA is transferring to an EVV proprietary system, the Provider or FMSA, TMHP, and HHSC will establish an effective date of transfer for the proprietary system that may be different than the desired effective date of the transfer.
* An FMSA must notify CDS Employers 60 days in advance of the planned Go-Live date to allow time for the FMSA to train CDS Employers and CDS Employees on the new EVV System.
* A Provider or FMSA must complete all required EVV System training before using the new EVV System.
* A Provider or FMSA who transfers to a new EVV vendor or proprietary system:
  + Will not receive a grace period and will be subject to all EVV policies including those related to compliance and enforcement; and
  + May have EVV claims denied or recouped if there are no matching accepted EVV visit transactions in the EVV Aggregator.
* After a Provider or FMSA begins using a new EVV System, the Provider or FMSA must return all alternative devices supplied by the previous EVV vendor to the previous EVV vendor, if applicable.

**12. Are the EVV Systems accessible for people with disabilities?**

The EVV vendors provide accessible systems, but if a CDS Employer, service provider or CDS Employee needs an accommodation to use the EVV System, the vendor will determine if an accommodation can be provided. However, vendors will not provide a device or special software if the system user needs this type of accommodation.

If the Provider or FMSA is using a proprietary system, the Service Provider, CDS Employer or CDS Employee must contact the Provider or FMSA to determine accessibility features of the system and if an accommodation can be provided.

**EVV SERVICE AUTHORIZATIONS**

**13. What responsibilities do Providers and FMSAs have regarding service authorizations issued by an MCO for an EVV required service?**

A Provider and FMSA must do the following regarding service authorizations issued by an MCO for an EVV-required service:

* + Manually enter into the EVV System the most current service authorization for an EVV required service, including:
    - Name of the MCO;
    - Name of the Provider or FMSA;
    - Provider or FMSA Tax Identification Number;
    - National Provider Identifier (NPI) or Atypical Provider Identifier (API);
    - Member Medicaid ID;
    - Healthcare Common Procedural Coding System (HCPCS) code and Modifier(s);
    - Authorization start date; and
    - Authorization end date.
  + Perform Visit Maintenance if the most current service authorization is not entered into the EVV System; and
  + Manually enter service authorization changes and updates into the EVV System as necessary.

**EVV CLOCK IN AND CLOCK OUT METHODS**

**14. What are the approved methods a Service Provider or CDS Employee may use to clock in and to clock out to begin and to end service delivery when providing services to a member in the home or in the community?**

A Service Provider or CDS Employee must use one of the three approved electronic verification methods described below to clock in to begin service delivery and to clock out to end service delivery when providing services to a member in the home or in the community. A Service Provider or CDS Employee may use one method to clock in and a different method to clock out.

1. Mobile method
   * A Service Provider must use one of the following mobile devices to clock in and clock out:

* the Service Provider’s personal smart phone or tablet; or
* a smart phone or tablet issued by the Provider.
  + A Service Provider must not use a Member’s smart phone or tablet to clock in and clock out.
  + A CDS Employee must use one of the following mobile devices to clock in and clock out:
* the CDS Employee’s personal smart phone or tablet;
* A smart phone or tablet issued by the FMSA; or
* the CDS Employer’s smart phone or tablet if the CDS Employer authorized the CDS Employee to use their smart phone or tablet.
  + To use a mobile method, a Service Provider or CDS Employee must use an EVV application provided by the EVV vendor or the PSO that the Service Provider or CDS Employee has downloaded to the smart phone or tablet.
  + The mobile method is the only method that a Service Provider or CDS Employee may use to clock in and clock out when providing services in the community.

1. Home phone landline
   * A Service Provider or CDS Employee may use the Member’s home phone landline, if the Member agrees, to clock in and clock out of the EVV System.
   * To use a home phone landline, a Service Provider or CDS Employee must call a toll-free number provided by the EVV vendor or the PSO to clock in and clock out.
   * If a Member does not agree to a Service Provider’s or CDS Employee’s use of the home phone landline or if the Member’s home phone landline is frequently not available for the Service Provider or CDS Employee to use, the Service Provider or CDS Employee must use another approved clock in and clock out method.
   * The Provider or FMSA must enter the Member’s home phone landline into the EVV System and ensure that it is a landline phone and not an unallowable landline phone type.
2. Alternative device

* A Service Provider or CDS Employee may use an HHSC-approved alternative device to clock in and clock out when providing services in the Member’s home.
* An alternative device is an HHSC-approved electronic device provided at no cost by an EVV vendor or EVV PSO.
* An alternative device produces codes or information that identifies the precise date and time service delivery begins and ends.
* The alternative device codes are active for only seven days after the date of service and must be entered into the EVV system before the code expires.
* The Service Provider or CDS Employee must follow the instructions provided by the Provider or CDS Employer to use the alternative device to record a visit.
* An alternative device must always remain in the Member’s home even during an evacuation.

**15. What actions must the Provider or FMSA take if a Service Provider or CDS Employee does not clock in or clock out or enters inaccurate information in the EVV System while clocking in or clocking out?**

* If a Service Provider does not clock in or clock out of the EVV System or an approved clock in or clock out method is not available, then the Provider must manually enter the visit in the EVV System.
* If a Service Provider makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the Provider must perform Visit Maintenance to correct the inaccurate service delivery information in the EVV System.
* If a CDS Employee does not clock in or clock out for any reason, the FMSA or CDS Employer must create a manual visit by performing Visit Maintenance in accordance with the CDS Employer’s selection on Form 1722 to manually enter the clock-in and clock-out information and other service delivery information, if applicable.
* If a CDS Employee makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the FMSA or CDS Employer must perform Visit Maintenance in accordance with the CDS Employer’s selection on Form 1722 to correct the inaccurate service delivery information in the EVV System.
* After the Visit Maintenance time frame has expired, the EVV System locks the EVV visit transaction and the program provider, FMSA or CDS Employer may only complete Visit Maintenance if the MCO approves a Visit Maintenance Unlock Request.
* The EVV Policy Handbook requires the Provider, FMSA or CDS Employer to ensure that each EVV visit transaction is complete, accurate and validated.

**EVV VISIT MAINTENANCE**

**16. Is there a timeframe in which Providers, FMSAs, and CDS Employers must perform Visit Maintenance?**

In general, a Provider, FMSA, or CDS Employer must complete any required Visit Maintenance after a visit prior to the end of the Visit Maintenance timeframe as set in HHSC EVV Policy Handbook.

Note: the standard Visit Maintenance timeframe as set in EVV Policy Handbook may be changed by HHSC to accommodate Providers impacted by circumstances outside of their control.

**17**. **Are Providers, FMSAs, and CDS Employers required to include information in the EVV System to explain why they are performing Visit Maintenance?**

Yes. Program providers, FMSAs or CDS Employers must select the most appropriate Reason Code Number(s), Reason Code Description(s) and must enter any required free text when completing Visit Maintenance in the EVV System.

* Reason Code Number(s) describe the purpose for completing Visit Maintenance on an EVV visit transaction.
* Reason Code Description(s) describe the specific reason Visit Maintenance is necessary.
* Free text is additional information the program provider, FMSA or CDS Employer enters to further describe the need for Visit Maintenance.

[MCO must refer their Providers and FMSAs to the Reason Code table on the HHSC EVV Website via the appropriate link (MCO must insert the link to the HHSC EVV Website)]

**EVV TRAINING**

**18. What are the EVV training requirements for each EVV System user?**

* Providers and FMSAs must complete the following training:
  + EVV System training provided by the EVV vendor or EVV PSO;
  + EVV Portal training provided by TMHP; and
  + EVV Policy training provided by HHSC or the MCO.
* CDS Employers must complete training based on delegation of Visit Maintenance on Form 1722, CDS Employer’s Selection for Electronic Visit Verification Responsibilities:
  + Option 1: CDS Employer agrees to complete all Visit Maintenance and approve their employee’s time worked In the EVV System;
    - EVV System training provided by the EVV vendor or EVV PSO;
    - Clock in and clock out methods; and
    - EVV Policy training provided by HHSC, the MCO or FMSA.
  + Option 2: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf; however, CDS Employer will approve their employee’s time worked in the system:
    - EVV System training provided by EVV vendor or EVV PSO; and
    - EVV Policy training provided by HHSC, the MCO or FMSA.
  + Option 3: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf:
    - Overview of EVV Systems training provided by EVV Vendor or EVV PSO; and
    - EVV policy training provided by HHSC, the MCO or FMSA.

**•** Providers and CDS Employers must train Service Providers and CDS Employees on the EVV methods used to clock in when an EVV required service begins and clock out when the service ends.

[The MCO must provide a link for more information about the MCO’s EVV training requirements.]

**COMPLIANCE REVIEWS**

**19. What are EVV Compliance Reviews?**

* EVV Compliance Reviews are reviews conducted by the MCO to ensure Providers, FMSAs, and CDS Employers are in compliance with EVV requirements and policies.
* The MCO will conduct the following reviews and initiate contract or enforcement actions if Providers, FMSAs or CDS Employers do not meet any of the following EVV compliance requirements:
  + EVV Usage Review - meet the minimum EVV Usage Score;
  + EVV Required Free Text Review – document EVV required free text; and
  + EVV Landline Phone Verification Review - ensure valid phone type is used.

[The MCO must provide a link for more information about the MCO’s EVV Compliance Reviews, if applicable]

**EVV CLAIMS**

**20. Are Providers and FMSAs required to use an EVV System to receive payment for EVV required services?**

Yes. All EVV claims for services required to use EVV must match to an accepted EVV visit transaction in the EVV Aggregator before reimbursement of an EVV claim by the MCO. The MCO may deny or recoup an EVV claim that does not match an accepted visit transaction.

**21. Where does a Provider or FMSA submit an EVV claim?**

Providers and FMSAs must submit all EVV claims to the HHSC Claims Administrator in accordance with the MCO’s submission requirements.

[The MCO must provide additional information or a link for more information on the claims’ submission and the process for corrected or adjusted claims].

**22. What happens if a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator?**

If a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator, the MCO will reject or deny the claim and require the Provider or FMSA to submit the claim to the HHSC Claims Administrator.

**23. What happens after the HHSC Claims Administrator receives an EVV claim from a Provider or FMSA?**

The HHSC Claims Administrator will forward the EVV claims to the EVV Aggregator for the EVV claims matching process. The EVV Aggregator will return the EVV claims and the EVV claims match result code(s) back to the HHSC Claims Administrator for further claims processing. After completing the EVV claims matching process, the HHSC Claims Administrator forwards the claim to the MCO for final processing.

**24. How does the automated EVV claims matching process work?**

The claims matching process includes:

* Receiving an EVV claim line item.
* Matching data elements from each EVV claim line item to data elements from one or more accepted EVV transactions in the EVV Aggregator.
* Forwarding an EVV claim match result code to the MCO once the claims matching process is complete.

The following data elements from the claim line item and EVV transaction must match:

* Medicaid ID;
* Date of service;
* National Provider Identifier (NPI) or Atypical Provider Identifier (API);
* Healthcare Common Procedure Coding System (HCPCS) code;
* HCPCS modifiers; and
* Billed units to units on the visit transaction, if applicable.

Note: No unit match is performed on CDS EVV claims and unit match is not performed on visit transactions against the billed units on the claim line item for specific services. Refer to the EVV Service Bill Codes Table for the specific services that bypass the units matching process.

Based on the result of the EVV claims matching process, the EVV Portal displays an EVV claims match result code. After the EVV claims matching process, the EVV Aggregator returns an EVV claims match result code to the claims management system for final claims processing.

EVV claim match codes viewable in the EVV Portal are:

* EVV01 – EVV Successful Match
* EVV02 – Medicaid ID Mismatch
* EVV03 – Visit Date Mismatch
* EVV04 – Provider Mismatch (NPI/API) or Attendant ID Mismatch
* EVV05 – Service Mismatch (HCPCS and Modifiers, if applicable)
* EVV06 – Units Mismatch
* EVV07 – Match Not Required
* EVV08 – Natural Disaster

If the EVV Aggregator identifies a mismatch between an accepted EVV visit transaction and an EVV claim line item, the EVV claims matching process will return one of the EVV claim match result codes of EVV02, EVV03, EVV04, EVV05, or EVV06. The MCO will deny the EVV claim line item if it receives an EVV claim match result code of EVV02, EVV03, EVV04, EVV05, or EVV06.

When HHSC implements a bypass of the claims matching process for disaster or other temporary circumstance:

* The EVV claims matching process will return a match result code of EVV07 or EVV08.
* The MCO will not immediately deny an EVV claim with either of these claims match result codes for an unsuccessful EVV match.
* The MCO may still deny an EVV claim if other claim requirements fail the claims adjudication process.
* If allowed by HHSC, the MCO may complete a retrospective review of a paid EVV claim line item with a match result code of EVV07 or EVV08 to ensure the paid claim line item has a successful EVV match.

**25. How can a Provider and FMSA see the results of the EVV claims matching process?**

Providers and FMSAs may view the results of the EVV claims matching process in the EVV Portal. The EVV Portal contains a claim identifier for both the TMHP system and the MCO system. The MCO’s Provider Portal also provides additional claims status information, such as whether the MCO has paid or denied the claim. In addition, the MCO provides an Explanation of Payment (EOP) to Providers and FMSAs to inform them of whether the MCO paid or denied the claim, and if denied, the reason for denial.

[MCOs will provide the link to the TMHP EVV Training webpage, which takes the user directly to the “Accessing the EVV Portal Job Aid for Providers and FMSAs”]

**26. Could an MCO deny payment of an EVV claim even if the EVV claim successfully matches the EVV visit transaction?**

Yes. An MCO may deny payment for an EVV claim for a reason unrelated to EVV requirements, such as a Member’s loss of program eligibility or the Provider’s or FMSA’s failure to obtain prior authorization for a service.

REQUIRED LANGUAGE

## ATTACHMENT O (for MCOs serving MMC Members)

### Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)

Provider may appeal claim recoupment by submitting the following information to HHSC:

* A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
* **The Explanation of Benefits (EOB) showing the original payment.** Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
* **The EOB showing the recoupment and/or the plan's "demand" letter for recoupment.** If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
* **Completed clean claim.** All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

Texas Health and Human Services Commission

HHSC Claims Administrator Contract Management

Mail Code-91X

P.O. Box 204077

Austin, Texas 78720-4077

REQUIRED LANGUAGE

## ATTACHMENT P (for MCOs serving MMC Members)

### STATE FAIR HEARING INFORMATION

* **Can a Member ask for a State Fair Hearing?**

If a Member, as a member of the health plan, disagrees with the health plan’s decision, the Member has the right to ask for a State Fair Hearing. The Member may name someone to represent them by contacting the health plan and giving the name of the person the Member wants to represent him or her. A provider may be the Member’s representative if the provider is named as the Member’s authorized representative. The Member or the Member’s representative must ask for the State Fair Hearing within 120 days of the date on the health plan’s letter that tells of the decision being challenged. If the Member does not ask for the State Fair Hearing within 120 days, the Member may lose his or her right to a State Fair Hearing. To ask for a State Fair Hearing, the Member or the Member’s representative should either send a letter to the health plan at (address for health plan) or call (number for health plan).

If the Member asks for a State Fair Hearing within 10 days from the time the Member gets the hearing notice 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 hearing decision is made. If the Member does not request a State Fair Hearing within 10 days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.

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

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

REQUIRED LANGUAGE

## ATTACHMENT Q (for MCOs serving MMC Members)

### Verifying Member Medicaid Eligibility

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient’s eligibility for the date of service prior to services being rendered. There are two ways to do this:

* Use TexMedConnect on the TMHP website at [www.tmhp.com](http://www.tmhp.com).
* Call Provider Services at the patient’s medical or dental plan.

**Important:** Members can request a new card by calling 1-800-252-8263. Members also can go online to order new cards or print temporary cards at [www.YourTexasBenefits.com](http://www.YourTexasBenefits.com) and see their benefit and case information, view Texas Health Steps Alerts, and more.

**Important:** Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients. A copy is required during the appeal process if the client’s eligibility becomes an issue.

REQUIRED LANGUAGE

## ATTACHMENT R (for MCOs serving MMC Members)

### 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 health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   1. Be told how to choose and change your health plan and your primary care provider.
   2. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
   3. Change your primary care provider.
   4. Change your health plan without penalty.
   5. Be told how to change your health plan or 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 health care needs to you and talk to you about the different ways your health care problems can be treated.
   2. Be told why care or services were denied and not given.
4. 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 health care is best for you.
   2. Say yes or no to the care recommended by your provider.
5. You have the right to use each available complaint and appeal process through the managed care organization 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 your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
   2. Get a timely answer to your complaint.
   3. Use the plan’s appeal process and be told how to use it.
   4. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   5. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.
6. 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 health care 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 health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else’s convenience or is meant to force you to do something you do not want to do or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your 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.
9. You have a right to know that you are not responsible for paying for covered services.  Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

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.
   3. Learn what choices of health plans are available in your area.
2. You must abide by the health plan’s and Medicaid’s policies and procedures. That includes the responsibility to:
   1. Learn and follow your health plan’s rules and Medicaid rules.
   2. Choose your health plan and a primary care provider quickly.
   3. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
   4. Keep your scheduled appointments.
   5. Cancel appointments in advance when you cannot 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 health care needs and ask questions about the different ways your health care problems can be treated.
   3. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
   1. Work as a team with your provider in deciding what health care 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.

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.

REQUIRED LANGUAGE

## ATTACHMENT S (for MCOs serving CHIP Members)

### MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. “Limited provider network” means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment, depending on your income. Co-payments do not apply to CHIP Perinatal Members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. 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.
19. You have a right to know that you are only responsible for paying allowable co-payments for covered services.  Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

MEMBER RESPONSIBILITIES

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
9. Talk to your child’s provider about all of your child’s medications.

REQUIRED LANGUAGE

## ATTACHMENT T (for CHIP Perinate Members)

### MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child’s health plan, doctors, hospitals, and other providers.
2. You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency Perinatal services if you reasonably believe your unborn child’s life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child’s health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.
10. You have the right to talk to your Perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals, and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child’s doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
12. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child’s health status, medical care, or treatment.  Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

MEMBER RESPONSIBILITIES

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the doctor's decisions about your unborn child’s care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Member Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
7. Talk to your provider about all of your medications.

REQUIRED LANGUAGE

## ATTACHMENT U (for MCOs serving MMC Members, CHIP Members, and CHIP Perinate Newborn Members)

### MEMBER’S RIGHT TO DESIGNATE AN OB/GYN:

Option 1: MCO ***DOES NOT LIMIT*** TO NETWORK

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

### ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the Member:

* One well-woman checkup each year
* Care related to pregnancy
* Care for any female medical condition
* A referral to a specialist doctor within the network

Option 2: MCO ***LIMITS*** TO NETWORK

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

### ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the Member:

* One well-woman checkup each year
* Care related to pregnancy
* Care for any female medical condition
* A referral to a specialist doctor within the network

REQUIRED LANGUAGE

## ATTACHMENT V

### FRAUD INFORMATION

REPORTING WASTE, ABUSE, OR FRAUD BY A PROVIDER OR CLIENT

MEDICAID MANAGED CARE AND CHIP

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

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care 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 or CHIP ID.
* Using someone else’s Medicaid or CHIP 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.hhsc.state.tx.us/> Under the box labeled “I WANT TO” click “Report Waste, Abuse, and 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

REQUIRED LANGUAGE

## ATTACHMENT W

### Breast Pump Coverage in Medicaid and CHIP

Texas Medicaid and CHIP cover breast pumps and supplies when Medically Necessary after a baby is born. A breast pump may be obtained under an eligible mother’s Medicaid or CHIP client number; however, if a mother is no longer eligible for Texas Medicaid or CHIP and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant’s Medicaid client number.

|  |  |  |  |
| --- | --- | --- | --- |
| **Coverage in prenatal period** | **Coverage  at delivery** | **Coverage  for newborn** | **Breast pump coverage & billing** |
| STAR | STAR | STAR | STAR covers breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother’s Medicaid ID or the newborn’s Medicaid ID. |
| CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)**\*** | Emergency Medicaid | Medicaid fee-for-service (FFS) or STAR**\*\*** | Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn’s Medicaid ID. |
| CHIP Perinatal, with income above 198% FPL | CHIP Perinatal | CHIP Perinatal | CHIP covers breast pumps and supplies when Medically Necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn’s CHIP Perinatal ID. |
| STAR Kids | STAR Kids | Medicaid FFS  or STAR**\*\*** | Medicaid FFS, STAR, and STAR Health cover breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother’s Medicaid ID or the newborn’s Medicaid ID. |
| STAR+PLUS | STAR+PLUS | Medicaid FFS  or STAR**\*\*** |
| STAR Health | STAR Health | STAR Health |
| None, with income at or below 198% FPL | Emergency Medicaid | Medicaid FFS or STAR**\*\*** | Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn’s Medicaid ID. |

**\***CHIP Perinatal Members with household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the pregnant woman an Emergency Medicaid application 30 Days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.

**\*\***These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn’s Medicaid ID if the mother does not have coverage.

REQUIRED LANGUAGE

## ATTACHMENT X (for MCOs serving MMC Members)

### 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 for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO 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 should 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 health plan mails the appeal decision, 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, the Member’s authorized representative, or the Member’s LAR 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. The Member, the Member’s authorized representative, or the Member’s LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. 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, the State Fair Hearing decision 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.