carelon.

CARELON BEHAVIORAL HEALTH

TEXAS ADDENDUM

Any policies contained in this Provider Handbook Addendum will supersede those policies contained in Carelon Behavioral Health's National Provider Handbook. This Addendum is specific to your state. Providers should refer to their plan-specific section within this Addendum.

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Parkland Community Health Plan - Medicaid and CHIP

Carelon BH National Provider Manual Addendum

Dallas Service Area - Dallas, Collin, Ellis, Kaufman, Navarro, and Rockwall Counties

www.carelonbehavioralhealth.com/providers

800-945-4644

Last Updated - November 2024

The following chapters referenced below correspond with the chapters found in the Care/on National Provider Handbook. Information included under each chapter is specific to your Plan.

1. INTRODUCTION

Parkland Community Health Plan has contracted with, and will work in partnership with, Carelon Behavioral Health (Carelon), to manage the delivery of mental health and substance use disorder services for the Children's Health Insurance Program (CHIP) and the Medicaid State of Texas Access Reform (STAR) program.

This partnership was established in response to meet the needs of Parkland Community Health Plan members for behavioral health services given the expertise that Carelon has in this area.

Important contact information

Administrative Appeal	To request on administrative appeal, call the toll-free number included in the administrative denial letter received.
Potential Quality of Care (PQOC) Concerns	Report all Potential Quality of Care Concerns (PQOC) to Carelon within 24 hours using the clinical form available on Carelon's website at www.carelonbehavioralhealth.com/providers/forms-and-guides or follow local notification processes when applicable.

Changing your Provider Profile (e.g., name, address)	To change or update your Provider Profile (e.g., address, phone, etc.) use one of the following methods:
	• CAQH (Carelon's preferred method)
	  ○ Participating CAQH providers: Log in to your CAQH ProView
	  ○ New users: Register for CAQH Proview
	• The Carelon Provider Portal
	  ○ Log in to the Carelon Provider Portal
	  ○ Select "Update Demographic information"
	• Texas Provider Relations - TexasProviderRelations@carelon.com
	
	Note: Updating a Tax ID requires an accompanying W-9 form. The W-9 can be submitted via the provider portal as an attachment. Providers without access to the provider portal can contact the National Provider Service Line for assistance in submitting a W-9.

Claims	For general claim inquiries, call 800-888-3944. For technical questions related to direct claim submission via ProviderConnect, please contact the E-support service team at • **Telephone:** 888-247-9311 from 7 a.m. - 5 p.m. CT • **Fax:** 866-698-6032 For EDI claims use Carelon's payer ID: BHOVO for submission through our clearinghouse partner, Availity. For support with EDI Claims, please contact Availity's Customer Service line at 800-282-4548. For providers who are unable to submit a claim electronically, paper claims should be sent to Carelon Behavioral Health Attn: Customer Service P.O. Box 1866 Hicksville, NV 11802-1866
Claim Appeals	To request a claim appeal, write to the address on your provider summary voucher.
Clinical Appeals	To request a clinical appeal on a member's behalf, call the toll- free number included in the adverse determination letter received.
Complaints/Grievances	To file a complaint/grievance, call 800-945-4644 or email TexasProviderRelations@carelon.com
Credentialing	To obtain information pertaining to network participation status, contact TexasProviderRelations@carelon.com To send supporting documentation such as malpractice or insurance cover sheets, please fax to 866-612-7795.
Fraud and Abuse	To report compliance, ethics or fraud waste and abuse concerns, contact Carelon's Ethics and Compliance hotline at 888-293-3027. You may also email us at SIU@Carelon.com.
Member Benefits, Eligibility, and Authorizations	1-800-945-4644 • The Carelon Provider Portal ○ Log in to the Carelon Provider Portal
Member Customer Service	To reach member customer service, call 800-945-4644 (TTY 711)

Parkland Community Health Plan Member Services	Provider Customer Service: • HEALTHfirst - 1-888-672-2277 • KIDSfirst - 1-888-814-2352 Call Monday through Friday 8 am to 5 pm CST Provider Resources & Information I Parkland Community Health Plan I Parkland Community Health Plan (parklandhealthplan.com)
Medicaid Transportation **Non-Emergency Medical Transportation**	Dallas/Ft. Worth area: 1-855-687-3255 To schedule a free ride to and from a Food Bank or Grocery Store you must call 1-833-931-3844 at least two days in advance. Phone reservations, press 1. Monday-Friday, Sam- 5pm (CT) Where's My Ride, press 2. Monday-Saturday, Sam- 7pm (CT)
State Medicaid Client Hotline	800-252-8263

Behavioral Health Program Goals and Objectives

The primary goal of the program is to provide medically necessary care in the most clinically appropriate and cost-effective therapeutic settings. By ensuring that all PCHP members receive timely access to clinically appropriate behavioral health care services PCHP and Carelon believe that quality clinical services can achieve improved outcomes for our members.

This can be achieved by providing members with access to a full continuum of mental health and substance use services through Carelon's network of contracted providers.

2. ELECTRONIC RESOURCES

See Care/on national handbook

3. PARTICIPATING PROVIDERS

See Care/on national handbook

4. CREDENTIALING AND RE-CREDENTIALING

See Care/on national handbook

5. OFFICE PROCEDURES

Coordination with Non-Medicaid Non-CHIP Managed Care Covered Services

STAR members are eligible for the services described below. Network providers are expected to refer to and coordinate with these programs. These services are described in the Texas Medicaid Provider Procedures Manual (TMPPM); This list is not all-inclusive. Please see TMPPM for more information and an all-inclusive list.

- Texas Health Steps dental (including orthodontia)
- Texas Health Steps environmental lead investigation (ELI)
- Texas Health Steps medical case management
- Case management for children and pregnant women
- Early Childhood Intervention (ECI) case management/service coordination
  - Early Childhood Intervention (ECI) is a statewide program within the Texas Health and Human Services Commission (HHSC) for families with children birth, up to age 3, with developmental delays, disabilities or certain medical diagnoses that may affect development. ECI services support families as they learn how to help their children grow and learn.
- Early Childhood Intervention Specialized Skills Training
- Texas School Health and Related Services (SHARS)
  - SHARS allows local school districts, including public charter schools, to obtain Medicaid reimbursement for certain health-related services provided to students in special education under IDEA that are documented in a student's Individualized Education Program (IEP).
- Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program
- Tuberculosis services provided by DSHS- approved providers (directly observed therapy and contact investigation)
- HHSC hospice services
- Admissions to inpatient mental health facilities as a condition of probation for STAR, Texas Health Steps Personal Care Services for Members birth through age20
- HHSC contracted providers of long-term services and supports (LTSS) for individuals who have intellectual or developmental disabilities
- HHSC contracted providers of case management or service coordination services for individuals who have intellectual or developmental disabilities

Primary Care Providers (PCP)

The primary care provider (PCP) is important in the way that the members receive their medical care and serves as a "medical home" to STAR and CHIP members. To provide a medical home for the member, the PCP directs care coordination together with the client and family. Care coordination consists of managing services and resources for clients with special health needs and their families to maximize the members' potential and provide them with optimal healthcare. Notwithstanding the above, the member may also elect to choose a specialist as his/her PCP, if this type of provider would best suit the needs of the member. The PCP for a member with disabilities, special healthcare needs, or chronic or complex conditions may be a specialist physician who agrees to provide PCP services to the member. The specialty physician must agree to perform all PCP duties required in the contract, and PCP duties must be within the scope of the specialist's license.

Coordination with Primary Care/Treating Providers

As part of care coordination activities, participating providers should identify all providers/participating providers involved in the medical and/or behavioral health care and treatment of a member. Subject to any required consent or authorization from the member, participating providers should coordinate the delivery of care to the member with these providers/participating providers. All coordination, including PCP coordination, should be documented accordingly in the member treatment record. Carelon consent forms are available through the website.

Tips to Improve Coordination of Care:

1. Request a release of information from the member to coordinate with his/her medical providers or behavioral health providers. Use motivational interviewing techniques to encourage information sharing across providers.
   - Educate the member that care coordination improves patient safety and can lead to improved treatment outcomes. Explain in detail what will be shared and why.
   - Discuss any concerns about care coordination with the member. Encourage questions and provide adequate time for discussion.
2. Use a standard form to share information. You can use your own or one of the two versions available for free on Carelon's website.

   For coordination with a primary care provider:

   - Authorization for Behavioral Health Provider and Primary Care Provider to Share Confidential Information Form
   - Primary Care Provider Behavioral Health Communication Form

   For coordination with other provider types. such as another behavioral health provider:

   - Authorization For Carelon to Release Confidential Information (Also Available in Spanish)
3. Follow a standard process for sharing and requesting information with the member's medical or behavioral health provider(s).
   - Call the provider's office and ask the office manager or receptionist how best to communicate and share information. Discuss a protocol for any urgent medical or behavioral health needs.
   - Routinely communicate with any other treatment provider at specific points in treatment, such as when treatment begins, when there are changes in the member's status, or upon discharge.
4. Ensure that this coordination of care is documented in the member's medical record. Audit your own records for compliance with your policies and procedures.
5. Ensure that your intake paperwork/process includes medical history.
6. Keep the member in the communication loop, as clinically appropriate. Provide ongoing updates on communication between you and other providers.

Provider Responsibility

The individual provider is ultimately responsible for accuracy and valid reporting of all claims submitted for payment. A provider utilizing the services of a billing agency must ensure through legal contract (a copy of which must be made available to Carelon upon request) the responsibility of a billing service to report claim information as directed by the provider in compliance with all policies stated by Carelon.

Access and Availability

Continuous access is an important feature to the member. Twenty-four-hour PCP availability enables a member to access and use services appropriately, instead of relying on ERs for after-hours care. Continuous access can be provided through direct access to a PCP's office or through on-call arrangements with another office or service. Members should be informed of the PCP's normal office hours and should be instructed how to access urgent medical care after normal office hours.

Each provider shall provide covered services during normal business hours. Covered services shall be available and accessible to members, including telephone access, on a 24-hour, seven-day per week basis, to advise members requiring urgent or emergency services.

Specialists shall arrange for appropriate coverage by a participating provider when unavailable due to vacation, illness, or leave of absence. As a participating Carelon provider, you must be accessible to members 24 hours a day, seven days a week. The following are acceptable and unacceptable phone arrangements for contacting physicians after normal business hours.

Acceptable

- Office phones are answered after hours by an answering service. All calls answered by an answering service must be returned within 30 minutes.
- Office phone is answered after normal business hours by a recording in the language of each of the major population groups serviced, directing the patient to call another number to reach another provider designated to you. Someone must be available to answer the designated provider's phone. Another recording is not acceptable.
- Office phones are transferred after office hours to another location where someone will answer the phone and be able to contact another designated medical practitioner.
- Members who "no-show" for an appointment are contacted within 24 hours in an attempt to reschedule them.

NOTE: When a STAR member "no-shows," providers are expected to alert the member's Carelon/PCHP assigned service coordinator.

Unacceptable

- Office phones are only answered during office hours.
- Office phone is answered after hours by a recording, which tells the member to leave a message.
- Office phones are answered after hours by a recording that directs patients to go to an emergency room for any services needed.
- Returning after hours calls outside of 30 minutes
- Failing to follow-up with members who "no-show" for an appointment

Accessibility standards

Routine, Urgent, and Emergency Services Definitions

- **Routine Care** means health care for covered preventive and medically necessary Health Care. Services that are non-emergent or non-urgent. Initial outpatient Behavioral Health visits must be provided within 14 calendar days.
- **Urgent Behavioral Health Situation** means a Behavioral Health condition that requires attention and assessment within 24 hours, but which does not place the Member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment.
- **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 an average knowledge of health and medicine:

  (1) requires immediate intervention and/or medical attention without which Members would present an immediate danger to themselves or others, or

  (2) renders Members incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Behavioral Health Conditions include Emergency Detentions as defined under Chapter 573, Subchapter A, of the Texas Health and Safety Code and under Chapter 462, Subchapter C, of the Texas Health and Safety Code

Appointment Standards and After-Hours Accessibility

Type of Appointment/Service	Appointment Must be Offered:
General Appointment Standards	
Routine-Non Urgent Services	Within 14 calendar days, sooner if required by DFPS
Urgent Care	Within 24 hours
Emergency Services	Immediately, 24 hours per day, 7 days a week
Aftercare Appointment Standards *(Inpatient and 24-hour diversionary service must schedule on aftercare follow-up prior to a member's discharge)*	
Non-24-hour Diversionary	Within 2 calendar days
Post-discharge from Acute Inpatient Hospital Stay	7 days
All Other Outpatient Services	Within 10 business days
Intensive Care Coordination (ICC)	Within 2 business days
Service Availability	**Hours of Operation**
On-Call	▪ 24-hour on-call services for all members in treatment ▪ Ensure that members in treatment are aware of how to contact the treating or covering providers after hours and during provider vacations
Crisis Intervention	▪ Services must be available 24 hours per day, 7 days per week. ▪ Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours. ▪ After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room.

Service Availability	Hours of Operation
Outpatient Services	▪ Outpatient providers should have services available Monday through Friday from 8:00 a.m. to 5:00 p.m., CT, at a minimum. ▪ Evening and/or weekend hours should also be available at least two days per week
Interpreter Services	▪ Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency. Please contact Carelon for assistance with securing interpreter services for members.

NOTE: Providers are required to meet these standards, and to notify Carelon if they are temporarily or permanently unable to meet the standards. If a provider fails to begin services within these access standards, notice is sent out within one business day informing the member and provider that the waiting time access standard was not met.

Updates to Contact Information

Network Providers must inform both Carelon and HHSC's administrative services contractor of any changes to provider's address, telephone number, group affiliation, etc.

Providers are responsible for Continuity of Care related to:

1. Pregnant woman information (for MCOs serving MMC Members or CHIP Members and CHIP Perinate Newborn Members)
2. Member moves out of Service Area
3. Preexisting conditions not imposed (for MCOs serving MMC Members or CHIP Members and CHIP Perinate Newborn Members)

6. SERVICES TO MEMBERS

Role of Primary Care Provider/ Medical Home

PCPs provide all primary care Covered Services within the scope of the PCP's practice, including appropriate health education and instructions to the Covered Person and/or to family Covered Persons or primary caregivers. PCP's also arrange for the provision of Covered Services outside their scope of practice via referrals to other Participating Providers; a link to the referral form is found in Appendix N of the Parkland Provider Manual found here.

Primary Care Providers may provide behavioral health-related services within the scope of its practice.

Role of Pharmacy

Carelon does not manage pharmacy benefits for Parkland members. For more information regarding the formulary or anything regarding prescription drug coverage please click here or contact PCHP at 1-888-672-2777 for STAR members or 1-888-814-2352 for CHIP members.

PCHP is sub-contracted with a Pharmacy Benefits Manager (PBM) to provide prescription drugs to our members. The PBM for PCHP is Navitus. This PBM holds contracts with the individual pharmacies. The Pharmacy is contracted to provide all prescription drugs that are included on the PCHP formulary.

Texas Health Steps

What is Texas Health Steps?

THSteps is a children's benefit under Texas Medicaid which provides medical and dental preventative care and treatment to Medicaid clients from birth through 20 years of age. The program is designed to improve the health of Texas kids. For full information on the Texas Health Steps and Comprehensive Care program, including private duty nursing, prescribed pediatric extended care centers, and therapists, please see the Texas Medicaid Provider Procedures Manual at: TMPPM More information about the THSteps program is found at Appendix M of the Parkland Provider Manual found here.

For more information about THSteps, please refer to the Texas Health Steps website at **HHS** THSteps.

Documentation of completed Texas Health Steps components and elements

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

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

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

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

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

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

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

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

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

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

Newborn Screening: Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn Members and the Member's mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.

Anemia screening at 12 months.

Dyslipidemia Screening at 9 to 12 years of age and again 18-20 years of age

HIV screening at 16-18 years

Risk-based screenings include:

- dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis and gonorrhea/chlamydia.

Health education (including anticipatory guidance), is a federally mandated component of the medical checkup and is required in order to assist parents, caregivers and clients in understanding what to expect in terms of growth and development. Health education and counseling include healthy lifestyle practices as well as prevention of lead poisoning, accidents, and disease.

Dental referral every 6 months until the parent or caregiver reports a dental home is established.

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

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

Durable Medical Equipment and Other Products Normally Found in a Pharmacy

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

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must contact Parkland directly for more information.

Call STAR Provider Services at 888-672-2277 or CHIP Provider Services at 888-814-2352 for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20). Note: The MCO may elaborate on the scope of DME/other products for children
(birth through age 20).

Children of Migrant Farmworkers

Children of Migrant Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service but should be billed as a checkup.
Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup

Medicaid Managed Care and CHIP Covered Behavioral Health Services

Carelon defines behavioral health as both acute and chronic psychiatric and substance use disorders as referenced in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) of American Psychiatric Association.

The following details the Member benefit package available to Parkland Community Health Plan members specifically for behavioral health services offered by Carelon Behavioral Health. Please refer to the current Texas Medicaid Provider Procedures Manual for the listing of limitations and exclusions. You can also find additional information in the Parkland Provider Manual.

Behavioral Health Covered Services

Behavioral health services that are offered to CHIP and STAR members are:

Covered Behavioral Health Services

A wide range of mental health and substance use services are available, such as:

- Inpatient mental health services including partial hospitalization (PHP).
- Intensive Outpatient Services (IOP)
- Attention Deficit Hyperactivity Disorder (ADHD)
    - ADHD covered services eligible for reimbursement include outpatient counseling services for the management of ADHD symptoms to include coping skills, psychoeducation, etc. Medication management with psychiatric prescribers is also covered.
    - Primary care providers should have a strategy for diagnosing and long-term management of ADHD. Providers can discuss the efficacy of using medication to manage an ADHD diagnosis with their patients. Follow up appointments should be made at least monthly until the child's symptoms have been stabilized. Once a child is stable, AAP guidelines recommend an office visit every 3 to 6 months to assess learning and behavior.
- Substance Use Disorder Treatment including screening, assessment, brief intervention, withdrawal management, residential treatment, and outpatient services.
    - Includes Screening and Brief Intervention Services (SBIRT). Information regarding available training and standardized screening tools can be found through the Substance Abuse and Mental Health Services Administration. Additional information about SBIRT can also be found in the TMPPM.
- Therapy- individual, family, and group.
- Psychological & Neuropsychological testing

- Mental Health Targeted Case Management and Rehabilitative Services (MHR/TCM)

Medicaid Managed Care Non-Capitated Services

The following Texas Medicaid programs, services, or benefits have been excluded from MCO Covered Services. Medicaid Members are eligible to receive these Non-capitated Services on another basis, such as a Fee-for-Service basis, or through a Dental MCO (for most dental services). MCOs should refer to relevant chapters in the Texas Medicaid Provider Procedures Manual for more information.

- Texas Health Steps dental (including orthodontia)
- Texas Health Steps environmental lead investigations (ELI)
- Early Childhood Intervention (ECI) case management/ service coordination
- Early Childhood Intervention (ECI) Specialized Skills Training
- Texas School Health and Related Services (SHARS)
- Department of Assistance and Rehabilitative Services Blind Children's Vocational Discovery and Development Program
- tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Texas Health Steps Personal Care Services (PCS) for Members birth through age 20
- Community First Choice (CFC) services
- For members who are enrolled in STAR during an Inpatient Stay under one of the instances identified in the Span of Coverage where fee-for-service or the previous MCO is responsible for payment for Hospital facility charges associated with the Inpatient Stay, such charges are Non-Capitated Services
- Mental Health Targeted Case Management and Mental Health Rehabilitative Services for Dual Eligible Members.

Although Medicaid MCOs are not responsible for paying or reimbursing for Non-capitated Services, MCOs are responsible for educating Members about the availability of Non-capitated Services, and for providing appropriate referrals for Members to obtain or access these services. The MCO is responsible for informing Providers that bills for all Non-capitated Services must be submitted to HHSC's Claims Administrator for reimbursement.

Members Access to Behavioral Health Services

- 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 disorder.
- Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care.
- Are furnished in the most appropriate and least restrictive setting in which services can be safely provided.
- Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered.
- Are not experimental or investigative.
- Are not primarily for the convenience of the member or provider.

Carelon provides medically necessary covered services to all members beginning on the member's date of enrollment, regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior healthcare services. We do not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any member.

Other elements of members receiving behavioral health services are:

- Member may self-refer to any network behavioral health provider.
- Member has the right to obtain medication from any network pharmacy.
- A primary care provider may refer a member to a behavioral health provider if the behavioral health services needed are outside the scope of their practice, but PCP referral is never required for behavioral health services.
- There will be coordination between behavioral health and physical health services.
- Member as the right to obtain a second opinion; medical records and referral information must be documented using the DSM-V multi-axial classification.
- An authorization to release confidential information, such as medical records regarding treatment, should be signed by the member or guardian prior to receiving care from a behavioral health provider.
- Members under the age of 21 will be provided inpatient psychiatric services who have been ordered to receive the services by a court of competent jurisdiction.
- Coordination will be conducted with the LMHA and state psychiatric facilities regarding admission and discharge planning, treatment objectives, and projected length of stay for members committed by a court of law to a state psychiatric facility.
- Assessment documents for behavioral health will be made available for the use of primary care providers.
- Carelon and PCHP will work together to ensure that quality behavioral health services are provided to all members. This coordination will include monitoring, outreach and educational opportunities for providers including seminars for BH provider toolkit and BH access.

- Provider will contact the member within 24 hours of a missed appointment for the purpose of re-scheduling.
- Members who are discharged from an inpatient psychiatric facility will have a follow-up appointment within seven days from the date of discharge.

Attention Deficit Hyperactivity Disorder (ADHD) Covered Services

ADHD covered services eligible for reimbursement include:

- Outpatient counseling services for the management of ADHD symptoms to include coping skills and psychoeducation.
- Medication Management with psychiatric providers

Primary Care providers should have a strategy for diagnosing and offering long-term management of ADHD. Providers can discuss the efficacy of using medication to manage ADHD diagnosis with their patients.

Follow-up appointments should be made at least monthly util the child's symptoms have been stabilized. Once the child is stable, AAP guidelines recommend, and office visit every 3 to 6 months to assess learning and behavior.

Emergency Transportation

Parkland Community Health Plan does not require prior authorization or notification when Member presents with an emergency medical condition or an emergency behavioral condition for emergency room or ambulance services.

Ambulance Transportation

Parkland Community Health Plan covers emergency and medically necessary nonemergency ambulance transportation.

- Emergency Ambulance Transportation In the event a Member's condition is life-threatening or potentially life-threatening and requires the use of special equipment, life support systems and close monitoring by trained attendants while in route to the nearest medical facility, the ambulance transport is considered an emergency service and does not require Parkland Community Health Plan prior authorization.

Facility to facility transportation is considered emergent when meeting the definition found in 1 TAC §353.2. Facility to facility transport is considered emergent when the service is not eligible at the first facility.

- Non-Emergency Ambulance Transportation Non-emergency ambulance transportation is defined as ambulance transport provided for a Parkland Community Health Plan Member to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the Member's home after discharge when the Member has a medical condition such that the use of ambulance is the only appropriate means of transportation. Non-emergency ambulance transportation services must be prior authorized and coordinated by Parkland Community Health Plan before an ambulance is used to transport a Member in circumstances not involving an emergency.

The Ambulance Provider is responsible for ensuring the prior authorization was approved prior to transport as nonpayment will result without a prior authorization. Retrospective review may be performed to ensure that documentation supports the medical necessity of the transport.

Nonemergency Medical Transportation (Nemt) Services

What are NEMT services?

NEMT services provide transportation to covered health care services for Medicaid Members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. NEMT services do NOT include ambulance trips.

What services are part Non-Emergent Transportation (NEMT)

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be the Member, the Member's family member, friend, or neighbor.
- Members 20 years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain covered health care service. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.

- Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.

- Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

- For Members age 20 and younger, the MCO must authorize advanced funds to be used to purchase gas, meals, or lodging prior to the trip if the Member requires these funds in advance to access necessary Health Care Services. All other ITP requirements apply in these circumstances.

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

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

If you have a member, you think would benefit from receiving NEMT services, please refer him or her to Parkland at 1-888-667-7890 (HEALTHfirst) or 1-800-357-3162 (KIDSfirst) for more information.

Reporting Abuse, Neglect, Or Exploitation (ANE)

Medicaid Managed Care

Report Suspected Abuse, Neglect, And Exploitation:

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

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

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

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

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

Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at www.txabusehotline.org

Report to Local Law Enforcement:

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

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, HHSC, or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, HHSC, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).

- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

The Provider must provide the MCO with a copy of the abuse, neglect, and exploitation report findings within one Business Day of receipt of the findings from the Department of Family and Protective Services (DFPS).

Coordination With Texas Department of Family And Protective Services (DFPS)

Provider must coordinate with DFPS and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of DFPS and must respond to requests from DFPS, including:

- Providing Medical Records
- Recognition of abuse, neglect, and appropriate referral to DFPS

Member Complaint Process

A Member, or members' representative can file a complaint with Carelon verbally or by contacting a Member Advocate.

- Submit a complaint by phone:
  - Member Service: 800-945-4644
    TTY 711 (for members with hearing or speech loss)
- Submit a complaint by email: Corporate_CnG@carelon.com
- Submit a complaint by mail:
  - Carelon Behavioral Health, Inc.
    Attn: Member Complaint Department - Texas Medicaid
    P.O. Box 989 Latham, NY 12110

Member complaints will be reviewed and responded to, in writing, within 30 calendar days of receipt.

Carelon stores all the documentation related to Providers Complaints in a digital database. This includes retention of fax cover pages, emails to and from Carelon and maintaining a log of telephone communications.

Carelon stores all the documentation related to Provider Claim Appeals in a digital database. This includes retention of fax cover pages, emails to and from Carelon and maintaining a log of telephone communications.

Other options for filing a complaint

How to File a Complaint with the Texas Health and Human Services Commission

If a STAR member or provider is still not satisfied after completing Carelon's complaint or appeal process, the member may file a complaint directly with the Texas Health and Human Services Commission (HHSC).

- **Submit a complaint by phone:**
  Toll-free: 877-787-8999
  TTY (for hearing and speech impaired): 800-735-2989 or National Relay Service 711

- **Submit a complaint by email:** HPM Complaints@hhsc.state.tx.us

- **Submit a complaint by mail:**
  Texas Health and Human Services Commission Office of the Ombudsman, MC H-700
  P.O. Box 13247
  Austin, TX 78711-3247

If a CHIP member or provider is still not satisfied after completing Carelon's complaint or appeal process, the member may file a complaint directly with Texas Department of Insurance (TDI)

Texas Department of Insurance Consumer Protection (111-1A)
P.O. Box149091
Austin, Texas 78714-9091
Phone: 512-463-6500 or 800-252-3439
Fax: 512-475-1771
Email ConsumerProtection@tdi.state.tx.us

Members and Providers must exhaust the HMO's Complaint Process prior to contacting HHSC.

Member Appeal Process

An appeal is a request by a member or Provider to have Carelon reconsider an adverse determination. Anytime an authorization is denied in whole or part a letter is mailed to both the member and provider notifying of this decision as well as how to file an appeal. Two types of appeals are explained in detail in this chapter:

- Standard Appeals- A Standard Appeal is when a member or his or her authorized representative requests that Carelon reconsiders the denial of a service or payment for services, in whole or in part.
    - Standard appeals will be reviewed and a decision rendered within 30 calendar days.
- Expedited Appeals - A member may request an Expedited Appeal when the amount of time necessary to participate in a standard appeal process could jeopardize the member's life, health or ability to attain, maintain or regain maximum function.
    - Expedited appeals will be reviewed and a decision rendered within 72 hours of the request.

Timeframes for the appeals process

Appeals must be received 60 days from the date the **Member *Notice* of *Adverse Benefit Determination - Flyer*** is mailed.

Members may be able to keep getting services during the appeal process by checking yes where it says "Do you want services to continue?" on the health plan appeal request form. You can also contact Carelon at 1-800-945-4644 to request services continue during the appeal process. If the appeal is not overturned, the member may be responsible for paying for the services received during the appeal. This request must be made within 10 days of the date the notice is mailed.

Upon receipt of the appeal request orally or in writing, Carelon will send a letter within 5 business days acknowledging the request. A decision will be sent, in writing, within 30 calendar days of the request being received.

If more time is needed to submit information to Carelon that may help the appeal; a request can be made to extend the appeal decision date for an additional 14 days.

Carelon will send, in writing, the decision to either approve or deny the appeal. We will also include information about the right to a state fair hearing and external medical review. If a member chooses to request a state fair hearing, that request must be received no later than 120 days after the appeal decision letter is mailed.

If assistance is needed to request an appeal; whether standard or expedited the member can contact Carelon directly at:

Phone: 1-844-231-7949

Fax: 781-994-7636

Email: Woburn.appeals@carelon.com

Member request for State Fair Hearing only

Can a Member ask for a State Fair Hearing?

If a Member, as a member of the health plan, disagrees with the health plan's decision, the Member has the right to ask for a State Fair Hearing. The Member may name someone to represent them by contacting the health plan and giving the name of the person the Member wants to represent him or her. A provider may be the Member's representative if the provider is named as the Member's authorized representative. The Member or the Member's representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter that tells of the decision being challenged. If the Member does not ask for the State Fair Hearing within 120 days, the Member may lose his or her right to a State Fair Hearing. To ask for a State Fair Hearing, the Member or the Member's representative should either send a letter to the health plan at PO Box 1856, Hicksville, NY 11802-1856, call 1-800-945-4644, or fax 781-994-7636.

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

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

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

Member request for an External Medical Review and State Fair Hearing

Can a Member ask for an External Medical Review?

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

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to Carelon Behavioral Health by using the address or fax number at the top of the form.
- Call the MCO at 1-800-945-4644
- Email the MCO at Woburn.appeals@carelon.com; or
- Fax 781-994-7636

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

The Member, the Member's authorized representative, or the Member's LAR may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. The Member, the Member's authorized representative, or the Member's LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing the Member can also request the Independent Review Organization to be present at the State Fair Hearing. The Member can make both of these requests by contacting the Member's MCO at 1-800-945-4644 or the HHSC Intake Team at EMR Intake Team@hhsc.state.tx.us.

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

Can a Member ask for an emergency External Medical Review?

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

7. MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights and Responsibilities - STAR Members

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect.
    b. 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:
    a. Be told how to choose and change your health plan and your primary care provider.
    b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
    c. Change your primary care provider.
    d. Change your health plan without penalty.

e. 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:

    a. 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.

    b. Be told why care or services were denied and not given.

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:

    a. Work as part of a team with your provider in deciding what health care is best for you.

    b. Say yes or no to the care recommended by your provider.

5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:

    a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.

    b. Get a timely answer to your complaint.

    c. Use the plan's appeal process and be told how to use it.

    d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.

    e. 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:

    a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.

    b. Get medical care in a timely manner.

    c. 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.

    d. 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.

e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do or is to punish you.

8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

MEMBER RESPONSIBILITIES:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:

    a. Learn and understand your rights under the Medicaid program.
    b. Ask questions if you do not understand your rights.
    c. 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:

    a. Learn and follow your health plan's rules and Medicaid rules.
    b. Choose your health plan and a primary care provider quickly.
    c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
    d. Keep your scheduled appointments.
    e. Cancel appointments in advance when you cannot keep them.
    f. Always contact your primary care provider first for your non-emergency medical needs.
    g. Be sure you have approval from your primary care provider before going to a specialist.
    h. 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:

    a. Tell your primary care provider about your health.
    b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
    c. Help your providers get your medical records.

4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:

    a. Work as a team with your provider in deciding what health care is best for you.
    b. Understand how the things you do can affect your health.
    c. Do the best you can to stay healthy.
    d. Treat providers and staff with respect.
    e. Talk to your provider about all of your medications.

Member Rights and Responsibilities - CHIP Members

MEMBER RIGHTS:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.

2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."

3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.

4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.

5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.

6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.

7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.

8. Children who are diagnosed with special health care needs or a disability have the right to special care.

9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.

10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.

11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment, depending on your income. Co-payments do not apply to CHIP Perinatal Members.

12. You have the right and responsibility to take part in all the choices about your child's health care.

13. You have the right to speak for your child in all treatment choices.

14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.

15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.

16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.

17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.

18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

19. You have a right to know that you are only responsible for paying allowable co-payments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

MEMBER RESPONSIBILITIES

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

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.

2. You must become involved in the doctor's decisions about your child's treatments.

3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.

4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.

5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.

6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.

7. If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.

8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.

9. Talk to your child's provider about all of your child's medications.

8. PARTICIPATING PROVIDER COMPLAINTS AND GRIEVANCES

Provider Complaint Process

Participating provider complaints regarding issues other than those related to the terms of the provider agreement and/or performance under the provider agreement (e.g., service complaints, complaints about Carelon's policies and procedures or the policies and procedures applicable to a specific client benefit plan or government-sponsored health benefit program, etc.) should be directed to:

- **Submit a complaint by phone:**
  Parkland Hotline: 800-945-4644
  TTY 711 (for members with hearing or speech loss)

- **Submit a complaint by email:** TexasProviderRelations@carelon.com

- **Submit a complaint by mail:**
  Carelon Behavioral Health, Inc.
  Attn: Provider Complaint Department - Texas Medicaid
  P.O. Box 989 Latham, NY 12110

Provider complaints will be reviewed and responded to, in writing, within 30 calendar days of receipt.

Carelon stores all the documentation related to Providers Complaints in a digital database. This includes retention of fax cover pages, emails to and from Carelon and maintaining a log of telephone communications.

Carelon stores all the documentation related to Provider Claim Appeals in a digital database. This includes retention of fax cover pages, emails to and from Carelon and maintaining a log of telephone communications.

Other options for filing a complaint

How to File a Complaint with the Texas Health and Human Services Commission

If a STAR member or provider is still not satisfied after completing Carelon's complaint or appeal process, the member may file a complaint directly with the Texas Health and Human Services Commission (HHSC).

- **Submit a complaint by phone:**
  Toll-free: 877-787-8999
  TTY (for hearing and speech impaired): 800-735-2989 or National Relay Service 711

- **Submit a complaint by email:** HPM Complaints@hhsc.state.tx.us

- **Submit a complaint by mail:**
  Texas Health and Human Services Commission Office of the Ombudsman, MC H-700
  P.O. Box 13247
  Austin, TX 78711-3247

If a CHIP member or provider is still not satisfied after completing Carelon's complaint or appeal process, the member may file a complaint directly with Texas Department of Insurance (TDI)

Texas Department of Insurance Consumer Protection (111-1A)
P.O. Box149091
Austin, Texas 78714-9091
Phone: 512-463-6500 or 800-252-3439
Fax: 512-475-1771
Email: ConsumerProtection@tdi.state.tx.us

Members and Providers must exhaust the HMO's Complaint Process prior to contacting HHSC.

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

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

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

Mail appeal requests to:
Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, Texas 78720-4077

Fraud Information

Reporting Waste, Abuse, or Fraud by A Provider or Client

Medicaid Managed Care and CHIP

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

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

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

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

- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhsc.state.tx.us/ Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:
  - MCO's name - Carelon Behavioral Health
  - MCO's office/director address
  - MCO's toll free phone Provider Services number 800-945-4644
  - Ethics and Compliance hotline 888-293-3027

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

9. CLAIMS PROCEDURES

Span of Coverage/ MCO Responsibility

The following table describes payment responsibility for Medicaid enrollment changes that occur during an Inpatient Stay, as of the Member's Effective Date of Coverage with the receiving MCO (New MCO).

	Scenario	Hospital Facility Charge	All Other Covered Services
1	Member Retroactively enrolled in MCO Program	New MCO	New MCO
2	Member prospectively moves from FFS to MCO Program	FFS	New MCO
3	Member moves between MCOs in the same Program	Former MCO	New MCO
4.	Member moves between MCO Programs	Former MCO	New MCO

The following table describes payment responsibility for Medicaid enrollment changes that occur during a stay in a residential substance use disorder treatment facility or residential detoxification for substance use disorder treatment facility (collectively, CDTF), beginning on the Member's Effective Date of Coverage with the New MCO.

	Scenario	CDTF Charges	All Other Covered Services
1	Member Retroactively enrolled in MCO Program	New MCO	New MCO
2	Member prospectively moves from FFS to MCO Program	New MCO	New MCO
3	Member moves between MCOs in the same Program	Former MCO	New MCO
4	Member moves between MCO Programs	Former MCO	New MCO

CHIP Cost-Share Table

CHIP Cost-Sharing	
	Effective July 1, 2022
Enrollment Fees (for 12-month enrollment period):	
	Charge
At or below 151% of FPL* or otherwise exempt from cost-sharing.	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50
Co-Pays (per visit):	
At or below 151% FPL	**Charge**
Office Visit (non-preventative) No Co-Pay is applied for MH/SUD Office Visits.	$5
Non-Emergency ER	$5
Generic Drug	$0
Brand Drug	$5
Facility Co-pay, Inpatient (per admission) No Co-Pay is applied for MH/SUD residential treatment services.	$35
Cost-sharing Cap	5% (of family's income)**
Above 151% up to and including 186% FPL	**Charge**
Office Visit (non-preventative) No Co-Pay is applied for MH/SUD Office Visits.	$20
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$25 for insulin, $35 for all other drugs***
Facility Co-pay, Inpatient (per admission) No Co-Pay is applied for MH/SUD residential treatment services.	$75
Cost-sharing Cap	5% (of family's income)**
Above 186% up to and including 201% FPL	**Charge**
Office Visit (non-preventative) No Co-Pay is applied for MH/SUD Office Visits.	$25

CHIP Cost-Sharing	
	Effective July 1, 2022
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$25 for insulin, $35 for all other drugs***
Facility Co-pay, Inpatient (per admission) No Co-Pay is applied for MH/SUD residential treatment services.	$125
Cost-sharing Cap	5% (of family's income)**

***There are no co-pays for who are Native Americans or Alaskan Natives.

Time Limits for Filing Claims

Carelon must receive claims for covered services within the designated filing limit:

- Within 95 days of the dates of service on outpatient claims
- Within 95 days of the date of discharge on inpatient claims
- Within 95 days of the date on the remittance and status report from the other health plan in instances where the claim was submitted to the wrong payer.

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the 95-day filing limit will be denied.

Carelon will adjudicate claims received within 30 days.

Providers have 120 days from the date of disposition to appeal the claim. Carelon will review and adjudicate the claim within 30 days of receipt of the appeal.

10. UTILIZATION MANAGEMENT

Court-Ordered Commitments

A "Court-Ordered Commitment" means a confinement of a member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C. Carelon is required to provide inpatient psychiatric services to members under the age of 21, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, related to Court-Ordered Commitments to psychiatric facilities. Carelon will not deny, reduce or controvert the medical necessity of inpatient psychiatric services provided pursuant to a Court-Ordered Commitment for members under age 21.

Service Coordination Services

Service Coordination is designed to meet the individual needs of a member with behavioral health risk and facilitate appropriate and quality care. Adults and children are identified by either direct referral to the program or by data analytics and stratified into tiers based on complexity of condition and associated risk factors. An individual's behavioral health problem is evaluated, and a case management plan is developed in collaboration with the member and whenever possible the member's providers, PCP, family members and/or caregivers, and other pertinent collateral contacts. CM interventions are generally telephonic.

Program Objectives

The overall objectives of Carelon's Service Coordination program include, but are not limited to, the following:

- Promote effective identification of members with high risk and/or complex medical/ behavioral health conditions
- Develop and implement interventions designed to improve health outcomes for identified sub- populations
- Improve coordination and support during transitions between care settings
- Coordinate with health plan care management staff and primary care physicians ensuring a member's medical and behavioral health issues are addressed in an integrated manner
- Address social determinants of health to promote likelihood of positive outcomes in the community
- Promote health, wellness, and independence through the use of self-care health management tools and resource options
- Improve medication adherence by assessing the member's knowledge of medications and performing medication reconciliation

- Decrease reliance on acute inpatient treatment and increase and maintain community tenure
- Improve member clinical outcomes and reduce costs
- Improve member experience with case management
- Improve population health

Service Coordination and Interventions

Service Coordination interventions are based on member needs and goals and may include:

- Comprehensive assessments and care planning that promotes the development of a member-centric comprehensive care plans with performance goals and shared decision making
- Assistance in locating and accessing available benefits, and behavioral health and community services.
- Linkages to peer support services
- Appointment and transportation assistance
- Education about and linkage to available state and community resources
- Coordination of care among providers, including, behavioral health providers, primary care providers, health homes and other medical providers
- Support and coordination of services during transition of care to ensure safe transitions
- Motivational interviewing to support behavior change and member engagement
- Health information and education to increase disease or condition knowledge that support adherence and self-management
- Medication Reconciliation
- Provision of condition specific self-management tools and assistance in developing self-management strategies
- Support to members and providers in the development of and adherence to crisis plans
- Interventions to address barriers to care and treatment adherence
- Attendance and participation in wrap-around meetings, case conferences, Integrated Care Team meetings, to further coordinate the member's care, when and where deemed appropriate

To reach a Service Coordinator, please contact Carelon Member Services at 1-800-945-4644.

Mental Health Rehabilitative (MHR) Services and Targeted Case Management (TCM)

Mental health targeted case management (MHTCM) services are case management services to persons within targeted groups. The target population that may receive MHTCM as part of the Texas Medicaid Program are persons, regardless of age, with a diagnosis or diagnoses of serious mental illness (SMI) or serious emotional disturbance (SED) as defined in the latest edition of the American Psychiatric Association's DSM, and who have been determined via a uniform assessment process to need MHTCM services. Persons of any age with a single diagnosis of intellectual and developmental disabilities (IDD) and related conditions, or a single diagnosis of substance use disorder (SUD) are not eligible for MHTCM services.

MHTCM consists of intensive case management and routine case management. Intensive case management services are predominantly community-based case management activities provided to the child or youth or to the LAR on behalf of the child or youth (who may or may not be present) to assist a child or youth and caregiver or LAR in obtaining and coordinating access to necessary care and services appropriate to the child or youth's needs. Routine case management services are primarily office-based case management activities that assist a person, caregiver, or LAR in obtaining and coordinating access to necessary care and services appropriate to the child's or youth's needs.

Intensive case management and routine case management are benefits for persons who are 20 years of age and younger. Intensive case management and routine case management are not payable on the same day.

Routine case management is a benefit for persons who are 21 years of age and older.

MHTCM is a benefit for persons who are 21 years of age and older (adults) and who have serious mental illness (SMI), such as schizophrenia, major depression, bipolar disorder, post-traumatic stress disorder, or other severely disabling mental disorders (excluding a single diagnosis of IDD and related disorders or a single diagnosis of SUD) that require crisis resolution or ongoing and long-term support and treatment.

Adults with a diagnosis of schizophrenia or bipolar disorder are automatically eligible for services. Adults with any other mental health diagnosis require evidence of significant difficulty functioning across one or more domains, such as work or school, to be eligible for services.

An MHTCM reimbursable session is the provision of a case management activity by an authorized case manager during a meeting with a person who is authorized to receive that specific type of case management. A billable unit of MHTCM is 15 continuous minutes of contact.

MHTCM is not payable when delivered on the same day as psychosocial rehabilitative services.

Mental health rehabilitative services are defined as providing assistance in maintaining or improving functioning and may be considered rehabilitative when necessary to help a person achieve a rehabilitation goal as defined in their plan of care. Mental health rehabilitative services are provided to a person with a serious mental illness (SMI), as defined in the latest edition of the American Psychiatric Association's (APA's) Diagnostic and Statistical Manual of Mental Disorders (DSM).

Mental health rehabilitative services may only be provided by a member of the person's therapeutic team. The therapeutic team must include enough staff to adequately address the rehabilitative needs of persons assigned to the team.

Team members must be appropriately credentialed and have completed required trainings to provide the full array of component services, have regularly scheduled team meetings either in person or by teleconference, and every member of the team must be knowledgeable of the needs and the services available to the specific persons assigned to the team.

Psychosocial rehabilitation is not reimbursable on the same day as MHTCM services or skills training and development.

Provider Requirements for delivering MHTCM/MHR Services

- Training and certification to administer the Adult Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) assessment tools. Click here for more information on registering for all required training.
- Texas Health and Human Services Resiliency and Recovery Utilization Management Guidelines (RRUMG) are to be followed.
- Attestation from Provider entity to Carelon Behavioral Health that organization has the ability to provide, either directly or through sub-contract, the members with the full array of MHR and TCM services as outlined in the RRUMG.
- HHSC-established qualifications and supervisory protocols must be met.
- Must be a registered user of the Clinical Management for Behavioral Health Services (CMBHS) where the CANS and ANSA assessments are housed.

MH TCM/MHR services include the following:

Service Category	Procedure Codes	Modifiers
Day Program for Acute Needs	H2012	
Medication Training and Support	H0034	HQ: group services for adults HA/HQ: group services for child/youth
Crisis Intervention	H2011	HA: child/youth
Skills Training and Development	H2014	HQ: group services for adults HA: individual services for child/youth HA/HQ: group services for child/youth
Psychosocial Rehabilitation Services	H2017	TD: individual services provided by RN HQ: group services HQ/TD: group services provided by RN ET: individual crisis services

In Lieu of Services - In the 2016 Medicaid and CHIP managed care final rule, CMS finalized 42 CFR § 438.3(e)(2)1 that formally recognized states' and managed care plans' abilities to cover services or settings that are substitutes for services or settings covered under the state plan (also known as ILOS).

The following services are considered In Lieu of Services (ILOS) and allowed under certain conditions.

Inpatient Services in an Institution of Mental Disease (IMD): Services include hospitalization at an IMD in lieu of an acute care inpatient hospital setting. Inpatient services in an IMD are to treat acute psychiatric conditions and are allowed for up to 15 calendar days per month for members aged 21-64 only.

Partial Hospitalization Services: Partial hospitalization services provide a structured day program of outpatient behavioral health services. Partial Hospitalization Programs (PHPs) may provide services for mental health, SUD, or both. These services resemble highly structured, short-term hospital inpatient programs. The treatment level is more intense than outpatient day treatment or psychosocial rehabilitation.

Intensive Outpatient (IOP) Services: Intensive outpatient services, also referred to as IOP services are used to treat behavioral health issues that do not require detoxification or 24-hour supervision. IOPs are generally less intensive than PHPs. They may be delivered for mental health, SUD, or both. Intensive outpatient services are organized non-residential services providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per Day.

Coordination Specialty Care (CSC) Services: CSC is designed to meet the needs of persons with an early onset of psychosis. Persons enrolled in CSC receive mental health services that are based on a comprehensive, recovery-oriented model of treatment for persons with first-episode psychosis. CSC utilizes a shared-decision making and team-based approach to develop a plan of care tailored to the individualized needs of the person. CSC services are for people aged 15–30 who have a psychotic disorder diagnosed within the past two years and who live in the service area of a CSC provider.

Members are not required to opt into ILOS. ILOS are voluntary options for members when medically appropriate and cost-effective. Members must agree to receive ILOS before the services are provided. The intent of providing CSC, partial hospitalization services, or IOP services, as an in-lieu-of service, is to prevent or reduce inpatient hospitalization. However, there may be cases where inpatient hospitalization is medically necessary. The Member must receive the most clinically appropriate service during an episode of care.

As providers encounter members in need of in-lieu-of services, they must notify them of the availability of appropriate service(s). Providers must contact Carelon to request authorization for these services via telephone at 1-800-945-4644 or via the provider electronic portal (see Carelon PA list and resources for more information). Carelon will work with members and providers to access and authorize the services that are clinically indicated. All requests, including voluntary status, must be documented in the provider's medical record.

Members may request ILOS services directly by contacting PCHP or PCHP's material subcontractor Carelon Behavioral Health (Carelon) or providers of this service. Service Coordination teams and Utilization Management teams will offer and coordinate in-lieu-of services with members, when clinically indicated, to avoid admissions to or support the transition out of higher levels of care to offer additional service options to members. All referrals and requests will be reviewed by Carelon licensed clinicians to ensure medical necessity.

Value-Added Services – Members have access to an array of Value-Added services through Parkland Community Health Plan. For more information, please visit the Parkland Community Health website.

Those services currently include:

- 24-hour Nurse Line
- Extra Vision Services
- Extra Dental Services
- Sports Physicals
- Free Car Seats
- Free Meal Services
- Free Rides
- Free Cell Phone

Earn reward points for completing certain wellness activities listed on this website. Then, spend those points on gift cards and fun, healthy items from the Rewards Catalog.

Members can earn rewards for completing:

New Member PCP Visit

$20 value for new members who complete a PCP visit within 90 days of joining Parkland Community Health Plan.

Postpartum Visits

$60 value per pregnancy when you receive your postpartum checkup within 7-84 days of delivery while enrolled with Parkland Community Health Plan.

Member Portal Registration

$20 value for first-time member enrollment in the online Member Portal at ParklandHealthPlan.com, once per lifetime.

Health Survey Completion

$20 value when you complete Parkland Community Health Plan's yearly Health Risk Assessment.

7-day Behavioral Health Follow-Up Appt

$30 value each year when you complete a behavioral health follow-up within 7 days after hospitalization for a behavioral health diagnosis.

30-day Behavioral Health Follow-Up Appt

$20 value when you complete a behavioral health follow-up within 8-30 days after hospitalization for a behavioral health diagnosis.

Flu Vaccine

$20 value for Members getting the annual flu shot , between the months of December 2023 through August 2024.

Well Child Check-Ups

Up to $160 value for the completion of up to 6 timely well-baby checkups between ages 0-15 months and up to 2 timely well-child checkups between ages 16-30 months.

Well-Adolescent Check-Ups

$20 value to be used on either a gift card or other items from a rewards catalog when you complete a timely Well-Adolescent checkup for ages 12-18.

ADHD Management and Follow-Up Appts

$20 value annually when you receive initial medications for ADHD and receive a follow-up visit within 30 days of initiation.

Be in Control Program

Free membership in Parkland Community Health Plan's Be in Control program, with educational materials and resources to support the management of asthma and diabetes.

$20 value when you remain enrolled for 3 months in the Be in Control program.

$50 value if you are asthmatic and remain enrolled for 6 months annually in Parkland Community Health Plan's free Be in Control program.

Diabetes Management

$15 value annually for completion of a diabetic (retinal or dilated) eye exam for members 15 years and older (excludes CHIP Perinate).

$15 value for completing the HB/A1c blood test once every 6 months for diabetic Members ages 18 and older (excludes CHIP Perinate).

Step-Up Challenge

***$**30 value each year for everyone age 10 and older who completes the free 3-week Step-Up Challenge.*

Receive a FREE pedometer when you register for the Step-Up Challenge. Track your steps and meet the daily walking goals for three weeks to win the challenge.

Asthma Medication Management

$60 value for members who refill asthma medication prescription (every 60 days for 2 refills worth $10) annually.

7-day Hospital Follow-Up

$30 value annually when you complete a follow-up visit with your primary care provider within 7 days after a hospitalization discharge.

Clinical Practice Guidelines

Carelon Behavioral Health's Medical Necessity Criteria (MNC), also known as clinical criteria, are reviewed and updated at least annually to ensure that they reflect the latest developments in serving individuals with behavioral health diagnoses. Carelon Behavioral Health's Corporate Medical Management Committee (CMMC) adopts, reviews, revises and approves Medical Necessity Criteria per client and regulatory requirements. Carelon Behavioral Health Texas uses Change Healthcare's InterQual® Behavioral Health Criteria for mental health requests and the Texas Administrative Code's (TAC) criteria for Substance Use Disorder Criteria. Network providers may give advice on development or adoption of UM criteria and on instructions for applying the criteria. These comments and opinions may be received through practitioner participation on committees, provider newsletter requests for review, and by considering comments from practitioners to whom the criteria have been circulated to for input and feedback. Carelon Behavioral Health disseminates criteria sets via the provider handbook, provider forums, newsletters, Internet site, and individual training sessions. In addition, members are provided copies free of charge upon request. Each Region and/or Engagement Center (EC) has ultimate responsibility to incorporate the levels of care included in a plan's benefits into the MNC that Carelon Behavioral Health uses. Before a criteria set is approved for use within a Region and/or EC, it is reviewed by the CMMC to ensure adherence to clinical best practices guidelines and overall core criteria standards. The core set of criteria is annually approved by the CMMC. It is Carelon Behavioral Health's policy to authorize payment only for services that are medically necessary and provided for the identification and/or treatment of a member's illness. Carelon Behavioral Health uses its Medical Necessity Criteria as guidelines, not absolute standards, and considers them in conjunction with numerous factors such as age, comorbidities, complications, progress of treatment, psychosocial situations, home environment, characteristics of the local delivery system, and availability of alternative levels of care. Carelon Behavioral Health also considers the service area's ability to support the patient

after hospital discharge as well as a member's needs, strengths, and treatment history in determining the best placement for a member. Medical Necessity Criteria are applied to determine appropriate care for all members. In general, services will only be certified if the clinical presentation meets the specific medical necessity criteria for a particular level of care. However, in addition to the clinical presentation, the member's individual needs, social determinants of heath, and characteristics of the local service delivery system are also taken into consideration as well as family, community, and natural supports. UM Clinicians are trained to apply the appropriate medical necessity clinical criteria. Audits of case activity documentation of both peer advisors and clinicians are conducted on a regular basis. The audit process enables monitoring of inter-rater reliability and ensures consistency across physician reviewers and clinicians.

The audit may address the following areas:

- Timeliness of review process
- Completeness/adequacy of documentation
- Care management adherence to clinical policy guidelines.
- Consistent application of clinical criteria
- Clinical appropriateness of decision-making
- Quality and content of telephonic discussion

11. QUALITY MANAGEMENT/QUALITY IMPROVEMENT

Focus Studies and Utilization Reporting Requirements

Carelon, along with PCHP, has integrated behavioral health into its Quality Assessment and Performance Improvement (QAPI) Program to ensure a systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of behavioral health services provided to PCHP members. A special focus of these activities is the improvement of physical health outcomes resulting from behavioral health integration into the member's overall care. Carelon and PCHP will routinely monitor claims, encounters, referrals, and other data for patterns of potential over and under-utilization and target areas where opportunities to promote efficient and effective use of services exist.

12. ADDITIONAL HELPFUL RESOURCES

Eligibility and Enrollment

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

- Use TexMedConnect on the TMHP website at www.tmhp.com
- Call Provider Services at the patient's medical or dental plan

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

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

HHSC Determines CHIP and STAR Eligibility

The Texas Health and Human Services Commission (HHSC) is responsible for determining CHIP and STAR eligibility. For information regarding eligibility, contact HHSC CHIP hotline at 1-800-647-6558 or STAR hotline at 1-800-964-2777.

Role of Enrollment Broker

HHSC uses an Enrollment Broker to receive and process applications for CHIP and STAR. The enrollment broker cannot authorize or determine eligibility. The role of the enrollment broker is to ensure all required documentation and forms are gathered. Once eligibility is determined by HHSC, the enrollment broker mails out welcome letters and information on available health plans in each area. The enrollment broker receives each member's plan and Primary Care Provider (PCP) selection documentation and notifies health plans of their new members.

General Eligibility for STAR

STAR members receive a Medicaid card from the State. To confirm eligibility, providers may contact Carelon or visit the Carelon Provider portal. Providers may also call the state Automated Inquiry System (AIS) at 1-800-925-9126. Currently, members are enrolled for a twelve (12) consecutive month period.

If a STAR member loses his/her Medicaid card, he/she may obtain a temporary Medicaid form. This form is called a Temporary ID (Form 1027-A). More information regarding this temporary ID is available by calling the STAR Help Line at 1-800-964-2777.

Enrollment Process

CHIP eligibility is for 12 continuous months. HHSC or Maximus, the administrative services contractor, presents health plan options to individuals and families eligible for STAR or CHIP. STAR or CHIP eligible members enroll in the managed care program of their choice and select a primary care provider or primary care site (PCS). If HHSC does not receive enrollment information within 45 business days, it assigns the member to a STAR plan, and then submits the member information to the selected plan who assigns a PCP.

CHIP eligible members must enroll in a CHIP health maintenance organization (HMO) plan in 90 business days, or they will not be eligible for CHIP services. CHIP eligible members will not be defaulted into a plan.

HHSC will automatically re-enroll any member who loses STAR or CHIP eligibility but becomes eligible again within six months or less. Members will automatically return to the same health plan and PCP as they had prior to disenrollment, if available. Members may choose to switch plans.

Span of Eligibility (Members' Right to Change Health Plans)

CHIP members may request to change:

- For any reason within 90 business days of CHIP enrollment and once thereafter
- For cause at any time
- If the member moves to a different service delivery area
- During the annual re-election period

STAR members can change health plans by calling the Texas Medicaid Managed Care Program helpline at 1-800-964-2777. However, members cannot change from one health plan to another health plan while receiving inpatient services. If the call to change health plans is before the 15th of the month, the change will take place on the first day of the following month. If the call is after the 15th of the month, the change will take place on the first day of the second month after that.

For example: If the request to change plans occurs on or before April 15th, the change will take place on May 1st. If the request to change plans occurs after April 15th the change will take place on June 1st.

HHSC will make the final decision.

For additional information, please visit our Provider website found here.

For more information regarding Parkland Community Health Plan please visit their website here or visit their Provider Manual.