Document History Log

|  |  |  |  |
| --- | --- | --- | --- |
| **STATUS**1 | **DOCUMENT**  **REVISION**2 | **EFFECTIVE**  **DATE** | **DESCRIPTION**3 |
| Baseline | n/a | November 15, 2005 | Initial version Uniform Managed Care Manual, Chapter 3.4 Medicaid Managed Care Member Handbook Critical Elements |
| Revision | 1.1 | September 1, 2006 | Chapter 3.4 is modified regarding Members accessing family planning services. Requires HMOs to include family planning list obtained from DSHS website. |
| Revision | 1.2 | September 30, 2006 | Chapter 3.4 is modified to include STAR+PLUS critical elements in the Member Handbook. |
| Revision | 1.3 | April 30, 2007 | Chapter 3.4 is modified to include the Foster Care Model critical elements in the Member Handbook. Chapter 3.4 is also modified to include other clerical revisions. |
| Revision | 1.4 | January 8, 2008 | All provisions of Chapter 3.4 are modified to remove the Foster Care Model. Information regarding the Foster Care Model can be found in Chapter 3.15 Foster Care Member Handbook Critical Elements.  References to STARLink updated to reflect name change to Medicaid Managed Care Helpline.  Attachment O revised to reflect changes to the Fair Hearings process.  Added required language Attachment R for “What can be done if my pharmacy cannot get my prescription approved?”  Added required language Attachment S for “What if I am a Migrant Farm Worker?” |
| Revision | 1.5 | May 20, 2009 | Added language regarding the HHS Office of Civil Rights to Attachment L, “Member Rights and Responsibilities.”  Added language as Attachment T, “What is the Medicaid Limited Program?”  Re-lettered subsequent section. |
| Revision | 1.6 | October 10, 2009 | Chapter 3.4 is revised to conform to the style and preferred terms required by the Consumer Information Tool Kit.  Attachment L, “Member Rights and Responsibilities,” is revised to include additional Member notices.  Attachment O, Fair Hearings, is revised to remove the statement “The Member does not have a right to a fair hearing if Medicaid does not cover the service requested.” |
| Revision | 1.7 | April 1, 2010 | Attachment O, “Fair Hearings,” is revised to clarify the process for continuing benefits. |
| Revision | 1.8 | June 1, 2010 | Attachment M, “Complaints” is revised to correct the phone number and to add the HPM Complaints email address. |
| Revision | 1.9 | September 3, 2010 | Added language as Attachment U, “How do I get help if I have mental health, alcohol, or drug problems?” for the Dallas Service Area Only. Subsequent section is re-lettered. |
| Revision | 1.10 | March 1, 2011 | Added language as Attachment V, “How many times can I change my/my child’s Primary Care Provider?” Subsequent section is re-lettered. |
| Revision | 1.11 | July 10, 2011 | Section III. C. is updated to replace “Medicaid identification (ID) cards (Form 3087)” with “Your Texas Benefits Medicaid Card.”  Section III. I. is updated to remove the requirement for the HMO to have a local telephone number.  Attachment A, “Medicaid Identification Form (Form 3087)” is renamed “Your Texas Benefits Medicaid Card” and the content is revised.  Attachment P, “Fraud and Abuse” is updated. |
| Revision | 2.0 | March 1, 2012 | Revision 2.0 applies to contracts issued as a result of HHSC RFP numbers X29-10-0020 and X29-12-0002. The chapter is reformatted to convert the outline narrative to a form and to delete final checklist as redundant.   1. Section III. A. is added and subsequent sections renumbered. 2. Add requirement that Member Services Line include how to access Covered Services. 3. Add required language regarding “What is the Medicaid Limited Program?” (Attachment C) 4. Modify required language regarding “Physician Incentive Plans” (Attachment D) 5. Modify optional language regarding “What if I want to change health plans?” (Attachment E) 6. Modify required language regarding “What does Medically Necessary mean?” (Attachment F) 7. Add required language regarding “What do I do if I need Emergency Dental Care?” (Attachment H) 8. Add required language regarding “How do I get my medications?” (Attachment K) 9. Add pharmacy questions in Section I. 10. Add alternative language regarding family planning in Section I for MCOs that do not offer family planning. 11. Modify required language regarding “What if I can’t get the medication my doctor ordered approved?” (Attachment L) 12. Add question “Where can I find a list of birthing centers?” to Section I. 13. Re-letter all existing required language attachments as appropriate. |
| Revision | 2.1 | March 15, 2012 | Attachment Z “What if I Need Durable Medical Equipment or Other Products Normally Found in a Pharmacy?” is added.  All subsequent attachments are re-lettered. |
| Revision | 2.2 | August 15, 2012 | Section II. is modified to remove the name of the MCO’s parent company from the front cover.  Section III. N. is modified to make the question match the required language “Do you want to report Waste, Abuse, or Fraud?”  Modify language regarding “What if I want to change health plans?” to remove the 90-day lock-in language. (Attachment E) and to remove “Optional to Use” |
| Revision | 2.3 | May 1, 2013 | Section III. requirements regarding Case Management for Children and Pregnant Women (CPW) are revised.  Attachments Q and R are added, and all subsequent attachments are re-lettered.  Attachment EE is clarified. |
| Revision | 2.4 | September 1, 2014 | Section III. D. is modified to change temporary “ID Cards” to “verification forms”.  Section III. E. is modified to change “Medicaid Limited Program” to “Medicaid Lock-in Program” and to add question and “Can a specialist ever be considered a PCP?”  Section III. H. is modified to add question “Will my STAR+PLUS benefits change if I am in a Nursing Facility? (STAR+PLUS Only)”  Section III. I. is modified to add required language for the question “What is urgent medical care?” and to add questions “What should I do if my child or I need urgent medical care?”, “How do I get my medications if I am in a Nursing Facility?”, and “What are mental health rehabilitation services and mental health targeted case management?” Section III.I is also modified to add a reference to required language for "Medical Transportation Program (MTP)"  Attachment A "Your Texas Benefits Medicaid Card" is modified to update requirements.  Attachment C is modified to change “Medicaid Limited Program” to “Medicaid Lock-in Program.”  Attachment D "Physician Incentive Plans" is modified for clarity.  Attachment G “What is Urgent Medical Care?” is added and all subsequent attachments are re-lettered.  Attachment I “Are Emergency Dental services Covered” is modified to include services provided by a dentist in a hospital or ambulatory surgical center.  Attachment S "What Services are Offered by Texas Health Steps" is modified to clarify references to dental care.  Attachment U "Medical Transportation Program (MTP)” is added.  Attachment GG, “Fraud and Abuse” is modified to change “Click Here to Report Waste, Abuse, and Fraud” to “Under the box “I WANT TO” click “Report Waste, Abuse, and Fraud”” to conform to language on the OIG website. |
| Revision | 2.5 | April 1, 2015 | Section III. D. is modified to clarify the question on the temporary verification form.  Section III.I. is modified to add questions “What is Early Childhood Intervention (ECI)?”, “How can I receive healthcare after my baby is born (and I am no longer covered by Medicaid)?”, and to remove the question “Are Emergency Dental Services Covered?”, and “What do I have to do if I need help with completing my renewal application?”  Attachment I “Are Emergency Dental Services for Children Covered by the health plan?” is clarified.  Attachment Q “Where do I find a family planning services provider?” is modified to correct the URL.  Attachment U "Medical Transportation Program (MTP)” is modified to update the contact information and to correct the phone number for MTP.  Attachment V “What dental services does [insert MCO’s name] cover for children?” is modified to clarify that Medicaid medical plans will pay for emergency services provided in a hospital or ambulatory surgical center, and for treatment and devices for craniofacial anomalies.  Attachment Y “How can I receive healthcare after my baby is born (and I am no longer covered by Medicaid)?” is added. |
| Revision | 2.6 | December 15, 2015 | Revision 2.6 applies to contracts issued as a result of HHSC RFP numbers X29-10-0020, X29-12-0002, X29-13-0042, and X29-13-0071.  Section II. is modified to add STAR Kids.  Section III. C. is modified to change “Medicaid Managed Care Helpline” to “Ombudsman Managed Care Assistance Team,” to update the phone numbers, and to add STAR Kids Nurse Hotline.  Section III. E. is modified to add applicability to STAR Kids.  Section III. H. is modified to add LTSS for STAR Kids.  Section III. I. is modified to add applicability to STAR Kids and “What is a Transition Specialist?”, “What is a Health Home?”, and “What is a PPECC?”  Section III. O. “Reporting Abuse, Neglect, and Exploitation” is added and subsequent sections are re-lettered.  Attachment D “Physician Incentive Plans” is modified to update the language.  Attachment E “What if I want to change health plans?” is modified to remove once a month limitation and in a facility limitation and to add applicability to STAR Kids.  Attachment F “I am in MDCP,” “I am in the YES waiver,” “I am in the CLASS waiver,” “I am in the DBMD waiver,” “I am in the HCS waiver,” “I am in the TxHmL waiver,” is added and all subsequent attachments are re-lettered.  Attachment G “Will I continue to receive STAR Kids benefits if I go into a Nursing Facility” is added.  Attachment H “Medically Necessary” is modified to change “Alberto N., et. Al. v. Janek” to “Alberto N., et. Al. v. Traylor.”  Attachment U “What Services are offered by Texas Health Steps?” is modified to add applicability to STAR Kids.  Attachment CC “Can my Medicare provider bill me for services or supplies if I am in both Medicare and Medicaid?” is modified to add applicability to STAR Kids.  Attachment KK ““Reporting Abuse, Neglect, and Exploitation” is added. |
| Revision | 2.7 | February 1, 2019 | General Instructions is modified to reflect the name change from Consumer Information Tool Kit to HHS Brand Guide.  Attachment HH “Complaints” is modified to update the MCCO Research and Resolution address. |
| Revision | 2.8 | April 8, 2019 | Attachment A “Your Texas Benefits Medicaid Card” is modified to update the phone number for a lost or stolen card and available card information.  *Section H “Benefits” is modified to add questions which must be included and answered in the handbook.*  *Texas Women’s Health Program name updated to Healthy Texas Women Program throughout the chapter.* |
| Revision | 2.9 | September 1, 2019 | Administrative change made as follows:  Attachment HH “Complaints” is modified to change the complaint address and email address for Members to send written complaints to the Ombudsman Managed Care Assistance Team effective September 1, 2019. |
| Revision | 2.9.1 | October 15, 2019 | Accessibility approved version. |
| Revision | 2.10 | October 9, 2020 | Attachment A “Your Texas Benefits Medicaid Card” is modified to add information on the Your Texas Benefits Medicaid Client Portal and to add language on how to order or print a temporary card and how to opt out of sharing health information on the Your Texas Benefits website. |
| Revision | 2.11 | April 21, 2021 | Modified “day” and “calendar day” to the Contract term, “Day” and capitalized “Business Day” where applicable throughout the chapter.  Section II.C. is modified to add NEMT Services and Where’s my Ride? Hotline information and delete medical transportation services from the other important phone numbers information bullet.  Section II. I. is modified to change the MTP information bullet to NEMT.  Attachment W is modified to change MTP required language to NEMT required language.  Attachment FF is modified to add member responsibilities while using NEMT Services. |
| Revision | 2.11.1 | June 25, 2021 | Chapter modified to add the Spanish translation of the NEMT language in Attachments W, U, and FF. |
| Revision | 2.12 | May 1, 2022 | ‘General instructions added explaining the use of terms ‘emergency’ and ‘expedited’ throughout the chapter.  Section II(K)(L) modified to add External Medical Review language.  Attachment NN, addition of External Medical Review Required Language  Attachment JJ: Revised timeframe guidelines to match policy and language revisions for clarity |
| Revision | 2.13 | May 2, 2022 | Spanish Language Update |
| Revision | 2.14 | May 2, 2022 | Administrative Update – Language deleted from Attachment NN (both English and Spanish versions) to read: “Go in-person to a local HHSC office”. |
| Revision | 2.15 | September 1, 2022 | Section II.I is modified to add STAR ~~and CHIP~~ as the program that provides Service Coordination.  Attachment T is modified to update who members can contact to learn about CPW services. |
| Revision | 2.16 | July 17, 2023 | Attachment NN is modified to remove the language that the Member may request an IRO be present at the State Fair Hearing.  Attachment NN is modified to clarify who the Member must contact for a State Fair Hearing withdrawal. |

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

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

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

# Applicability of Chapter 3.4

This chapter applies to Medicaid Managed Care Organizations (MCOs) participating in the STAR Program, STAR Kids Program and/or the STAR+PLUS Program. The requirements in this chapter apply to all Programs, except where noted.

## GENERAL INSTRUCTIONS TO MCO

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

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

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

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

| **Required Critical Elements** | **Page Number** |
| --- | --- |
| **I. FRONT COVER** |  |
| The front cover must include, at a minimum: |  |
| * MCO name |  |
| * MCO logo |  |
| * Program logo (STAR, STAR Kids, or STAR+PLUS) |  |
| * The words “STAR MEMBER HANDBOOK,” “STAR Kids MEMBER HANDBOOK,” or “STAR+PLUS MEMBER HANDBOOK” |  |
| * Member Services hotline number |  |
| * Month/year (may be placed on front or back cover) |  |
| **II. CONTENTS** |  |
| **A. Table of Contents** |  |
| The Member Handbook must include a table of contents. |  |
| **B. Introduction** |  |
| This includes information the MCO would like to share with its Members about its health plan (benefits and eligibility information). The MCO must inform the Member that Member Services is available for help. In addition, the MCO must explain that the Member Handbook will be made available in audio, larger print, Braille, other language, etc. when a Member requests it or when the MCO identifies a Member who needs it. (This information should be located within the first three pages of the Member Handbook.) |  |
| **C. Phone Numbers** |  |
| The following information should be located within the first three pages of the Member Handbook. |  |
| * Toll-free Member Services line. Information should include the following explanations: |  |
| * + Regular business hours (8 a.m. to 5 p.m. local time for Service Area, Monday through Friday, excluding state-approved holidays) |  |
| * + For after-hours and weekend coverage, an answering service or other similar mechanism, that allows callers to obtain information from a live person, may be used. |  |
| * Requirements of the Members Services line include: |  |
| * + How to access all Covered Services – including what to do in an emergency or crisis |  |
| * + Availability of information in English and Spanish |  |
| * + Availability of interpreter services through Member Services line |  |
| * + TTY Line for the deaf and hard of hearing |  |
| * + Information on the availability of Service Coordination (STAR Kids and STAR+PLUS only) |  |
| * Requirements of the behavioral health and substance abuse services line include: |  |
| * + 24 hours a day, 7 days a week, toll-free number |  |
| * + How to access services – including what to do in an emergency or crisis |  |
| * + Availability of information in English and Spanish |  |
| * + Availability of interpreter services |  |
| * Toll-free Nurse Hotline (STAR Kids Only). Information should include the following explanations: |  |
| * + To be available 24 hours a day, 7 days a week |  |
| * + Must be staffed with nurses who are knowledgeable about the STAR Kids Program, Covered Services, the STAR Kids Population, and Provider resources. |  |
| Requirements of the Nurse Hotline include: |  |
| * + Availability of information in English and Spanish |  |
| * + Availability of interpreter services through Member Services line |  |
| * + TTY Line for the deaf and hard of hearing |  |
| * Nonemergency Medical Transportation (NEMT) Services and “Where’s My Ride?” line (if separate from other hotlines). Information should include the following explanations: |  |
| * Hours of the NEMT Services hotline |  |
| * Hours of the “Where’s My Ride?” line |  |
| * How to access NEMT Services |  |
| * Availability of information in English and Spanish |  |
| * Availability of interpreter services |  |
| * TTY Line for the deaf and hard of hearing |  |
| * Other important health plan quick reference phone numbers and what they are used for (these are suggested; MCO may want to include phone numbers more unique to its plan): |  |
| * + Nurse line |  |
| * + Eye care |  |
| * + Ombudsman Managed Care Assistance Team 1-866-566-8989 |  |
| * + STAR, STAR Kids, and STAR+PLUS Program Help Line |  |
| * + Dental Contractors |  |
| **D. Member Identification (ID) Cards** |  |
| * Information about (insert MCO name) ID card, including |  |
| * + Sample ID card |  |
| * + How to read it |  |
| * + How to use it |  |
| * + How to replace it if lost |  |
| * Information about Your Texas Benefits Medicaid Card. (MCO will use HHSC’s provided language – ***Attachment A***.) |  |
| * Information on how to obtain a temporary verification form when the Your Texas Benefits Medicaid Card is lost or stolen - Form 1027-A. |  |
| **E. Primary Care Providers** |  |
| The following questions must be included and answered in the handbook: |  |
| * What do I need to bring with me to my doctor’s appointment? |  |
| * What is a Primary Care Provider? |  |
| * Can a specialist ever be considered a Primary Care Provider? |  |
| * How can I change my Primary Care Provider? |  |
| * Can a clinic be my Primary Care Provider? (Rural Health Clinic/Federally Qualified Health Center) |  |
| * How many times can I change my/my child’s Primary Care Provider? (MCO will use HHSC’s provided language – ***Attachment B***.) |  |
| * When will my Primary Care Provider change become effective? |  |
| * Are there any reasons why a request to change a Primary Care Provider may be denied? |  |
| * Can my Primary Care Provider move me to another Primary Care Provider for non-compliance? |  |
| * What if I choose to go to another doctor who is not my Primary Care Provider? |  |
| * How do I get medical care after my Primary Care Provider’s office is closed? |  |
| * What is the Medicaid Lock-in Program? (MCO will use HHSC’s provided language – ***Attachment C***.) |  |
| **Note**: For STAR Kids and STAR+PLUS Members who are covered by Medicare, no Primary Care Provider will be assigned. |  |
| **F. Physician Incentive Plan Information** (MCO will use HHSC’s provided language – **Attachment D**.) |  |
| **G. Changing Health Plans** |  |
| The following questions must be included and answered in the handbook: |  |
| * What if I want to change health plans? (MCO will use HHSC’s provided language – ***Attachment E***.) |  |
| * Who do I call? |  |
| * How many times can I change health plans? |  |
| * When will my health plan change become effective? |  |
| * Can (insert MCO name) ask that I get dropped from their health plan (for non-compliance, etc.)? |  |
| **H. Benefits** |  |
| The following questions must be included and answered in the handbook: |  |
| * What are my health care benefits? |  |
| * + How do I get these services? |  |
| * + Are there any limits to any Covered Services? |  |
| * What are my Long-Term Services and Supports (LTSS) benefits? (STAR Kids and STAR+PLUS Only) |  |
| * + How do I get these services? |  |
| * + What number do I call to find out about these services? |  |
| * + I am in the Medically Dependent Children Program (MDCP). How will I receive my LTSS? (STAR Kids Only) (MCO will use HHSC’s provided language – ***Attachment F***.) |  |
| * + I am in the Youth Empowerment Services waiver (YES). How will I receive my LTSS? (STAR Kids Only) (MCO will use HHSC’s provided language – ***Attachment F***.) |  |
| * + I am in the Community Living Assistance and Support Services (CLASS) waiver. How will I receive my LTSS? (STAR Kids Only) (MCO will use HHSC’s provided language – ***Attachment F***.) |  |
| * + I am in the Deaf Blind with Multiple Disabilities (DBMD) waiver. How will I receive my LTSS? (STAR Kids Only) (MCO will use HHSC’s provided language – ***Attachment F***.) |  |
| * + I am in the Home and Community-based Services (HCS) waiver. How will I receive my LTSS? (STAR Kids Only) (MCO will use HHSC’s provided language – ***Attachment F***.) |  |
| * + I am in the Texas Home Living (TxHmL) waiver. How will I receive my LTSS? (STAR Kids Only) (MCO will use HHSC’s provided language – ***Attachment F***.) |  |
| * Will my STAR Kids or STAR+PLUS benefits change if I am in a Nursing Facility? (STAR Kids and STAR+PLUS Only) |  |
| * Will I continue to receive STAR Kids benefits if I go into a Nursing Facility? (MCO will use HHSC’s provided language – ***Attachment G***.) |  |
| * What are my Acute Care benefits? (STAR Kids and STAR+PLUS Only) |  |
| * + How do I get these services? |  |
| * + What number do I call to find out about these services? |  |
| * What services are not covered? |  |
| * What are my prescription drug benefits? |  |
| * What extra benefits do I get as Member of (insert MCO name)? |  |
| * + How can I get these benefits? |  |
| * What health education classes does (insert MCO name) offer? |  |
| * What other services can (insert MCO name) help me get? (Non-capitated Services) |  |
| **I. Health Care and Other Services** |  |
| The following questions must be included and answered in the handbook: |  |
| * What does Medically Necessary mean? Both Acute Care and behavioral health (MCO will use HHSC’s provided language – ***Attachment H***.) |  |
| * What is routine medical care? |  |
| * + How soon can I expect to be seen? |  |
| * What is urgent medical care? (MCO will use HHSC’s provided language – ***Attachment I***.) |  |
| * + What should I do if my child or I need urgent medical care?(MCO will use HHSC’s provided language – ***Attachment I***.) |  |
| * + How soon can I expect to be seen? (MCO will use HHSC’s provided language – ***Attachment I***.) |  |
| * What are LTSS? (STAR Kids and STAR+PLUS Only) |  |
| * + How do I get these services? |  |
| * What is emergency medical care? (MCO will use HHSC’s provided language – ***Attachment J***.) |  |
| * + How soon can I expect to be seen? |  |
| * + Are emergency dental services covered by the health plan? (MCO will use HHSC’s provided language- ***Attachment K****.*) |  |
| * What do I do if my child needs emergency dental care? (MCO will use HHSC’s provided language – ***Attachment L***.) |  |
| * What is post stabilization? (MCO will use state provided language – ***Attachment M***.) |  |
| * How do I get medical care after my Primary Care Provider’s office is closed? (Include information regarding 24-hour access to services.) |  |
| * What if I get sick when I am out of town or traveling? (MCO will use HHSC’s provided language- ***Attachment N****.*) |  |
| * + What if I am out of the state? |  |
| * + What if I am out of the country? (MCO will use HHSC’s provided language- ***Attachment O****.*) |  |
| * What if I need to see a special doctor (specialist)? |  |
| * + What is a referral? |  |
| * + How soon can I expect to be seen by a specialist? |  |
| * What services do not need a referral? |  |
| * How can I ask for a second opinion? |  |
| * How do I get help if I have behavioral (mental) health, alcohol, or drug problems? (This question applies to all STAR, STAR Kids, and STAR+PLUS MCOs. ***Attachment P*** is HHSC’s required language for the MCOs in the Dallas Service Area. ***Attachment P*** does not apply to other Service Areas or to STAR Kids in the Dallas Service Area.) |  |
| * + Do I need a referral for this? |  |
| * What are mental health rehabilitation services and Mental Health Targeted Case Management? |  |
| * + How do I get these services? |  |
| * How do I get my medications? (MCO will use HHSC’s provided language – ***Attachment Q****.*) |  |
| * + How do I find a Network drug store? |  |
| * + What if I go to a drug store not in the Network? |  |
| * + What do I bring with me to the drug store? |  |
| * + What if I need my medications delivered to me? |  |
| * + Who do I call if I have problems getting my medications? |  |
| * + What if I can’t get the medication my doctor ordered approved? (MCO will use HHSC’s provided language – ***Attachment R***.) |  |
| * + What if I lose my medication(s)? |  |
| * + What if I also have Medicare? (STAR Kids and STAR+PLUS MCOs Only.) |  |
| * + How do I get my medications if I am in a Nursing Facility? (STAR Kids and STAR+PLUS MCOs Only) |  |
| * How do I get family planning services? (MCOs that do not provide family planning must submit alternative language for HHSC’s approval.) |  |
| * + Do I need a referral for this? |  |
| * + Where do I find a family planning services provider? (MCO will use HHSC’s provided language – ***Attachment S***.) |  |
| * What is Case Management for Children and Pregnant Women (CPW)? |  |
| * + Case Management for Children and Pregnant Women (MCO will use HHSC’s provided language – ***Attachment T***.) |  |
| * What is Early Childhood Intervention (ECI)? |  |
| * + Do I need a referral for this? |  |
| * + Where do I find an ECI provider? |  |
|  |  |
|  |  |
| * What is Service Coordination? (STAR, STAR Kids and STAR+PLUS Only.) |  |
| * + What will a Service Coordinator do for me? |  |
| * + How can I talk with a Service Coordinator?   + How can I get Service Coordination? |  |
| **Note:** Include information and phone number for Service Coordination (STAR Kids and STAR+PLUS Only.) |  |
| * What is a Transition Specialist? (STAR Kids Only) |  |
| * + What will a Transition Specialist do for me? |  |
| * + How can I talk to a Transition Specialist? |  |
| * What is a Health Home? (STAR Kids Only) |  |
| * What is a Prescribed Pediatric Extended Care Center (PPECC)? (STAR Kids Only) |  |
| * What is Texas Health Steps? (STAR and STAR Kids Only) |  |
| * + What services are offered by Texas Health Steps? (MCO will use HHSC’s provided language – ***Attachment U***.) |  |
| * + How and when do I get Texas Health Steps medical and dental checkups for my child? |  |
| * + Does my doctor have to be part of the (insert MCO name) network? |  |
| * + Do I have to have a referral? |  |
| * + What if I need to cancel an appointment? |  |
| * + What if I am out of town and my child is due for a Texas Health Steps checkup? |  |
| * What if I am a Migrant Farmworker? (MCO will use HHSC’s provided language – ***Attachment V***.) |  |
| * What Nonemergency Medical Transportation (NEMT) Services are available to me? (MCOs will use HHSC’s provided language – ***Attachment W.***) |  |
| * + What services are offered? |  |
| * + Who do I call for a ride to a medical appointment? |  |
| * How do I get eye care services? |  |
| * What dental services does [Insert MCO's name] cover for children? (MCO will use HHSC’s provided language – ***Attachment X***.) |  |
| * Can someone interpret for me when I talk with my doctor? |  |
| * + Who do I call for an interpreter? |  |
| * + How far in advance do I need to call? |  |
| * + How can I get a face-to-face interpreter in the provider’s office? |  |
| * What if I need OB/GYN care? (MCO will use HHSC’s provided language – ***Attachment Y****.*) |  |
| * + Do I have the right to choose an OB/GYN? |  |
| * + How do I choose an OB/GYN? |  |
| * + If I do not choose an OB/GYN, do I have direct access? |  |
| * + Will I need a referral? |  |
| * + How soon can I be seen after contacting my OB/GYN for an appointment? (Accessing requirements for perinatal care is within 2 weeks of request.) |  |
| * + Can I stay with my OB/GYN if they are not with (insert MCO name)? |  |
| * What if I am pregnant? |  |
| * + Who do I need to call? |  |
| * + What other services/activities/education does (insert MCO name) offer pregnant women? |  |
| * + Where can I find a list of birthing centers? |  |
| * Can I pick a Primary Care Provider for my baby before the baby is born?  (Does not apply to STAR Kids and STAR+PLUS Dual Eligibles) |  |
| * + How and when can I switch my baby’s Primary Care Provider? (Does not apply to STAR Kids Dual Eligibles and STAR+PLUS Dual Eligibles) |  |
| * + Can I switch my baby’s health plan? (Optional HHSC-provided language in ***Attachment Z*** - STAR Only) |  |
| * How do I sign up my newborn baby? |  |
| * + How and when do I tell my health plan? |  |
| * + How can I receive healthcare after my baby is born (and I am no longer covered by Medicaid)? (MCO will use HHSC’s provided language – ***Attachment AA***.) |  |
| * + How and when do I tell my caseworker? |  |
| * Who do I call if I have special health care needs and need someone to help me? |  |
| * What if I am too sick to make a decision about my medical care? |  |
| * + What are advance directives? |  |
| * + How do I get an advance directive? |  |
| * What do I have to do if I need help with completing my renewal application? (MCOs will use information on how to renew from the chipmedicaid.org webpage http://chipmedicaid.org/CommunityOutreach/How-to-Renew) |  |
| * What happens if I lose my Medicaid coverage? (MCO will use HHSC’s provided language – ***Attachment BB***.) |  |
| * What if I get a bill from my doctor? |  |
| * + Who do I call? |  |
| * + What information will they need? |  |
| * Can my Medicare provider bill me for services or supplies if I am in both Medicare and Medicaid? (MCO will use HHSC’s provided language – ***Attachment CC***) (STAR Kids and STAR+PLUS Only.) |  |
| * What do I have to do if I move? (MCO will use HHSC’s provided language – ***Attachment DD***.) |  |
| * What if I have other health insurance in addition to Medicaid? (MCO will use HHSC’s provided language – ***Attachment EE****.*) |  |
| * What are my rights and responsibilities? (MCO will use HHSC’s provided language – ***Attachment FF***.) |  |
| * What if I need durable medical equipment (DME) or other products normally found in a drug store? (MCO will use HHSC’s provided language – ***Attachment GG***.) |  |
| **J. Complaint Process** |  |
| The following questions must be included and answered in the handbook: |  |
| * What should I do if I have a Complaint? (Optional HHSC provided language – ***Attachment HH***.) |  |
| * + Who do I call? (Include at least one toll-free telephone number) |  |
| * + Can someone from (insert MCO name) help me file a Complaint? |  |
| * + How long will it take to process my Complaint? |  |
| * + What are the requirements and timeframes for filing a Complaint? |  |
| * + Information on how to file a Complaint with HHSC, once I have gone through the (insert MCO name) Complaint process. |  |
| **K. Appeal Process** |  |
| The following questions must be included and answered in the handbook: |  |
| * What can I do if my doctor asks for a service or medicine for me that’s covered but (insert MCO name) denies it or limits it? |  |
| * How will I find out if services are denied? |  |
| * + Timeframes for the appeals process – the MCO must complete the entire standard Appeal process within 30 Days after receipt of the initial written or oral request for Appeal. This deadline may be extended for up to 14 Days at the request of a Member; or the MCO shows that there is a need for more information and how the delay is in the Member’s interest. If the MCO needs to extend, the Member must receive written notice of the reason for delay. |  |
| * + When does a Member have the right to ask for an Appeal – include option for the request of an appeal for denial of payment for services in whole or in part. |  |
| * + Include notification to Member that in order to ensure continuity of current authorized services, the Member must file the appeal on or before the later of: 10 Days following the MCO’s mailing of the notice of the Action or the intended effective date of the proposed Action. |  |
| * + Appeals must be accepted orally or in writing. |  |
| * Can someone from (insert MCO name) help me file an Appeal? * Member’s option to request an External Medical Review and State Fair Hearing no later than 120 Days after the date the MCO mails the appeal decision notice. |  |
| * Member’s option to request only a State Fair Hearing Review no later than 120 Days after the MCO mails the appeal decision notice. |  |
| **L. Expedited MCO Appeal** |  |
| The following questions must be included and answered in the handbook: |  |
| * What is an emergency Appeal? (MCO will use HHSC’s provided language **– *Attachment II***.) |  |
| * How do I ask for an emergency Appeal? |  |
| * Does my request have to be in writing? (must be accepted orally or in writing) |  |
| * What are the timeframes for an emergency Appeal? |  |
| * What happens if the MCO denies the request for an emergency Appeal? |  |
| * Who can help me file an emergency Appeal? |  |
|  |  |
| **M. State Fair Hearing** (MCO will use HHSC’s provided language – **Attachment JJ**.)  **N. External Medical Review (MCO will use HHSC’s provided language – Attachment NN.** |  |
| **O. Reporting Abuse, Neglect, and Exploitation (STAR Kids and STAR+PLUS only)** |  |
| How do I report suspected abuse, neglect, or exploitation? (MCO will use HHSC's provided language – **Attachment KK**.) |  |
| **P. Fraud Information** |  |
| The following question must be included and answered in the handbook: |  |
| * Do you want to report Waste, Abuse, or Fraud? (MCO will use HHSC’s provided language – ***Attachment LL***.) |  |
| **Q. Information That Must Be Available on an Annual Basis** (MCO will use HHSC’s provided language – **Attachment MM**.) |  |
| **III. Back Cover** |  |
| Month and year can be on the front or back cover. |  |
|  |  |

REQUIRED LANGUAGE

ATTACHMENT A

## Your Texas Benefits (YTB) Medicaid Card

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

You will be issued only one card and will receive a new card only if your card is lost or stolen. If your Medicaid card is lost or stolen, you can get a new one by calling toll-free 1-800-252-8263, or by going online to order or print a temporary card at [www.YourTexas](http://www.YourTexas)Benefits.com.

If you are not sure if you are covered by Medicaid, you can find out by calling toll-free at 1-800-252-8263. You can also call 2-1-1. First pick a language and then pick option 2.

Your health information is a list of medical services and drugs that you have gotten through Medicaid. We share it with Medicaid doctors to help them decide what health care you need. If you don’t want your doctors to see your medical and dental information through the secure online network, call toll-free at 1-800-252-8263 or opt out of sharing your health information at www.YourTexasBenefits.com.

The YTB Medicaid card has these facts printed on the front:

* Your name and Medicaid ID number.
* The date the card was sent to you.
* The name of the Medicaid program you’re in if you get:
  + Medicare (QMB, MQMB)
  + Healthy Texas Women Program (HTW)
  + Hospice
  + STAR Health
  + Emergency Medicaid, or
  + Presumptive Eligibility for Pregnant Women (PE).
* Facts your drug store will need to bill Medicaid.
* The name of your doctor and drug store if you’re in the Medicaid Lock-in program.

The back of the YTB Medicaid card has a website you can visit ([www.YourTexasBenefits.com](http://www.YourTexasBenefits.com)) and a phone number you can call toll-free (1-800-252-8263) if you have questions about the new card.

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

**The YourTexasBenefits.com Medicaid Client Portal**

You can use the Medicaid Client Portal to do all of the following for yourself or anyone whose medical or dental information you are allowed to access:

* View, print, and order a YTB Medicaid card
* See your medical and dental plans
* See your benefit information
* See STAR and STAR Kids Texas Health Steps alerts
* See broadcast alerts
* See diagnoses and treatments
* See vaccines
* See prescription medicines
* Choose whether to let Medicaid doctors and staff see your available medical and dental information

To access the portal, go to www.YourTexasBenefits.com.

* Click **Log In**.
* Enter your User name and Password. If you don’t have an account, click **Create a new account**.
* Click **Manage**.
* Go to the “Quick links” section.
* Click **Medicaid & CHIP Services**.
* Click **View services and available health information**.

**Note:** The YourTexasBenefits.com Medicaid Client Portal displays information for active clients only. A Legally Authorized Representative may view the information of anyone who is a part of their case.

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

Cuando alguien es aceptado en el programa Medicaid, recibe la tarjeta YTB de Medicaid. Esta tarjeta de plástico será su tarjeta habitual de Medicaid. Debe llevarla consigo debidamente protegida, tal y como lo hace con la licencia de manejar o las tarjetas de crédito. Cuando usted vaya a una cita médica, el consultorio puede usar la tarjeta para verificar que usted es beneficiario de Medicaid.

Recibirá una sola tarjeta; solo en caso de que la pierda o se la roben recibirá una nueva. Si pierde su tarjeta de Medicaid o se la roban, puede obtener una nueva llamando sin costo al 1-800-252-8263, o pedir e imprimir una tarjeta temporal por internet en [www.YourTexasBenefits.com](http://www.YourTexas).

Si no está seguro de tener cobertura de Medicaid, llame sin costo al 1-800-252-8263 para informarse. También puede llamar al 2-1-1. Seleccione un idioma primero y después oprima el 2.

Su información de salud consta de una lista de los servicios médicos y medicamentos que usted ha recibido a través de Medicaid. Compartimos esa información con los médicos de Medicaid para ayudarles a decidir qué tipo de atención médica necesita usted. Si no desea que sus médicos vean su información médica y dental a través de la red segura en línea, llame sin costo al 1-800-252-8263; o bien, visite www.YourTexasBenefits.com y elija no compartir su información de salud.

La tarjeta YTB de Medicaid tiene estos datos impresos en el frente:

* Su nombre y número de identificación de Medicaid
* La fecha en que se le envió la tarjeta
* El nombre del programa de Medicaid en el que está inscrito si recibe:
  + Medicare (QMB, MQMB)
  + Programa Healthy Texas Women (HTW)
  + Atención para pacientes terminales
  + Programa STAR Health
  + Medicaid de Emergencia, o
  + Presunción de derecho a beneficios (PE) para mujeres embarazadas
* Los datos que la farmacia necesita para enviar el cobro a Medicaid
* Si está en el programa de proveedor único de Medicaid (Medicaid Lock-in), el nombre de su médico y farmacia

En el reverso de la tarjeta aparecen la dirección web ([www.YourTexasBenefits.com](http://www.YourTexasBenefits.com)) y el número gratuito 1-800-252-8263, recursos que puede usar si tiene preguntas sobre su nueva tarjeta YTB de Medicaid.

Si no tiene su tarjeta consigo, el médico, el dentista o la farmacia pueden verificar por teléfono o en línea que usted es beneficiario de Medicaid.

**El portal de YourTexasBenefits.com para beneficiarios de Medicaid**

Puede usar el portal para beneficiarios de Medicaid para hacer todo lo siguiente (tanto para usted como para otra persona a cuya información médica o dental tenga acceso):

* Ver, imprimir o pedir una nueva tarjeta de YTB de Medicaid
* Ver sus planes de seguro médico y dental
* Ver los detalles de sus beneficios
* Ver las alertas de STAR y STAR Kids de Pasos Sanos de Texas
* Ver las alertas públicas
* Ver los diagnósticos y tratamientos
* Ver su historial de vacunas
* Ver los medicamentos recetados
* Elegir si da su autorización para que los médicos y el personal de Medicaid vean su información médica y dental

Para acceder al portal, visite www.YourTexasBenefits.com.

* Haga clic en **Entrar al sistema**.
* Introduzca su nombre de usuario y contraseña. Si no tiene una cuenta, haga clic en **Crear una cuenta**.
* Haga clic en **Maneje su cuenta o sus aplicaciones**.
* Vaya a la sección “Enlaces rápidos”.
* Haga clic en **Servicios de Medicaid y CHIP**.
* Haga clic en **Ver servicios e información de salud disponibles**.

**Nota:** El portal de YourTexasBenefits.com para beneficiarios de Medicaid muestra información solo de los beneficiarios actuales. Un representante legalmente autorizado puede ver la información de cualquier persona que forme parte de su caso.

REQUIRED LANGUAGE

ATTACHMENT B

## How many times can I change my/my child’s Primary Care Provider?

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

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

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

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

REQUIRED LANGUAGE

ATTACHMENT C

## What is the Medicaid Lock-in Program?

You may be put in the Lock-in Program if you do not follow Medicaid rules.  It checks how you use Medicaid drug store services. Your Medicaid benefits remain the same.  Changing to a different MCO will not change the Lock-In status.

To avoid being put in the Medicaid Lock-in Program:

* Pick one drug store at one location to use all the time.
* Be sure your main doctor, main dentist, or the specialists they refer you to are the only doctors that give you prescriptions.
* Do not get the same type of medicine from different doctors.

To learn more call [insert MCO name].

## ¿Qué es el Programa Lock-in de Medicaid?

Si usted no sigue las reglas de Medicaid, puede que le asignen al Programa Lock-in. Este programa revisa cómo utiliza los servicios de farmacia de Medicaid. Sus beneficios de Medicaid no cambian. Cambiar a una MCO diferente no cambiará su estado en el programa.

Para evitar que lo pongan en el Programa Lock-in de Medicaid:

* Escoja una farmacia en particular y úsela todo el tiempo.
* Asegúrese de que su doctor de cabecera, dentista primario o los especialistas a los que le envían, sean los únicos doctores que le receten medicamentos.
* No obtenga el mismo tipo de medicamento de diferentes doctores.

Para más información, [insert MCO name].

REQUIRED LANGUAGE

ATTACHMENT D

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

**If the MCO offers a physician incentive plan:**  The MCO cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Members.

(Insert name of MCO) cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Members. You have the right to know if your Primary Care Provider (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can call (insert toll-free telephone number**)** to learn more about this.

La MCO no puede hacer pagos bajo un plan de incentivos para doctores si los pagos están diseñados para persuadir a los proveedores a reducir o limitar los Servicios Médicamente Necesarios cubiertos para los miembros

(Insert name of MCO) no puede hacer pagos bajo un plan de incentivos para doctores si los pagos están diseñados para persuadir a los proveedores a reducir o limitar los Servicios Médicamente Necesarios cubiertos para los miembros. Usted tiene el derecho de saber si su proveedor de cuidado primario (doctor de cabecera) participa en el plan de incentivos para doctores. También tiene el derecho de saber cómo funciona el plan. Puede llamar gratis al (insert toll-free telephone number**)** para más información.

**If the MCO does not offer a physician incentive plan then use the following language:**

The MCO cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Members. Right now, (insert name of MCO) does not have a physician incentive plan.

La MCO no puede hacer pagos bajo un plan de incentivos para doctores si los pagos están diseñados para persuadir a los proveedores a reducir o limitar los Servicios Médicamente Necesarios cubiertos para los miembros. En este momento, (insert name of MCO) no tiene un plan de incentivos para doctores.

OPTIONAL LANGUAGE

ATTACHMENT E

## What if I want to change health plans?

You can change your health plan by calling the Texas STAR, STAR Kids, or STAR+PLUS Program Helpline at 1-800-964-2777. You can change health plans as often as you want.

If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

* If you call on or before April 15, your change will take place on May 1.
* If you call after April 15, your change will take place on June 1.

## ¿Qué hago si quiero cambiar de plan de salud?

Puede cambiar su plan de salud llamando a la Línea de Ayuda de STAR, STAR Kids o STAR+PLUS de Texas al 1-800-964-2777. Usted puede cambiar su plan de salud siempre que quiera.

Si llama para cambiar de plan de salud el día 15 del mes o antes, el cambio entrará en vigor el día primero del mes siguiente. Si llama después del 15 del mes, el cambio entrará en vigor el día primero del segundo mes siguiente. Por ejemplo:

* Si llama el día 15 de abril o antes, el cambio entrará en vigor el 1 de mayo.
* Si llama después del 15 de abril, el cambio entrará en vigor el 1 de junio.

REQUIRED LANGUAGE

ATTACHMENT F

## I am in the Medically Dependent Children Program (MDCP). How will I receive my LTSS?

State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) as well as all MDCP services will be delivered through your STAR Kids MCO. Please contact your MCO service coordinator if you need assistance with accessing these services.

## Estoy recibiendo servicios del Programa de Niños Médicamente Dependientes (MDCP). ¿Cómo recibiré los servicios de apoyo a largo plazo (LTSS)?

Los LTSS de un plan estatal, tales como servicios de atención personal (PCS), servicios de una enfermera particular (PDN) y Community First Choice (CFC), así como todos los servicios del MDCP, se prestarán a través de la MCO de STAR Kids. Favor de comunicarse con su coordinador de servicios de la MCO si necesita ayuda con el acceso a estos servicios.

## I am in the Youth Empowerment Services waiver (YES). How will I receive my LTSS?

State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through your STAR Kids MCO. Your YES waiver services will be delivered through the Department of State Health Services. Please contact your MCO service coordinator if you need assistance with accessing these services. You can also contact your Local Mental Health Authority (LMHA) case manager for questions specific to YES waiver services.

## Estoy recibiendo Servicios de Empoderamiento Juvenil (programa opcional YES). ¿Cómo recibiré los servicios de apoyo a largo plazo (LTSS)?

Los LTSS de un plan estatal, tales como servicios de atención personal (PCS), servicios de una enfermera particular (PDN) y Community First Choice (CFC), se prestarán a través de la MCO de STAR Kids. Los servicios del programa opcional YES se prestarán a través del Departamento Estatal de Servicios de Salud. Favor de comunicarse con su coordinador de servicios de la MCO si necesita ayuda con el acceso a estos servicios. También puede contactar al administrador de casos de la Autoridad Local de Servicios de Salud Mental (LMHA) con preguntas específicas sobre el programa opcional YES.

## I am in the Community Living Assistance and Support Services (CLASS) waiver. How will I receive my LTSS?

State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through your STAR Kids MCO. Your CLASS waiver services will be delivered through the Department of Aging and Disability Services. Please contact your MCO service coordinator if you need assistance with accessing these services. You can also contact your CLASS case manager for questions specific to CLASS waiver services.

## Estoy recibiendo servicios del programa opcional de Servicios de Apoyo y Asistencia para Vivir en la Comunidad (CLASS). ¿Cómo recibiré los servicios de apoyo a largo plazo (LTSS)?

Los LTSS de un plan estatal, tales como servicios de atención personal (PCS), servicios de una enfermera particular (PDN) y Community First Choice (CFC), se prestarán a través de la MCO de STAR Kids. Sus servicios opcionales del programa CLASS se prestarán a través del Departamento de Servicios para Adultos Mayores y Personas Discapacitadas. Favor de comunicarse con su coordinador de servicios de la MCO si necesita ayuda con el acceso a estos servicios. También puede contactar al administrador de casos de CLASS con preguntas específicas sobre el programa opcional CLASS.

## I am in the Deaf Blind with Multiple Disabilities (DBMD) waiver. How will I receive my LTSS?

State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through your STAR Kids MCO. Your DBMD waiver services will be delivered through the Department of Aging and Disability Services. Please contact your MCO service coordinator if you need assistance with accessing these services. You can also contact your DBMD case manager for questions specific to DBMD waiver services.

## Estoy recibiendo servicios del programa opcional para Personas Sordociegas con Discapacidades Múltiples (DBMD). ¿Cómo recibiré los servicios de apoyo a largo plazo (LTSS)?

Los LTSS de un plan estatal, tales como servicios de atención personal (PCS), servicios de una enfermera particular (PDN) y Community First Choice (CFC), se prestarán a través de la MCO de STAR Kids. Los servicios opcionales del DBMD se prestarán a través del Departamento de Servicios para Adultos Mayores y Personas Discapacitadas. Favor de comunicarse con su coordinador de servicios de la MCO si necesita ayuda con el acceso a estos servicios. También puede contactar al administrador de casos del DBMD con preguntas específicas sobre el programa opcional para DBMD.

## I am in the Home and Community-based Services (HCS) waiver. How will I receive my LTSS?

State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through your STAR Kids MCO. Your HCS waiver services will be delivered through the Department of Aging and Disability Services. Please contact your MCO service coordinator if you need assistance with accessing these services. You can also contact your HCS service coordinator at your local intellectual and developmental disability authority (LIDDA) for questions specific to HCS waiver services.

## Estoy recibiendo servicios del programa opcional de Servicios en el Hogar y en la Comunidad (HCS). ¿Cómo recibiré los servicios de apoyo a largo plazo (LTSS)?

Los LTSS de un plan estatal, tales como servicios de atención personal (PCS), servicios de una enfermera particular (PDN) y Community First Choice (CFC), se prestarán a través de la MCO de STAR Kids. Los servicios opcionales de HCS se prestarán a través del Departamento de Servicios para Adultos Mayores y Personas Discapacitadas. Favor de comunicarse con su coordinador de servicios de la MCO si necesita ayuda con el acceso a estos servicios. También puede contactar al coordinador de servicios de HCS por medio de la autoridad local de discapacidad intelectual y del desarrollo (LIDDA) con preguntas específicas sobre el programa opcional de HCS.

## I am in the Texas Home Living (TxHmL) waiver. How will I receive my LTSS?

State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) will be delivered through your STAR Kids MCO. Your TxHmL waiver services will be delivered through the Department of Aging and Disability Services. Please contact your MCO service coordinator if you need assistance with accessing these services. You can also contact your TxHmL service coordinator at your local intellectual and developmental disability authority (LIDDA) for questions specific to TxHmL waiver services.

## Estoy recibiendo servicios del programa opcional de Texas para Vivir en Casa (TxHmL). ¿Cómo recibiré los servicios de apoyo a largo plazo (LTSS)?

Los LTSS de un plan estatal, tales como servicios de atención personal (PCS), servicios de una enfermera particular (PDN) y Community First Choice (CFC), se prestarán a través de la MCO de STAR Kids. Los servicios opcionales de TxHmL se prestarán a través del Departamento de Servicios para Adultos Mayores y Personas Discapacitadas. Favor de comunicarse con su coordinador de servicios de la MCO si necesita ayuda con el acceso a estos servicios. También puede contactar al coordinador de servicios de TxHmL por medio de la autoridad local de discapacidad intelectual y del desarrollo (LIDDA) con preguntas específicas sobre el programa opcional de TxHmL.

REQUIRED LANGUAGE

ATTACHMENT G

## Will I continue to receive STAR Kids benefits if I go into a Nursing Facility?

A STAR Kids Member who enters a Nursing Facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) will remain a STAR Kids Member. The MCO must provide Service Coordination and any Covered Services that occur outside of the Nursing Facility or ICF/IID when a STAR Kids Member is a Nursing Facility or ICF/IID resident. Throughout the duration of the Nursing Facility or ICF/IID stay, the STAR Kids MCO must work with the Member and the Member's Legally Authorized Representative (LAR) to identify Community-Based Services and LTSS programs to help the Member return to the community.

## ¿Seguiré recibiendo los beneficios de STAR Kids si ingreso a un centro para convalecientes?

Un miembro de STAR Kids que ingresa en un centro para convalecientes o centro de atención intermedia para personas con discapacidad intelectual (ICF/IID) seguirá siendo miembro de STAR Kids. Cuando un miembro de STAR Kids es residente de un centro para convalecientes o ICF/IID, la MCO tiene que brindar coordinación de servicios y cualquier servicio cubierto que ocurra fuera del centro para convalecientes o ICF/IID. Durante la estancia en el centro para convalecientes o ICF/IID, la MCO de STAR Kids tiene que trabajar con el miembro y el representante legalmente autorizado (LAR) para identificar programas de Servicios en la Comunidad (CS) y programas de servicios de apoyo a largo plazo (LTSS) que le ayudarán al miembro a volver a la comunidad.

REQUIRED LANGUAGE

ATTACHMENT H

**Medically Necessary** means:

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

**Médicamente necesario** significa:

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

REQUIRED LANGUAGE

ATTACHMENT I

## What Is Urgent Medical Care?

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

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

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

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

## How Soon Can I Expect to Be Seen?

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

## ¿Qué es la atención médica urgente?

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

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

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

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

## ¿Cuánto tiempo esperaré para que me vean?

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

REQUIRED LANGUAGE

ATTACHMENT J

## Emergency Medical Care

Emergency medical care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions.

**Emergency Medical Condition** means:

A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

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

**Emergency Behavioral Health Condition** means:

Any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson, possessing average knowledge of medicine and health:

1. requires immediate intervention or medical attention without which the Member would present an immediate danger to themselves or others; or
2. which renders the Member incapable of controlling, knowing, or understanding the consequences of their actions.

**Emergency Services and Emergency Care** means:

Covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition or Emergency Behavioral Health Condition, including post-stabilization care services.

## Atención médica de emergencia

La atención médica de emergencia se presta para los padecimientos médicos y de salud mental y abuso de sustancias que sean de emergencia.

**Padecimiento médico de emergencia** significa:

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

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

**Padecimiento de salud mental y abuso de sustancias de emergencia** significa:

Cualquier padecimiento, sin importar la naturaleza o causa del padecimiento, que según la opinión de una persona prudente con un conocimiento promedio de salud y medicina:

1. requiera intervención o atención médica inmediata, sin la cual el miembro podría representar un peligro inmediato para sí mismo o para otras personas; O
2. hace que el miembro sea incapaz de controlar, saber o entender las consecuencias de sus acciones.

**Servicios de emergencia y Atención de emergencia** significa:

Servicios cubiertos de paciente interno y externo que brinda un proveedor certificado para prestar esos servicios y que se necesitan para valorar o estabilizar un padecimiento médico o de salud mental y abuso de sustancias de emergencia, entre ellos, los servicios de atención de posestabilización.

REQUIRED LANGUAGE

Attachment K

## Are Emergency Dental Services Covered by the health plan?

[Insert MCO’s name] covers limited emergency dental services in a hospital or ambulatory surgical center, including payment for the following:

* Treatment for dislocated jaw.
* Treatment for traumatic damage to teeth and supporting structures.
* Removal of cysts.
* Treatment of oral abscess of tooth or gum origin.
* Hospital, physician, and related medical services such as drugs for any of the above conditions.

## ¿Están cubiertos los servicios dentales de emergencia por el plan de salud?

[Insert MCO’s name] cubre servicios limitados dentales de emergencia en un hospital o en un centro quirúrgico ambulatorio, lo cual incluye el pago para lo siguiente:

* Tratamiento para luxación mandibular.
* Tratamiento para traumatismo de los dientes y estructuras de soporte.
* Extracción de quistes.
* Tratamiento de abscesos bucales provenientes de los dientes o las encías.
* Hospital, doctores y servicios médicos relacionados, como medicamentos para cualquiera de los padecimientos anteriores.

REQUIRED LANGUAGE

Attachment L

## What do I do if my child needs Emergency Dental Care?

During normal business hours, call your child’s Main Dentist to find out how to get emergency services. If your child needs emergency dental services after the Main Dentist’s office has closed, call us toll-free at (insert MCO’s toll-free telephone number) or call 911.

## ¿Qué hago si mi hijo necesita servicios dentales de emergencia?

Durante las horas normales de operación, llame al dentista primario del niño para saber cómo obtener servicios de emergencia. Si su hijo necesita servicios dentales de emergencia después de que el consultorio del dentista primario haya cerrado, llámenos gratis al (insert MCO’s toll-free telephone number) o llame al 911.

REQUIRED LANGUAGE

ATTACHMENT M

## What is post-stabilization?

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

## ¿Que es la posestabilización?

Los servicios de atención de posestabilización son servicios cubiertos por Medicaid que lo mantienen en un estado estable después de recibir atención médica de emergencia.

REQUIRED LANGUAGE

ATTACHMENT N

## What if I get sick when I am out of town or traveling?

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

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

## ¿Qué hago si me enfermo cuando estoy fuera de la ciudad o de viaje?

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

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

REQUIRED LANGUAGE

ATTACHMENT O

## What if I am out of the country?

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

## ¿Qué hago si estoy fuera del país?

Medicaid no cubre los servicios médicos prestados fuera del país.

REQUIRED LANGUAGE

ATTACHMENT P (Dallas Service Area Only)

## How do I get help if I have mental health, alcohol, or drug problems?

If you live in the Dallas Service Area, you will receive treatment for mental health, alcohol, and drug use through NorthSTAR. NorthSTAR provides these types of behavioral health services to Members who live in the following counties: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall. If you have behavioral health issues, call the NorthSTAR program toll-free at 1-888-800-6799 to receive services in your area.  You do not need a referral from your Primary Care Physician but you may want to talk to your Primary Care Physician about the issue.

## ¿Cómo consigo ayuda si tengo un problema de salud mental, de alcohol o de drogas?

Si vive en el área de servicio de Dallas, recibirá tratamiento para la salud mental y el consumo de alcohol y drogas por medio de NorthSTAR. NorthSTAR ofrece estos tipos de servicios de salud mental y abuso de sustancias a los miembros que viven en los siguientes condados: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro y Rockwall. Si tiene algún problema de salud mental o abuso de sustancias, llame gratis al programa NorthSTAR al 1-888-800-6799 para recibir servicios en su área. No necesita un envío a servicios de su proveedor de cuidado primario pero quizás quiera hablar con él del asunto.

REQUIRED LANGUAGE

ATTACHMENT Q

## How do I get my medications?

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

## ¿Cómo obtengo mis medicamentos?

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

REQUIRED LANGUAGE

ATTACHMENT R

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

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

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

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

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

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

REQUIRED LANGUAGE

ATTACHMENT S

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

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

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

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

REQUIRED LANGUAGE

ATTACHMENT T

## Case Management for Children and Pregnant Women

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

### Who can get a case manager?

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

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

### What do case managers do?

A case manager will visit with you and then:

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

### What kind of help can you get?

Case managers can help you:

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

### How can you get a case manager?

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

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

## Administración de Casos para Mujeres Embarazadas y Niños

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

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

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

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

### ¿Qué hacen los administradores de casos?

Un administrador de casos se reunirá con usted y entonces:

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

### ¿Qué tipo de ayuda puede recibir?

Los administradores de casos pueden ayudarle a:

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

**¿Cómo puede obtener un administrador de casos?**

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

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

REQUIRED LANGUAGE

ATTACHMENT U

## What services are offered by Texas Health Steps?

Texas Health Steps is the Medicaid health-care program for STAR and STAR Kids children, teens, and young adults, birth through age 20.

Texas Health Steps gives your child:

* Free regular medical checkups starting at birth.
* Free dental checkups starting at 6 months of age.
* A case manager who can find out what services your child needs and where to get these services.

Texas Health Steps checkups:

* Find health problems before they get worse and are harder to treat.
* Prevent health problems that make it hard for children to learn and grow like others their age.
* Help your child have a healthy smile.

When to set up a checkup:

* You will get a letter from Texas Health Steps telling you when it’s time for a checkup. Call your child’s doctor or dentist to set up the checkup.
* Set up the checkup at a time that works best for your family.

If the doctor or dentist finds a health problem during a checkup, your child can get the care he or she needs, such as:

* Eye tests and eyeglasses.
* Hearing tests and hearing aids.
* Dental care
* Other health care.
* Treatment for other medical conditions.

Call [insert health plan information here] or Texas Health Steps 1-877-847-8377 (1-877-THSTEPS) (toll-free) if you:

* Need help finding a doctor or dentist.
* Need help setting up a checkup.
* Have questions about checkups or Texas Health Steps.
* Need help finding and getting other services.

If you can’t get your child to the checkup, Medicaid may be able to help. Children with Medicaid and their parent can get free rides to and from the doctor, dentist, hospital, or drug store. Contact your MCO for more information.

## ¿Cuáles servicios ofrece Pasos Sanos de Texas?

Pasos Sanos de Texas es el programa de atención médica de STAR y STAR Kids para niños, adolescentes y adultos jóvenes, desde el nacimiento hasta los 20 años.

Pasos Sanos de Texas le brinda al niño:

* Exámenes médicos periódicos gratis, a partir del nacimiento.
* Exámenes dentales gratis a partir de los 6 meses.
* Un administrador de casos que puede averiguar qué servicios necesita su hijo y dónde obtener estos servicios.

Los exámenes de Pasos Sanos de Texas:

* Encuentran problemas de salud antes de que empeoren y sean más difíciles de tratar.
* Evitan problemas de salud que dificultan que su hijo aprenda y crezca como otros niños de su edad.
* Ayudan a su hijo a tener una sonrisa sana.

Cuándo programar un examen:

* Usted recibirá una carta de Pasos Sanos de Texas que dice cuándo le toca un examen. Llame al doctor o dentista de su hijo para programar un examen.
* Haga la cita para la hora que le convenga más a su familia.

Si el doctor o dentista encuentra un problema de salud durante un examen, su hijo puede recibir la atención que necesita; por ejemplo:

* Exámenes de la vista y anteojos.
* Pruebas de la audición y audífonos.
* Servicios dentales
* Otros tipos de atención médica.
* Tratamiento de otros padecimientos médicos.

Llame a [insert health plan information here] o gratis a Pasos Sanos de Texas al 1-877-847-8377 (1-877-THSTEPS) si usted:

* Necesita ayuda para encontrar a un doctor o dentista.
* Necesita ayuda para programar un examen.
* Tiene preguntas sobre los exámenes o sobre Pasos Sanos de Texas.
* Necesita ayuda para encontrar y recibir otros servicios.

Si no tiene cómo llevar a su hijo al examen, Medicaid tal vez pueda ayudar. Los niños con Medicaid y sus padres reciben transporte gratis de ida y vuelta al doctor, dentista, hospital o a la farmacia. Comuníquese con su MCO para más información.

REQUIRED LANGUAGE

ATTACHMENT V

## What if I am a Migrant Farmworker?

You can get your checkup sooner if you are leaving the area.

## ¿Y si soy trabajador de campo migrante?

Si piensa salir de la región, puede recibir su examen más pronto.

REQUIRED LANGUAGE

ATTACHMENT W

## 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 transportation to nonemergency health care appointments for Members who have no other transportation options. These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get Medicaid services. These trips do NOT include ambulance trips.

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

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

If you need an attendant to travel to your appointment with you, NEMT services will cover the transportation costs of your attendant.

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

### How to get a ride?

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

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

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

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

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

Los servicios de NEMT proporcionan transporte a las citas médicas que no son de emergencia para los miembros que no tienen otras opciones de transporte. Estos viajes incluyen los traslados al médico, al dentista, al hospital, a la farmacia y a otros lugares en los que usted recibe servicios de Medicaid. Estos viajes NO incluyen los viajes en ambulancia.

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

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

Si necesita que un acompañante viaje a su cita con usted, servicios de NEMT cubrirá los gastos de transporte de su acompañante.

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

**Cómo obtener transporte**

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

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

REQUIRED LANGUAGE

ATTACHMENT X

## What dental services does [Insert MCO's name] cover for children?

[Insert MCO’s name] covers emergency dental services in a hospital or ambulatory surgical center, including, but not limited to, payment for the following:

* Treatment of dislocated jaw.
* Treatment for traumatic damage to teeth and supporting structures.
* Removal of cysts.
* Treatment of oral abscess of tooth or gum origin.

[Insert MCO’s name] covers hospital, physician, and related medical services for the above conditions. This includes services the doctor provides and other services your child might need, like anesthesia or other drugs.

[Insert MCO's name] is also responsible for paying for treatment and devices for craniofacial anomalies.

Your child’s Medicaid dental plan provides all other dental services including services that help prevent tooth decay and services that fix dental problems. Call your child’s Medicaid dental plan to learn more about the dental services they offer.

## ¿Qué servicios dentales cubre [Insert MCO's name] para los niños?

[Insert MCO’s name] cubre servicios dentales de emergencia en un hospital o centro de servicio ambulatorio, lo cual incluye, pero no limitado a, el pago para lo siguiente:

* Tratamiento para luxación de la mandíbula.
* Tratamiento para lesiones traumáticas a los dientes y las estructuras de soporte.
* Extracción de quistes.
* Tratamiento de abscesos bucales provenientes de los dientes o las encías.

[Insert MCO’s name] cubre el hospital, doctores y servicios médicos relacionados de los padecimientos anteriores. Esto incluye los servicios que el doctor brinda y otros servicios que su hijo necesite, como la anestesia u otros medicamentos.

[Insert MCO's name] también es responsable de pagar el tratamiento y dispositivos para anomalías craneofaciales.

El plan dental de Medicaid de su hijo ofrece todos los otros servicios dentales, entre ellos, servicios que previenen las caries y servicios para arreglar los problemas dentales. Llame al plan dental del niño para aprender más sobre los servicios dentales que ofrecen.

REQUIRED LANGUAGE

ATTACHMENT Y

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

## Select the language that applies to your Health Plan

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

#### ATTENTION FEMALE MEMBERS

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

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

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

#### AVISO IMPORTANTE PARA LA MUJER

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

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

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

oPTION 2: mco LIMITS SELECTION TO PCP’S NETWORK

#### ATTENTION FEMALE MEMBERS

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

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

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

#### AVISO IMPORTANTE PARA LA MUJER

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

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

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

OPTIONAL LANGUAGE

ATTACHMENT Z (STAR Only)

## Can I switch my baby’s health plan?

For at least 90 Days from the date of birth, your baby will be covered by the same health plan that you are enrolled in. You can ask for a health plan change before the 90 Days is up by calling the Enrollment Broker at 1-800-964-2777.

You cannot change health plans while your baby is in the hospital.

## ¿Puedo cambiar el plan de salud de mi bebé?

Por lo menos durante 90 días después de su nacimiento, el bebé tendrá cobertura bajo el mismo plan de salud que usted. Usted puede pedir un cambio de plan de salud antes de los 90 días llamando al agente de inscripción al 1-800-964-2777.

No puede cambiar de plan de salud mientras su bebé esté en el hospital.

REQUIRED LANGUAGE

ATTACHMENT AA

## How can I receive healthcare after my baby is born (and I am no longer covered by Medicaid)?

After your baby is born you may lose Medicaid coverage. You may be able to get some health care services through the Healthy Texas Women Program and the Department of State Health Services (DSHS). These services are for women who apply for the services and are approved.

### Healthy Texas Women Program

The Healthy Texas Women Program provides family planning exams, related health screenings and birth control to women ages 18 to 44 whose household income is at or below the program’s income limits (185 percent of the federal poverty level). You must submit an application to find out if you can get services through this program.

To learn more about services available through the Healthy Texas Women Program, write, call, or visit the program’s website:

Healthy Texas Women Program

P.O. Box 14000

Midland, TX 79711-9902

Phone: 1-800-335-8957

Website: www.texaswomenshealth.org/

Fax: (toll-free) 1-866-993-9971

### DSHS Primary Health Care Program

The DSHS Primary Health Care Program serves women, children, and men who are unable to access the same care through insurance or other programs. To get services through this program, a person’s income must be at or below the program’s income limits (200 percent of the federal poverty level). A person approved for services may have to pay a co-payment, but no one is turned down for services because of a lack of money.

Primary Health Care focuses on prevention of disease, early detection and early intervention of health problems. The main services provided are:

* Diagnosis and treatment
* Emergency services
* Family planning
* Preventive health services, including vaccines (shots) and health education, as well as laboratory, x-ray, nuclear medicine or other appropriate diagnostic services.

Secondary services that may be provided are nutrition services, health screening, home health care, dental care, rides to medical visits, medicines your doctor orders (prescription drugs), durable medical supplies, environmental health services, treatment of damaged feet (podiatry services), and social services.

You will be able to apply for Primary Health Care services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.com/.

To learn more about services you can get through the Primary Health Care program, email, call, or visit the program’s website:

Website: www.dshs.state.tx.us/phc/

Phone: (512) 776-7796

Email: PPCU@dshs.state.tx.us

### DSHS Expanded Primary Health Care Program

The Expanded Primary Health Care program provides primary, preventive, and screening services to women age 18 and above whose income is at or below the program’s income limits (200 percent of the federal poverty level). Outreach and direct services are provided through community clinics under contract with DSHS. Community health workers will help make sure women get the preventive and screening services they need. Some clinics may offer help with breast feeding.

You can apply for these services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.com/.

To learn more about services you can get through the DSHS Expanded Primary Health Care program, visit the program’s website, call, or email:

Website: www.dshs.state.tx.us/ephc/Expanded-Primary-Health-Care.aspx

Phone: (512) 776-7796

Fax: (512)-776-7203

Email: PPCU@dshs.state.tx.us

### DSHS Family Planning Program

The Family Planning Program has clinic sites across the state that provide quality, low-cost, and easy-to-use birth control for women and men.

To find a clinic in your area visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.com/.

To learn more about services you can get through the Family Planning program, visit the program’s website, call, or email:

Website: www.dshs.state.tx.us/famplan/

Phone: (512) 776-7796

Fax: (512)-776-7203

Email: PPCU@dshs.state.tx.us

## ¿Cómo puedo recibir atención médica después de que nazca mi bebé (y ya no reciba cobertura de Medicaid)?

Después del nacimiento de su bebé, es posible que usted pierda su cobertura de Medicaid. Podría recibir algunos servicios de atención médica por medio del Programa de Salud para la Mujer de Texas y del Departamento Estatal de Servicios de Salud (DSHS). Estos servicios son para las mujeres que solicitan los servicios y son aprobadas.

### Programa de Salud para la Mujer de Texas

El Programa de Salud para la Mujer de Texas brinda exámenes de planificación familiar, pruebas de detección relacionadas y control de la natalidad a las mujeres entre 18 y 44 años cuyos ingresos del hogar no exceden los límites de ingresos del programa (185% del nivel federal de pobreza). Usted tiene que presentar una solicitud para saber si puede recibir servicios por medio de este programa.

Para más información acerca de los servicios disponibles por medio del Programa de Salud para la Mujer de Texas, escriba, llame o visite el sitio web:

Healthy Texas Women Program

P.O. Box 14000

Midland, TX 79711-9902

Teléfono: 1-800-335-8957

Sitio web: www.texaswomenshealth.org/

Fax: (gratis): 1-866-993-9971

### Programa Atención Primaria de Salud del DSHS

El Programa Atención Primaria de Salud del DSHS atiende a mujeres, niños y hombres que no pueden recibir la misma atención por medio de un seguro u otro programa. Para recibir servicios por medio de este programa, los ingresos de las personas no deben exceder los límites de ingresos del programa (200% del nivel federal de pobreza). Las personas aprobadas para recibir servicios tendrán que pagar un copago, pero a nadie se le niega los servicios por falta de dinero.

La Atención Primaria de Salud se centra en la prevención de enfermedades y la detección e intervención tempranas de problemas de salud. Los servicios principales que se prestan son:

* Diagnóstico y tratamiento
* Servicios de emergencia
* Planificación familiar
* Servicios de salud preventivos, incluso vacunas y educación sobre la salud, así como pruebas de laboratorio, radiografías, medicina nuclear u otros servicios de diagnóstico adecuados.

Los servicios secundarios que se podrían prestar son servicios de nutrición, pruebas de detección, atención médica en casa, servicios dentales, transporte a las citas médicas, medicamentos que ordena el doctor (medicamentos recetados), equipo médico duradero, servicios de salud ambiental, tratamiento de pies (servicios de podología) y servicios sociales.

Usted podrá solicitar los servicios de Atención Primaria de Salud en ciertas clínicas en su región. Para encontrar una clínica donde puede hacer la solicitud, vaya al buscador de clínicas de Servicios de Salud Familiar y Comunitaria del DSHS en http://txclinics.com/.

Para más información acerca de los servicios que puede recibir por medio del programa de Atención Primaria de Salud, envíe un correo electrónico, llame o visite el sitio web del programa:

Sitio web: www.dshs.state.tx.us/phc/

Teléfono: (512) 776-7796

Correo electrónico: PPCU@dshs.state.tx.us

### Programa Atención Primaria de Salud Ampliado del DSHS

El programa Atención Primaria de Salud Ampliado brinda servicios primarios, preventivos y de detección a las mujeres de 18 años o más cuyos ingresos no exceden los límites de ingresos del programa (200% del nivel federal de pobreza). Los servicios directos y de extensión se prestan a través de clínicas comunitarias contratadas por el DSHS. Los trabajadores comunitarios de salud ayudan a asegurar que las mujeres reciban los servicios de prevención y detección que necesitan. Algunas clínicas podrían ofrecer ayuda con la lactancia materna.

Usted puede solicitar estos servicios en ciertas clínicas en su región. Para encontrar una clínica donde puede hacer la solicitud, vaya al buscador de clínicas de Servicios de Salud Familiar y Comunitaria del DSHS en http://txclinics.com/.

Para más información acerca de los servicios que puede recibir por medio del programa de Atención Primaria de Salud Ampliado del DSHS, vaya al sitio web del programa, llame o envíe un correo electrónico:

Sitio web: www.dshs.state.tx.us/ephc/Expanded-Primary-Health-Care.aspx

Teléfono: (512) 776-7796

Fax: (512)-776-7203

Correo electrónico: PPCU@dshs.state.tx.us

### Programa de Planificación Familiar del DSHS

El Programa de Planificación Familiar tiene clínicas en todo el estado que ofrecen a hombres y mujeres planificación familiar de calidad, a bajo costo y fácil de usar.

Para encontrar una clínica en su región, vaya al buscador de clínicas de Servicios de Salud Familiar y Comunitaria del DSHS en http://txclinics.com/.

Para más información acerca de los servicios que puede recibir por medio del programa de Planificación Familiar, vaya al sitio web del programa, llame o envíe un correo electrónico:

Sitio web: www.dshs.state.tx.us/famplan/

Teléfono: (512) 776-7796

Fax: (512)-776-7203

Correo electrónico: PPCU@dshs.state.tx.us

REQUIRED LANGUAGE

ATTACHMENT BB

## What happens if I lose my Medicaid coverage?

If you lose Medicaid coverage but get it back again within six (6) months you will get your Medicaid services from the same health plan you had before losing your Medicaid coverage. You will also have the same Primary Care Provider you had before.

## ¿Qué hago si pierdo la cobertura de Medicaid?

Si pierde la cobertura de Medicaid pero la vuelve a tener dentro de seis (6) meses, recibirá los servicios de Medicaid del mismo plan de salud que tenía antes de perder la cobertura. También tendrá el mismo proveedor de cuidado primario de antes.

REQUIRED LANGUAGE

ATTACHMENT CC (STAR Kids and STAR+PLUS Only)

## Can my Medicare provider bill me for services or supplies if I am in both Medicare and Medicaid?

You cannot be billed for Medicare "cost-sharing," which includes deductibles, coinsurance, and co-payments that are covered by Medicaid.

## ¿Puede mi proveedor de Medicare enviarme una cuenta por servicios o artículos si estoy recibiendo Medicare y Medicaid?

No. No le pueden enviar una cuenta por los gastos de participación en los costos de Medicare, lo cual incluye deducibles, coaseguro y copagos.

REQUIRED LANGUAGE

ATTACHMENT DD

## What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office and (Insert MCO’s name) Member Services Department at (Insert MCO’s 1-800#). Before you get Medicaid services in your new area, you must call (Insert MCO’s name), unless you need emergency services. You will continue to get care through (Insert MCO’s name) until HHSC changes your address.

## ¿Qué tengo que hacer si me mudo?

Tan pronto sepa su nueva dirección, avise a la oficina local de beneficios de la HHSC y al departamento de Servicios para Miembros de (Insert MCO's name) al (Insert MCO's 1-800#). Antes de recibir servicios de Medicaid en la nueva área de servicio, usted tiene que llamar a (Insert MCO’s name), a menos que necesite servicios de emergencia. Continuará recibiendo atención por medio de (Insert MCO’s name), hasta que la HHSC cambie su dirección.

REQUIRED LANGUAGE

ATTACHMENT EE

## Medicaid and Private Insurance

You are required to tell Medicaid staff about any private health insurance you have. You should call the Medicaid Third Party Resources hotline and update your Medicaid case file if:

* Your private health insurance is canceled.
* You get new insurance coverage.
* You have general questions about third party insurance.

You can call the hotline toll-free at 1-800-846-7307.

**If you have other insurance you may still qualify for Medicaid**. When you tell Medicaid staff about your other health insurance, you help make sure Medicaid only pays for what your other health insurance does not cover.

**IMPORTANT**: Medicaid providers cannot turn you down for services because you have private health insurance as well as Medicaid. If providers accept you as a Medicaid patient, they must also file with your private health insurance company.

## Medicaid y el seguro privado

Usted tiene que avisar al personal de Medicaid sobre cualquier seguro médico privado que tenga. Debe llamar a la línea directa de Medicaid de Recursos para Terceros y actualizar el expediente de su caso de Medicaid si:

* Le cancelan el seguro médico privado.
* Consigue nueva cobertura de seguro.
* Tiene preguntas generales sobre el seguro de terceros.

Puede llamar gratis a la línea directa al 1-800-846-7307.

**Si tiene otro seguro, aun puede llenar los requisitos de Medicaid**. Cuando usted le dice al personal de Medicaid que tiene otro seguro médico, asegura que Medicaid solo pague lo que el otro seguro médico no paga.

**IMPORTANTE**: Los proveedores de Medicaid no pueden negarse a atenderlo porque tiene seguro médico privado además de Medicaid. Si los proveedores lo aceptan como paciente de Medicaid, también tienen que enviar una solicitud de pago a su compañía de seguro privado.

REQUIRED LANGUAGE

ATTACHMENT FF

## 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.
   3. Be given information about your health, plan, services, and providers.
   4. Be told about your rights and responsibilities.
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 Complaint and appeal process available through the Managed Care Organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
   1. Make a Complaint to your health plan or to the state Medicaid program about your health care, your Provider, or your health plan.
   2. Get a timely answer to your complaint.
   3. Use the plan’s appeal process and be told how to use it.
   4. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   5. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   1. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   2. Get medical care in a timely manner.
   3. Be able to get in and out of a health care Provider’s office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   4. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   5. Be given information you can understand about your health plan rules, including the Health Care Services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else’s convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment.  Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a Covered Service.
9. You have a right to know that you are not responsible for paying for Covered Services.  Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for Covered Services.
10. You have a right to make recommendations to your health plan’s member rights and responsibilities.

**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 keep yourself healthy. That includes the responsibility to:
   1. Work as a team with your provider in deciding what health care is best for you.
   2. Understand how the things you do can affect your health.
   3. Do the best you can to stay healthy.
   4. Treat providers and staff with respect.
   5. Talk to your provider about all of your medications.

Additional Member Responsibilities while using <NEMT Services> or <MCO name of transportation program>

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

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

## DERECHOS y RESPONSABILIDADES DEL MIEMBRO

**Derechos del Miembro:**

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

**RESPONSABILIDADES DEL MIEMBRO:**

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

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

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

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

REQUIRED LANGUAGE

ATTACHMENT GG

## What if I need durable medical equipment (DME) or other products normally found in a drug store?

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

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

## ¿Qué debo hacer si necesito equipo médico duradero (DME) y otros artículos que se encuentran normalmente en una farmacia?

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

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

REQUIRED LANGUAGE

ATTACHMENT HH

## Complaints

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

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

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

Texas Health and Human Services Commission

Ombudsman Managed Care Assistance Team

P.O. Box 13247

Austin, Texas 78711-3247

If you can get on the Internet, you can submit your complaint at:

hhs.texas.gov/managed-care-help

## Quejas

### ¿Qué hago si tengo una queja?

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

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

Texas Health and Human Services Commission Ombudsman Managed Care Assistance Team

P.O. Box 13247

Austin, Texas 78711-3247

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

hhs.texas.gov/managed-care-help

REQUIRED LANGUAGE

ATTACHMENT II

**What is an Emergency Appeal?**

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

**¿Qué es una apelación de emergencia?**

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

REQUIRED LANGUAGE

ATTACHMENT JJ

## STATE FAIR HEARING

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

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

You have the right to keep getting any service the health plan denied or reduced, based on previously authorized services, at least until the final State Fair Hearing decision is made if you ask for a State Fair Hearing by the later of: (1) 10 calendar days following the date the health plan mailed the internal appeal decision letter, or (2) the day the health plan’s internal appeal decision letter says your service will be reduced or end. If you do not request a State Fair Hearing by this date, the service the health plan denied will be stopped.If you ask for a State Fair Hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most State Fair Hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

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

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

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

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

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

Usted tiene el derecho de seguir recibiendo cualquier servicio que el plan médico le denegó o redujo, basado en los servicios previamente autorizados, por lo menos hasta que se tome la decisión final de la audiencia imparcial estatal, si pide una audiencia imparcial estatal para la fecha que ocurra más tarde: (1) 10 días naturales después de la fecha en que el plan médico envió la carta con la decisión de la apelación interna, o (2) la fecha en que el servicio se reducirá o cancelará de acuerdo con la carta de la decisión de la apelación interna. Si no pide una audiencia imparcial estatal antes de esta fecha, el servicio que el plan médico le denegó se cancelará. Si pide una audiencia imparcial estatal, recibirá un paquete de información con la fecha, la hora y el lugar de la audiencia. La mayoría de las audiencias imparciales estatales se hacen por teléfono. En la audiencia, usted o su representante podrá explicar por qué necesita el servicio que el plan médico le denegó.

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

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

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

REQUIRED LANGUAGE

ATTACHMENT KK

You have the right to respect and dignity, including freedom from Abuse, Neglect, and Exploitation.

## What are Abuse, Neglect, and Exploitation?

**Abuse** is mental, emotional, physical, or sexual injury, or failure to prevent such injury.

**Neglect** results in starvation, dehydration, overmedicating or under medicating, unsanitary living conditions, etc. Neglect also includes lack of heat, running water, electricity, medical care, and personal hygiene.

**Exploitation** is misusing the resources of another person for personal or monetary gain. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

## Reporting Abuse, Neglect, and Exploitation

The law requires that you report suspected Abuse, Neglect, or Exploitation, including unapproved use of restraints or isolation that is committed by a provider.

Call 9-1-1 for life-threatening or emergency situations.

### Report by Phone (non-emergency)

24 hours a day, 7 days a week, toll-free.

Report to the Department of Aging and Disability Services (DADS) by calling 1-800-647-7418 if the person being abused, neglected, or exploited lives in or receives services from a:

* Nursing Facility;
* Assisted living facility;
* Adult day care center;
* Licensed adult foster care provider; or
* Home and Community Support Services Agency (HCSSA) or home health agency.

Suspected Abuse, Neglect or Exploitation by a HCSSA must also be reported to the Department of Family and Protective Services (DFPS).

Report all other suspected abuse, neglect, or exploitation to DFPS by calling 1-800-252-5400.

### Report Electronically (non-emergency)

Go to https://txabusehotline.org. This is a secure website. You will need to create a password-protected account and profile.

### Helpful Information for Filing a Report

When reporting abuse, neglect, or exploitation, it is helpful to have the names, ages, addresses, and phone numbers of everyone involved.

Usted tiene derecho al respeto y a la dignidad, incluso estar libre de abuso, maltrato, descuido y explotación.

## ¿Qué es abuso, maltrato, descuido y explotación?

El **abuso o maltrato** es daño mental, emocional, físico o sexual, o el hecho de no prevenir estos daños.

El **descuido** causa hambre, deshidratación, exceso o falta de medicación, condiciones de vida insalubres, etc. El descuido también incluye la falta de calefacción, agua corriente, electricidad, atención médica e higiene personal.

La **explotación** es el mal uso de los recursos de otra persona para obtener beneficios personales o monetarios. Esto incluye cobrar cheques de Seguro Social o de Seguridad de Ingreso Suplementario (SSI), abusar de una cuenta de cheques conjunta y tomar propiedad y otros recursos.

## Cómo reportar el abuso, maltrato, descuido y la explotación

La ley requiere que usted informe sobre sospechas de abuso, maltrato, descuido o explotación, incluso el uso no aprobado de restricciones o aislamiento cometido por un proveedor.

Llame al 9-1-1 para situaciones de emergencia o que ponen en peligro la vida.

### Informe por teléfono (si no es una emergencia)

las 24 horas del día, los 7 días de la semana, gratis

Informe al Departamento de Servicios para Adultos Mayores y Personas Discapacitadas (DADS) llamando al 1-800-647-7418 si la persona que sufre abuso, maltrato, descuidado o explotación vive en o recibe servicios de alguno de los siguientes:

* Un centro para convalecientes;
* Un centro de asistencia con la vida diaria;
* Un centro de cuidado de adultos durante el día;
* Un proveedor de cuidado temporal de adultos con licencia, o
* Una agencia de Servicios de Apoyo en Casa y en la Comunidad (HCSSA) o una agencia de servicios de salud en casa.

Las sospechas de abuso, maltrato, descuido o explotación cometidos por una HCSSA también se tienen que reportar al Departamento de Servicios para la Familia y de Protección (DFPS).

Informe al DFPS sobre cualquier otra sospecha de abuso, maltrato, descuido o explotación llamando al 1-800-252-5400.

### Informe electrónicamente (si no es una emergencia)

Vaya a https://txabusehotline.org. Este es un sitio web seguro. Usted tendrá que crear una cuenta y un perfil protegidos por una contraseña.

### Información útil al presentar un informe

Al informar sobre el abuso, maltrato, descuido o la explotación, es útil tener el nombre, la edad, la dirección y los teléfonos de cada persona involucrada.

REQUIRED LANGUAGE

ATTACHMENT LL

## Fraud and Abuse

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

Let us know if you think a doctor, dentist, pharmacist at a drug store, other 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 ID.
* Not telling the truth about the amount of money or resources he or she has to get benefits.

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

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

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

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

## Fraude y Abuso

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

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

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

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

* Llame a la Línea Directa de la Fiscalía General (OIG) al 1-800-436-6184;
* Visite https://oig.hhsc.state.tx.us/ debajo de la caja marcada "I WANT TO" clic “Report Waste, Abuse, and Fraud Online” para llenar una forma en línea; O
* Denúncielo directamente al plan de salud:
  + MCO’s name
  + MCO’s office/director address
  + MCO’s toll free phone number

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

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

REQUIRED LANGUAGE

ATTACHMENT MM

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

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

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

La siguiente información debe estar a la disposición de los miembros año tras año (Requisito de la Ley del Equilibrio Presupuestario). Debe comunicarse como se indica a continuación:

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

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

ATTACHMENT NN

**EXTERNAL MEDICAL REVIEW INFORMATION**

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

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

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

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

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

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

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

Can I ask for an emergency External Medical Review?

If you believe that waiting for a standard External Medical Review will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you, your parent or your legally authorized 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 review through HHSC, you must first complete [insert MCO’s name]’s internal appeals process.

**ANEXO NN**

**INFORMACIÓN SOBRE LA REVISIÓN MÉDICA EXTERNA**

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

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

* Llenar la "Solicitud de una audiencia imparcial estatal y una revisión médica externa" que se adjunta a la carta de notificación al miembro de la decisión de apelación interna de la MCO y enviarlo por correo o por fax a <MCO name> usando la dirección o el número de fax que aparecen en la parte superior de la solicitud;
* Llamar a la MCO al <MCO telephone number>;
* Enviar un correo electrónico a la MCO a <MCO email address>, o bien,
* Si el miembro solicita una revisión médica externa en un plazo de 10 días de haber recibido la decisión de la apelación del plan médico, el miembro tiene el derecho de seguir recibiendo cualquier servicio que el plan médico denegó, basado en los servicios previamente autorizados, por lo menos hasta que se haya tomado una decisión final sobre la audiencia imparcial estatal. Si el miembro no solicita una revisión médica externa en un plazo de 10 días de haber recibido la decisión de la apelación del plan médico, el servicio que el plan médico le denegó se cancelará.

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

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

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

¿Puedo pedir una revisión médica externa de emergencia?

**Si cree que esperar la decisión de la revisión médica externa estándar pondría en grave peligro su vida o salud, o su capacidad de lograr, mantener o recuperar el máximo funcionamiento, usted, uno de sus padres o su representante legalmente autorizado puede pedir una revisión médica externa de emergencia y una audiencia imparcial estatal escribiendo o llamando a [insert MCO’s name]. Para llenar los requisitos para una** r**evisión médica externa de emergencia y una audiencia imparcial estatal de emergencia por medio de la HHSC, primero tiene que completar el trámite de apelación interna de [insert MCO’s name].**