**DOCUMENT HISTORY LOG**

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| **STATUS1** | **DOCUMENT**  **REVISION2** | **EFFECTIVE**  **DATE** | **DESCRIPTION3** |
| Baseline | 2.0 | May 1, 2016 | Initial version Uniform Managed Care Manual, Chapter 3.33 "STAR Kids Provider Manual Combined Required Critical Elements".  Chapter 3.33 applies to contracts issued as a result of HHSC RFP number X29-13-0071. |
| Revision | 2.1 | December 1, 2016 | Applicability is modified to add language regarding combined program manuals.  Section V. A. is modified to add "Documentation of completed Texas Health Steps components and elements" and a reference to required language in Attachment C. All subsequent Attachment references are re-lettered.  Section V. E. is modified to add a reference to MTP required language in Attachment F and to remove sub-bullets as redundant.  Section VII. 8. regarding payment responsibility for Medicaid enrollment changes that occur during Continuous Inpatient Stay in a Hospital is deleted.  Attachment C "Documentation of completed Texas Health Steps components and elements" is added and all subsequent attachments are re-lettered.  Attachment F "Medical Transportation Program (MTP)" is added and all subsequent attachments are re-lettered.  Attachment P "Span of Coverage (Hospital) - Responsibility during a Continuous Inpatient Stay" is deleted and all subsequent attachments are re-lettered.  Attachment Q "Verifying Member Eligibility" is modified to add section on provider access to Medicaid health information. |
| Revision | 2.2 | November 15, 2018 | Section V. B. is modified to add Prescribed Pediatric Extended Care Centers and to include the acronym for Private Duty Nursing .  Attachment E " Prescribed Pediatric Extended Care Centers" is added and all subsequent attachments are re-lettered.  Attachment P "Provider Appeal Process to HHSC (related to claim recoupment)" is modified to clarify the process.  Attachment R "Verifying Member Medicaid Eligibility" is modified to clarify information regarding the portal. |
| Revision | 2.3 | May 1, 2019 | Attachment I modified to add statement to comply with CMS requirements for reporting abuse, neglect, and exploitation.  Attachment J changes DFPS to Adult Protective Services |
| Revision | 2.4 | February 21, 2020 | Attachment R “Verifying Member Medicaid Eligibility and MCO Enrollment” is modified to update the options for providers to verify Medicaid eligibility and information on provider and client views on the Medicaid Client Portal. |
| Revision | 2.4.1 | June 17, 2020 | Accessibility approved version posted. |
| Revision | 2.5 | April 21, 2021 | Modified “day” and “calendar day” to the Contract term, “Day,” and capitalized “Business Day” where applicable throughout chapter.  Section V.B. is modified to add reference to NEMT services.  Section V.E. deletes the reference to HHSC’s Medical Transportation Program.  Section VII. E. deletes nonemergency transportation information.  Section XI. is modified to add NEMT services as a special billing example.  Section XIII. modifies the general transportation and ambulance/wheelchair van bullet to emergency and nonemergency transportation.  Attachment G is modified to provide required language on NEMT and remove the language on MTP. |
| Revision | 2.6 | May 1, 2022 | Added section titled, “GENERAL INSTRUCTIONS TO MCO” to provide guidance to MCOs on the use of the term ‘emergency’.  Section VI (E): Addition of MDCP/DBMD escalation help line Information  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 V for “External Medical Review Information”.  Amended the term “fair hearing” to contract-defined term “State Fair Hearing” throughout the document.  Attachment S: Added EMR and MDCP-DBMD escalation help line language.  Attachment W: Added to include description of MDCP/DBMD escalation help line and when to utilize.  Section VIII(B)(7). Removes requirement for Member to confirm an orally submitted internal appeal request in writing.  Attachment S – Revisions made to Member Rights, item 5. Page 46 adding external medical review information. |
| Revision | 2.7 | May 2, 2022 | Administrative Update – Language deleted from Attachment V which reads: “Go in-person to a local HHSC office”. |
| Revision | 2.8 | September 1, 2022 | Section V.B is modified to add reference to Case Management for Children and Pregnant Women (CPW).  Section V. E is modified to remove CPW from Medicaid Non-capitated Services list. |
| Revision | 2.9 | 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 O is modified to provide required language on EVV. |
| Revision | 2.10 | July 17, 2023 | Attachment V is modified to remove the language that the Member may request an IRO be present at the State Fair Hearing.  Attachment V 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 vers ions.

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 3.33

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR Kids Program.

MCOs may develop a distinct STAR Kids provider manual or choose to develop a combined manual to include STAR Kids, STAR+PLUS, STAR, and CHIP. 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 Kids, STAR+PLUS, STAR, or CHIP must be contained in a specific section for that particular program, or the MCO may reference the program in the section title (e.g. For STAR Only).

**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: |  |
| * MCO name |  |
| * MCO logo |  |
| * STAR Kids |  |
| * STAR Kids logo |  |
| * Service Area |  |
| * The words “PROVIDER MANUAL” |  |
| * Provider services number |  |
| * Date of current publication |  |
| * Website address |  |
| **II. TABLE OF CONTENTS** |  |
| * The Provider Manual must include a Table of Contents. |  |
| **III. INTRODUCTION** |  |
| * Background |  |
| * Quick reference phone list |  |
| * Objectives of Program |  |
| * Role of Primary Care Provider (or “Medical Home”) * Explain that STAR Kids Dual Eligible Members are not required to have a PCP. |  |
| * Include which practice areas a MCO may have in their STAR Kids PCP Network. |  |
| * Role of a Health Home |  |
| * Role of specialty care Provider |  |
| * Role of Long Term Services and Supports (LTSS) Providers |  |
| * Role of MCO Service Coordinator |  |
| * Role of MCO Transition Specialist |  |
| * Role of Pharmacy |  |
| * Role of Main Dental Home (MCO will use HHSC’s provided language – **Attachment A.**) |  |
| * Network limitations (e.g., Primary Care Providers, Specialists, OB/GYN) |  |
| **IV. DEFINITIONS** |  |
| At a minimum, include definitions for the following: (MCO will use HHSC’s provided language – **Attachment B.**) |  |
| * 1915(i) Home and Community-Based Services - Adult Mental Health (HCBS-AMH) |  |
| * Community Living Assistance and Support Services (CLASS) Waiver Program |  |
| * Deaf Blind with Multiple Disabilities (DBMD) Waiver Program |  |
| * Dual-Eligible |  |
| * Home and Community-based Services (HCS) Waiver Program |  |
| * Long Term Services and Supports (LTSS) |  |
| * Medical Dependent Children Program (MDCP) Waiver Program |  |
| * Texas Home Living (TxHML) Waiver Program |  |
| * Youth Empowerment Services (YES) Waiver Program |  |
| **V. COVERED SERVICES** |  |
| STAR Kids benefits are governed by the MCO’s contract with the Health and Human Services Commission (HHSC), and include: medical, vision, behavioral health, pharmacy and Long Term Services and Supports (LTSS). MDCP services are covered for individuals who qualify for and are approved to receive MDCP. |  |
| 1. Texas Health Steps Services |  |
| * Refer provider to the *Texas Medicaid Provider Procedures Manual* for information regarding Texas Health Steps. |  |
| * Documentation of completed Texas Health Steps components and elements (MCO will use HHSC's provided language - **Attachment C**) |  |
| * Children of Migrant Farmworkers (MCO will use HHSC’s provided language – **Attachment D.**) |  |
| 1. **Covered Services** |  |
| * At a minimum, the participating MCO must provide a benefit package to Members that includes Fee-for-Service (FFS) acute care and LTSS services currently covered under the Texas Medicaid program. MDCP services are covered for individuals who qualify for and are approved to receive MDCP. |  |
| * MCO may refer to the current Texas Medicaid Provider Procedures Manual (TMPPM) for listing of limitations and exclusions. |  |
| * MCO must include a description of the following LTSS services: |  |
| * Adaptive Aids (MCO responsible for STAR Kids MDCP Members only) * Case Management for Children and Pregnant Women |  |
| * Community First Choice services |  |
| * Day Activity and Health Services (DAHS) (only for Members 18years **of** age and older) |  |
| * Employment Assistance (MCO responsible for STAR Kids MDCP Members only) |  |
| * Financial Management Services (Include Support Consultation for Consumer-Directed Service Option only) |  |
| * Flexible Family Support Services (MCO responsible for STAR Kids MDCP Members only) |  |
| * Minor home modifications (MCO responsible for STAR Kids MDCP Members only) |  |
| * Personal Care Services |  |
| * Private Duty Nursing (PDN) |  |
| * Respite Care (MCO responsible for STAR Kids MDCP Members only) |  |
| * Supported Employment (MCO responsible for STAR Kids MDCP Members only) |  |
| * Transition Assistance Services (MCO responsible for STAR Kids MDCP Members only) |  |
| * Prescribed Pediatric Extended Care Centers (PPECC) (MCO will use HHSC’s provided language – **Attachment E**.) |  |
| * 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. |  |
| * Nonemergency Medical Transportation (NEMT) Services (MCO will use HHSC’s provided language – **Attachment G**.) |  |
| 1. **Service Coordination Services** |  |
| * MCOs must include an explanation/description of Service Coordination, including the following: |  |
| * The role of the Service Coordinator |  |
| * How a provider can access a member's Service Coordinator |  |
| * Include the definition of STAR Kids Screening and Assessment Instrument |  |
| * Include the definition of STAR Kids Screening and Assessment Process |  |
| * Explain how the Screening and Assessment Process and Screening and Assessment Instrument are used to prioritize which Members require the most immediate attention and what level of service meets the Member's needs. |  |
| * Service Coordination services |  |
| * Service Coordination for Level 1, 2, and 3 Members |  |
| * Individual Service Plan |  |
| * Discharge planning |  |
| * Continuity of Care Transition Plan |  |
| 1. **Adult Transition Planning** (MCO will use HHSC’s provided language – **Attachment F**) |  |
| 1. **Coordination with Non-Medicaid Managed Care Covered Services *(Non-Capitated Services)*** |  |
| MCO must include the following references to Texas Medicaid Provider Procedures Manual (TMPPM). |  |
| * Texas Health Steps dental (including orthodontia) |  |
| * Texas Health Steps environmental lead investigation (ELI) |  |
| * Early Childhood Intervention (ECI) targeted case management/service coordination |  |
| * Early Childhood Intervention Specialized Skills Training |  |
|  |  |
| * Texas School Health and Related Services (SHARS) |  |
| * Department of Assistive and Rehabilitative Services (DARS) Blind   Children’s Vocational Discovery and Development Program |  |
| * Tuberculosis services provided by Department of State Health Services DSHS-approved providers (directly observed therapy and contact investigation) |  |
| * Health and Human Services Commission (HHSC) hospice   services |  |
| * HHSC or DSHS HCBS Waiver programs, including CLASS, DBMD, HCS, TxHmL and YES |  |
| * Court-Ordered Commitments to inpatient mental health facilities as a condition of probation |  |
| * PASRR screenings, evaluations, and specialized services |  |
| 1. **Behavioral Health** |  |
| * Definition of behavioral health |  |
| * List behavioral health Covered Services |  |
| * MCO responsible for authorized inpatient Hospital services, this   includes services provided in Freestanding Psychiatric Facilities |  |
| * Primary Care Provider requirements for behavioral health (exclude   STAR Kids Dual Eligible) |  |
| * Behavioral Health Services: |  |
| * Member access to behavioral health services |  |
| * Attention Deficit Hyperactivity Disorder (ADHD) |  |
| * Health Home |  |
| * Self-referral (any Network behavioral health provider) |  |
| * Primary Care Provider referral |  |
| * Coordination between behavioral health and physical health   services |  |
| * Medical records documentation and referral information (required to document using the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) classifications) |  |
| * Consent for disclosure of information |  |
| * Court-Ordered Commitments |  |
| * Coordination with the Local Mental Health Authority (LMHA) and state psychiatric facilities |  |
| * Assessment instruments for behavioral health available for use by a Primary Care Provider |  |
| * Focus studies |  |
| * Utilization management reporting requirements (specify by   individual mental health service type) |  |
| * Procedures for follow-up on missed appointments |  |
| * Member discharged from inpatient psychiatric facilities need to have follow-up within 7 Days from the date of discharge |  |
| * Behavioral health Value-added Services, if any (list the VASs offered by MCO) |  |
| * Behavioral health emergencies |  |
| * Substance Use Disorder |  |
| * Specialized Service Coordination (explain provider's role in the coordination of care) |  |
| * Mental Health Rehabilitative (MHR) Services and Targeted Case Management(TCM) |  |
| * Definition of severe and persistent mental illness (SPMI) |  |
| * Definition of severe emotional disturbance (SED) |  |
| * Member access to and benefits of MHR Services and TCM |  |
| * Provider requirements: |  |
| * Training and certification to administer the Child and Adolescent Needs and Strengths (CANS) assessment tool for members between the ages of 0-18 years of age and the Adult Needs and Strength Assessment (ANSA) for members 19 and 20. |  |
| * Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG) |  |
| * 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 |  |
| * HHSC-established qualification and supervisory protocols |  |
| 1. **QUALITY MANAGEMENT** |  |
| * Include practice guidelines |  |
| * Focus studies |  |
| * Utilization management reporting requirements |  |
| 1. **PROVIDER RESPONSIBILITIES** |  |
| 1. **General Responsibilities** |  |
| * Primary Care Provider (Medical Home) responsibilities (exclude STAR Kids Dual Eligible Members) |  |
| * Include the difference between a PCP and Health Home |  |
| * Availability and accessibility |  |
| * 24 hour availability |  |
| * + - **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. |  |
| * Plan termination |  |
| * Member’s right to designate an OB/GYN as their Primary Care (exclude STAR Kids Dual Eligible Members) |  |
| * For Members with disabilities, special health care needs, and Chronic or Complex conditions, the right to designate a specialist as their Primary Care Provider as long as the specialist agrees. (exclude STAR Kids Dual-Eligible Members) |  |
| * 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 |  |
| * + - Member’s right to obtain medication from any Network pharmacy |  |
| * + - Member information on advance directive |  |
| * + - Referral to specialists and health-related services (documentation of coordination of referrals and services provided between Primary Care Provider and specialist) (exclude STAR Kids Dual-Eligible Members) |  |
| * How to help a Member find dental care (MCO will use HHSC’s provided language – **Attachment H.**) |  |
| * Primary Care Provider may provide behavioral health-related services within the scope of its practice (exclude STAR Kids Dual-Eligible Members) |  |
| * Referral to Network facilities and contractors |  |
| * Access to second opinion |  |
| * Specialty care Provider responsibilities (must include availability and accessibility standards) |  |
| * Verify Member eligibility or authorizations for service |  |
| * Continuity of Care related to: |  |
| * Pregnant woman information |  |
| * Member moves out of Service Area |  |
| * Pre-existing conditions |  |
| * Out-of-Network Providers (Explain the various limits associated with each of the following scenarios.) |  |
| 1. Members receiving Community-Based Services on the STAR Kids Operational Start Date |  |
| 1. Member changes MCOs and has an existing prior authorization with their previous MCO |  |
| 1. Members who, at the time of enrollment in the MCO, have been diagnosed with and receiving treatment for a terminal illness and remains in the MCO |  |
| 1. Necessary, covered services are not available in-network |  |
| 1. Members receiving any other services on the STAR Kids Operational Start Date. |  |
| * 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. |  |
| * Justification to MCO regarding Out-of-Network referrals, including partners not contracted with MCO |  |
| * 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 I.) |  |
| * 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 I.) * 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 Adult Protective Services. |  |
| * Required to complete the mandatory challenge survey |  |
| * Explain the purpose and frequency of this survey |  |
| 1. Long-Term Services and Supports Provider Responsibilities |  |
| * Responsibility to contact Health Plan to verify Member eligibility or authorizations for service |  |
| * Continuity of Care |  |
| * Medicare/Medicaid coordination |  |
| * Notification to MCO of change in Member’s physical condition or eligibility |  |
| * Community First Choice (MCO will use HHSC’s provided language – Attachment J.) |  |
| * Employment Assistance responsibilities |  |
| * Providers must develop and update quarterly a plan for delivering employment assistance services. |  |
| * Supported Employment responsibilities |  |
| * Providers must develop and update quarterly a plan for delivering supported employment services. * 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 Adult Protective Services. |  |
| 1. **Pharmacy Provider Responsibilities** |  |
| * Adhere to the formulary |  |
| * Adhere to the preferred drug list (PDL) |  |
| * Coordinate with the prescribing physician |  |
| * Ensure Members receive all medications for which they are eligible |  |
| * 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)** |  |
| * 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: |  |
| * Providing medical records |  |
| * Recognition of abuse and neglect, and appropriate referral to DFPS |  |
| 1. **Routine, Urgent, and Emergency Services** |  |
| * Definitions |  |
| * Requirements for scheduling appointments |  |
| * Emergency prescription supply (MCO will use HHSC’s provided language – **Attachment K.**) |  |
| * Emergency transportation (explanation) |  |
| * Emergency dental services (MCO will use HHSC’s provided language – Attachment L.) |  |
| * Non-emergency dental services (MCO will use HHSC’s provided language – **Attachment M.**) |  |
| * + - * + Durable medical equipment and other products normally found in a pharmacy (MCO will use HHSC’s provided language – **Attachment N.**)   + MDCP/DBMD escalation help line (MCO will use HHSC’s provided language) - (Attachment W) |  |
| 1. **Electronic Visit Verification (EVV)** |  |
| **General Information about EVV** |  |
| * 1. What is EVV? (MCO will use HHSC’s provided language – **Attachment O**.) |  |
| * 1. Is there a law that requires the use of EVV? (MCO will use HHSC's provided language - **Attachment O.)** |  |
| * 1. Which services must a Service Provider or CDS Employee electronically document and verify using EVV? (MCO will use HHSC’s provided language – **Attachment O**.) |  |
| * 1. Who must use EVV? (MCO will use HHSC’s provided language – Attachment O.) |  |
| EVV Systems |  |
| * 1. Do Providers and FMSAs have a choice of EVV Systems? (MCO will use HHSC’s provided language – Attachment O.) |  |
| * 1. Does a CDS Employer have a choice of EVV Systems? (MCO will use HHSC’s provided language – Attachment O.) |  |
| * 1. What is the process for a Provider or FMSA to select an EVV System? (MCO will use HHSC’s provided language – Attachment O.) |  |
| * 1. What requirements must a Provider or FMSA meet before using the selected EVV System? (MCO will use HHSC’s provided language – Attachment O.) |  |
| * 1. Does a Provider or FMSA pay to use the selected EVV System? (MCO will use HHSC’s provided language – Attachment O.) |  |
| * 1. Can a Provider or FMSA change EVV Systems? (MCO will use HHSC’s provided language – Attachment O.) |  |
| * 1. What is the process to change from one EVV System to another EVV System? (MCO will use HHSC’s provided language – Attachment O.) |  |
| * 1. Are the EVV Systems accessible for people with disabilities? (MCO will use HHSC’s provided language – Attachment O.) |  |
| **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 O.) |  |
| **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 O.) |  |
| * 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 O.) |  |
| **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 O.) |  |
| * 1. Are Providers, FMSAs, and CDS Employers required to include information in the EVV System to explain why they are performing Visit Maintenance? (MCO will use HHSC’s provided language – Attachment O.) |  |
| **EVV Training** |  |
| * 1. What are the EVV training requirements for each EVV System user? (MCO will use HHSC’s provided language – Attachment O.) |  |
| **Compliance Reviews** |  |
| * 1. What are EVV Compliance Reviews? (MCO will use HHSC’s provided language – Attachment O.) |  |
| **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 O.) |  |
| * 1. Where does a Provider or FMSA submit an EVV claim? (MCO will use HHSC’s provided language – Attachment O.) |  |
| * 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 O.) |  |
| * 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 O.) |  |
| * 1. How does the automated EVV claims matching process work? (MCO will use HHSC’s provided language – Attachment O.) |  |
| * 1. How can a Provider and FMSA see the results of the EVV claims matching process? (MCO will use HHSC’s provided language – Attachment O.) |  |
| * 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 O.) |  |
| 1. **MEDICAID MANAGED CARE PROVIDER COMPLAINT/APPEAL PROCESS** |  |
| 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 P.**) |  |
| 1. **MEDICAID MANAGED CARE MEMBER COMPLAINT/APPEAL PROCESS** |  |
| 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.       2. 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.       3. Member’s option to request only a State Fair Hearing no later than 120 Days after the MCO mails the appeal decision notice. |  |
|  |  |
|  |  |
| 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? | \_\_\_\_\_\_\_\_\_\_\_\_ |
| **D. Member request for State Fair Hearing only** (MCO will use HHSC’s provided language – **Attachment Q.**)  E. Member request for an External Medical Review and State Fair Hearing (MCO will use HHSC’s provided language – Attachment V.) |  |
| 1. **MEDICAID MANAGED CARE MEMBER ELIGIBILITY AND ADDED BENEFITS** |  |
| **Eligibility** |  |
| Determination by HHSC |  |
| * 1. **Verifying Eligibility** |  |
| * Verifying Member Medicaid Eligibility and MCO Enrollment (MCO will use HHSC’s provided language – **Attachment R.**) |  |
| * Your Texas Benefits Medicaid Card |  |
| * Temporary ID (Form 1027-A) |  |
| * MCO ID card |  |
| * + - If the Member also received Medicare benefits, Medicare is responsible for most primary and acute services and some behavioral health services; therefore, the Primary Care Provider’s name, address, and telephone number are not listed on the Member’s ID card. (STAR Kids Dual Members) |  |
| * Call MCO |  |
| * Automated Inquiry System (AIS) line/TXMedConnect |  |
| * + - Provider Portal |  |
| * + - Electronic eligibility verification, e.g., NCPDP E1 Transaction (for Pharmacies only) |  |
| * 1. **Added Benefits** |  |
| * Spell-of-illness limitation does not apply |  |
| * $200,000 annual limit on inpatient services does not apply |  |
| * Unlimited prescriptions (Benefit is only available for Members who are NOT covered by Medicare.) |  |
| * Value-added Services (list the VASs offered by MCO and how a member can access the services) |  |
| 1. **MEMBER RIGHTS AND RESPONSIBILITES** |  |
| 1. **Medicaid Managed Care Member Rights and Responsibilities** (MCO will use HHSC’s provided language – **Attachment S.**) |  |
| 1. **Member’s Right to Designate an OB/GYN** (MCO will use HHSC’s provided language – **Attachment T.**) (excludes STAR Kids Dual Eligible Members) |  |
| 1. **Fraud Reporting** (MCO will use HHSC’s provided language – **Attachment U.**) |  |
| **XI. MEDICAID MANAGED CARE ENCOUNTER DATA, BILLING AND CLAIMS ADMINISTRATION** |  |
| * Where to send claims/Encounter Data |  |
| * In addition claim submission instructions for state plan services for all STAR Kids members and MDCP waiver services, include specific instructions on where to send claims for the following scenarios: |  |
| 1. Daily rate claims for services rendered in a nursing facility or Intermediate Care Facility for Indivuduals with Intellectual Disabilities (ICF/IDDs) or other related conditions (UMCC, Att B-1, 8.1.2) |  |
| 1. Claims for custom DME or augmentative devices when the member changes MCOs and the authorizing MCO is not the Member's MCO on the date of delivery. (UMCC, Att A, Section 5.03, (g)) |  |
| 1. Claims for minor home modifications for a MDCP STAR Kids Waiver Member when the Member changes MCOs and the authorizing MCO is not the Member's MCO on the date of completion of the modifications. (UMCC, Att A, Section 5.03, (h)) |  |
| 1. Claims for LTSS (Provide specific instructions on who is responsible for LTSS services based on the various waiver programs,) |  |
| * Provider portal functionality (both 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 |  |
| * No co-payments STAR Kids Members |  |
| * Coordination of benefits with third-party resources, to include Medicare for Dual Eligible STAR Kids Members |  |
| * Billing Members: |  |
| * Member acknowledgment statement (explanation of use) |  |
| * Private pay form agreement (provide sample and explanation of use) |  |
| * 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 covered |  |
| * Provider portal |  |
| * Continuity of Care and Out-of-Network Provider requirements |  |
| **XII. MEDICAID MANAGED CARE MEMBER ENROLLMENT AND DISENROLLMENT FROM MCO** |  |
| * + - 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. |  |
| * + - * 1. **MEDICAID MANAGED CARE SPECIAL ACCESS REQUIREMENTS** |  |
| * Emergency and nonemergency ambulance transportation |  |
| * 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. |  |
| * Access to telemedicine, telemonitoring, and telehealth |  |

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

**1915(i) Home and Community Based Services- Adult Mental Health (HCBS-AMH)**

Home and Community Based Services-Adult Mental Health (HCBS-AMH) is a state-wide program that provides home and community-based services to adults with serious mental illness. The HCBS-AMH program provides an array of services, appropriate to each Member's needs, to enable him or her to live and experience successful tenure in their chosen community. Services are designed to support long term recovery from mental illness.

**Community Living Assistance and Support Services (CLASS) Waiver Program**   
  
The Community Living Assistance and Support Services (CLASS) program provides home and community-based services to people with related conditions as a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). A related condition is a disability, other than an intellectual disability, that originated before age 22 that affects the ability to function in daily life.

**Deaf Blind with Multiple Disabilities (DBMD) Waiver Program**

The Deaf Blind with Multiple Disabilities (DBMD) program provides home and community-based services to people who are deaf blind and have another disability. This is a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). The DBMD program focuses on increasing opportunities for consumers to communicate and interact with their environment.

**Dual-Eligible**

Medicaid recipients who are also eligible for Medicare

**Home and Community-based Services (HCS) Waiver Program**

The Home and Community-based Services (HCS) program provides individualized services and supports to people with intellectual disabilities who are living with their families, in their own homes or in other community settings, such as small group homes where no more than four people live. The local authority provides service coordination.

**Long Term Services and Supports (LTSS)**

LTSS means assistance with daily healthcare and living needs for individuals with a long-lasting illness or disability.

**Medical Dependent Children Program (MDCP) Waiver Program**

The Medically Dependent Children Program (MDCP) provides services to support families caring for children who are medically dependent and encourages the transition of children in nursing homes back to the community.

**Texas Home Living (TxHmL) Waiver Program**

The Texas Home Living (TxHmL) program provides selected essential services and supports to people with an intellectual disability or a related condition who live in their own home or their family's home.

**Youth Empowerment Services (YES) Waiver Program**

The Youth Empowerment Services (YES) waiver provides comprehensive home and community-based mental health services to youth between the ages of 3 and 18, up to a youth's 19th birthday, who have a serious emotional disturbance. The YES Waiver not only provides flexible supports and specialized services to children and youth at risk of institutionalization and/or out-of-home placement due to their serious emotional disturbance, but also strives to provide hope to families by offering services aimed at keeping children and youth in their homes and communities.

REQUIRED LANGUAGE

## ATTACHMENT C

**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.
2. **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.  
  
 **REQUIRED LANGUAGE**

## ATTACHMENT D

**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 E

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

A client has a choice of Private Duty Nursing (PDN), Prescribed Pediatric Extended Care Center (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 client 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 client's medical condition or the authorized hours are not commensurate with the client's medical needs. In accordance with 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 F

**ADULT TRANSITION PLANNING**

**STAR Kids Only**

<MCO> will help to assure that teens and young adult Members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their 21st birthday. Each MCO is responsible for conducting ongoing transition planning starting when the Member turns 15 years old. The MCO must provide transition planning services as a team approach through the named Service Coordinator if applicable and with a Transition Specialist within the Member Services Division. Transition Specialists must be an employee of the MCO and wholly dedicated to counseling and educating Members and others in their support network about considerations and resources for transitioning out of STAR Kids. Transition Specialists must be trained on the STAR+PLUS system and maintain current information on local and state resources to assist the Member in the transition process. Transition planning must include the following activities:

1. Development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model without a break in service.
2. Prior to the age of 10, the MCO must inform the Member and the Member’s LARregarding LTSS programs offered through the Health and Human Services Commission (HHSC) and, if applicable, provide assistance in completing the information needed to apply. HHSC LTSS programs include CLASS, DBMD, TxHmL, and HCS.
3. Beginning at age 15, the MCO must regularly update the ISP with transition goals.
4. Coordination with DARS to help identify future employment and employment training opportunities.
5. If desired by the Member or the Member's LAR, coordination with the Member's school and Individual Education Plan (IEP) to ensure consistency of goals.
6. Health and wellness education to assist the Member with Self-Management.
7. Identification of other resources to assist the Member, the Member's LAR, and others in the Member's support system to anticipate barriers and opportunities that will impact the Member's transition to adulthood.
8. Assistance applying for community services and other supports under the STAR+PLUS program after the Member's 21st birthday.
9. Assistance identifying adult healthcare providers.

REQUIRED LANGUAGE

## ATTACHMENT G

**NONEMERGENCY MEDICAL TRANSPORTATION (NEMT) SERVICES**

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

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

<NEMT services provide or MCO name of transportation program provides> transportation to covered health care services for 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. <NEMT services do or MCO name of transportation program does> NOT include ambulance trips.

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

* Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
* Commercial airline transportation services.
* Demand response transportation services, which is curb-to-curb transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
* Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be 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 a 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, <NEMT services or MCO name of transportation program> 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 NEMT services or MCO name of transportation program>, please refer him or her to <MCO Name> at <contact information for NEMT services> for more information.

REQUIRED LANGUAGE

## ATTACHMENT H

**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 I

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.

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). In addition, the provider is responsible for reporting individual remediation on confirmed allegations to the MCO.

**Report to the Health and Human Services Commission (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 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

**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 J

**Community First Choice:**

**Provider Responsibilities**

* The CFC services must be delivered in accordance with the Member’s service plan.
* The program provider must maintain 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 (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 Adult Protective Services investigation has begun through the completion of the investigation (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 Adult Protective Services hotline (1-800-252-5400).
* 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 of 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 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 K

**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 L

**EMERGENCY DENTAL SERVICES**

**Medicaid Emergency Dental Services:**

(Insert MCO’s name) is responsible for emergency dental services provided to Medicaid Members in a hospital, free standing emergency room, or an ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) including but not limited to:

* treatment of a dislocated jaw, traumatic damage to teeth and supporting structures, removal of cysts;
* treatment of oral abscess of tooth or gum origin; and
* treatment and devices for correction of craniofacial anomalies and drugs.

REQUIRED LANGUAGE

## ATTACHMENT M

**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.

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

REQUIRED LANGUAGE

## ATTACHMENT N

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

<MCO> 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 and young adults (birth through age 20), <MCO> 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 O

**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.

1. **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, 2024.

1. **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 on the HHSC EVV website

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.]

1. **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 Employer as 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**

1. **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

1. **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.

1. **What is the process for a Provider or FMSA to select an EVV System?**
   1. To select an EVV vendor, 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].

* 1. 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.]

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

Before using a selected EVV System:

* 1. 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);

* 1. Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:
     1. An EVV Proprietary System Request Form
     2. EVV PSO Detailed Questionnaire (DQ)
     3. TMHP Interface Access Request
  2. A 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.
  3. If selecting either an EVV vendor or an EVV Proprietary System, a Provider or FMSA must:
     1. Complete all required EVV training as described in the answer in the **EVV TRAINING** section below; and
     2. Complete the EVV System onboarding activities:
        1. Manually enter or electronically import identification data;
        2. Enter or verify Member service authorizations;
        3. Setup member schedules (if required); and
        4. Create the CDS Employer profile for CDS Employer credentials to the EVV System.

1. **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.

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

Yes. A Provider or FMSA may:

* Transfer from an EVV vendor to another EVV vendor approved by the state.
* 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.

1. **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.

1. **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**

1. **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**

1. **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;
* 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. *Note, if a Service Provider or CDS Employee are unable to use a mobile method in the community, they must manually enter their clock in and/or clock out times in the EVV System.*

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.

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?**

* 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 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**

1. **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, FMSAs, or CDS Employers impacted by circumstances outside of their control.

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

Yes. 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.

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

[MCO must refer their Providers, FMSAs, and CDS Employers 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**

1. **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**

1. **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**

1. **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.

1. **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].

1. **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.

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

The HHSC Claims Administratorwill 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 Administratorfor further claims processing. After completing the EVV claims matching process, the HHSC Claims Administrator forwards the claim to the MCO for final processing.

1. **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 found on the HHSC EVV website 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.

1. **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 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”]

1. **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 P

**Provider Appeal Process to HHSC (related to claim recoupment)**

Upon notification of a claims payment recoupment, the first step is for the provider to recheck Member eligibility to determine if a Member eligibility change was made to Fee-for-Service or to a different managed care organization on the date of service.

1. **Member eligibility changed to Fee-for-Service on the date of service**

Provider may appeal claim payment 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. 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.
* **Note:** Label the request **"Expedited Review Request"** at the top of the letter to ensure the appeal request is reviewed prior to eighteen (18) months from the date of service.

Mail Fee-for-Service related 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

Prepare a new paper claim for each claim that was recouped, and insert the new claims as attachments to the administrative appeal letter. Include documentation such as the original claim and the statement showing that the claims payment was recouped.

Submission of the new claims is not required before sending the administrative appeal letter.  However, if a provider appeals prior to submitting the new claims, the provider must subsequently include the new claims with the administrative appeal.

HHSC Claims Administrator Contract Management only reviews appeals that are received within eighteen (18) months from the date-of-service. In accordance with 1 TAC § 354.1003, providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Contract Management and all claims must be finalized within 24 months from the date of service.

1. **Member eligibility changed from one Managed Care Organization (MCO) to another on the Date-of-Service**

Providers may appeal claims payment recoupments and denials of services by submitting the following information to the appropriate MCO to which the Member eligibility was changed on the date of service:

* 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. The EOB showing the recoupment and/or the MCO's "demand" letter for recoupment** must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
* **Documentation must identify** the client name, identification number, DOS, and recoupment amount, and other claims information.
* **Note:** Label the request **"Expedited Review Request"** at the top of the letter to ensure the appeal request is reviewed prior to 18 months from the date of service.

Submit appeals online at:

(Insert hyperlink to MCO's website location for submission of appeals)

Mail Fee-for-Service related appeals 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 Q

**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 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 R

**Verifying Member Medicaid Eligibility and MCO Enrollment**

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 Medicaid eligibility and MCO enrollment for the date of service prior to services being rendered. There are several ways to do this:

* Use TexMedConnect on the TMHP website at www.tmhp.com.
* Log into your TMHP user account and accessing Medicaid Client Portal for providers.
* Call the TMHP Contact Center or the Automated Inquiry System (AIS) at 1-800-925-9126 or 1-512-335-5986.
* Call Provider Services at the patient’s medical or dental plan.

**Important:** Do not send patients who forgot or lost their cards to an HHSC benefits office for a paper form. They can request a new card by calling1-800-252-8263. Medicaid Members also can go online to order new cards or print temporary cards.

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

**Providers access to Medicaid medical and dental health information**

Medicaid providers can log into their TMHP user account and access the Medicaid Client Portal for providers. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan (FFS or Managed Care). This information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be.

The specific functions available are:

* Access to a Medicaid patient’s medical and dental health information including medical diagnosis, procedures, prescription medicines and vaccines on the Medicaid Client Portal through My Account.
* Enhances eligibility verification available on any device, including desktops, laptops, tablets, and smart phones with print functionality.
* Texas Health Steps and benefit limitations information.
* A viewable and printable Medicaid Card.
* Display of the Tooth Code and Tooth Service Code for dental claims or encounters.
* Display of the Last Dental Anesthesia Procedure Date.

Additionally, an online portal is available to patients at www.YourTexasBenefits.com where they can:

* View, print, and order a Your Texas Benefits Medicaid card
* See their medical and dental plans
* See their benefit information
* See Texas Health Steps Alerts
* See broadcast alerts
* See diagnosis and treatments
* See vaccines
* See prescription medicines
* Choose whether to let Medicaid doctors and staff see their available medical and dental information

Note: The YourTexasBenefits.com Medicaid Client Portal displays information for active patients only. Legally Authorized Representatives can view anyone who is part of their case.

REQUIRED LANGUAGE

## ATTACHMENT S

**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. MDCP/DBMD escalation help line for Members receiving Waiver services via the Medically Dependent Children Program or Deaf/Blind Multi-Disability Program. (Attachment W)
   3. Get a timely answer to your complaint.
   4. Use the plan’s appeal process and be told how to use it.
   5. Ask for a an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   6. Ask for a State Fair Hearing without an External Medical Reviewfrom 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.

REQUIRED LANGUAGE

## ATTACHMENT T (Excludes STAR Kids Dual Eligible 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 U

**FRAUD INFORMATION**

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

MEDICAID MANAGED CARE

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

The Member, 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, it is the State Fair Hearing decision that is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

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

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

## REQUIRED LANGUAGE

## ATTACHMENT W (MDCP/DBMD Escalation Help Line)

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

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

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

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

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

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

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

**Who can call the help line?**

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

**Can members call any time?**

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