801 Seventh Avenue
Fort Worth, Texas 76104-2796
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cookchp.org

STAR Kids

Provider Manual

Tarrant Service Area
Denton, Hood, Johnson, Parker, Tarrant, Wise

August 2023

Introduction

Welcome to Cook Children's Health Plan. Thank you for joining one of the most established and respected healthcare systems in the southwest. As a valued partner in our network, we will work together to deliver an inspiring ***Promise – knowing every child's life is sacred, we promise to improve the well-being of every child in our care and our communities.***

Childhood is simple, until it isn't. When things get complicated, Cook Children's is here to help. Our Provider Manual will serve as a useful reference when working with Cook Children's Health Plan and with our shared Members who receive services through the Texas Health and Human Services Commission STAR Kids program.

Background

A century ago, the first children's hospital in Fort Worth opened with 30 beds and a promise to provide every child in the area access to medical care. From these humble beginnings, Cook Children's has grown to become one of the country's leading integrated pediatric health care systems.

Based in Fort Worth, Texas, we're proud of our long and rich tradition of serving our community. For 100 years we've worked to improve the health of children from across our primary service area of Denton, Hood, Johnson, Parker, Tarrant and Wise counties. We combine the art of caring with leading technology and extraordinary collaboration to provide exceptional care for every child. This has earned Cook Children's a strong, far- reaching reputation with patients traveling from around the country and the globe to receive life-saving pediatric care.

Our not-for-profit organization is comprised of eight companies, including our Medical Center, Physician Network, Home Health Company, Northeast Hospital, Pediatric Surgery Center, Health Plan, Health Services Inc., and Health Foundation. With more than 60 primary, specialty and urgent care locations throughout Texas, families can access our top-ranked specialty programs and network of services to meet the unique needs of their child.

Cook Children's Health Plan

Since 1998, Cook Children's Health Plan has provided essential coverage to low-income families in our six-county service area who qualify for government-sponsored programs, including Medicaid STAR Kids. Enrollment in Medicaid and CHIP has grown to more than 120,000 Members, including children and expectant mothers. Members receiving services associated with STAR, STAR

Kids and CHIP are supported by a plan network of more than 570 doctors, more than 1,300 specialists and 43 hospitals. In November 2016, STAR Kids was integrated into Cook Children's Health Plan.

Objectives of Program

Cook Children's Health Plan is committed to providing services for children with disabilities who have Medicaid coverage to:

- Improve coordination and customization of care
- Increase Access to care
- Improve health outcomes
- Improve quality of care

Continually strive to improve both Member and Provider satisfaction.

Quick Reference Phone List

Topic	Description
General Correspondence Address	Cook Children's Health Plan P.O. Box 2488 Fort Worth, TX 76113-2488 Website: cookchp.org
Member Services Telecommunication Device for the Deaf (for deaf or hearing impaired)	For verification of eligibility and benefits: Toll Free: 888-243-3312 Fax : 682-885-8401 Email: CCHPCustomerScv@cookchildrens.org TTY/TDD: 682-885-2138 TTY/TDD Toll Free 844-644-4137 Our representatives speak English and Spanish to help you. We have an interpreter service that can help with other languages at no cost.
Care Management	For Prior Authorizations, Medical Necessity Denials & Appeals, Case Management, Baby Steps Program, and Disease Management: Toll Free: 888-243-3312 TTY/TDD: 682-885-2138 TTY/TDD Toll Free 844-644-4137 STAR Kids Fax: 682-303-0005 STAR Kids Toll Free Fax: 844-843-0005 Email: CCHPPriorAuthorizations@cookchp.org Our representatives are available 8:00 a.m. to 5:00 p.m. Monday to Friday, except for state holidays. Interpreter Services and TTY/TDD are available for Utilization Management questions.

	For Emergencies after hours/weekends, Members should call 9-1-1 or go to the nearest emergency department. If the Member is experiencing a behavioral health crisis the Member should call 833-391-3733 (crisis line number available 24 hours 7 days a week). If the call is not an emergency, leave a message and your call will be returned the next business day Pharmacy assistance is available 8:00 a.m. to 5:00 p.m. Monday to Friday, except for state holidays.
Claims and Billing	For claim status, payment inquiries, and appeals: Toll Free: 888-243-3312 Fax: 682-885-8404 To submit paper claims: Cook Children's Health Plan Attention: Claims Department P.O. Box 21271 Eagan, MN. 55121-0271 To submit appeals: Cook Children's Health Plan Attention: Claims Department PO Box 2488 Fort Worth, TX 76113-2488 Fax: 682-885-8404 Email: CCHPClaimAppeals@cookchildrens.org
Compliance	Member and Provider Complaints or to report Fraud, Waste and Abuse: Toll Free: 888-243-3312 Email: CCHPCompliance@cookchildrens.org

Network Development	For credentialing, contracting, Provider demographic updates and changes: Toll Free: 888-243-3312 Fax: 682-885-8403 Email: CCHPNetworkDevelopment@cookchildrens.org
Outreach	Questions about Migrant Farm Workers, Texas Health Steps and Well Child Appointments: Toll Free: 888-243-3312 Fax: 682-303-2244 Email: OutreachCCHP@cookchildrens.org
Provider Relations	Provider Education and Training Toll Free: 888-243-3312 Fax: 682-885-8436 Email: CCHPProviderRelations@cookchildrens.org
Vision Services National Vision Administrators	Toll Free: 888-830-5630 Fax: 888-830-5560 Email: Providers@e-nva.com
Pharmacy Navitus Help Desk	Toll Free: 877-908-6023 Fax: 866-808-4649 Email: ProviderRelations@navitus.com Website: Navitus.com
Dental Services DentaQuest MCNA United Healthcare Dental	Medicaid (STAR) Members under the age of 21 Toll Free: 800-516-0165 Toll Free: 855-691-6262 Toll Free: 877-901-7321
Dental Value Add Liberty Dental	Toll Free: 888-902-0349 TTY/TDD Toll Free: 866-222-4306
Nurse Advice Line	Toll Free: 888-830-5630

Childhood Lead Poisoning Prevention DSHS	Phone: 888-830-5630
Comprehensive Care Program TMHP	Toll Free: 800-925-9126
Critical Incident Reporting	Fax: 682-885-8494 Email: CCHPQualityImprovement@cookchildrens.org
Department of Assistive and Rehabilitative Services Inquiries	Toll Free: 800-628-5115
Department of Family and Protective Services	Toll Free: 800-252-5400
Early Childhood Intervention	Toll Free: 800-628-5115
Family Planning Program	Phone: 512-458-7796
HHSC Help Line (Members)	Toll Free: 800-252-8263
HHSC Vendor Drug Services (Providers only)	Toll Free: 800-435-4165
Maximus Enrollment Broker	Toll Free: 877-782-6440
Medical Transportation Program	Toll Free: 877-633-8747
Office of the Inspector General Hotline	Medicaid Fraud & Abuse Toll Free: 800-436-6184
Texas CHIP Program Helpline	Toll Free: 800-647-6558
Texas Health Steps Program	Toll Free: 877-847-8377
Texas Medicaid Managed Care Helpline	Ombudsman Managed Care Assistance Team Toll Free: 866-566-8989

	TTY/TDD: 866-222-4306
Texas Medicaid & Healthcare Partnership	Toll Free: 800-925-9126 Toll Free: 888-863-3638 Website: tmhp.com
Texas Vaccines for Children Program	Toll Free: 800-252-9152
To enroll as a Healthy Texas Women Provider	Toll Free: 800-925-9126 Website: tmhp.com
To enroll as a Texas Health Steps Provider call TMHP	Toll Free: 800-925-9126 Website: tmhp.com
Women, Infants, and Children Nutrition Program	Toll Free: 800-942-3678

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Section 1: Provider Responsibilities

Primary Care Provider Responsibilities

Role of the Primary Care Provider

Primary Care Providers (PCP) are responsible for furnishing all primary care related services within the scope of the Provider's practice and are responsible for arranging and coordinating referrals for all medically necessary health care services required by the Member.

STAR Kids Primary Care Providers in the Cook Children's Health Plan network are located in and around the following counties:

- Tarrant, Wise, Johnson, Parker, Hood and Denton
- The following Provider types may serve as Primary Care Providers:
- Pediatricians
- Family/General Practice
- Internists
- Obstetrics/Gynecologists (OB/GYN)
- Advanced Practice Nurses
- When practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology
- Certified Nurse Midwives (CNM)
- When practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology
- Physician Assistants (PAs)
- When practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Community Clinics
- Specialist Physicians
    - Who are willing to provide a medical home to selected Members with special needs and conditions

Primary Care Provider Medical Home Responsibilities

A Primary Care Provider must assess the medical and behavioral health needs of Members for referral to Specialty Care Providers (SCP), provide referral care as needed, coordinate the Member's care with Specialty Providers after the referral, and serve as a Medical Home to Members. The Medical Home concept establishes a relationship between the Primary Care Provider and the patient in which the physician provides comprehensive primary care to the patient and facilitates partnerships between the physicians, Member, acute care and other care Providers when appropriate.

Note: Dual Eligible STAR Kids Members are not required to have a Primary Care Provider.

Through the medical home, the Member has an ongoing relationship with the physician who is trained to be the first contact for the Member and to provide continuous and comprehensive care. The physician is responsible for providing all of the care the Member needs or for coordinating with other qualified Providers to provide care including preventative care, acute care, chronic care and end of life care.

Primary Care Providers who provide covered services for STAR Kids Members must either have admitting privileges at a hospital that is part of the Cook Children's Health Plan Provider Network, or make referral arrangements with an in network Provider who has admitting privileges to a network hospital.

Role of a Health Home

Cook Children's Health Plan is committed to providing a consistent and integrated source of healthcare for our STAR Kids Members through a person-centered Health Home. Primary Care Providers coordinate with Members, caregivers, other Providers, STAR Kids Service Coordinators, and state and non-state entities to assure that the Member's medical and behavioral health needs are met. Other Primary Care Provider requirements include screening, identification, and referral to medically necessary or functionally necessary covered services and assessment and coordination of non-clinical services that impact the Member's health. Cook Children's Health Primary Care Providers must provide patient and family-centered care that serves the goals of improving Member care, outcomes, and satisfaction.

Primary Care Provider Medical Home vs Health Home

The medical home and health home models are similar in nature in promoting well-coordinated, patient-centered, high quality and effective care. Although the terms often are used interchangeably, distinction between the two should be noted. The health home model of service delivery expands on the medical home model by enhancing coordination and integration of medical and behavioral health care to better meet the needs of patients,

particularly those with multiple chronic conditions.

Specialty Care Provider Responsibilities

Role of the Specialty Care Provider

The Specialty Care Provider provides diagnostic treatments and/or management options, tests and treatment plans, as requested by the Primary Care Provider. Primary Care and Specialty Care Providers shall work together to maintain ongoing communication regarding the Member's care and treatment. Specialty Care Providers shall offer Member access to covered services twenty-four hours a day seven days a week. Such access shall include regular office hours on weekdays and availability by telephone outside of such regular hours including weekends and holidays.

Designate a Specialist as a Primary Care Provider

Specialist Physicians may be willing to provide a medical home to selected Members with special needs and conditions. Members that have disabilities, special health care needs, chronic or complex health care needs have the right to request a Specialist Physician as a Primary Care Provider. Members, their legally authorized representative or Primary Care Providers, or the Member's designee may initiate the request. In order to accept such a request, the Specialist Physician must agree to provide all primary care services, (i.e. immunizations, well child care/annual check-ups, coordination of all health care services required by the Member).

The Member or their Legally Authorized Representative (LAR) must also sign the agreement. The Cook Children's Health Plan Medical Director reviews and determines Cook Children's Health Plan approval for Specialist (physician) as a Primary Care Provider. The request form to be used for review and approval of a Specialist to act as a Primary Care Provider is located in the Appendix section of this Provider Manual.

Network Limitations

Cook Children's Health Plan Members must seek services from Cook Children's Health Plan network Providers. Providers may refer to any contracted specialist or OB/GYN within the Cook Children's Health Plan network. Providers must ensure that all necessary prior authorizations are obtained prior to providing services. To determine if a covered service requires a prior authorization Providers may use the Prior Authorization Lookup tool located on our website at cookchp.org. Network Providers should submit a prior authorization request through our Secure Provider Portal. Out-of-network Providers may refer to the Prior Authorization Request Form located on our website cookchp.org.

This section does not apply to STAR Kids Dual Eligible Members.

Verifying Member Eligibility

Prior to providing care to Members, Providers are responsible for verifying a Member's eligibility, identifying which health plan a Member is assigned to, identifying the name of the assigned Primary Care Provider and verifying covered services and whether they require prior authorization. Additional information on verifying eligibility is located in the Member Enrollment and Eligibility section of this Provider Manual.

Availability and Accessibility

Appointment Availability

Access to Primary Care Providers, Specialty Care Providers, Ancillary Providers, Behavioral Health Providers, and Network Facility Providers must be available to Members for routine, urgent, and emergent care as follows:

Waiting times for appointments:

- Emergency services must be provided upon Member presentation at the service delivery site, including at non-network and out of area facilities.
- Treatment for an urgent condition, including urgent specialty care, must be provided within twenty-four hours.
- Routine primary care must be provided within fourteen calendar days.
- Routine specialty care must be provided within twenty-one calendar days.
- Initial outpatient behavioral health visits must be provided within ten calendar days.
- Initial outpatient behavioral health visits must be provided within seven calendar days upon discharge from an inpatient psychiatric setting.
- Community-based services for non-MDCP STAR Kids Waiver Members must be initiated within seven calendar days from the date the health plan authorizes services unless the referring Provider or Member states otherwise.
- Primary Care Providers must make referrals for specialty care on a timely basis, based on the urgency of the Member's medical condition, but no later than five calendar days.
- Prenatal care must be provided within fourteen calendar days, except for high-risk pregnancies or new Members in the third trimester, for whom an appointment must be offered within five days, or immediately, if an emergency exists.
- Preventive health services for adults must be offered within ninety days.
- Preventive health services for children, such as Texas Health Steps medical checkups must be offered in accordance with the Texas Health Steps periodicity schedule published in the Texas Medicaid Provider Procedures Manual.
    - For a new Member birth through age twenty, overdue or upcoming Texas Health Steps medical checkups, must be offered as soon as practicable, but

in no case later than fourteen calendar days of enrollment for newborns, and no later than ninety days of enrollment for all other eligible child Members

- The Texas Health Steps annual medical checkup for an existing Member age thirty six months and older is due on the child's birthday
- The annual medical checkup is considered timely if it occurs no later than three-hundred sixty four calendar days after the child's birthday

After Hours Access

Primary Care Providers must be accessible to Members twenty-four hours a day, seven days a week. It is important to keep Cook Children's Health Plan updated with changes to your on-call Providers. The answering service or paging mechanism must provide a response to a Member call within thirty minutes.

Acceptable After-Hours Coverage:

The following are acceptable and unacceptable telephone arrangements for contacting Primary Care Providers after their normal business hours:

- The office telephone is answered after-hours by an answering service that meets language requirements of the major population groups and that can contact the Primary Care Provider or another designated medical practitioner.
    - All calls answered by an answering service must be returned within thirty minutes.
- The office telephone is answered after normal business hours by a recording in the language of each of the major population groups served, directing the Member to call another number to reach the Primary Care Provider or another Provider designated by the Primary Care Provider.
    - Someone must be available to answer the designated Provider's telephone. Another recording is not acceptable.
- The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the Primary Care Provider or another designated medical Provider, who can return the call within thirty minutes.

Unacceptable after-hours coverage:

- The office telephone is only answered during office hours
- The office telephone is answered after-hours by a recording that tells Members to leave a message
- The office telephone is answered after-hours by a recording that directs Members to go to an Emergency Room for any services needed
- Returning after-hours calls outside of thirty minutes

Monitoring Access

Cook Children's Health Plan is required to systematically and regularly verify that covered services furnished by network Providers are available and accessible to Members in compliance with the standards established by the Health and Human Services Commission. The survey must be conducted each fiscal year and will include verification of Provider directory information and monitor adherence to Provider requirements. Providers are required to complete the mandatory survey.

At a minimum, the challenge survey will include verification of the following elements:

- Provider name
- Address
- Phone number
- Office hours
- Days of operation
- Practice limitations
- Languages spoken
- Provider type / Provider specialty
- Length of time a patient must wait between scheduling an appointment and receiving treatment
- Accepting new patients (Primary Care Providers only)
- Texas Health Steps Provider (Primary Care Providers only)

Cook Children's Health Plan will enforce access and other network standards as required by the Health and Human Services Commission and take appropriate action with noncompliant Providers.

Routine, Urgent and Emergency Services

Cook Children's Health Plan follows the Texas Health and Human Services Commission definition of emergency medical condition and emergency behavioral health condition. Based on the following definitions, Cook Children's Health Plan Members may call 911 or seek care from any Provider in an office, clinic, or emergency room. Treatment for emergency conditions does not require prior authorization or a referral from the Member's Primary Care Provider. Emergency Care staff should contact the Member's Primary Care Provider or Cook Children's Health Plan toll free at 888-243-3312 if a Member presents with a non-emergent condition.

Routine Care

Routine Care means health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent. A non-emergent condition is a condition that is neither acute nor severe and can be diagnosed and treated immediately, or that

allows adequate time to schedule an office visit for a history, physical or diagnostic studies prior to diagnosis and treatment.

Urgent Condition

Urgent Condition means a health condition including an urgent behavioral health situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within twenty-four hours by the Member's Primary Care Provider or Primary Care Provider designee to prevent serious deterioration of the Member's condition or health.

Urgent Behavioral Health Situation

Urgent behavioral health situation means a behavioral health condition that requires attention and assessment within twenty-four 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 Medical Condition

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

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- In the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child

Emergency Prescription Supply

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

The seventy-two hour emergency supply should be dispensed any time a prior authorization cannot be resolved within twenty-four hours for a medication on the vendor drug program

formulary that is appropriate for the Member's medical condition. If the prescribing Provider cannot be reached or is unable to request a prior authorization, the pharmacy should submit an emergency seventy-two hour prescription.

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

To be reimbursed for a seventy-two hour emergency prescription supply, pharmacies should submit the following information:

- "8" in 'Prior Authorization Type Code' (field 461-EU)
- "801" in 'Prior Authorization Number Submitted' (field 462-EV)
- "3" in 'Days Supply' (field 405-D5 in the Claim segment of the billing transaction)
- The quantity submitted in 'Quantity Dispensed' (field 442-E7) should not exceed the quantity necessary for a three day supply according to the directions for administration given by the prescriber
- If the medication is a dosage form that prevents a three day supply from being dispensed, e.g. an inhaler, it is still permissible to indicate that the emergency prescription is a three day supply, and enter the full quantity dispense

Please consult the Vendor Drug Program Pharmacy Provider Procedures Manual, the Texas Medicaid Provider Procedures Manual and this Provider Manual section for information regarding reimbursement of seventy-two hour emergency supplies of prescription claims. It is important that pharmacies understand the seventy-two hour emergency supply policy procedure to assist Medicaid clients.

Call Navitus toll free 877-907-6023 for more information about the seventy-two hour emergency prescription supply.

Emergency Behavioral Health Condition

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:

- Requires immediate intervention and/or medical attention without which Members would present an immediate danger to themselves or others, or;
- Renders Members incapable of controlling, knowing or understanding the consequences of their actions.
- Care for non-life-threatening emergency must be treated within six hours.

Cook Children's Health Plan will pay for professional, facility, and ancillary services provided in a hospital emergency department that are medically necessary to perform the medical

screening examination and stabilization of a Member presenting with an emergency medical condition or an emergency behavioral health condition, whether rendered by in network Providers or out-of-network Providers.

Cook Children's Health Plan will pay for post-stabilization care services obtained within or outside the network that are not pre-approved by a Provider or other health plan representative, but administered to maintain, improve, or resolve the Member's stabilized condition if:

- Cook Children's Health Plan does not respond to a request for pre-approval within one hour.
- Cook Children's Health Plan cannot be contacted.
- Cook Children's Health Plan representative and the treating physician cannot reach an agreement concerning the Member's care and a network physician is not available for consultation. In this situation, the health plan will give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached.
    - The health plan's financial responsibility ends as follows:
- The network physician with privileges at the treating hospital assumes responsibility for the Member's care.
- The network physician assumes responsibility for the Member's care through transfer.
- The health plan representative and the treating physician reach an agreement concerning the Member's care.
- The Member is discharged.

Cook Children's 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.

Emergency Dental Services

Medicaid Emergency Dental Services

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

- Treatment of a dislocated jaw, traumatic damage to teeth and supporting structures, removal of cysts.
- Treatment of oral abscess of tooth or gum origin and;

- Treatment and devices for correction of craniofacial anomalies and drugs.

Non-Emergency Dental Services

Medicaid Non-emergency Dental Services

Cook Children's Health Plan is not responsible for paying for routine dental services provided to Medicaid Members. These services are paid through Dental Managed Care Organizations.

Cook Children's Health Plan is responsible for paying for treatment and devices for craniofacial anomalies and of Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for Members age six months through thirty-five months.

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

- OEFV is billed by Texas Health Steps Providers on the same day as the Texas Health Steps medical checkup.
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
- Documentation must include all components of the OEVF.
- Texas Health Steps Providers must assist Members with establishing a Main Dental Home and document Member's Main Dental Home choice in the Member's file.

Cook Children's Health Plan is responsible for paying for treatment and devices for craniofacial anomalies.

Additional information on Oral Evaluation and Fluoride Varnish can be found in the Texas Health Steps section of this Provider Manual.

Durable Medical Equipment and Other Products Normally Found in a Pharmacy

Cook Children's Health Plan reimburses for Durable Medical Equipment (DME) and products commonly found in a pharmacy. Refer to the Texas Medicaid Provider Procedures Manual, Durable Medical Equipment (DME) and Comprehensive Care Program (CCP) sections for additional information regarding the scope of coverage of Durable Medical Equipment and other products commonly found in a pharmacy. For all qualified Members, this includes medically necessary items such as nebulizers, ostomy supplies or bedpans, and other supplies and equipment. For children and young adults (birth through age twenty (20)), Cook Children's Health Plan 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 durable medical equipment or other products normally found in a pharmacy for children (birth through age twenty), a pharmacy must be enrolled directly with Cook Children's Health Plan on a medical services agreement. Pharmacies that would like to contract directly with Cook Children's Health Plan to dispense covered DME may contact Cook Children's Health Plan Network Development at 888-243-3312. Once contracted, claims for these supplies are submitted to Cook Children's Health Plan. Please refer to the Claims and Billing section of this Provider Manual for additional information related to claim submission.

Call the Cook Children's Health Plan Member Services Department at 888-243-3312 for more information about DME and other covered products commonly found in a pharmacy for children (birth through age twenty).

MDCP/DBMD Escalation Help Line

What is the MDCP/DBMD escalation help line?

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

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

When should Members call the escalation help line?
Call when you have tried to get help but have not been able to get the help you need. If you don't know who to call, you can call 844-999-9543 and they will work to connect you with the right people.

Is the escalation help line the same as the HHSC Office of the Ombudsman?

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

Who can call the help line?

The Member, Member's authorized representatives or Member's legal representative can call.

Can Members call any time?

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

Referrals

The Primary Care Provider may arrange for a referral to an in network Specialist Provider when a Member requires specialty care services. A Specialist may refer to another in network Specialist if the Primary Care Provider is notified and concurs with the referral. Primary Care Providers are responsible for coordinating appropriate referrals to other Providers and Specialists, and manage, monitor and document the services of other Providers. Referral documentation must be included in the Member medical record.

This section does not apply to STAR Kids Dual Eligible Members.

Referrals from a network Primary Care Provider to a network Specialist (for evaluation only), network facility, or contractor does NOT require prior authorization. Some treatment(s) may require a prior authorization when performed by an in network Provider. Providers should ensure authorization is not required prior to performing treatment(s).

All out of network referrals **MUST** receive prior authorization from Cook Children's Health Plan before the out of network referral can occur. Out of network referrals may be permitted when services are unavailable from a Cook Children's Health Plan in network Provider, Facility or Contractor.

The Provider is responsible for initiating the prior authorization process when a Member requires medical services or inpatient admission.
Members may access the following services without a Primary Care Provider referral:

- Network Ophthalmologist or Therapeutic Optometrist to provide Eye Health Care services other than surgery
- Emergency Services
- OB/GYN Care
- Behavioral Health Services

Vision Services

Cook Children's Health Plan has contracted with a Vision Provider for routine vision screenings. A vision screening is an examination by an Optometrist or other Provider to determine the need for and to prescribe corrective lenses and frames. The Providers for these services are listed in the Provider Directory or Members may call the Vision Provider

indicated on the Member's ID card.
Member's may select and have access to, without a Primary Care Provider referral, a network Ophthalmologist or Therapeutic Optometrist to provide Eye Health Care Services, other than surgery. For a medical diagnosis, the Member should contact their Primary Care Provider to be referred to an Ophthalmologist.

Behavioral Health

Behavioral Health Referrals

We all recognize that the prevalence of psychosocial complaints and chemical dependency disorders are high. Providers should make every effort to elicit and diagnose these problems. Cook Children's Health Plan considers it to be part of the Provider's scope of care to provide basic screening and evaluation procedures for detection and treatment of, or referral for, any known suspected behavioral health problems and disorders from attention deficit disorder, to chemical dependency, depression, and anxiety states.

Should you encounter any Member who appears to be in need of mental health or chemical dependency services, please direct that Member to contact Member Services at 800-964-2247 for assistance in locating a network Behavioral Health Provider. In such instances, a referral is not required.

Additional information on behavioral health services is located in the Behavioral Health Services section of this Provider Manual.

Member's Right to Designate an OB/GYN

Cook Children's Health Plan allows the Member to pick any OB/GYN, whether that doctor is in the same network as the Member's Primary Care Provider or not. The Member has the right to designate their OB/GYN as their Primary Care Provider.

Attention Female Members

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

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

All high risk pregnancies and teen pregnancies are required to be reported to the Care Management Team at Cook Children's Health Plan. Network Providers should submit the

High Risk Delivery Notification through our Secure Provider Portal. Out of network Providers refer to the High Risk Pregnancy Notification and Delivery Notification forms located on our website at cookchp.org.

This section does not apply to STAR Kids Dual Eligible Members.

Access to Second Opinion

Cook Children's Health Plan ensures that each Member has the right to a second opinion regarding the use of any medically necessary covered service. Either a Member or an in network Provider may request a second opinion. The second opinion must be obtained from a network Provider when available. If a network Provider is not available, the Member may obtain the second opinion from an out of network Provider at no additional cost to the Member. In state Providers are considered prior to considering out of state Providers. All out of network requests require prior authorization from Cook Children's Health Plan. The health plan may also request a second opinion. The reasons include, but are not limited to:

- A Member or Provider voices a concern about care.
- When an experimental or investigational service is requested.
- Possible outcomes or risks of requested treatment are identified by Cook Children's Health Plan.

When Cook Children's Health Plan requests a second opinion, the health plan will arrange the appointment and notify the Member and Primary Care Provider of the date and time of the appointment. Cook Children's Health Plan will request that the consulting Provider send his/her opinion to the Primary Care Provider and the health plan.

Advance Directive

Federal and state law requires Providers to maintain written policies and procedures for informing and providing written information to all adult Members eighteen (18) years of age and older about their rights to refuse, withhold, or withdraw medical treatment and mental health treatment through advance directives (Social Security Act §1902[a][57] and §1903[m][1][A]). The Provider's written policies and procedures must comply with provisions contained in 42 CFR §§434.28 and 489, Subpart I, relating to the following state laws and rules:

- A Member's right to self-determination in making healthcare decisions.
- The Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:
    - A Member's right to execute an advance written directive to physicians and family or surrogates, or to make a non-written directive to administer, withhold,

or withdraw life sustaining treatment in the event of a terminal or irreversible condition.

- A Member's right to make written and non-written Out-of-Hospital Do Not Resuscitate (DNR) orders.
- A Member's right to execute a Medical Power of Attorney to appoint an agent to make healthcare decisions on the Member's behalf if the Member becomes incompetent Chapter 137, The Texas Civil Practice and Remedies Code, which includes a Member's right to execute a Declaration for Mental Health Treatment in a document making a declaration of preferences or instructions regarding mental health treatment.
-

Providers must comply with the requirements of state and federal laws, rules and regulations relating to advance directives.

Cook Children's Health Plan Members who have questions or would like additional information about Advance Directive can call Cook Children's Health Plan STAR Kids Customer Care Department at 844-843-0004.

Long Term Services and Support

Role of Long Term Services and Support Providers

Long Term Services and Supports (LTSS) provide assistance with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping). Long Term Services and Supports include, but are not limited to, Nursing Facility Care, Adult Daycare Programs, Home Health Aide Services, Personal Care Services, Private Duty Nursing, Transportation, and Supported Employment as well as assistance provided by a family caregiver. Care planning and care coordination services help Members and families navigate the health system and ensure that the proper Providers and services are in place to meet Members' needs and preferences; these services can be essential for Long Term Services and Support Members who often have substantial acute care needs as well.

LTSS Providers are required to provide covered health services to Members within the scope of their health plan agreement and specialty license. In addition, LTSS Providers have certain responsibilities for the STAR Kids program and the Members they serve. These responsibilities include but are not limited to the following:

- Contacting Cook Children's Health Plan to verify Member eligibility and obtain authorizations for service as appropriate
- Providing continuity of care
- Coordinating with Medicaid and Medicare
- Coordinating Medicaid/Medicare benefits for dual eligible if applicable

- Notifying Cook Children's Health Plan of any change in the STAR Kids Member's physical condition or eligibility

Cook Children's Health Plan must require that LTSS Providers submit periodic cost reports and supplemental reports to HHSC in accordance with 1 Tex. Admin. Code Chapter 355, including Subchapter A (Cost Determination Process) and 1 Tex. Admin. Code § 355.403 (Vendor Hold). If an LTSS Provider fails to comply with these requirements, HHSC will notify Cook Children's Health Plan to hold payments to the LTSS Provider until HHSC instructs the health plan to release the payments. HHSC will forward notices directly to LTSS Providers about such costs reports and information that is required to be submitted.

Service Delivery Options

There are three options available to Members desiring to self-direct the delivery of Personal Care Services (PCS), Personal Care Services or acquisition, maintenance and enhancement of skills in CFC, and for the MDCP STAR Kids in home or out of home respite, Supported Employment, and Employment Assistance. The three options are:

- Consumer Directed Services Option.
    - The Member is required to select a Financial Management Services Agency (FMSA) to handle functions such as processing payroll, withholding taxes, and filing tax-related reports to the Internal Revenue Service and the Texas Workforce Commission for these services.
    - The FMSA is also responsible for providing training on being an employer, verifying Provider qualifications (including criminal history and registry checks), and approving the budget.
- Service-Related Option.
- Agency Option.

Cook Children's Health Plan will provide information, including the risks and benefits about the three options to all eligible Members.

In addition to providing information concerning the three options, Cook Children's Health Plan will provide Member orientation in the option selected by the Member. Cook Children's Health plan will provide information regarding all available options:

- At initial assessment
- At annual reassessment or annual contact with the Member
- At any time when a Member requests the information
- In the Member Handbook

Cook Children's Health Plan will contract with Providers who are able to offer PCS, in home

or out of home respite, Community First Choice services, Supported Employment, and Employment Assistance and will educate/train Cook Children's Health Plan network Providers regarding the three options.

Provider Responsibilities for Employment Assistance (EA) & Supported Employment (SE)

Employment Assistance is provided as an HCBS STAR Kids Waiver service to a Member to help the Member locate competitive employment or self-employment. EA services include, but are not limited to, the following:

- Identifying a Member's employment preferences, job skills, and requirements for a work setting and work conditions
- Locating prospective employers offering employment compatible with an Member's identified preferences, skills, and requirements
- contacting a prospective employer on behalf of an Member and negotiating the Member's employment

Supported Employment (SE) services provide assistance as HCBS STAR Kids Waiver service to a Member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which Members without disabilities are employed. SE provides the supports necessary in order to sustain paid employment.

SE Services include, but are not limited to, the following:

- Employment adaptations, supervision, and training related to a Member's diagnosis
- If the Member is under age twenty-two (22), ensure provision of SE, as needed, if the services are not available through the local school district
- If the Member is under age twenty-two (22), SE may be provided through the SPW if documentation is maintained in the Member's record, that the service is not available to the Member under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq)

The Provider must develop and update quarterly a plan for delivering EA/SE including documentation of the following information:

- Name of the Member
- Member's employment goal
- Strategies for achieving the Member's employment goal, including those addressing the, Member's anticipated employment support needs

- Names of the people, in addition to the Member, whose support is or will be needed to ensure successful employment placement, including the corresponding level of support those persons are providing or have committed to providing
- Any concerns about the effect of earnings on benefits, and a plan to address those concerns
- Progress toward the Member's employment goal
- If progress is slower than anticipated, an explanation of why the documented strategies have not been effective, and a plan improve the effectiveness of the Member's employment search

Community First Choice (CFC):

Provider Responsibilities

- The CFC services must be delivered in accordance with the Member's service plan.
- The Program Provider must maintain current documentation which includes the Member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable).
- The HCS or TxHmL Program Provider must ensure that the rights of the Members are protected (e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- The Program Provider must ensure, through initial and periodic training, the continuous availability of qualified service Providers who are trained on the current needs and characteristics of the Member being served.
    - This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the Member that are required to ensure the Member's health, safety, and welfare.
        - The Program Provider must maintain documentation of this training in the Member's record.
- The Program Provider must ensure that the staff Members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The Program Provider must also show documentation regarding actions that must be taken when from the time they are notified that an Adult Protective Services investigation has begun through the completion of the investigation (e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.).
    - The Program Provider must also provide the Member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the Adult Protective Services hotline 800-252-5400.
- The Program Provider must address any complaints received from a Member/ LAR and have documentation showing the attempt(s) at resolution of the complaint. The

Program Provider must provide the Member/LAR with the appropriate contact information for filing a complaint.

- The Program Provider must not retaliate against a staff Member, Service Provider, Member (or someone on behalf of a Member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- The Program Provider must ensure that the Service Providers meet all the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas Driver's License and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the Program Provider must ensure that the Provider of ERS has the appropriate licensure.
- For CFC ERS, the Program Provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the Program Provider must ensure that any additional training requested by the Member/LAR of CFC PAS or habilitation (HAB) Service Providers is procured.
- The use of seclusion is prohibited.
    - Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The Program Provider must adhere to the MCO financial accountability standards.
- The Program Provider must prevent conflicts of interest between the Program Provider, a staff member, or a Service Provider and a Member, such as the acceptance of payment for goods or services from which the Program Provider, staff member, or Service Provider could financially benefit.
- The Program Provider must prevent financial impropriety toward a Member, including unauthorized disclosure of information related to a Member's finances and the purchase of goods that a Member cannot use with the Member's funds.

Electronic Visit Verification (EVV)

General Information about EVV

What is EVV?

Electronic Visit Verification (EVV) is a computer-based system that electronically documents and verifies the occurrence of a visit by a Service Provider or CDS Employee, as defined in Chapter 8.7.1 of the UMCM, to provide certain services to a Member and documents the precise time service provision begins and ends. The EVV System documents the following:

- Type of service provided (Service Authorization Data);

- Name of the Member to whom the service is provided (Member Data);
- Date and times the visit began and ended;
- Service delivery location;
- Name of the Service Provider or CDS Employee who provided the service (Service Provider Data); and
- Other information HHSC determines is necessary to ensure the accurate adjudication of Medicaid claims.
- EVV is a method by which a person, including but not limited to a personal care attendant, who enters a STAR Kids Member's home to provide a service will document their arrival time and departure time using a telephonic or computer-based application system
    - This visit information will be recorded and used as an electronic version of a paper time sheet for an attendant and used to support claims to the MCO for targeted EVV services.

Is there a law that requires the use of EVV?

Yes. In December of 2016, the federal 21st Century Cures Act added Section 1903(l) to the Social Security Act (42 USC. § 1396b(l)) to require all states to implement the use of EVV. Texas Government Code, Section 531.024172, requires HHSC to implement an EVV System to electronically verify certain Medicaid services in accordance with federal law.

To comply with these statutes, HHSC required the use of EVV for all Medicaid personal care services requiring an in-home visit, effective January 1, 2021. HHSC plans to require the use of EVV for Medicaid home health care services requiring an in-home visit, effective January 1, 2024.

Which services must a Service Provider or Consumer Directed Services (CDS) Employee electronically document and verify using EVV?

The EVV required services that must be electronically documented and verified through EVV are listed on the HHSC EVV website. Refer to the programs, services and service delivery options required to use electronic visit verification on the HHSC EVV website.

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

- EVV Service Bill Codes Table

Who must use EVV?

The following must use EVV:

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

EVV Systems

Do Providers and FMSAs have a choice of EVV Vendors?

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

- Data Logic Software Inc.
- First Data Government Solutions

EVV Vendor System

- An EVV Vendor system is an EVV System provided by an EVV Vendor selected by the HHSC Claims Administrator, on behalf of HHSC, that a Provider or FMSA may opt to use instead of an EVV Proprietary System.
    - TMHP EVV Vendors

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

- To select an EVV Vendor, a Provider or FMSA, signature authority and the agency's appointed EVV System administrator must complete, sign, and date the EVV Provider Onboarding Form located on the EVV Vendor's website.
    - TMHP EVV Vendors
- To use an EVV Proprietary System, a Provider or FMSA, signature authority, and the agency's appointed EVV System administrator, must visit the TMHP Proprietary System webpage to review the EVV Proprietary System Operator (PSO) Onboarding process and HHSC EVV Proprietary System approval process.
    - TMHP Proprietary Systems
- Providers and Financial Management Services Agencies (FMSAs) have a choice of EVV Vendors
- Texas Medicaid & Healthcare Partnership (TMHP) has selected two EVV Vendors on behalf of the Health and Human Services Commission:

- DataLogic Software, Inc.
- First Data Government Solutions
- Providers and FMSAs are required to select an EVV system to be in compliance with EVV state and federal law
- More information on EVV Vendors is located at tmhp.com
- To select an EVV Vendor from the state vendor pool, the Provider or FMSA signature authority and, if applicable, the agency's appointed EVV system administrator, must complete, sign and date the EVV Provider Onboarding Form located on the EVV Vendor's website
- Providers and FMSAs can choose to use an HHSC approved EVV Proprietary System to comply with EVV requirements instead of an EVV Vendor system from the state vendor pool
- An EVV Proprietary System is purchased or developed by the Provider or FMSA.
- For more information on EVV Proprietary System visit tmhp.com.
- To elect the use of an EVV Proprietary System, the Provider or FMSA signature authority, and if applicable, the agency's appointed EVV system administrator, must visit the TMHP Proprietary System website to review the proprietary system request and HHSC approval process
- Provider EVV default process for non-selection
- Mandated Providers that do not make an EVV Vendor selection or who do not implement use of their selected vendor, are subject to contract actions and are defaulted to a selected vendor by HHSC.

Can a Provider or FMSA change EVV systems?

Yes. A Provider or FMSA may:

- Transfer from an EVV Vendor to another EVV Vendor approved by the state.
- Transfer from an EVV Vendor to an EVV Proprietary System;
- Transfer from an EVV Proprietary System to an EVV Vendor; or
- Transfer from one EVV Proprietary System to another EVV Proprietary System.
    - Providers and FMSAs must request a transfer to another EVV system at least one hundred twenty calendar days prior to the desired transfer date
    - If transferring to an EVV Vendor system within the state vendor pool, the transfer may occur sooner than one hundred twenty days if the Provider or FMSA and the EVV Vendors agree on an earlier date
    - If transferring to an EVV Proprietary System, the transfer may only occur after HHSC agrees on an implementation date with the Provider or FMSA, and HHSC provides written approval of the EVV Proprietary System
    - FMSA's must notify Consumer Directed Services (CDS) employers sixty calendar days in advance of the planned transfer date to allow time for retraining employers and their employees on the new EVV system

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

Before using a selected EVV System:

- The Provider or FMSA must submit an accurate and complete form directly to the selected EVV Vendor.
    - TMHP EVV Vendors
- Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:
    - EVV Proprietary System Request Form
    - EVV PSO Detailed Questionnaire (DQ)
    - TMHP Interface Access Request
- A Provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHSC to use an EVV Proprietary System to comply with HHSC EVV requirements.
- If selecting either an EVV Vendor or an EVV Proprietary System, a Provider or FMSA must:
    - Complete all required EVV training as described in the answer in the **EVV TRAINING** section below; and
    - Complete the EVV System onboarding activities:
        - Manually enter or electronically import identification data;
        - Enter or verify Member service authorizations;
        - Setup Member schedules (if required); and
        - Create the CDS Employer profile for CDS Employer credentials to the EVV System.

Can a Provider elect not to use EVV?

EVV is required to document delivery of the following STAR Kids services:

- Personal Care Services (PCS)
- Community First Choice attendant care and habilitation (PAS/HAB)
- MDCP In Home Respite
- MDCP flexible family support services

Is EVV required for CDS Employers?

Yes. If you are a CDS Employer, there are three EVV options:

- Option 1
    - The CDS Employer agrees to perform all visit maintenance and approve their

employee's time worked in the EVV system.

- Option 2
  - The CDS Employer elects to have their FMSA complete all visit maintenance on their behalf; however, the CDS Employer will approve their employee's time worked in the EVV system.
- Option 3
  - The CDS Employer elects to have their FMSA complete all visit maintenance on their behalf and confirm the employee's time worked in the EVV system based on approval documentation from the CDS Employer.

Form 1722 located on the HHSC website details the different visit maintenance options for CDS Employers.

Does a CDS Employer have a choice of EVV Systems?

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

Can a Provider or FMSA change EVV Systems?

Yes. A Provider or FMSA may:

- Transfer from an EVV Vendor to another EVV Vendor approved by the state.
- Transfer from an EVV Vendor to an EVV Proprietary System;
- Transfer from an EVV Proprietary System to an EVV Vendor; or
- Transfer from one EVV Proprietary System to another EVV Proprietary System.

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

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

- To request a transfer to an EVV Vendor, a Provider or FMSA must submit an EVV Provider Onboarding Form to the new EVV Vendor.
- To request a transfer to an EVV Proprietary System, a Provider or FMSA must submit the PSO Request packet and complete the EVV PSO Onboarding Process.
- A Provider or FMSA must submit an EVV Provider Onboarding Form to the newly selected EVV Vendor or an EVV PSO Request packet to TMHP at least one hundred twenty days before the desired effective date of the transfer.
- If a Provider or FMSA is transferring to an EVV Vendor, the effective date of the transfer may be earlier than the desired effective date of the transfer if the Provider or FMSA and the newly selected EVV Vendor agree on an earlier date.

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

Are the EVV Systems accessible for people with disabilities?

How do Providers with assistive technology (ADA) needs use EVV?

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

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

- If you use assistive technology, and need to discuss accommodations related to the EVV system or materials, please contact the HHSC approved EVV Vendors or proprietary system

DataLogic (Vesta) Software, Inc.

Contact	Email	Phone
Customer Support for Providers	info@vestaevv.com	844-880-2400
Customer Support for FMSAs & CDS Employers	info@vestaevv.com	877-329-3574
Website: www.vestaevv.com		

First Data Government Solutions LLC

Contact	Email	Phone
Customer Support	authenticCareTXSupport@firstdata.com	877-829-2002
Website: http://solutions.fiserv.com/authenticare-tx		

EVV Proprietary System

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

EVV use of alternative device process and required alternative device forms

Providers, CDS Employers or FMSAs on behalf of a CDS Employer, can order an alternative device through an EVV Vendor.

- The EVV Vendor will provide instructions on how to order a device to the requestor upon receipt of a complete order
  - Depending on the shipping method, it may take additional days to deliver the order
  - EVV Vendor has ten business days to process and ship the device
- The electronic process allows Provider agencies to:
  - Order a new or replacement small alternative device
  - Track small alternative device order(s)
  - Manage, assign and un-assign alternative device
  - Manage shipping addresses
  - Equipment provided by an EVV contractor to a Provider, if applicable, must be returned in good condition

A Provider Agency Representative, FMSA or CDS Employer must place the alternative device in the Member's home on or before the first service delivery date after receiving the device. The Provider Agency Representative or FMSA should ask the Member/LAR where they would like the device to be placed.

- The location of the device should be accessible to the attendant at all times
- The Provider Agency or FMSA should explain to the Member/LAR what the purpose of the alternative device is and how the device works

- Provider Agencies, FMSAs or CDS Employer may choose to utilize the EVV Vendor zip tie when placing the device in the Member's home
- If a Member disagrees with the agency policy on installing the device with or without a zip tie, the Provider Agency or FMSA must document the issue in the Member's file, and use their preferred method

The alternative device must be in the home at all times. If the alternative device does not remain in the home at all times, visits may be subject to recoupment and a Medicaid fraud referral may be made to the Office of Inspector General.

EVV Service Authorizations

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

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

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

EVV Clock in and Clock Out Methods

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

A Service Provider or CDS Employee must use one of the three approved electronic verification methods described below to clock in to begin service delivery and to clock out to

end service delivery when providing services to a Member in the home or in the community. A Service Provider or CDS Employee may use one method to clock in and a different method to clock out.

Mobile Method

- No protected health information (PHI) is stored on the phone while utilizing the EVV mobile application
- A Service Provider must use one of the following mobile devices to clock in and clock out:
    - The Service Providers personal smartphone or tablet, or
    - A smartphone or tablet issued by the Provider
- A Service Provider must not use a Member's mobile device to clock in and clock out
- A CDS Employee must use one of the following mobile devices to clock in and clock out:
    - The CDS Employee's personal smartphone or tablet:
    - Smartphone or tablet issued by the FMSA; or
    - The CDS Employer's smart phone or tablet if the CDS Employer authorized the CDS Employee to use their smart phone or tablet.
- To use a mobile method, a Service Provider or CDS Employee must use an EVV application provided by the EVV Vendor or the PSO that the service Provider or CDS Employee has downloaded to the smart phone or tablet.
- The mobile method is the only method that a service Provider or CDS Employee may use to clock in and clock out when providing services in the community. Note, if a service Provider or CDS Employee are unable to use a mobile method in the community, they must manually enter their clock in and/or clock out times in the EVV System.
- The cell phone used for the EVV mobile app has to be a smartphone and has an Apple iOS or Google Android mobile platform
    - The smart phone should not be a rooted or jailbroken mobile phone
        - Rooting is the process of getting around the Android's security architecture and gaining access to the Android operating system code.
        - Jailbreaking is the process of removing the limitations put in place by a device's manufacturer
        - The EVV system will not allow the agency to register a rooted or jailbroken phone
- The attendant or CDS employee is responsible for keeping their phone charged.
    - Attendant's or CDS employee's failure to keep their phone charged, resulting in being unable to clock in and out, is a failure to use the EVV system
    - The Provider Agency, FMSAs, CDS Employers, CDS employees and attendant understands Cook Children's Health Plan, the EVV Vendor, EVV Proprietary System and HHSC are not liable for:

- Any cost incurred while using the EVV mobile app
- Any virus(es) on the smartphone
- Hacked, broken, damaged, lost or stolen smartphone
- Non-working smartphone

Home Phone Landline

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

Alternative Device

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

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

- If a Service Provider does not clock in or clock out of the EVV System or an approved clock in or clock out method is not available, then the Provider must manually enter the visit in the EVV System.

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

EVV Visit Maintenance

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

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

Note: The standard visit maintenance timeframe as set in EVV Policy Handbook may be changed by HHSC to accommodate Providers, FMSAs, or CDS Employers impacted by circumstances outside of their control.

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

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

- Reason Code Number(s) describe the purpose for completing Visit Maintenance on an EVV visit transaction.
- Reason Code Description(s) describe the specific reason Visit Maintenance is necessary.

- Free text is additional information the Provider, FMSA or CDS Employer enters to further describe the need for Visit Maintenance.
- HHSC EVV Reason Codes

EVV Aggregator

The EVV Aggregator is a centralized database that collects, validates and stores statewide EVV visit data transmitted by an EVV system.

- Provides validated Provider contract or enrollment data to EVV systems.
- Accepts or rejects confirmed EVV visit transactions using standardized validation edits and returns results to EVV systems.
- Stores all accepted and rejected EVV visit transactions.
- Matches EVV claim line items to accepted EVV visit transactions in the EVV Aggregator and sends matching results to the appropriate payer for EVV claims processing.
- Texas Medicaid & Healthcare Partnership (TMHP), the Texas Medicaid claims administrator, is responsible for operating and maintaining the EVV Aggregator and EVV Portal.

EVV Portal

The EVV Portal is an online system that allows users to perform searches and view reports associated with the EVV visit data in the EVV Aggregator.

Users can:

- View EVV visit transactions ready for billing
- Access standard EVV reports and run queries on EVV visit data
- Check the status and identify reasons for rejection of submitted EVV visit transactions

EVV Compliance Reviews

What are EVV Compliance Reviews?

EVV Compliance Reviews are reviews conducted by the MCO to ensure Providers, FMSAs, and CDS Employers are in compliance with EVV requirements and policies.

The MCO will conduct the following reviews and initiate contract or enforcement actions if Providers, FMSAs or CDS Employers do not meet any of the following EVV compliance requirements:

- EVV Usage Review - meet the minimum EVV Usage Score;

- EVV Required Free Text Review – document EVV required free text; and
- EVV Landline Phone Verification Review - ensure valid phone type is used.
- Cook Children's Health Plan Electronic Visit Verification
-

All Providers/FMSAs providing the mandated services must use the EVV system and must maintain compliance with the following requirements:

- The Provider/FMSA must enter Member information, Provider/FMSA information and service schedules if applicable to program requirement into the EVV system for validation either through an automated system or a manual system
- The Provider, FMSA or CDS Employer must ensure that attendants providing services applicable to EVV are trained and comply with all processes required to verify service delivery through the use of EVV
    - Eighty percent adherence to Provider compliance plan
        - HHSC EVV Compliance Plan
            - A set of requirements that establish a standard for EVV usage that must be adhered to by Provider agencies and FMSAs.
            - Provider agencies and FMSAs must achieve and maintain an HHSC EVV compliance plan score of at least eighty percent per review period.
                - Reason codes must be used each time a change is made to an EVV visit record in the EVV System.

Provider Agencies, FMSAs and CDS Employers must complete any and all required visit maintenance in the EVV system within sixty days of the visit (date of service) unless otherwise specified by HHSC visit maintenance not completed prior to claim submission is subject to claim denial or recoupment. Provider Agencies and FMSAs must submit EVV claims to TMHP.

- TMHP will perform a claim match with the accepted EVV transaction and then forward to the respective MCO. No visit maintenance will be allowed more than sixty days after the date of service and before claims submission, unless an exception is granted.
- To request a change on visits greater than sixty days of the visit (date of service), a Provider, FMSA or CDS Employer can submit an HHSC EVV visit maintenance unlock request securely to CCHPEVV@cookchildrens.org.
    - HHSC EVV Visit Maintenance Unlock Request form is located at cookchp.org.
- The EVV compliance plan is located under the policy section of the HHSC EVV website named Compliance Oversight Reviews Policy.
- The Provider Agency and FMSA must ensure quality and appropriateness of care and services rendered by continuously monitoring for potential administrative quality issues.

    - The Provider Agency and FMSA must systematically identify, investigate, and resolve compliance and quality of care issues through the corrective action plan process.
- Providers and FMSAs should notify the appropriate MCO, or HHSC, within forty-eight hours of any ongoing issues with EVV Vendors or issues with EVV Systems.
- Any Corrective Action Plan required by an MCO is required to be submitted by the network Provider to the MCO within ten calendar days or receipt of request.
- MCO Provider Agencies may be subject to termination from the MCO network for failure to submit a requested corrective action plan in a timely manner.

EVV Complaint Process

Complaints regarding an EVV system should be directed to HHSC at: Electronic Visit Verification.

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

- If the Provider or FMSA selects an EVV Vendor system, the Provider or FMSA uses the system free of charge.
- If a Provider or FMSA elects to use an EVV Proprietary System, the Provider or FMSA is responsible for all costs for development, operation, and maintenance of the system.
- The EVV Vendors may offer additional software such as billing solutions for a fee
- HHSC/MCOs do not require Providers or FMSAs to purchase any software when selecting an EVV Vendor system.

Use of reason codes

- Provider agencies must adhere to the standardized, approved reason codes established by HHSC when completing visit maintenance in the EVV system
- Reason Codes must be used each time a change is made to an EVV visit record in the EVV System
- Additional information regarding reason codes can be found at: cookchp.org

EVV Training

What are the EVV training requirements for each EVV System user?

- Providers and FMSAs must complete the following training
    - EVV System training provided by the EVV Vendor or EVV PSO;
    - EVV Portal training provided by TMHP; and
    - EVV Policy training provided by HHSC or the MCO.

- CDS Employers must complete training based on delegation of Visit Maintenance on Form 1722, CDS Employer's Selection for Electronic Visit Verification Responsibilities:
    - Option 1: CDS Employer agrees to complete all Visit Maintenance and approve their employee's time worked In the EVV System;
        - EVV System training provided by the EVV Vendor or EVV PSO;
        - Clock in and clock out methods; and
        - EVV Policy training provided by HHSC, the MCO or FMSA.
    - Option 2: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf; however, CDS Employer will approve their employee's time worked in the system:
        - EVV System training provided by EVV Vendor or EVV PSO; and
        - EVV Policy training provided by HHSC, the MCO or FMSA.
    - Option 3: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf:
        - Overview of EVV Systems training provided by EVV Vendor or EVV PSO; and
        - EVV policy training provided by HHSC, the MCO or FMSA.
- Providers and CDS Employers must train service Providers and CDS Employees on the EVV methods used to clock in when an EVV required service begins and clock out when the service ends.
    - Cook Children's Health Plan Electronic Visit Verification Reference to the Cook Children's Health Plan EVV training is available at cookchp.org
    - Providers and FMSAs can reach out to TMHP at evv@tmhp.com
- CDS Employers should contact their respective FMSA with any questions regarding EVV

DataLogic (Vesta) Software, Inc.

Contact	Email	Phone
Customer Support for Providers	info@vestaevv.com	844-880-2400
Customer Support for FMSAs & CDS Employers	info@vestaevv.com	877-329-3574
Website: www.vestaevv.com		

First Data Government Solutions LLC

Contact	Email	Phone
Customer Support	authenticCareTXSupport@firstdata.com	877-829-2002
Website: http://solutions.fiserv.com/authenticare-tx		

EVV Claims

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

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

Where does a Provider or FMSA submit an EVV claim?

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

For more information on claim submission, visit Section 5 Claims and Billing of this Provider Manual or review the HHSC Claims Submission Policy.

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

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

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

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

How does the automated EVV claims matching process work?

The claims matching process includes:

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

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

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

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

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

EVV claim match codes viewable in the EVV Portal are:

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

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

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

- The EVV claims matching process will return a match result code of EVV07 or EVV08.

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

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

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

- TMHP EVV Training webpage

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

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

Will claim payment be affected by the use of the EVV?

- Providers must adhere to EVV guidelines in the HHSC Provider Compliance Plan when submitting a claim
- Providers and FMSAs are required to submit EVV related claims to TMHP
- Claims must be received within ninety-five calendar days of the EVV Visit
- Providers and FMSAs should check EVV Portal for accepted EVV visit before submitting an EVV Claim
- Claims should be submitted after visit maintenance is completed

What if I need assistance?

If you have questions contact Cook Children's Health Plan:

- Phone: 888-243-3312
- Send an email to CCHPEVV@cookchildrens.org

We will assist you or refer to the EVV contact information guide for help.

Texas Vaccines for Children Program

Since 1994, Texas has participated in the Federal Vaccines for Children Program (VFC). Our version is called the Texas Vaccines for Children Program (TVFC). The Program was initiated by the passage of the Omnibus Budget Reconciliation Act of 1993. This legislation guaranteed vaccines would be available at no cost to Providers, in order to immunize children (birth through eighteen years of age) who meet the eligibility requirements.

Qualified Medicaid and CHIP Providers can enroll in the TVFC Program by completing the TVFC/ASN Programs Agreement online at Information for Providers - Texas Vaccines for Children webpage.

Texas Agency Administered Programs and Case Management Services Texas Department of Family and Protective Services (DFPS)

Cook Children's Health Plan works with Texas Department of Family and Protective Services to ensure that the at-risk population, both children in custody and not in custody of Texas Department of Family and Protective Services, receive the services they need. Children who are served by Texas Department of Family and Protective Services may transition into and out of Cook Children's Health Plan more rapidly and unpredictably than the general population, experiencing placements and reunification inside and out of the Service Area.

Providers must coordinate with the DFPS and foster parents for the care of a child who is receiving services from or has been placed in conservatorship of DFPS.

During this transition, Providers must respond to requests from DFPS including:

- Provide medical records to Texas Department of Family and Protective Services
- testify in hearings
- Schedule medical and behavioral health services appointments within fourteen days unless requested earlier by Texas Department of Family and Protective Services
- Refer suspected cases of abuse or neglect to Texas Department of Family and Protective Services

A Member in the custody of Texas Department of Family and Protective Services may continue to receive services until he or she is disenrolled from Cook Children's Health Plan due to loss of Medicaid Managed Care eligibility or placement in foster care.

Notification of Updates in Provider Information

Network Providers must inform both Cook Children's Health Plan and the Health and Human Services administrative services contractor of any changes to the Provider's contact information including address, telephone number, group affiliation, etc. The health plan also requests that Providers inform us of any updates to the panel status, such as an update from a closed panel to an open panel as well as any changes to age restrictions. Providers must also ensure that the health plan has current billing information on file to facilitate accurate payment delivery.

Providers may submit demographic changes through our Secure Provider Portal or by completing the Provider Information Change Form located on our website cookchp.org.

Providers must also communicate changes to Texas Medicaid & Healthcare Partnership. TMHP's Provider Enrollment and Management System (PEMS) step by step guide provides guidance on submitting demographic updates to TMHP. Providers can locate more information about on tmhp.com.

Credentialing and Recredentialing

Cook Children's Health Plan's credentialing process is designed to meet the National Committee for Quality Assurance (NCQA) and state requirements for the evaluation of Providers who apply for participation. Providers must submit all required information in order to complete the credentialing or recredentialing process. Incomplete applications cannot be processed until all requested documentation is received.

New Providers must complete a Letter of Interest Form along with all of the required documents. The Letter of Interest form is located on our website at cookchp.org, select Providers, and then select Joining the Network. Send the completed packet to Network Development by email CCHPNetworkDevelopment@cookchildrens.org or fax 682-885-8403.

Upon receipt of a completed application and any requested documentation, the credentialing process for a new Provider will be completed within ninety days. The recredentialing process will occur at least every three - years. In addition to verifying credentials, the health plan will consider Provider performance data including Member complaints and appeals, quality of care and utilization management.

Practitioner Rights

When the credentialing process is initiated for practitioners and organizations, the applicant is entitled to:

- Review information submitted to support their credentialing application
- Correct erroneous information

Receive the status of their credentialing or recredentialing application, upon request
Providers may contact the Network Development team for Credentialing, Contracting, and corrections of erroneous information by phone 888-243-3312, fax 682-885-8403 or email CCHPNetworkDevelopment@cookchildrens.org.

Provider Contracts

Cook Children's Health Plan believes effective quality improvement requires Provider/ practitioner involvement to the fullest extent possible in quality initiatives. Contracts specifically require Provider/Practitioner to:

- Cooperate with Quality Improvement activities
- Provide Cook Children's Health Plan with access to Member medical records to the extent permitted by state and federal law
- Allow Cook Children's Health Plan to use their performance data for quality improvement activities
- Maintain the confidentiality of Member information and records

Termination

Provider Requests Termination

If a Provider chooses to leave the network, a ninety day written notice is required. Refer to 'Advance Notice to Members' in the Term and Termination section of the Service Agreement.

Provider's choosing to leave Cook Children's Health Plan are required to:

- Notify their health plan Members of their upcoming termination date
- Notify the health plan in their termination request if Members should be reassigned to another Provider in the office
- Please send the written notice to:
    - Fax: 682-885-8403
    - Email: CCHPNetworkDevelopment@cookchildrens.org
    - Or mail:
    - Cook Children's Health Plan
    - Attention: Network Development
    - PO Box 2488
    - Fort Worth, TX 76113-2488

Termination of Provider by Cook Children's Health Plan

Cook Children's Health Plan may terminate a Provider's participation in the health plan in accordance with its participation contract with the Provider and any applicable appeal procedures. Cook Children's Health Plan will follow the procedures outlined in §843.306 of the Texas Insurance Code if terminating a contract with a Provider. At least ninety days before the effective date of the proposed termination of the Provider's contract, Cook Children's Health Plan must provide a written explanation to the Provider of the reasons for the termination.

The health plan may immediately terminate a Provider contract in a case involving:

- Imminent harm to patient health
- An action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs the Provider's ability to practice medicine, dentistry, or another profession
- Fraud or malfeasance

Not later than thirty days following receipt of the termination notice, a Provider may request a review of Cook Children's Health Plan's proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a license, or fraud or malfeasance. The advisory review panel must be composed of Physicians and Providers, as those terms are defined in §843.306 of the Texas Insurance Code, including at least one representative in the Provider's specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of Cook Children's Health Plan. The decision of the advisory review panel must be considered by Cook Children's Health Plan but is not binding on the health plan. Within sixty days following the Provider's request for review and before the effective date of the termination, the advisory review panel must make its formal recommendation, and Cook Children's Health Plan must communicate its decision to the Provider. Cook Children's Health Plan must provide to the affected Provider, on request, a copy of the recommendations of the advisory review panel and the health plan's determination.

A Provider's participation in Cook Children's Health Plan shall be automatically terminated for any of the following:

- Loss, suspension, or probation of professional licensure, certification, or registration
- Loss of either state or federal or both controlled substances registration
- Loss of required professional liability insurance coverage
- Exclusion from the Medicare, Medicaid, or any other federal health care program
- Failure to meet the board certification requirement unless granted an exception as set forth in the criteria

Termination for Gifts or Gratuities

Network Providers may not offer or give anything of value to an officer or employee of the Health and Human Services Commission or the State of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. The health plan may terminate the network Provider contract at any time for violation of this requirement.

Marketing Guidelines for Providers

Cook Children's Health Plan Providers must adhere to marketing guidelines as outlined in the Health and Human Services Uniform Managed Care Manual and in your health plan contract.

Those guidelines include the following:

- Providers are permitted to inform their patients about the CHIP and Medicaid Managed Care (MCO) Programs in which they participate
- Providers may inform their patients of the benefits, services, and specialty care services offered through the MCO in which they participate
    - However, Providers may not recommend one MCO over another MCO, offer patients incentives to select one MCO over another MCO, or assist the patient in deciding to select a specific MCO
- At the patients' request, Providers may give patients the information necessary to contact a particular MCO or refer the Members to an MCO Member Orientation
- Providers must distribute or display Health-related Materials for all contracted MCOs or choose not to distribute or display for any contracted MCO:
    - Health-related posters cannot be larger than 16" x 24"
    - Health-related materials may have the MCO's name, logo, and contact information
    - Providers are not required to distribute or display all health-related materials provided by each MCO with whom they contract
    - A Provider can choose which items to distribute or display as long as the Provider distributes or displays one or more items from each contracted MCO that distributes items to the Provider and the Provider does not give the appearance of supporting one MCO over another
- Providers must display stickers submitted by all contracted MCOs or choose to not display stickers for any contracted MCOs.

    - MCO stickers indicating the Provider participates with a particular MCO/Dental Contractor cannot be larger than 5" x 7” and cannot indicate anything more than “MCO/Dental Contractor is accepted or welcomed here”
- Providers may choose whether to display items such as children’s books, coloring books, and pencils provided by each contracted MCO. Items may only be displayed in common areas
- Providers may distribute applications to families of uninsured children and assist with completing the application.
- Providers may direct Members to enroll in the CHIP and Medicaid Managed Care Programs by calling the HHSC Administrative Services Contractor
- The MCO may conduct Member Orientation and health education for its Members in a private/conference room at a Provider’s office, but not in common areas at Provider’s office
- Bargains, premiums, or other considerations on prescriptions may not be advertised in any manner in order to influence a Member’s choice of pharmacy or promote the volume of prescriptions provided by the pharmacy
- Advertisement may only convey participation in the program

Fraud Information

Reporting Waste, Abuse or Fraud by a Provider or a Member

Medicaid Managed Care

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

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

For example, tell us if you think someone is:

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

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

- Call the OIG Hotline at 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
- You can report directly to your health plan:
- Cook Children’s Health Plan
- PO Box 2488 Fort Worth
- TX 76113-2488
- Phone: 888-243-3312

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

- When reporting 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

Provider’s Annual Medicaid Payments

If a network Provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), the network Provider must:

- Establish written policies for all employees, managers, contractors, subcontractors and agents of the network Provider
    - The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A) of the Social Security Act
- Include as part of such written policies detailed provisions regarding the network Provider’s policies and procedures for detecting and preventing Fraud, Waste and Abuse

- Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A) of the Social Security Act, the rights of employees to be protected as whistleblowers, and the Provider's policies and procedures for detecting and preventing Fraud, Waste and Abuse

Reporting Abuse, Neglect or Exploitation

Medicaid Managed Care

Report suspected Abuse, Neglect, and Exploitation

Cook Children's Health Plan and Providers must report any allegation or suspicion of Abuse, Neglect, and Exploitation (ANE) that occurs within the delivery of Long Term Services and Supports to the appropriate entity. The managed care contracts include Cook Children's Health Plan and Provider responsibilities related to identification and reporting of ANE. Additional state laws related to Cook Children's Health Plan and Provider requirements continue to apply.

The Provider must provide Cook Children's Health Plan 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. In addition, the Provider is responsible for reporting individual remediation on confirmed allegations to Cook Children's Health Plan.

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

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

Contact HHSC at 800-458-9858.

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

- An adult with a disability or child residing in or receiving services from one of the following Providers or their contractors:
    - Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services

- A person who contracts with a Medicaid managed care organization to provide behavioral health services
- A managed care organization
- An officer, employee, agent, contractor, or subcontractor of a person or entity listed above and
- An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS at 800-252-5400 or, in non-emergency situations, online at 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

Providers are required to train staff and inform Members on how to report abuse, neglect and exploitation in accordance with Texas Human Resources Code, section 48 and Texas Family Code, section 261.

Laws, Rules and Regulations

The network Provider understands and agrees that the following laws, rules and regulations, and all amendments or modifications apply to the network Provider agreement:

- Environmental protection laws
    - Pro-Children Act of 1994 (20 U.S.C.§6081 *et seq.* regarding the provisions of

a smoke-free workplace and promoting the non-use of all tobacco products National Environmental Policy Act of 1969 (42 U.S.C.§4321 *et seq.*) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality") relating to the institution of environmental quality control measures
    - Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with respect to Federal Contracts, Grants and Loans")
    - State Clean Air Implementation Plan (42 U.C.S. § 740 *et seq)* regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and
    - Safe Drinking Water Act of 1974 (21 U.S.C. § 349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water
- State and Federal anti-discrimination laws:
    - Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d *et seq.)* and as applicable 45 C.F.R. Part 80n or 7 C.F.R. Part 15
    - Section 504 of the Rehabilitation Act of 1973 (29U.S.C. §794)
    - Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq.)*
    - Age Discrimination Act of 1975 (42 U.S.C. §6101-6107)
    - Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688)
    - Food Stamp Act of 1977 (7 U.S.C. § 200 *et seq.)*
    - Executive Order 13279, and it's implementing regulations of 45 C.F.R. Part 87 or 7 C.F.R. Part 16 and
    - The HHSC agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement
- The Immigration and Nationality Act (8 U.S.C. §1101 *et seq.)* and all subsequent immigration laws and amendments
- The Health Insurance Portability Act of 1996 (HIPAA) (Public Law 104-191, and
- The Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 *et. Seq*.

Program Violations

Program violations arising out of performance of the contracts are subject to administrative enforcement by the Health and Human Services Commission Office of Inspector General (OIG) as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G.

Required Medical Record Documentation

The following is a list of standards that medical records must reflect all aspects of patient care, including ancillary services:

- Each page or electronic file in the record contains the Member's name and ID number

- Age, sex, address and phone number are recorded
- All entries are dated (month, day and year) and the author identified
- All entries are legible to individuals other than the author
- Allergies and adverse reactions (including immunization reactions) are prominently noted in the record
- Past medical history is recorded for all Members seen three or more times
- Immunizations are noted in the record as complete or up to date
- Medication information is recorded in a consistent and readily accessible location
- Current problems and active diagnoses are recorded in a consistent and readily accessible location
- Member education regarding physical and/or behavioral health problems is documented
- Notation concerning tobacco, alcohol and substance abuse and documentation of relevant Member education is present on an age appropriate basis
- Consultations, referrals and specialist reports are included
- Emergency care is documented
- Hospital discharge summaries are included
- Evidence and results of screening for medical, preventive and behavioral health screening are present
- Diagnostic information is appropriately recorded
- Treatment provided and results of treatment are recorded
- Documentation of the team Members involved in the care of Members requiring a multidisciplinary team
- Documentation in both the physical and behavioral health records showing appropriate integration of care
- Documentation of individual encounters must provide adequate evidence of, at a minimum:
    - History and physical examination
    - Appropriate subjective and objective information is obtained for the presenting complaints
- For Members receiving behavioral health treatment, documentation to include "at risk" factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning and significant social history)
- Admission or initial assessment includes current support systems or lack of support systems
- For Members receiving behavioral health treatment, an assessment is done with each visit relating to client status/symptoms to treatment process
- Documentation may indicate initial symptoms of behavioral health condition as decreased, increased, or unchanged during treatment period
- Plan of treatment that includes activities/therapies and goals to be carried out
- Diagnostic tests

- Therapies and other prescribed regimens. For Members who receive behavioral health treatment, documentation shall include evidence of family involvement, as applicable, and include evidence that family was included in therapy sessions, when appropriate
- Follow-up Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN
- Unresolved problems from previous visits are addressed in subsequent visits
- Referrals and results thereof
- Consultation, lab and imaging reports noted to indicate review and follow-up plans by primary care Provider
- All other aspects of patient care, including ancillary services
- For Members 18 years of age and older, documentation of advance directives and/or mental health declaration, or indication of education

Providers are required to maintain medical records, including electronic medical records that conform to the requirements of the Health Insurance Portability Act (HIPAA) and other State and Federal laws. Medical records should be kept in a secure location and accessible only by authorized personnel.

Access to Records

Receipt of Record Review Request

Provider must provide at no cost to the Texas Health and Human Services Commission:

- All information required under Cook Children's Health Plan's managed care contract with HHSC, including but not limited to, the reporting requirements and other information related to the Provider's performance of its obligation under the contract.
- Any information in its possession sufficient to permit Health and Human Services Commission to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats, and instructions specified by HHSC.

Upon receipt of a record review request from the Health and Human Services Commission Office of Inspector General (OIG) or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions, a Provider must provide, at no cost to the requesting agency, the records requested within three business days of the request.

If the OIG or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request or in less than twenty-four hours, the Provider must provide the

records requested at the time of the request or in less than twenty-four hours.

The request for record review includes clinical medical or dental Member records; other records pertaining to the Member; any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services; documents related to diagnosis, treatment, service, lab results, charting; billing records, invoices, documentation of delivery items, equipment or supplies; radiographs and study models related to orthodontia services; business and accounting records with backup support documentation; statistical documentation; computer records and data; and/or contracts with Providers and subcontractors.

Failure to produce the records or make the records available for the purpose of reviewing, examining, and securing custody of the records may result in OIG imposing sanctions against the Provider as described in 1 TEX. ADMIN. CODE Chapter 371 Subchapter G.

Audit or Investigation

Providers must provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the Provider contract and any records, books, documents, and papers that are related to the Provider contract and/or the Provider's performance of its responsibilities under the contract:

- United States Department of Health and Human Services or its designee
- Comptroller General of the United States or its designee
- Managed Care Organization Program personnel from HHSC or its designee
- Office of Inspector General
- Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee
- Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC
- Office of the State Auditor of Texas or its designee
- State or Federal law enforcement agency
- A special or general investigating committee of the Texas Legislature or its designee
- Any other state or federal entity identified by HHS, or any other entity engaged by HHSC

Providers must provide access wherever it maintains such records, books, documents, and papers. The Provider must provide such access in reasonable comfort and provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described herein.

Requests for access may be for, but are not limited to, the following requests:

- Examination
- Audit
- Investigation
- Contract administration
- The making of copies, excerpts, or transcripts
- Any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions

The Provider understands and agrees that the acceptance of funds under this contract acts as acceptance of the State Auditor's Office (SAO), or any successor agency, to conduct an investigation in connection with those funds. The Provider further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested at no cost.

Medicaid Managed Care Special Access Requirements

Cultural Competency Reading/Grade Level Consideration

Because of the cultural diversity of the Cook Children's Health Plan population, not all Members have comprehensive reading levels. Therefore, in order to facilitate understanding all Cook Children's Health Plan Member materials, such as the Member Handbook, website and correspondence, will be written at or below a sixth grade Flesch-Kincaid level in both English and Spanish. This will be accomplished by testing all text with the Microsoft Word's readability tool. Other languages will be provided when the language required is spoken by ten percent or more of the enrolled population. Additionally, the health plan will provide written translation in languages other than English and Spanish when requested.

Sensitivity and Awareness

Cultural and linguistic competency is defined as a set of linguistic, human interaction, and ethnic, cultural, and physical and mental disability awareness skills that permit effective communication and interaction among human beings. The term culture, in this definition, also includes the beliefs, rituals, values, institutions and customs associated with racial, ethnic, religious or social groups and individuals of all nationalities. Understanding and maintaining sensitivity to all of the factors that impact human behavior, attitudes and communications is integral to assuring the provision of quality, compassionate and effective health care services to the Members of Cook Children's Health Plan.
Cultural (or multicultural) competency is addressed in this plan from two perspectives:

- Human interaction and sensitivity and
- Culturally effective health care services to Cook Children's Health Plan Members by network Providers

Physicians and other health care practitioners are compelled to understand the customs, rituals, and family values of the various cultural groups (in addition to assuring effective linguistic translations/communications) of their patients in order to provide quality and effective health care.

Within the service area of Cook Children's Health Plan, many diverse cultural groups are represented. It is the beliefs, customs, languages, rituals, values and other aspects of the North Texas regional population which must be understood and addressed by Cook Children's Health Plan staff and affiliated Providers in order to provide quality service and quality, effective health care. Cook Children's Health Plan will, as part of this plan, conduct an education and training program on cultural competency described below.

Employee Training

Cook Children's Health Plan hires a diverse group of employees in all levels of our organization. Cook Children's Health Plan does not discriminate with regard to race, religion or ethnic background when hiring staff. All new employees will be trained on this plan during Cook Children's Health Plan's new employee orientation. All employees will have access to the plan as a guide for providing culturally competent services to our Members.

Provider Training

Cook Children's Health Plan contracts with a diverse Provider network. Cook Children's Health Plan's Providers speak a wide array of languages including Spanish, Vietnamese, Chinese and Hindi to name a few. Cook Children's Health Plan's Provider Directory includes the languages spoken in the Provider offices to assist our Members with selecting a Provider that would meet their medical needs as well as having the ability to directly speak to the Provider in their language. All Providers that are new to the health plan receive an initial orientation which includes information about this plan. All Providers also receive education and training on an ongoing basis.

Providers should educate themselves about the health care issues common to different cultures and ethnicities. When an encounter with a Member is difficult due to cultural barriers, they should prepare for future visits by researching and asking for the Members input.

Newsletters

Cook Children's Health Plan develops Member newsletters and Provider newsletters on a quarterly basis. These newsletters are used to communicate information to our Members and Providers about any new information of interest. It is also used as a tool to remind our Members and Providers about various aspects of this plan.

Member Handbook

Cook Children's Health Plan's Member Handbook is sent to every new Member that joins our health plan. The Member Handbook includes information about our Cultural Competency and Translation Services Plan. Information included in the handbook consists of an explanation of the translation services available to our Members, the ability to speak to a Spanish speaking Member Services Representative, the ability to communicate with our health plan using the TTY/TDD phone as well as information requesting the Member materials in ways to assist Members with other disabilities such as materials for the visually impaired.

Language Translation Services

Cook Children's Health Plan provides several options for the non-English speaking or hearing-impaired Members (or their parents) to communicate with the health plan. Cook Children's Health Plan will coordinate language translation services with the Provider as needed. These options are described in the sections below.

In House Translation Services

Cook Children's Health Plan employs bilingual staff Members in the Member Services, Claims, and Care Management departments. Bilingual staff is available for Spanish translation services Monday through Friday from 8:00 a.m. - 5:00 p.m. by calling toll free 800-964-2247.

Cyra Communications

Cook Children's Health Plan subscribes to CyraCom International (CyraCom), a translation service offering competent translations of most commonly spoken languages around the world. This service is available to our Members 8:00 p.m. - 5:00 p.m. Monday through Friday, excluding holidays. Cook Children's Health Plan staff is trained in how to access this line in order to communicate with Members from essentially all local ethnic groups. CyraCom interpreters have received special training in terminology and standard business practices in the HMO and healthcare industries.

All CyraCom operators are trained in the following key areas:

- Facilitate emergency room and critical care situations
- Accelerate triage and medical advice
- Simplify the admitting process
- Improve billing and collection processes
- Process insurance claims
- Process prescriptions

- Provide outpatient and in home care
- Change primary care Providers
- Communicate with non-English speaking family Members

Cook Children's Health Plan Members can access the CyraCom translation services by calling the main number to Cook Children's Health Plan at 888-243-3312. Cook Children's Health Plan employees will conference in a CyraCom translator who can facilitate the communication. Network Providers who encounter a Cook Children's Health Plan Member who cannot speak English may also contact the health plan for translation services. Either an in house Cook Children's Health Plan translator will be provided via telephone or a CyraCom translator will be conferenced in to assure that effective communication occurs. Providers are made aware of services available through information included in the Provider Manual and periodic Provider Newsletters.

Multi-lingual Written Member Materials

All published Member materials will be available in both English and Spanish. Whenever a particular segment of the Cook Children's Health Plan population reaches ten percent or more of the total population, materials will be translated into the predominant language of that population.

Multi-lingual Web Site

Cook Children's Health Plan has established and maintains a web site for our Members in both English and Spanish. Cook Children's Health Plan's website is constructed such that Members with access devices that have industry-standard technological capabilities can easily access and surf the web site. The web site will be translated into additional languages as that specific segment of the population reaches ten percent or more of the total population. The Cook Children's Health Plan website is located at cookchp.org.

Multi-lingual Recorded Messages

Cook Children's Health Plan will record all voice messages on its main business lines and Member Services Hotline/Call Center in both English and Spanish. When a particular segment of the Cook Children's Health Plan population reaches ten percent or more of the total population, recorded messages will be added to main business lines and Member Services Hotline/Call Center in the predominant language of that additional population (or populations).

Provider Directory Language Information

The Provider Directory published by Cook Children's Health Plan will be in both English and Spanish (and other languages when needed as described above) and will identify Providers

who are proficient in various languages. This information will help Cook Children's Health Plan Members select Providers who are culturally compatible with their family and who can communicate effectively with the Member(s).

Services for Hearing, Visual, & Access Impaired

Cook Children's Health Plan has many years of experience within the organization in communicating with children and family Members who are either visually or hearing impaired or both. In addition, Cook Children's Health Plan accesses all Cook Children's Health Care System resources available on an as-needed basis to assure effective communications with its hearing and visually impaired Members and their families.

Services for the Hearing Impaired

Cook Children's Health Plan has a service agreement with Texas Interpreting Services (TIS). TIS employ staff Members who are proficient in sign language communications for hearing impaired individuals. These services are available to Cook Children's Health Plan staff and Providers on an as-needed basis. If a Provider is in need of a sign language interpreter, they can contact Cook Children's Health Plan in advance of the scheduled appointment and the health plan will coordinate services with TIS.

Telecommunications Devices for the Deaf (TDD)

Cook Children's Health Plan employs telecommunications devices that can effectively communicate with hearing impaired Members. Whenever a "silent call" is received on the Cook Children's Health Plan Member and/or Provider Hot Line, staff will handle such calls by utilizing telephonic communications devices that permit the representative to communicate with the Member/caller using the TTY/TDD.

Internet Member Services Access

In addition, Members who are hearing impaired may communicate via electronic mail (email) over the internet, whenever the Member has access to such services, for all of their business relative to STAR.

Services for the Visually Impaired

Cook Children's Health Plan also provides alternative communication services for Members/families who are visually impaired.
These services include:

- Verbal communications and assistance via phone or in person to assist the Member with:
    - Understanding plan benefits

- Selecting an appropriate primary care Provider
- Resolving billing or other questions
- Other concerns or questions regarding their plan or plan benefits

- Audiotape versions of the Member Handbook and other Member communications regarding the plan or plan benefits and limitations are available upon request

Access to Services for Members with Physical and Modality Limitations

As part of the inventory of items that Cook Children's Health Plan Provider Relations staff checks when performing on site office survey visits to network Provider offices/ locations, information is gathered to determine if the facilities provide access for Members with physical and mobility limitations. The results of the audits are documented and reported to the Quality Management Committee on a quarterly basis.
Providers are required to meet the minimum standards for access prescribed by the Americans with Disabilities Act (ADA) and terms and conditions outlined in the Cook Children's Health Plan Provider Services Agreement.

Telemedicine, Telehealth, and Telemonitoring Access

Telemedicine, Telehealth, and Telemonitoring are covered services and are benefits of Texas Medicaid as provided in the Texas Medicaid Provider Procedures Manual. Prior authorization is not required for these services. Cook Children's Health Plan encourages network participation with Providers offering these services to provide better access to healthcare for our Members. The health plan will accept and process Provider claims for these services in conformity with the Texas Medicaid benefit.

Provider Coordination

Cook Children's Health Plan will comply with the HHSC standards regarding care for persons with disabilities or chronic and complex conditions. Specialty Providers may function as a Primary Care Provider for treatment of Members with chronic/complex conditions when approved by the health plan.

Cook Children's Health Plan will ensure the Members with special health care needs have adequate access to Primary Care Providers and Specialists skilled in treating persons with disabilities or chronic or complex conditions. Case Management services are available to assist Members with special health care needs, their families and health care Providers to facilitate access to care, continuity and coordination of services.

Section 2: STAR Kids Medicaid Member Enrollment

Enrollment

The Texas Health and Human Services Commission in coordination with the state Enrollment Broker administer the enrollment process for Medicaid eligible individuals. Eligible individuals must reside in one of the counties in the Tarrant Service Area. Medicaid clients who are eligible for STAR Kids choose a Managed Care Plan and a Primary Care Provider using the official state enrollment form or by calling the Enrollment Broker. The date that a Medicaid client becomes eligible for STAR Kids Medicaid and the effective date of enrollment with the Managed Care Plan are not the same. HHSC will make the final determination regarding Medicaid eligibility.

The Help Line (Enrollment Broker) is available 8:00 a.m. - 8:00 p.m., Central Time, Monday through Friday at:

- Telephone: 877-782-6440
- Telecommunications device for the deaf (TDD): 800-267-5008

Automatic Re-enrollment

If a Member loses Medicaid eligibility but becomes eligible again within six months or less, the Member will automatically be enrolled in the same health plan the Member was enrolled in prior to losing their Medicaid eligibility or the Member may choose to switch health plans. The Member will also be re-enrolled with the same Primary Care Provider as they had before if they pick the same health plan as long as that Primary care Provider is still in the Cook Children's Health Plan network.

Disenrollment

Members may request disenrollment from Cook Children's Health Plan. Any request from a Member for disenrollment from the plan will require medical documentation from their Primary Care Provider or documentation that indicates sufficiently compelling circumstances that merit disenrollment. The Health and Human Service Commission will make the final decision regarding eligibility, enrollment, disenrollment and automatic re-enrollment.

Providers cannot take retaliatory action against Members when a Member is disenrolled from a managed care plan or from a Provider's panel.

Disenrollment from Cook Children's Health Plan

Cook Children's Health Plan has a limited right to request a Member be disenrolled from the Plan without the Member's consent. The Health and Human Services Commission must approve the request for disenrollment of a Member for good cause. Cook Children's Health Plan will take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable documented measures may include providing education and counseling regarding the offensive acts or behaviors.

The Health and Human Services Commission may permit disenrollment of a Member under the following circumstances:

- Member misuses or loans their Cook Children's Membership card to another person to obtain services
- Member's behavior is disruptive or uncooperative to the extent that Member's continued enrollment in the Managed Care Plan seriously impairs the Managed Care Plan's or Provider's ability to provide services to either the Member or other Members, and Member's behavior is not related to a developmental, intellectual, or physical disability or behavioral health condition
- Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow the Managed Care Plan to treat the underlying medical condition

Cook Children's Health Plan will work with a Member before asking them to leave the plan. The Texas Health and Human Services Commission will make the final determination.

Member Removal from a Provider Panel

Providers may request that a Member be removed from their panel for the following reasons:

- The Member gives their Cook Children's Health Plan identification card to another person for the purpose of obtaining services
- The Member continually disregards the advice of their Primary Care Provider
- The Member repeatedly uses the emergency room in an inappropriate fashion

The request to remove a Member from a Provider Panel must be in writing and sent to Cook Children's Health Plan Member Services Department. Providers may contact Cook Children's Health Plan at 888-243-3312 with questions regarding this process.

Pregnant Women and Infants

The Medicaid Enrollment Broker processes applications for pregnant women within fifteen

days of receipt. Once an applicant is certified as eligible, a Medicaid ID number will be issued to verify eligibility and to facilitate Provider reimbursement. Pregnant women, including pregnant teens, may be retroactively enrolled in the STAR Kids Program based on their date of eligibility.

Mothers are encouraged to contact the Enrollment Broker to enroll the newborn in the STAR program. Mothers are also encouraged to select a Primary Care Provider for the newborn prior to birth. Primary Care Provider selections can be done by calling Cook Children's Health Plan Member Services at 800-964-2247.

Pregnant Teens

Providers are required to contact Cook Children's Health Plan immediately when a pregnant STAR Kids teen is identified.

Newborn Process

In the STAR Program, newborns are automatically assigned to the managed care plan the mother is enrolled with at the time of the newborn's birth for a period of at least ninety days. The mother can ask for a health plan change before the ninety days by calling the Enrollment Broker. The Member cannot change from one health plan to another plan during an inpatient hospital stay.

Health Plan Changes

STAR Kids Medicaid Members have the right to change plans. Members / Members LAR must call the Enrollment Broker at 877-782-6440 to initiate a plan change. If a plan change request is received before the middle of the month, the plan change is effective on the first day of the following month. If the request is received after the middle of the month, the plan change will be effective on the first day of the second month following the request, as shown below.

Example	
Request received on or before	Mid-May
Change effective	June 1
Request received after	Mid-May
Change effective	July 1

Members can change health plans by calling the Texas Medicaid Managed Care Program Helpline at 877-782-6440. However, a Member **cannot** change from one health plan to another health plan during an inpatient hospital stay.

STAR Kids Medicaid Member Eligibility

The Texas Health and Human Services Commission will make the final determination regarding Medicaid eligibility or STAR Kids. Medicaid clients who are eligible for STAR Kids choose a Managed Care Plan and a Primary Care Provider using the official state enrollment form or by calling the Enrollment Broker.

The Provider is responsible for requesting and verifying the client's current eligibility before providing services. The Provider must also verify and abide by prior authorization or administrative requirements established by the managed care plan.

The Medicaid Member's managed care plan information can be verified by:

- Calling the Your Texas Benefits help line at 855-827-3747
- Checking the Member's health plan ID card
- Calling the Member's health plan at 888-243-3312

The Member's managed care eligibility can also be verified using:

- The Texas Medicaid & Healthcare Partnership Automated Inquiry System (AIS) at 800-925-9126
- National Council for Prescription Drug Programs (NCPDP) E1 transaction – the E1 transaction is submitted through the pharmacy's point-of-sale system

Verifying Member Medicaid Eligibility and MCO Enrollment

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient's Medicaid eligibility and MCO enrollment for the date of service prior to services being rendered.

There are several ways to do this:

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

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

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

Providers Access to Medicaid Medical and Dental Health Information

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

The specific functions available are:

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

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

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

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

Your Texas Benefits Medicaid Card

Clients receive a Your Texas Benefits Medicaid Card that can be used to verify the client eligibility for various state-funded programs, including Medicaid. The front of the card includes the client's name, Member ID, the ID of the agency that issued the card, and the date on which the card was sent.

The back of the card provides:

- An eligibility verification contact number
    - The number can be used to determine:
        - Program eligibility dates
        - Retroactive eligibility (when applicable)
        - Eligible services (when applicable)
        - Medicaid managed care eligibility
- An eligibility website address for clients and non-pharmacy Providers
- A non-managed care pharmacy claims assistance contact number
- The Medicaid Client Hotline contact number 800-252-8263

Members can "opt out" of electronically sharing their Medicaid health information by calling 800-252-8263 or online at YourTexasBenefits.com.

Medicaid Eligible Members will only be issued one card and will only receive a new card in the event of being lost or stolen. Members can call 855-827-3748 if their Medicaid ID card is lost or stolen. Members can visit the Your Texas Benefits website YourTexasBenefits.com or call 800-252-8263 or 2-1-1 if they have questions about their new card or to confirm if they are eligible for Medicaid.

Temporary Medicaid Identification

When a Member's Your Texas Benefits Medicaid card has been lost or stolen, HHS issues a temporary Medicaid verification Form H1027-A. The Medicaid Eligibility Verification (Form H1027-A) is acceptable as evidence of eligibility during the eligibility period specified unless the form contains limitations that affect the eligibility for the intended service. Providers must accept the temporary form as valid proof of eligibility and contact the managed care health plan to confirm current eligibility. If the Member is not eligible for medical assistance or certain benefits, the Member is treated as a private-pay patient.

TexMedConnect

TexMedConnect is a free, web-based, claims submission application provided by TMHP. Technical support and training for TexMedConnect are also available free from TMHP. Providers can submit claims, eligibility requests, claim status inquiries, appeals, and

download ER&S Reports (in either PDF or ANSI 835 formats) using TexMedConnect. TexMedConnect can interactively submit individual claims that are processed in seconds. Providers can use TexMedConnect on the TMHP website at tmhp.com.

Automated Inquiry System (AIS)

The Automated Inquiry System (AIS) is the contact for prompt answers to Medicaid client eligibility, appeals, claim status inquiries, benefit limitations, and check amounts. Contact the TMHP Contact Center or AIS at 800-925-9126 or 512-335-5986 to access this service. Eligibility and claim status information is available on AIS twenty-three hours a day, seven days a week, with scheduled down time between 3 a.m. and 4 a.m., Central Time. All other AIS information is available from 6a.m. until 6 p.m., Central Time, Monday through Friday. TMHP call center representatives are available from 7 a.m. - 7 p.m., Central Time, Monday through Friday. AIS offers fifteen transactions per call.

Verifying Health Plan Eligibility

Providers are responsible for verifying a Member's eligibility, identifying which health plan a Member is assigned to, identifying the name of the assigned Primary Care Provider and verifying covered services and if they require prior authorization for each visit prior to providing care to Members.

There are several ways this can be done:

- Member identification cards
- Telephone verification
    - Cook Children's Health Plan Member Service
- (local) 682-885-2247
    - Cook Children's Health Plan Member Services
- (toll free) 800-964-2247
- Membership listings
- Cook Children's Health Plan Secure Provider Portal

Cook Children's Health Plan recommends that Providers verify eligibility through all available means prior to providing care to Members.

Pharmacy Providers can verify eligibility electronically through NCPDP E1 Transaction, National Council for Prescription Drug Programs (NCPDP) E1 transaction. The E1 transaction is submitted through the pharmacy's point-of-sale system.

Cook Children's Health Plan Identification Card

The Cook Children's Health Plan STAR Kids Member identification card identifies the health

plan and Primary Care Provider that has been selected by the Member. If the Member also received Medicare benefits, Medicare is responsible for most primary and acute services and some behavioral health services; therefore, the Primary Care Provider's name, address, and telephone number are not listed on the Member's ID card. The card includes the following essential information:

- Member Name
- Member Identification Number
- Health Plan Telephone Number
    - The toll-free phone number on the STAR Kids Member ID card is only for Members
    - Providers will use existing CHIP and STAR Health Plan phone number to verify eligibility
- Primary Care Provider's name and telephone number

While the health plan identification card does identify the Member, it does not confirm eligibility. This is because Member eligibility can change on a monthly basis without notice. Provider should use all available resources to confirm current Member eligibility prior to rendering services. Primary Care Providers should not treat any Member whose identification materials identify a different Primary Care Provider or health plan.

An example of a STAR Kids Member ID Card is located in the Appendix section of this Provider Manual.

Dual Eligible Members

Dual eligible Members have both Medicare and Medicaid health insurance coverage. Medicare or the Member's Medicare Health Maintenance Organization (HMO) is the primary payer and will reimburse all Medicare covered services. The state Medicaid program serves as a secondary payer and will provide all medically necessary covered services that are not covered by Medicare to dual eligible Members.

Cook Children's Health Plan Service Coordinators will communicate and coordinate services with the Member's Medicare Primary Care Provider to ensure continuity of care. Dual eligible Members should notify their service coordinators that they have Medicare coverage, and will provide the name of their chosen Primary Care Provider.

Dual eligible STAR Kids Members do not have to select a separate Primary Care Providers through Cook Children's Health Plan.

Member Listing for Primary Care Provider

Each Primary Care Provider receives a monthly listing of Members who selected that Provider as their Primary Care Provider. The Membership listing is available on our Secure Provider Portal at cookchp.org.

STAR Kids Member Rights and Responsibilities

Member Rights

- You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination
    - That includes the right to:
        - Be treated fairly and with respect
        - Know that your medical records and discussions with your Providers will be kept private and confidential
- 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:
            - Be told how to choose and change your health plan and your primary care Provider
            - Choose any health plan you want that is available in your area and choose your Primary Care Provider from that plan
            - Change your Primary Care Provider
            - Change your health plan without penalty
            - Be told how to change your health plan or your Primary Care Provider
- You have the right to ask questions and get answers about anything you do not understand
    - That includes the right to:
        - 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
        - Be told why care or services were denied and not given
- You have the right to agree to or refuse treatment and actively participate in treatment decisions
    - That includes the right to:
        - Work as part of a team with your Provider in deciding what health care is best for you
        - Say yes or no to the care recommended by your Provider

- You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings.
    - That includes the right to:
        - Make a complaint to your health plan or to the state Medicaid program about your health care, your Provider or your health plan
        - MDCP/DBMD Escalation Help Line for Members receiving waiver services via the Medically Dependent Children Program or Deaf/Blind Multi-Disability Program
        - Get a timely answer to your complaint
        - Use the plan's appeal process and be told how to use it
        - Ask for a an External Medical Review from the state Medicaid program and receive information about how that process works
        - Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works
- You have the right to timely access to care that does not have any communication or physical access barriers
    - That includes the right to:
        - Have telephone access to a medical professional twenty-four hours a day, seven days a week to get any emergency or urgent care you need
        - Get medical care in a timely manner
        - 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
        - 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
        - Be given information you can understand about your health plan rules, including the health care services you can get and how to get them
- 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
- 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
- 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

- You must learn and understand each right you have under the Medicaid program.
  - That includes the responsibility to:
    - Learn and understand your rights under the Medicaid program
    - Ask questions if you do not understand your rights
    - Learn what choices of health plans are available in your area
- You must abide by the health plan's and Medicaid's policies and procedures
  - That includes the responsibility to:
    - Learn and follow your health plan's rules and Medicaid rules
    - Choose your health plan and a primary care Provider quickly
    - Make any changes in your health plan and Primary Care Provider in the ways established by Medicaid and by the health plan
    - Keep your scheduled appointments
    - Cancel appointments in advance when you cannot keep them
    - Always contact your Primary Care Provider first for your non-emergency medical needs
    - Be sure you have approval from your Primary Care Provider before going to a specialist
    - Understand when you should and should not go to the emergency room
- You must share information about your health with your Primary Care Provider and learn about service and treatment options
  - That includes the responsibility to:
    - Tell your Primary Care Provider about your health
    - Talk to your Providers about your health care needs and ask questions about the different ways your health care problems can be treated
    - Help your Providers get your medical records
- You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy
  - That includes the responsibility to:
    - Work as a team with your Provider in deciding what health care is best for you
    - Understand how the things you do can affect your health.
    - Do the best you can to stay healthy
    - Treat Providers and staff with respect
    - Talk to your Provider about all of your medications

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

Section 3: STAR Kids Covered Services

Covered Services

STAR Kids benefits are governed by Cook Children's Health Plan's contract with the Health and Human Services Commission, and include: medical, vision, behavioral health, pharmacy and Long Term Services and Supports (LTSS). Medical Dependent Children Program (MDCP) services are covered for individuals who qualify for and are approved to receive MDCP.

Cook Children's Health Plan STAR Kids Members are entitled to all medically necessary services covered under the Texas Medicaid STAR Kids Program. The health provides a benefit package that includes all medically necessary services currently covered under the traditional, Fee-for-Service acute care and Long Term Services and Supports (LTSS) Medicaid program. The following information provides an overview of benefits provided for STAR Kids Members.

Benefits include, but may not be limited to:

- Emergency and non-emergency ambulance services
- Audiology services, including hearing aids
- Behavioral Health Services including
    - Inpatient mental health services – The health plan may provide these services in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting
    - Mental Health Rehabilitative Services and Mental Health Targeted Case Management for individuals who are not dually eligible in Medicare and Medicaid
    - Outpatient mental health services
        - Psychiatry services
        - Substance use disorder treatment services, including outpatient services such as:
            - Assessment
            - Detoxification services
            - Counseling treatment
            - Medication assisted therapy
    - Residential services, which may be provided in a chemical dependency treatment facility in lieu of an acute care inpatient setting, including:
        - Detoxification services
        - Substance use disorder treatment (including room and board)

- Prenatal care provided by a Physician, Certified Nurse Midwife (CNM), nurse practitioner (NP), Clinical Nurse Specialist (CNS), and Physician Assistant (PA) in a licensed birthing center
- Birthing services provided by a Physician and Certified Nurse Midwife (CNM) in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Day Activity and Health Services (DAHS)
- Dialysis
- Drugs and biologicals provided in an inpatient setting
- Durable medical equipment and supplies
- Early Childhood Intervention (ECI) Services
- Emergency services
- Family planning services
- Home health care services provided in accordance with 42 C.F.R § 440.70, and as directed by HHSC
- Hospital services, inpatient and outpatient
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
    - Inpatient services, outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient or outpatient setting for:
        - All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed
        - Surgery and reconstruction on the other breast to produce symmetrical appearance
        - Treatment of physical complications from the mastectomy and treatment of lymphedemas; and
        - Prophylactic mastectomy to prevent the development of breast cancer
        - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
- Medical checkups and Comprehensive Care Program (CCP) Services through the Texas Health Steps Program (EPSDT), including private duty nursing, Prescribed Pediatric Extended Care Center (PPECC) services, certified respiratory care practitioner services, and therapies (speech, occupational, physical)
- Oral evaluation and fluoride varnish in the medical home in conjunction with Texas Health Steps medical checkup for children six months through thirty-five months of age
- Optometry, glasses and contact lenses, if medically necessary

- Outpatient drugs and biologicals; including pharmacy-dispensed and Provider administered outpatient drugs and biologicals
- Personal Care Services (PCS)
- Podiatry
- Prescribed pediatric extended care center (PPECC) services
- Primary care services
- Private Duty Nursing (PDN) services
- Radiology, imaging, and X-rays
- Specialty physician services
- Telemonitoring
- Telehealth
- Therapies - physical, occupational and speech
- Transplantation of organs and tissues
- Vision services

Breast Pump Coverage

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

Coverage in Prenatal Period	Coverage at Delivery	Coverage for Newborn	Breast pump coverage & billing
STAR Kids	STAR Kids	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when medically necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when medically necessary for the newborn when the mother does not have coverage.

			Breast pumps and supplies must be billed under the newborn's Medicaid ID.

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

Community First Choice (CFC) Services for Those Members Who Qualify for These Services

The state provides an enriched array of services to Members who would otherwise qualify for care in a Nursing Facility, an ICF/IDD, or an Institution for Mental Diseases (IMD).

- Personal Care Services - CFC - all qualified Members may receive medically and functionally necessary Personal Assistance Services under CFC
- Habilitation, acquisition, maintenance and enhancement of skills - all qualified Members may receive this service to enable the Member to accomplish ADLs, IADLs and health-related tasks
- Emergency Response Services - CFC - (Emergency call button) - All qualified Members may receive necessary Emergency Response Services under CFC
- Support Management - all qualified Members may receive voluntary training on how to select, manage and dismiss attendants

Services for MDCP STAR Kids

The following is a list of covered services for Members who qualify for MDCP STAR Kids services. Cook Children's Health Plan must provide medically and functionally necessary services to Members who meet the functional and financial eligibility for MDCP STAR Kids.

- Respite Care
- Supported Employment
- Financial Management Services
- Adaptive Aids
- Employment Assistance
- Flexible Family Support Services
- Minor home modifications
- Transition Assistance Services

Limitations and Exclusions from Covered Services

Please refer to the current Texas Medicaid Provider Procedures Manual for a complete listing of limitations and exclusions. The limitations and exclusions can be accessed online at tmhp.com.

Added Benefits

- STAR Kids Members are not limited to the thirty -day spell-of-illness
- $200,000.00 annual limit on inpatient services does not apply for STAR Kids Members
- Unlimited prescriptions for STAR Kids Members who are NOT covered by Medicare
- A list of the Value Added Services is located on cookchp.org

Family Planning Services

Family Planning services, including sterilization, are covered STAR Kids Member benefits. These services can be provided by an in network Provider for Cook Children's Health Plan. Family planning services are preventive health, medical, counseling, and educational services that assist Members in controlling their fertility and achieving optimal reproductive and general health. Family planning services must be provided by a physician or under physician supervision.

In accordance with the Provider agreement, family planning Providers must assure Members, including minors, that all family planning services are confidential and that no information will be disclosed to a spouse, parent, or other person without the Members permission. Health care Providers are protected by law to deliver family planning services to minor Members without parental consent or notification.

Only family planning patients, not their parents, their spouse or other individuals, may consent to the provision of family planning services. However, counseling should be offered to adolescents, which encourages them to discuss their family planning needs with a parent, adult family Member, or other trusted adult.

Value Added Services

Value added services are extra health care benefits offered by Cook Children's Health Plan above the Medicaid program benefits. A list of the Value Added Services on cookchp.org.

Coordination with Non-Medicaid Managed Care Covered Services (Non-Capitated Services)

STAR Kids Members are eligible for the services described below. Cook Children's Health Plan and our network Providers are expected to refer to and coordinate with these programs. These services are described in the Texas Medicaid Provider Procedures Manual (TMPPM).

Texas Health Steps Dental Services (Including orthodontia)

Primary and preventative dental services for STAR Members are covered from birth through the age of twenty years, except Oral Evaluation and Fluoride Varnish benefits (OEFV) provided as part of a Texas Health Steps Medical Checkup for Members age six through thirty-five months. Children should have their first dental checkup at six months of age and every six months thereafter. Services may include but are not limited to medically necessary dental treatment for exams, cleanings, x-rays, fluoride treatment, orthodontia, and restorative treatment. Children under the age of six months can receive dental services on an emergency basis.

Texas Health Steps Environmental Lead Investigation (ELI)

In accordance with current federal regulations, Texas Health Steps requires blood lead screening at ages notated on the Texas Health Steps Periodicity Schedule and must be performed during the medical checkup.

Providers may obtain more information about the medical and environmental management of lead poisoned children from the DSHS Childhood Lead Poisoning Prevention Program by calling toll free 800-588-1248 or visiting the Texas Childhood Lead Poisoning Prevention Program webpage.

Early Childhood Intervention (ECI)

Early Childhood Intervention Case Management and Service Coordination is a statewide program for families with children, birth to three years old, with disabilities and developmental delays. Early Childhood Intervention teaches families how to help their children reach their potential through education and developmental services. Services are provided in the child's natural environment, such as home, daycare, or grandparent's home. Families with children enrolled in Medicaid, or whose income is below two-hundred percent of the Federal poverty Level, do not pay for Early Childhood Intervention services. Federal law requires Providers to refer children to Early Childhood Intervention within two business days of identifying a developmental disability or delay. To make a referral, Providers may call the Early Childhood Intervention Care Line toll free at 888-754-0524 to identify an Early Childhood Intervention program in the Member's area.

For information about Early Childhood Intervention resources available to Providers, call:

- Early Childhood Intervention Care Line 888-754-0524
- Cook Children's Health Plan Care Management Department 888-243-3312
- Additional resource information available online at https://www.hhs.texas.gov/services/disability/early-childhood-intervention-services

A medical diagnosis or a confirmed developmental delay is not needed to refer. As soon as a delay is suspected, Providers may refer a child to Early Childhood Intervention even as early as birth. The local program conducts developmental screenings and assesses the child for developmental delay and eligibility. After a child is accepted and enrolled, an individual treatment plan is developed, and services are initiated. When a child is not accepted into the program, Early Childhood Intervention staff will refer the family to other resources.

Our network Providers must cooperate and coordinate with local Early Childhood Intervention programs to comply with Federal and State requirements relating to the developmental, review and evaluation of Individual Family Service Plan. Medically Necessary Health and Behavioral Health Services contained in an Individual Family Service Plan must be provided to the Member in the amount, duration, scope and setting established in the Individual Family Service Plan.

Early Childhood Intervention Specialized Skills Training (SST)

Specialized Skills Training (SST) is a rehabilitative service that promotes age- appropriate development by providing skills training to correct deficits and teach compensatory skills for deficits that directly result from medical, developmental, or other health-related conditions.

Specialized Skills Training services are provided by an Early Childhood Intervention Provider. The Early Childhood Intervention Provider ensures that Specialized Skills Training services are provided by an early intervention specialist who meets the criteria established in 40 TAC Part 2, Chapter 108, Subchapter C, §108.313.

Texas School Health and Related Services (SHARS)

School Health and Related Services (SHARS) is a Medicaid financing program and is a joint program of the Texas Education Agency and the Texas Health and Human Services Commission. The program allows local school districts/shared services arrangements to obtain Medicaid reimbursement for certain health-related services provided to students in special education. School districts/shared services arrangements receive federal Medicaid money for SHARS services provided to students who meet all three of the following requirements.

These students must:

- Be twenty years of age and younger and be eligible for Medicaid
- Meet eligibility requirements for Special Education described in the Individuals with Disabilities Education Act (IDEA) and
- Have Individual Educational Plans (IEPs) that prescribe the needed services

Covered services include: audiology, counseling, nursing services, occupational therapy, personal care services, physical therapy, physician services, psychological services, including assessments, speech therapy, and transportation in a school setting.

These services must be provided by qualified personnel who are under contract with or employed by the school district.

DARS Blind Children's Vocational Discovery and Development Program (Texas Commission for the Blind Case Management)

The Department of Assistive and Rehabilitative Services (DARS) Division for Blind Services (DBS) is the Medicaid Provider of case management for clients who are twenty-one years of age and younger and blind or visually impaired.

Any child who has a suspected or diagnosed visual impairment may be referred to Blind Children's Vocational Discovery and Development program. The Department of Assistive and Rehabilitative Services Division for Blind Services assesses the impact the visual impairment has on the child's development and provides blindness specific services to increase the child's skill level in the areas of independent living, communication, mobility, social, recreational, and vocational discovery and development. For more information, visit the Department of Assistive and Rehabilitative Services website dars.state.tx.us.

Blind Children's Vocational Discovery and Development program services are provided to help children who are blind and visually impaired to develop their individual potential. This program offers a wide range of services that are tailored to each child and their family's needs and circumstances. By working directly with the entire family, this program can help children develop the concepts and skills needed to realize their full potential.

Blind Children's Vocational Discovery and Development program services include the following:

- Assisting the client in developing the confidence and competence needed to be an active part of their community
- Providing support and training to children in understanding their rights and
- responsibilities throughout the educational process
- Assisting family and children in the vocational discovery and development process
- Providing training in areas like food preparation, money management,

- recreational activities, and grooming
- Supplying information to families about additional resources

Tuberculosis Services provided by the Department of State Health Service – approved Providers (Directly Observed Therapy and Contact Investigation)

All confirmed cases of Tuberculosis (TB) must be reported to the Local Tuberculosis Control Health Authority (LTCHA) using the most recent Department of State Health Services forms and procedures within one day of diagnosis for a contact investigation. Providers must document Members' referrals to Local Tuberculosis Control Health Authority in their medical records and notify Cook Children's Health Plan of the referrals. Cook Children's Health Plan must coordinate with the Local Tuberculosis Control Health Authority to ensure that all Members with confirmed or suspected tuberculosis have a contact investigation and receive directly observed therapy. Providers must report to Department of State Health Services or the Local Tuberculosis Control Health Authority any Member who is non-compliant, drug resistant or who is or may be posing a public health threat. Cook Children's Health Plan must cooperate with the local Tuberculosis Control Health Authority in enforcing the control measures and quarantine procedures contained in Chapter 81 of the Texas Health and Safety Code.

Medical Transportation Program through Texas Health and Human Services Commission

Medical Transportation services are available to Medicaid eligible clients that have no other means of transportation by the most cost-effective means. Medical Transportation can reimburse for gas if the Member has an automobile but no funds for gas. The transportation company for our service area is Access2Care. The Access2Care region includes fourteen counties: Dallas, Denton, Ellis, Erath, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somerville, and Tarrant.

Providers may call Access2Care for transportation services at the following numbers:

- Reservation Line: 844-572-8195, 24 hours a day, 7 days a week
- TTY: 711
- Complaints: 844-572-8195

Hospice:

Health and Human Services Commission manages the Hospice program. Members are dis-enrolled from Cook Children's Health Plan upon enrollment into hospice. Medicaid hospice provides palliative care to all Medicaid eligible clients who sign statements electing hospice services and are certified by physicians to have six months or less to live if their terminal

illnesses run their normal courses. Services include medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death. When clients elect hospice services, they waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services unrelated to their terminal illness. HHSC can be contacted at 512-438-3161.

HHSC or DSHS HCBS Waiver Programs

Community Living Assistance and Support Services (CLASS) Waiver Program

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

Deaf Blind with Multiple Disabilities (DBMD) Waiver Program

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

Home and Community-based Services (HCS) Waiver Program

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

Texas Home Living (TxHmL) Waiver Program

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

Youth Empowerment Services (YES) Waiver Program

The Youth Empowerment Services (YES) waiver provides comprehensive home and community-based mental health services to youth between the ages of three and eighteen up to a youth’s nineteenth birthday, who have a serious emotional disturbance. The YES Waiver not only provides flexible supports and specialized services to children and youth at risk of institutionalization and/or out-of-home placement due to their serious emotional

disturbance, but also strives to provide hope to families by offering services aimed at keeping children and youth in their homes and communities.

Admissions to Inpatient Mental Health Facilities as a Condition of Probation

When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

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.

Preadmission Screening and Resident Review

Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care.

PASRR requires that all applicants to a Medicaid-certified nursing facility:

- Be evaluated for serious mental illness (SMI) and/or intellectual disability
- Be offered the most appropriate setting for their needs (in the community a nursing facility, or acute care settings)
- Receive the services they need in those settings

Long Term Services and Support

Adaptive Aids (STAR Kids MDCP Members Only)

Adaptive aids and medical supplies are specialized medical equipment and supplies which include devices, controls, or appliances that enable Members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Texas State Plan, such as: vehicle modifications, service animals and supplies, environmental adaptations, aids for daily living, teachers, adapted utensils, and certain types of lifts.

Case Management for Children and Pregnant Women (CPW)

Case Management for Children and Pregnant Women (CPW) is a Medicaid program that

assists a person (children birth through twenty years of age and women with high-risk pregnancies of all ages) in gaining access to medical, social, educational and other service needs related to the person's health condition, health risk or high-risk condition.
Cook Children's Health Plan Service Coordination Supervisor or Manager will review all requests that are submitted to the Health Plan for CPW services. STAR Kids Members will have a health plan Service Coordinator provide assistance with accessing medical and social services.

STAR Kid Members requesting a CPW Provider for assistance with accessing educational services related to the Member's health condition, health risk, or high risk condition will be assigned to the CPW Provider of their choice. If a Provider has not been specified in the request, the health plan will assign the contracted CPW Provider in the nearest zip code to the Member.

If a CPW service request is submitted to the health plan and the request does not follow the guidelines for CPW services, an outreach phone call will be made to the requester to discuss a solution.

A Member may have both a Service Coordinator and a CPW Provider if the CPW Provider is providing educational services as specified in the guidance. A discussion with the Member's Service Coordinator will take place before a CPW Provider is assigned to ensure there is no duplication of services.

The health plan will work with the Member/LAR to find a solution that honors the Member/LAR preference. If the requested CPW Provider is not currently contracted with the health plan, an outreach will be made to work with that Provider.

Community First Choice Services

Community First Choice (CFC) provides certain services and supports to individuals living in the community who are enrolled in the Medicaid program and meet CFC eligibility requirements. Services and supports may include:

- Activities of daily living (eating, toileting, and grooming), activities related to living independently in the community, and health-related tasks (personal assistance services)
- Acquisition, maintenance, and enhancement of skills necessary for the individuals to care for themselves and to live independently in the community (habilitation)
- Providing a backup system or ways to ensure continuity of services and supports (emergency response services)
- Training people how to select, manage and dismiss their own attendants (support management)

CFC is available to individuals with a need for habilitation, personal assistance or emergency response services who receive services in the following waiver programs:

- Community Living Assistance and Support Services (CLASS)
- Deaf Blind with Multiple Disabilities (DBMD)
- Home and Community-based Services (HCS)
- Texas Home Living (TxHmL)

Day Activity and Health Services (DAHS)

(Only for Members eighteen years of age and older)

Licensed day activity and health services (DAHS) facilities provide daytime services to people who live in the community as an alternative to living in a nursing home or other institution. Services, which usually are provided Monday through Friday, address physical, mental, medical and social needs. Sometimes, this is called adult day care or adult day services.

Employment Assistance (EA)

(STAR Kids MDCP Members Only)

Assistance provided to an individual to help the individual locate paid employment in the community. EA includes: identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions; locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements; and contacting a prospective employer on behalf of an individual and negotiating the individual's employment. In the State of Texas, this service is not available to individuals receiving waiver services under a program funded under section 110 of the Rehabilitation Act of 1973.

Financial Management Services

Financial Management Services (FMS) provides assistance to Members with managing funds associated with the services elected for self-direction. The service includes initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers.

The FMS Provider, referred to as the Consumer Directed Services Agency, also:

- Serves as the Member’s employer-agent

- Provides assistance in the development, monitoring, and revision of the Member's budget
- Provides information about recruiting, hiring, and firing staff, including identifying the need for special skills and determining staff duties and schedule
- Provides guidance on supervision and evaluation of staff performance
- Provides assistance in determining staff wages and benefits
- Provides assistance in hiring by verifying employee's citizenship status and qualifications, and conducting required criminal background checks in the Nurse Aide Registry and Employee Misconduct Registry
- Verifies and maintains documentation of employee qualifications, including citizenship status, and documentation of services delivered
- Collects timesheets, processes timesheets of employees, processes payroll and payables, and makes withholdings for, and payment of, applicable federal, state, and local employment-related taxes
- Tracks disbursement of funds and provides quarterly written reports to the Member of all expenditures and the status of the Member's Consumer Directed Services budget
- Maintains a separate account for each Member's budget

The State allows a relative or legal guardian, other than a legally responsible Member, to be the Member's Provider for this service if the relative or legal guardian meets the requirements for this type of Provider.

Flexible Family Support Services

(STAR Kids MDCP Members Only)

Flexible Family Support Services (FFSS) promotes community inclusion in typical child/youth activities through the enhancement of natural supports and systems and through recognition that these supports may vary from setting to setting, from day to day, from moment to moment, hence the need for a diverse Provider base.

To accomplish this, FFSS Providers may provide personal care supports for activities of daily livings and instrumental activities of daily living, skilled care, non-skilled care and delegated skilled care supports to support inclusion. This service may be reimbursed if part of an approved service plan and if delivered in a setting where provision of such supports is not already required or included as a matter of practice.

Minor Home Modifications

(STAR Kids MDCP Members Only)

Minor Home Modifications (MHM) are those physical adaptations to a Member's home, required by the service plan, that are necessary to ensure the Member's health, welfare, and safety, or that enable the Member to function with greater independence in the home. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the Member's welfare. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the Member, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services are provided in accordance with applicable state or local building codes.

Modifications are not made to settings that are leased, owned, or controlled by waiver Providers. The State allows a Member to select a relative or legal guardian, other than a spouse, to be the Member's Provider for this service if the relative or legal guardian meets the requirements to provide this service.

Personal Care Services (PCS)

What is Personal Care Services?

Personal Care Services (PCS) is a Medicaid benefit that helps clients with everyday tasks. These tasks are called activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADL's include activities such as such as bathing, eating, going to the toilet, dressing and walking. IADL's include activities such as laundry, light housework and fixing meals.

To receive Personal Care Services, a Member must:

- Be birth through age twenty and have Medicaid
- Have a disability, physical or mental illness or a health problem that lasts for a long time
- Have a Practitioner Statement of Need signed by a practitioner (physician, advanced practice nurse, or physician assistant) who has examined the Member in the last twelve months
- Need help with ADLs and IADLs based on the Personal Care Assessment Form (PCAF)
- Provide a reason why the Member's guardian cannot help the Member with ADL's and IADL's

Private Duty Nursing

Private Duty Nursing (PDN) services are nursing services, as described by the Texas

Nursing Practice Act and its implementing regulations, for clients who meet the medical necessity criteria, and who require individualized, continuous, skilled care beyond the level of skilled nursing visits normally authorized under Texas Medicaid Home Health Skilled Nursing and Home Health Aide Services. PDN services may be provided by a registered nurse or a licensed vocational nurse.

Private Duty Nursing services provide nursing care and parent/guardian/ responsible adult training and education intended to:

- Optimize Member health status and outcomes
- Promote family-centered, community-based care as a component of an array of service options by:
    - Preventing prolonged and/or frequent hospitalizations or institutionalization
    - Providing cost effective and quality care in the most appropriate, least restrictive environment

Private Duty Nursing is considered medically necessary when a Member has a disability, physical, or mental illness, or chronic condition and requires continuous, skillful observations, judgments, and interventions to correct or ameliorate his or her health status.

To be eligible for Private Duty Nursing services, a Member must meet all the following criteria:

- Be birth through twenty years of age and eligible for Medicaid and Texas Health Steps
- Meet medical necessity criteria for Private Duty Nursing
- Have a Primary Physician who must:
    - Provide a prescription for Private Duty Nursing
    - Establish a Plan of Care
    - Provide documentation to support the medical necessity of Private Duty Nursing services
    - Provide continuing medical care and supervision of the Member, including, but not limited to, examination or treatment within thirty calendar days prior to the start of Private Duty Nursing services, or examination or treatment that complies with the Texas Health Steps periodicity schedule, or is within six months of the Private Duty Nursing extension Start of Care date, whichever is more frequent (for extensions of Private Duty Nursing services)
        - This requirement may be waived based on review of the Member's specific circumstances
    - Provide specific written, dated orders for the Member who is receiving continuing or ongoing Private Duty Nursing services
    - Require care beyond the level of services provided under Texas Medicaid (Title XIX) home health services

- Members who are birth through seventeen years of age must reside with a responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable
    - A parent or guardian of a minor client, or the client's spouse may not be reimbursed for PDN services even if he or she is an enrolled Provider or employed by an enrolled Provider

Private Duty Nursing is based on the need for skilled care in the Member's home, nurse Provider's home, client's school, client's daycare facility. The place of service must be able to support the Member's health and safety needs and it must be adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the Member. Necessary primary and backup utilities, communication, fire, and safety systems must be available at all times. The amount and duration of Private Duty Nursing must always be commensurate with the Member's medical needs. Requests for services must reflect changes in the Member's condition that affect the amount and duration of Private Duty Nursing.

Prescribed Pediatric Extended Care Centers and Private Duty Nursing

A client has a choice of Private Duty Nursing, Prescribed Pediatric Extended Care Center (PPECC), or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services, and must be coordinated to prevent duplication.

A client may receive both in the same day, but not simultaneously (e.g., PDN) may be provided before or after PPECC services are provided). The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the client's medical condition or the authorized hours are not commensurate with the client's medical needs.

In accordance with 1 Tex. Admin. Code § 363.209(c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary.

Respite

(STAR Kids MDCP Members Only)

Respite care services are provided to individuals unable to care for themselves, and are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing unpaid services. Respite care may be provided in the following locations: Member's home or place of residence; adult foster care home; Medicaid certified

NF; and an assisted living facility.

Respite care services are authorized by a Member's Primary Care Provider as part of the Member's care plan. Respite services may be self-directed. Limited to thirty days per year.

Supported Employment

(STAR Kids MDCP Members Only)

Assistance provided, in order to sustain competitive employment, to an individual who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed. Supported Employment (SE) includes adaptations, supervision, training related to an individual's assessed needs, and earning at least minimum wage (if not self-employed).

Transition Assistance Services

(STAR Kids MDCP Members Only)

Transition Assistance Services pays for non-recurring, set-up expenses for Members transitioning from nursing homes to the STAR+PLUS HCBS program. Allowable expenses are those necessary to enable Members to establish basic households and may include: security deposits for leases on apartments or homes; essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, gas, and water; services necessary for the Member's health and safety, such as pest eradication and one-time cleaning prior to occupancy; and activities to assess need, arrange for, and procure needed resources.

Role of the Pharmacy

Cook Children's Health Plan Members receive pharmacy services through Navitus, Cook Children's Health Plan's contracted Pharmacy Benefit Manager (PBM). Navitus has a statewide network of contracted pharmacies who are enrolled in the Texas Vendor Drug Program (VDP), including all of the major pharmacy chains and VDP-enrolled independent pharmacies. Cook Children's Health Plan Providers are required to adhere to the Preferred Drug list (PDL).

Members have the right to obtain Medicaid covered medications from any Cook Children's Health Plan network pharmacy. These pharmacies are located on Cook Children's Health Plan website, cookchp.org. Providers and Members can also call Cook Children's Health

Plan Member Services department to locate a network pharmacy.

Pharmacy Provider Responsibilities

Network pharmacies are required to:

- Perform prospective and retrospective drug utilization reviews
- Coordinate with the prescribing physician
- Ensure Members receive all medications for which they are eligible
- Ensure adherence to the Medicaid and CHIP Formularies administered through the Texas Vendor Drug Program (VDP) and the Medicaid Preferred Drug List (PDL)
- The pharmacy must coordinate the benefits when a Member also receives Medicare Part D services or has other benefits

Member Prescriptions

Cook Children's Health Plan covers prescription medications. Our Members can get their prescriptions at no cost.

- Members have the right to obtain their prescriptions from any network pharmacy
- Providers should reference the Medicaid formulary and Medicaid Preferred Drug List (PDL)

Formulary and Preferred Drug List

The existing Texas Medicaid formulary currently utilized by the Vendor Drug Program (VDP) will be adopted. The formulary, along with a list of drugs requiring prior authorization can be found at Texas Vendor Drug Program (VDP) website at txvendordrug.com. The Medicaid formulary and Medicaid Preferred Drug List (PDL) are available for smartphones and on the web at epocrates.com.

The Texas Preferred Drug List and the prior authorization criteria to be used for Cook Children's Health Plan Members are available at txvendordrug.com. A list of covered drugs and preferred drugs may also be accessed through our Pharmacy Benefit Manager, Navitus Health Solutions.

To contact Navitus Health Solutions:

- Navitus Provider Portal: navitus.com
- Navitus Pharmacy Help Desk: 877-908-6023

Pharmacy Prior Authorization

Navitus processes Texas Medicaid pharmacy prior authorizations for Cook Children's Health Plan. The formulary, prior authorization criteria, and the length of the prior authorization approval are determined by HHSC. Information regarding the formulary and specific prior authorization criteria can be found at the Vendor Drug Website, eProcrates, and SureScripts for ePrescribing.

Prescribers can access prior authorization forms online via navitus.com under the "Providers" section or have them faxed by Customer Care to the prescribers' office. Prescribers will need their NPI and State to access the portal. Completed forms can be faxed twenty-four hours a day seven days a week to Navitus at 920-735-5312. Prescribers can also call Navitus Customer Care at 877-908-6023 select the prescriber option and speak with the prior authorization department between 8:00 a.m. - 5:00 p.m. Monday - Friday Central Time to submit a prior authorization request over the phone. After hours, Providers will have the option to leave voicemail. Decisions regarding prior authorizations will be made within twenty-four hours from the time Navitus receives the prior authorization request. The Provider will be notified by fax of the outcome or verbally if an approval can be established during a phone request.

Pharmacies will submit pharmacy claims to Navitus. Medications that require prior authorization will be undergo an automated review to determine if the criteria are met. If all the criteria are met, the claim is approved and paid, and the pharmacy continues with the dispensing process. If the automated review determines that all the criteria are not met, the claim will be rejected and the pharmacy will receive a message indicating that the drug requires prior authorization. At that point, the pharmacy should notify the prescriber and the above process should be followed.

Cancellation of Product Orders

A network Provider that offers delivery services for covered products, such as durable medical equipment (DME), limited home health supplies (LHHS), or outpatient drugs or biological products must reduce, cancel or stop delivery if the Member or the Member's authorized representative submits an oral or written request. The network Provider must maintain records documenting the request.

Main Dental Home

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

Role of Main Dental Home

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

How to Help a Member Find Dental Care

The dental plan Member ID card lists the name and phone number of a Member's main dental home provider. The Member can contact the dental plan to select a different main dental home Provider at any time. If the Member selects a different main dental home Provider, the change is reflected immediately in the dental plan's system, and the Member is mailed a new ID card within five business days.

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

Members with Special Healthcare Needs

Cook Children's Health Plan offers enhanced care management for Members with Special Health Care Needs (MSHCN). The enrollment process identifies Members with Special Health Needs. Primary Care and Specialty Care Providers should also notify the Cook Children's Health Plan Care Management Department of covered Members who may qualify for this program.

A Member can be classified as a Member with Special Health Care Needs if the answers to the following five questions can be answered 'yes.'

- Does the Member have a serious on-going illness, complex on-going condition or disability?
- Is the illness, condition, or disability one that has lasted for at least twelve months in a row or more, or is expected to last for at least twelve months in a row or more?
- Does the Member's illness, condition or disability cause (or without treatment, can it cause) limits in the Member's ability to function (activities such as walking, talking, running, eating, playing, learning or relating to others); and are these limits not usual for most people his or her age?
- Does the Member's illness, condition, or disability require regular, on-going treatment and review by doctors, therapists, or other trained health care professionals?

- Does the Member need health care or related services more often than most people do his or her age?

Access to Specialists

Members with Special Health Care Needs have direct access to in network specialty physicians. Cook Children's Health Plan does not require authorization or referrals from Primary Care Providers. Care Management staff coordinate care and authorize services if the Member's specialist is out-of-network to assure access until care is appropriately transitioned in network.

Early identification of Members that may benefit from case management is an integral component of the program and begins at the time of enrollment. Cook Children's Health Plan aggressively attempts to identify Members that may benefit from service coordination or case management services through use of the following: claims triggers, Health Needs Risk Assessment, utilization review activities, and referrals from Members, families, physicians and community agencies. When a Member is designated as having Member with Special Health Care Needs status, a Care Management team member will contact the Member or their legally authorized representative to discuss covered services. The Member or the Member's legally authorized representative have the right to request a specialist as a Primary Care Provider, out-of-network services applicable to the child's condition if not available in network, the availability of enhanced care coordination, and referral to community programs or resources. In collaboration with the Member, family, and the Member's health care Providers, the Care Management team Member develops a written service plan that meets the Member's health care needs. Referrals to community agencies when appropriate are included in the service plan.

Designation of a Specialist as a Primary Care Provider

Members that have disabilities, special health care needs, chronic or complex health care needs have the right to request a specialist physician as a Primary Care Provider. Members, their legally authorized representative or Primary Care Providers, or the Member's designee may initiate the request. In order to accept such a request, the specialist physician must agree to provide all primary care services, (i.e. immunizations, well child care/annual check-ups, coordination of all health care services required by the Member). The Member or their legally authorized representative must also sign the agreement. The Cook Children's Health Plan Medical Director reviews and determines Cook Children's Health Plan approval for Specialist (physician) as Primary Care Provider (PCP).

The form to be used for approval of a Specialist to act as a Primary Care Provider is located in the Appendix section of this Provider Manual.

This section does not apply to STAR Kids Dual Eligible Members

Out-of-network Providers and Continuity of Care

Cook Children's Health Plan takes special care to provide continuity in the care of newly enrolled Members whose physical or behavioral health condition could be placed in jeopardy if medically necessary covered services are disrupted, compromised, or interrupted. Upon notification from a Member or Provider of the existence of a prior authorization, Cook Children's Health Plan ensures Members receiving services through a prior authorization from either another health plan or fee-for-service receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following:

- Ninety calendar days after the transition to Cook Children's Health Plan
- Until the end of the current authorization period or
- Until Cook Children's Health Plan has evaluated and assessed the Member and issued or denied a new authorization

Cook Children's Health Plan is required to ensure that clients receiving Community Based Long Term Care Services prior to the Operational Start Date continue to receive those services for up to six months after the Operational Start Date, unless the health plan has completed the STAR Kids Screening and Assessment Process and issued new authorizations. During the transition, an HHSC's Administrative Services Contractor or an HHSC Agency will provide a file identifying Members with prior authorizations for acute care services and Members receiving Community Based Long Term Care Services. The health plan is required to work with HHSC and its Administrative Services Contractor to ensure that all necessary authorizations are in placed within the health plan's system for the continuation of Community Based Long Term Care Services and prior authorized acute care services. The health plan must describe the process it will use to ensure continuation of these services in its Transition/ Implementation Plan. The health plan will ensure that Community Based Long Term Care service Providers are informed and trained on this process prior to the Operational Start Date.

Cook Children's Health Plan allows a pregnant Member past the twenty-four week of pregnancy to remain under the care of her current Obstetrician/Gynecologist through her postpartum checkup, even if the Provider is Out-of-Network. If a Member wants to change her OB/GYN to one who is in the Cook Children's Health Plan network, she is allowed to do so if the Provider to whom she wishes to transfer agrees to accept her care in the last trimester of pregnancy.

Cook Children's Health Plan pays a Member's existing out-of-network Providers for medically necessary covered services until the Member's records, clinical information, and

care can be transferred to a network Provider or until such time as the Member is no longer enrolled in the health plan, whichever is shorter. Payment is made to out-of-network Providers in the time period required for network Providers. Cook Children's Health Plan complies with out-of-network Provider reimbursement rules as adopted by the Health and Human Services Commission.

With the exception of pregnant Members who are past the twenty-fourth week of pregnancy, Cook Children's Health Plan does not reimburse a Member's existing out-of-network Providers for ongoing care for:

- More than ninety days after a Member enrolls in the health plan or
- For more than nine months in the case of a Member who, at the time of enrollment in the health plan, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled in the health plan

Cook Children's Health Plan's obligation to reimburse the Member's existing out-of-network Provider for services provided to a pregnant Member past the twenty-fourth week of pregnancy extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

Cook Children's Health Plan provides or pays out-of-network Providers who provide medically necessary covered services to Members who move out of the service area through the end of the period for which capitation has been paid for the Member.

Cook Children's Health Plan provides Members with timely and adequate access to out-of-network services for as long as those services are necessary and not available within the network. If services become available from a network Provider, Cook Children's Health Plan is not obligated to provide a Member with access to out of network services.

Cook Children's Health Plan ensures that each Member has access to a second opinion regarding the use of any medically necessary covered service. A Member may access a second opinion from a network Provider or Out-of-Network Provider if a network is not available, at no cost to the Member.

Providers are encouraged to call the Cook Children's Health Plan Care Management Department at 888-243-3312 for assistance with any continuity of care/transition of care issues.

Pre-Existing Conditions

Cook Children's Health Plan is responsible for ensuring access to all medically necessary covered services for each eligible Member beginning on the Member's date of enrollment, regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior health care

services.

Ambulance Transportation

Cook Children's Health Plan covers emergency and medically necessary non-emergency 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 en route to the nearest medical facility, the ambulance transport is considered an emergency service and does not require Cook Children's Health Plan prior authorization.

Facility-to-facility ambulance transports may be considered emergencies if the required emergency treatment is not available at the first facility and the Member still requires emergency care. The transport must be to an appropriate facility, meaning the nearest medical facility equipped in terms of equipment, personnel, and the capacity to provide medical care for the illness or injury of the Member.

Non-Emergency Ambulance Transportation

Non-emergency ambulance transportation is defined as ambulance transport provided for a 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 as the use of ambulance is the only appropriate means of transportation. Non-emergency ambulance transportation services must be prior authorized and coordinated by Cook Children's Health Plan before an ambulance is used to transport a Member in circumstances not involving an emergency.

The Provider of record, the Ambulance Provider or those acting on their behalf may request approval for an ambulance by submitting an authorization request. Network Providers should submit a prior authorization request through our Secure Provider Portal. Out of network Provider may refer to the Prior Authorization Request Form located on our website at cookchp.org. Cook Children's Health Plan will provide the approval or denial for the prior authorization to the requesting Provider and the Ambulance Provider.

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 if within thirty days of transport.

Non-Emergency Medical Transportation (NEMT) Services

Access2Care

What is Access2Care?

Access2Care provide transportation to covered health care services for Members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. Access2Care does NOT include ambulance trips.

What services are part of Access2Care?

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

If you have a Member needing assistance while traveling to and from his or her appointment with you, Access2Care 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 fourteen years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children fifteen– seventeen 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 Access2Care, please refer him or her to Access2Care at 844-572-8195 for more information.

Section 4: Texas Health Steps Services

The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a federally mandated health care program of prevention, diagnosis, and treatment for Medicaid recipients from birth through twenty years of age.

In Texas, the EPSDT program is known as Texas Health Steps (THSteps). Texas Health Steps is administered by the Department of State Health Services (DSHS). For more information regarding Texas Health Steps services, Providers should refer to the Texas Medicaid Provider Procedures Manual at tmhp.com or the Texas Health Steps website at hhs.texas.gov.

Who Can Perform THSteps Examinations?

Only Medicaid enrolled THSteps Providers will be reimbursed for performing THSteps examinations. If the Provider performing the examination is not the Member's Primary Care Provider, the performing Provider must provide a report to the Primary Care Provider of record. If the performing Primary Care Provider diagnoses a medical condition that requires additional treatment, the patient must be referred back to the Primary Care Provider of record.

How Do I Become a THSteps Provider?

To enroll in Texas Medicaid, Providers must complete and submit the appropriate Texas Medicaid enrollment application, including all required forms as indicated in the application.

There are two ways Providers may enroll:

- To apply online, visit tmhp.com and follow the instructions for completing the online enrollment process
- Download, print, and complete the application forms
- To submit a paper application, you will need to download the enrollment forms. You can access these forms on tmhp.com. The forms you need are under Topics, Provider Enrollment.
- You can also request an enrollment package from Texas Medicaid & Healthcare Partnership by phone at 800-925-9126 or by mail at:

Texas Medicaid & Healthcare Partnership
Attn: Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

For enrollment assistance please contact the Texas Medicaid & Healthcare Partnership Contact Center toll free at 800-925-9126 and select option 2 or send email correspondence to Provider.Enrollment.Mailbox@tmhp.com.

Texas Health Steps Medical Checkups Periodicity Schedule

Providers are required to administer a complete Texas Health Steps medical checkup for Members from birth through age twenty, in accordance with the Texas Health Steps Periodicity Schedule. Providers can find an updated Texas Health Steps periodicity schedule at HHSC Texas Health Steps.

Texas Health Steps must be offered for all new Members age twenty and younger who are due, soon due or overdue for checkups or case management services. These services may be performed no later than:

- Fourteen days from the date of enrollment for newborns
- Ninety days from the date of enrollment for all other eligible child Members

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 twelve 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 zero to two years, and blood pressure three to twenty 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 (ImmTrac2)
  - 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 nine to twelve years of age and again eighteen to twenty years of age
    - HIV screening at sixteen to eighteen years of age
    - 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 includes healthy lifestyle practices as well as prevention of lead poisoning, accidents and disease
- **Dental referral** every six months until the parent or caregiver reports a dental home is established
    - Clients must be referred to establish a dental home beginning at six 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.

Sports physical exams do not qualify as Texas Health Steps Medical Checkup.

Exceptions to the Periodicity Schedule

On occasion, a child may require a Texas Health Steps checkup that is outside the schedule. Such reasons for an exception to periodicity include:

- Medical necessity (developmental delay, suspected abuse)
- Environmental high-risk (for example, sibling of child with elevated lead blood level)
- Required to meet state or federal exam requirements for Head Start, day care, foster care or pre-adoption
- Required for dental services provided under general anesthesia

Exceptions to periodicity must be billed on the CMS 1500 and should comply with the

standard billing requirements.

If a Provider other than the Primary Care Provider performs the Exception to Periodicity medical checkup, the Primary Care Provider must be provided with medical record information. In addition, all necessary follow-up care and treatment must be referred to the Primary Care Provider.

Additional information concerning Texas Health Steps can be accessed at tmhp.com.

Texas Vaccines for Children

The Texas Vaccines for Children (TVFC) Program is a federally funded, state-operated vaccine distribution program. It provides vaccines free of charge to enrolled Providers for administration to individual's birth through eighteen years of age. Providers may obtain vaccines free of charge from the Texas Vaccines for Children Program and must not charge the Member for the vaccines. Medicaid does not reimburse for vaccines that are available through TVFC. Providers may refer to TVFC webpage at https://dshs.texas.gov/immunize/tvfc/ for information about the program and for a list of vaccines available through the program.

ImmTrac2

ImmTrac2, the Texas immunization registry, is a free service from the Texas Department of State Health Services. It is a secure, confidential registry that stores immunization records electronically in one centralized system, available only to authorized users. Texas law requires health care Providers and "payors" (e.g., health insurance companies) to report specified immunization information regarding vaccines administered to children younger than eighteen years of age to the Texas Department of State Health Services. For more information, please visit the ImmTrac2 website at ImmTrac2: The Texas Immunization Registry.

Texas Health Steps Billing

A listing of the Texas Health Steps codes for each of the different exam types, immunizations, TB skin tests, and newborn hereditary/metabolic tests are included in the Texas Health Steps Quick Reference Guide and the Texas Medicaid Provider Procedures Manual found on the Texas Medicaid & Health Partnership website at tmhp.com.

THSteps medical checkups reflect the federal and state requirements for a preventive checkup. Preventive care medical checkups are a benefit of the THSteps program if they are provided by enrolled THSteps Providers and all of the required components are completed. An incomplete preventive medical checkup is not a benefit. The THSteps periodicity schedule specifies screening procedures required at each stage of the Members

life to ensure that health screenings occur at age-appropriate points in a Member's life. Checkups should be scheduled based on the ages on the periodicity schedule to accommodate the need for flexibility when scheduling checkup appointments.
Components of a medical checkup that have an available CPT code are not reimbursed separately on the same day as a medical checkup, with the exception of initial point-of- care blood lead testing, a Tuberculin Skin Test (TST), developmental and autism screening, vaccine administration, and Oral Evaluation and Fluoride Varnish (OEFV).

Children of Migrant Farm Workers

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.

Cook Children's Health Plan will send written notification to Primary Care Providers when Children of Migrant Farm Workers (CMFW) are assigned to their membership listing. For families in need of accelerated services, a representative will facilitate the appointment with the family, Provider's office, and Medicaid Medical Transportation Program (MTP) as appropriate.

Providers should notify Cook Children's Health Plan of a Member when they identify a migrant farm worker or the child of a migrant farm worker by calling 888-243-3312. Representatives are available to assist you from Monday to Friday, 8:00 a.m. - 5:00 p.m. Central Standard Time. This will allow Cook Children's Health Plan to complete an assessment to better coordinate and accelerate services for that Member.

Outreach

Cook Children's Health Plan representatives will contact new Members under the age of twenty-one that are due a Texas Health Steps medical checkup. Through outreach, new Members are educated about the importance of receiving timely Texas Health Steps medical checkups, the periodicity schedule, and any questions that they may have about the services their child can receive. Outreach assists with scheduling appointments by facilitating three way conference calls with Providers and the Medicaid Medical Transportation Program as needed.

Section 5: Claims and Billing

Statutory Requirements

Cook Children's Health Plan follows the authority of the following entities for claim processing requirements and timelines:

- Health and Human Services Commission (HHSC)
- Texas Medicaid Provider Procedures Manual (TMPPM)
- Texas Department of Insurance (TDI)
- National Correct Coding Initiative (NCCI)
- Centers for Medicare and Medicaid Services (CMS)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Claims Information

A clean claim has no defect, impropriety, or special circumstance, including incomplete documentation that delays timely payment. A Provider submits a clean claim by providing the required data elements on the standard claim form.

Claim Filing Deadline

Claims must be received by Cook Children's Health Plan within ninety-five days from the date of service. If a claim is not received within ninety-five days of the date of service, the claim will be denied.

Filing Deadline Calendar

Cook Children's Health Plan follows the most current filing deadline calendar located on the TMHP website at tmhp.com.

Prompt Payment Requirements

Clean claims received by are adjudicated in adherence to the following performance requirements and timeframes set by Health and Human Services:

- Ninety-eight percent of all clean claims within thirty days of receipt
- Ninety-nine percent of all clean claims within ninety days of receipt
- Ninety-eight percent of all appealed claims within thirty days of receipt
- One hundred percent of all claims, including appealed claims, within twenty-four months from date of service

Timeframes are based on calendar days and are subject to change due to updates in HHSC requirements, federal and state laws, rules, or regulations.

Cook Children's Health Plan is subject to remedies, including liquidated damages and reasonable attorney fees and taxes, if it fails to process and finalize clean claims or a portion of a clean claim within the statutory thirty day timeframe and performance requirements. This interest rate is calculated at an annual eighteen percent rate, accrued daily, for the period of time the clean claim remains unadjudicated. If the Provider agreement specifies a contracted penalty rate, then that provision controls and the Provider must be paid the contracted penalty rate.

Electronic Claim Submission

All Providers are encouraged to file claims electronically. Cook Children's Health Plan uses Availity as our electronic data interchange clearinghouse for batch claim submissions. Our partnership with Availity allows Providers to submit single claim submissions at no cost via Availity.com.

Product	Clearinghouse	CCHP Payor ID	Contact Phone
STAR Kids	Availity	CCHP9	800-282-4548

Submission of a claim to the clearinghouse does not guarantee that the claim was received by Cook Children's Health Plan. Providers are responsible for monitoring their error reports.

Providers must submit the appropriate NPI(s) and Taxonomy code(s). Providers must use the National Provider Identifier (NPI) and Taxonomy code combination as enrolled and attested with Texas Medicaid. Claims with incorrect, invalid or missing NPI and Taxonomy code combinations will reject or deny.

Vision Providers should contact National Vision Administrators, LLC at 888-830-5560.

For more information, please refer to the EDI Companion Guides on tmhp.com.

Pharmacy Claim Submission

All electronic pharmacy claims that are clean and payable must be paid within eighteen days from the date of claim receipt. All non-electronic pharmacy claims that are clean and payable must be paid within twenty-one days from the date of claim receipt. Pharmacy Providers may submit claims using the electronic transmission standards set forth in CFR Parts 160, 162 or 164; and by using a universal claim form that is acceptable to the Pharmacy Benefit

Manager, Navitus Health Solutions.

For a list of covered drugs and preferred drugs, prior authorization process, claim submission requirements, including allowable billing methods and special billing, or for general pharmacy questions, Providers may contact Navitus Health Solutions directly through the Navitus Provider Portal at navitus.com or call the Navitus Pharmacy Help Desk at 877-908-6023.

Electronic Claim Acceptance

Providers should verify that their electronic claims were accepted by Cook Children's Health Plan for payment consideration by referring to their **accepted** and **rejected** reports. Providers may confirm receipt of submitted claims through our Secure Provider Portal located on our website at cookchp.org. Providers must also track claim submissions against their claims payments to detect and correct all claim errors. Claims that are rejected or denied must be corrected and resubmitted within timely filing guidelines for payment consideration.

Some of the most common reasons for electronic professional claim rejections or denials are:

- Member information does not match – the name, date of birth, sex, and nine-digit Member identification number must be an exact match with the Member's identification number
- Missing, incorrect or invalid NPI(s) or Taxonomy code(s), Providers must use the appropriate NPI(s) and Taxonomy code combination as enrolled and attested with Texas Medicaid
- Other Health Insurance payment information is missing

After filing a claim, we recommend Providers check claim status within two weeks via our Secure Provider Portal located on our website at cookchp.org.

Paper Claim Submission

Cook Children's Health Plan discourages paper transactions. Should you find that you can only submit a claim on paper we accept the following original red claim forms:

- CMS-1450 (UB-04)
- CMS-1500 (HCFA-1500)

When filing a claim, Providers must use the National Provider Identifier (NPI) and Taxonomy code combination as enrolled and attested with Texas Medicaid. Claims with incorrect,

invalid or missing NPI and Taxonomy code combinations will reject or deny.

STAR Kids Member claims should be mailed to:

Cook Children's Health Plan
Attention: Claims Department
P. O. Box 21271
Eagan, MN. 55121-0271

Claims for Vision Services (routine and therapeutic services) are reimbursed through National Vision Administrators and are mailed to:

National Vision Administrators
Attention: Claims Department
P.O. Box 2187
Clifton, NJ 07015-2187

Electronic Funds Transfers and Electronic Remittance Advices

Providers must enroll in Electronic Funds Transfer (EFT) to receive payments electronically through direct deposit. To enroll in EFT, please visit the Electronic Submission Services page located on our website cookchp.org.

Electronic Remittance Advice (ERA) files are available through Availity. To enroll for ERA delivery visit Availity.com. For assistance, contact Availity Client Services at 800-282-4548.

Claim Status Assistance

Cook Children's Health Plan offers several methods to access claim status.

Secure Provider Portal

To check claim status online you must register for access to our Secure Provider Portal located on our website at cookchp.org.

Automated System

Interactive Voice Response (IVR) is an automated system available twenty-four hours a day, seven days a week to verify eligibility and claim status. Call 888-243-3312 to access the IVR system.

Provider Support Services

Claim representatives are available to assist with claim inquiries at 888-243-3312.

Provider Reimbursement

Cook Children's Health Plan will reimburse Providers according to their contractual agreement. The health plan cannot reimburse Providers for Medicaid services unless the Provider is enrolled with Texas Medicaid & Healthcare Partnership and is included on the state master file.

Reimbursement will be issued to Providers who render medically necessary covered services to eligible Members, for whom a capitation has been paid to Cook Children's Health Plan. To verify a covered service please contact Cook Children's Health Plan at 888-243-3312.

Long Term Service and Support Provider Reimbursement

Cook Children's Health Plan will not pay the Nursing Facility or Intermediate Care Facility for individuals with an intellectual disability or related conditions (ICF-IID) daily rate. Cook Children's Health Plan will not provide Home and Community Based Services (HCBS) Waiver services for the following programs: Home and Community Based Services (HCS), Community Living Assistance and Support Services (CLASS), Texas Home Living (TxHmL), Deaf Blind with Multiple Disabilities (DBMD), and Youth Empowerment Services (YES).

Cook Children's Health Plan will assist in coordinating services for Members enrolled in HCBS Waiver programs, but will not contract with HCBS Waiver Service Providers for services provided through those HCBS Waivers. For STAR Kids Members who reside in a nursing facility or ICF-IID, Cook Children's Health Plan is responsible for coordinating the Member's care with facility based LTSS Providers providing non-capitated services to the Member.

LTSS Enrollment Changes with custom DME and Augmentative Device

The following table describes payment responsibility for Medicaid enrollment changes that occur when a prior authorization exists for custom DME, before the delivery of the product. For the purpose of this section, MCO means Managed Care Organization (i.e. Cook Children's Health Plan).

Scenario	Custom DME	All Other Covered Services
Member moves between STAR Kids MCOs	Former MCO	New MCO

Member moves from FFS to STAR Kids MCO	New MCO	New MCO

LTSS Enrollment Changes with Home Modification

The following table describes payment responsibility for Medicaid enrollment changes that occur during a minor home modification service provided to an MDCP STAR Kids Waiver Member, before completion of the modification.

Scenario	Minor Home Modification	All Other Covered Services
Member moves between STAR Kids	Former MCO	New MCO

Span of coverage (Hospital) - Responsibility during a Continuous Inpatient Stay

If a Member is disenrolled from a STAR Kids MCO and enrolled in another STAR Kids MCO during an Inpatient Stay, then the former STAR Kids MCO will pay all facility charges until the Member is discharged from the Hospital, residential substance use disorder treatment facility, or residential detoxification for substance use disorder treatment facility, or until the Member loses Medicaid eligibility. The new STAR Kids MCO will be responsible for all other covered services on the Effective Date of Coverage with the STAR Kids MCO.

Scenario	Hospital Facility Charge	All Other Covered Services
Member Moves from FFS to STAR Kids	FFS	New MCO
Member moves from STAR, STAR Health or STAR+PLUS to STAR Kids	Former MCO	New MCO
Member Moves from CHIP to STAR Kids	New MCO	New MCO
Adult Member Moves from STAR Kids to STAR or STAR+PLUS	Former STAR Kids MCO	New STAR or STAR+PLUS MCO
Member Moves From STAR Kids to STAR Health	Former STAR Kids MCO	New STAR Health MCO

Member Retroactively Enrolled in STAR Kids	New MCO	New MCO
Member Moves Between STAR Kids MCOs	Former MCO	New MCO

This document is not intended to supersede any HHSC contract. This is a reference tool determining the span of coverage limitation.

Pharmacy Prior Authorization

Navitus processes Texas Medicaid pharmacy prior authorizations for Cook Children's Health Plan. The formulary, prior authorization criteria, and the length of the prior authorization approval are determined by HHSC. Information regarding the formulary and specific prior authorization criteria can be found at the Vendor Drug Website, eProcrates, and SureScripts for ePrescribing.

Prescribers can access prior authorization forms online via navitus.com under the "Providers" section or have them faxed by Customer Care to the prescribers' office. Prescribers will need their NPI and State to access the portal. Completed forms can be faxed twenty-four hours a day, seven days a week to Navitus at 920-735-5312. Prescribers can also call Navitus Customer Care at 877-908-6023 select the prescriber option and speak with the prior authorization department between 8A:00 a.m. – 5 p.m., Monday – Friday, Central Standard Time, to submit a prior authorization request over the phone. After hours, Providers will have the option to leave a voicemail. Decisions regarding prior authorizations will be made within twenty-four hours from the time Navitus receives the prior authorization request. The Provider will be notified by fax of the outcome or verbally if an approval can be established during a phone request.

Pharmacies will submit pharmacy claims to Navitus. Medications that require prior authorization will be undergo an automated review to determine if the criteria are met. If all the criteria are met, the claim is approved and paid, and the pharmacy continues with the dispensing process. If the automated review determines that all the criteria are not met, the claim will be rejected and the pharmacy will receive a message indicating that the drug requires prior authorization. At that point, the pharmacy should notify the prescriber and the above process should be followed.

Claim Documentation Requirements

Providers must include or adhere to the following documentation guidelines when considering claim submission.

- **National Provider Identifier and Taxonomy code:** Providers must use the National Provider Identifier(s) and Taxonomy code(s) combination as enrolled and attested with Texas Medicaid.
    - Claims with incorrect, invalid or missing NPI and Taxonomy code combinations will reject or deny
        - Example: Referring, Ordering, Rendering, Supervising, Billing and Service Provider(s)
- **National Drug Code:** The National Drug Code (NDC) is an eleven digit number on the package or container from which the medication is administered.
    - All Providers must submit a NDC for professional or outpatient claims submitted with a physician administered prescription drug procedure.
    - The description, unit of measure and unit quantity must also be included in the claim. Claims that do not have this information may be rejected or denied.
    - For additional NDC billing, guidelines please refer to the Texas Medicaid Provider Procedures Manual found on TMHP's website at tmhp.com.
- **Newborn Members without Medicaid:** If a Medicaid eligible newborn has not been assigned a number on the date of service, the Provider must wait until the identification number is assigned to file the claim.
    - The Provider must submit the claim with the Member identification number.
    - Providers must check eligibility regularly to ensure claims are received within the required ninety-five day timely filing deadline

Coordination of Benefits

Medicaid is secondary when coordinating benefits with all other insurance coverage, unless an exception applies under federal law. Coverage provided under Medicaid will pay benefits for covered services that remain unpaid after all other insurance coverage has been paid.

All other available third-party resources must meet their legal obligation to pay claims before Medicaid funds are used to pay for the care of a Medicaid Member, including Medicare for dual eligible STAR Kids Members. Providers must submit claims to other health insurers for consideration prior to billing Cook Children's Health Plan.

If Cook Children's Health Plan is aware of other third-party resources at the time of claim submission and the billing Provider is not, the claim will deny and the Explanation of Payment will instruct the Provider to bill the appropriate insurance carrier. If we become aware of the resource after payment for the service was rendered, Cook Children's Health Plan will pursue post payment recovery.

Providers have access to verify Coordination of Benefits through the Secure Provider Portal located on our website at cookchp.org.

Providers may submit supporting documentation regarding the termination of primary carrier benefits (making sure to include termination date and/or Explanation of Payment (EOP) showing denial of claim) via the Secure Provider Portal or by email to CCHPCOB@cookchildrens.org.

In cases where the other Payor makes payment, the claim must include the subscriber, Payor and payment information. If this information is not, the claim will deny.

If a Member has more than one primary insurance carrier (Medicaid would be the third Payor), the claim should not be submitted through EDI or the Secure Provider Portal and must be submitted on a paper claim.

Overpayments

An overpayment is any payment that a Provider receives in excess of the amount payable for a service rendered.

When an overpayment is identified by Cook Children's Health Plan, the refund request process is initiated. The Provider will receive written notification making them aware that an overpayment has been made in error. The Providers have thirty days from the date of the letter to respond to Cook Children's Health Plan. Failure to refund or respond to a request may result in an offset against future claim payments until the amount of the overpayment has been fully recovered. If the Provider determines the request is inaccurate, the Provider should contact Cook Children's Health Plan at 888-243-3312.

To ensure the refund request is applied correctly Providers should include a letter of explanation or the refund request letter and the Explanation of Payment. Providers can submit refund checks to:

Cook Children's Health Plan
Attention: Finance Department
P.O. Box 2488
Fort Worth, TX 76113-2488

When an overpayment is identified by the Provider, due to a billing error, the Provider should submit a corrected claim. The health plan will process the corrected claim and will recoup the overpayment.

When an overpayment is identified by the Provider due to a health plan processing error, the Provider should submit a claim appeal via the Secure Provider Portal requesting reconsideration and recoupment if appropriate.

Corrected Claims Process

A corrected claim is a correction or a change of information to a previously finalized claim. Corrected claims must be received by the health plan within ninety-five days of the date of service.

If submitting electronically:

The following guidelines must be completed for an ANSI-837P (Professional) and ANSI-837I (Institutional) claim to be considered a corrected bill.

- In the 2300 Loop, the CLM segment (claim information), CLM05-3 (claim frequency type code) must indicate the third digit of the Type of Bill being sent.
    - The third digit of the Type of Bill is the frequency and can indicate if the bill is an adjustment claim as follows:
        - "7" – REPLACEMENT (Replacement of Prior Claim)
- In the 2300 Loop, the REF segment (claim information), must include the original claim number issued to the claim being corrected.
    - The original claim number can be found on your electronic remittance advice
    - Example: Claim Frequency Code CLM*12345678*500***11::7**Y*A*Y*I*P~ REF*F8*(Enter the Claim Original Reference Number) REF01 must contain 'F8' REF02 must contain the original Cook Children's Health Plan claim number
- In the 2300 Loop, the NTE segment (free form 'Claim Note'), must include the explanation for the Corrected/Replacement Claim
    - NTE01 must contain 'ADD'
    - NTE02 must contain the free-form note indicating the reason for the corrected replacement claim
    - Example: NTE*ADD*CORRECTED PROCDURE CODE ON LINE 3

For more information, please refer to the EDI Companion Guides on tmhp.com.

If submitting by mail:

- A corrected CMS-1500 (HCFA) or CMS-1450 (UB-04) claim form is required
- Each corrected claim must include: a copy of the EOP and any other attachments needed if applicable
- Corrected claims must be received within ninety-five days of date of service to meet the timely filing requirements
- Provider should notate "Corrected Claim" on a paper CMS-1500 or CMS-1450 (UB-04)
- The UB-04 type of bill code (field four) shall include a seven in the third position to indicate the claim is a corrected claim

Submit corrected claims via EDI or mail to:

Cook Children's Health Plan
Attention: Claims Department
P.O. Box 21271
Eagan, MN. 55121-0271

Please note: A written or online appeal is not necessary for corrected claims

Federally Qualified Health Centers and Rural Health Centers

Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) are reimbursed their assigned encounter rate for general medical services. FQHCs and RHCs must bill a T1015 procedure code and the applicable modifier for general medical services. For more information, Providers should refer to the Texas Medicaid Provider Procedures Manual located at tmhp.com.

To ensure Cook Children's Health Plan has the correct encounter rate, Providers should forward new encounter rate letters to the Network Development Department by email at CCHPNetworkDevelopment@cookchildrens.org.

Obstetrics and Prenatal Care

Medicaid reimburses prenatal care, deliveries, and postpartum care as individual services. Providers may choose one of the following options for billing maternity services:

- Providers may itemize each service individually on one claim form and file at the time of delivery
    - The filing deadline is applied to the date of delivery
- Providers may itemize each service individually and submit claims as the services are rendered
    - The filing deadline is applied to each individual date of service

When billing for prenatal services, use modifier TH with the appropriate evaluation and management procedure code to the highest level of specificity. Failure to use modifier TH may result in recoupment of payment rendered.

Prenatal and postpartum care visits billed in an inpatient hospital are denied as part of another procedure when billed within the three days before delivery or the six weeks after delivery. The inpatient intrapartum and postpartum care are included in the fee for the delivery or Cesarean section and should not be billed separately.

One postpartum care procedure code may be reimbursed per pregnancy for STAR Kids Members. The claim for the postpartum visit may be submitted with either procedure code 59430 or with a delivery procedure code (59410, 59515, 59614, or 59622) that includes postpartum care. The reimbursement amount for the submitted procedure code covers all postpartum care per pregnancy regardless of the number of postpartum visits provided. Procedure code 59430 may be reimbursed once per pregnancy for Medicaid Members following a delivery if the delivery procedure code does not include postpartum care. Since delivery procedure codes 59410, 59515, 59614, and 59622 include postpartum care, procedure code 59430 will be denied if procedure codes 59410, 59515, 59614, or 59622 were submitted by any Provider for the same pregnancy.

Failure to submit a postpartum encounter claim when billing 59410, 59515, 59614, and 59622 (which includes postpartum care) may result in recoupment.

Ultrasound of the pregnant uterus is a benefit when medically indicated. Ultrasound of the pregnant uterus is limited to three per pregnancy. The initial three claims paid for obstetric ultrasounds do not require prior authorization. If it is necessary to perform more than three obstetrical ultrasounds on a Member during one pregnancy, the Provider must request prior authorization with documentation of medical necessity.

Please refer to the TMPPM at tmhp.com for additional information on Obstetrics and Prenatal Care.

Emergency Services Claims

Cook Children's Health Plan pays for emergency care in and out of the service area. Emergency care is defined as health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- In the case of a pregnant woman, serious jeopardy to the health of the fetus

The Provider should direct the Member to call 911 or go to the nearest emergency room or comparable facility if the Provider determines an emergency medical condition or emergency behavioral health condition exists. If an emergency condition does not exist, the Emergency Provider should direct the Member to their Cook Children's Health Plan Primary

Care Provider.

Cook Children's Health Plan does not require that the Member receive approval from the health plan or the Primary Care Provider prior to accessing emergency care. To facilitate continuity of care, Cook Children's Health Plan instructs Members to notify their Primary Care Provider as soon as possible after receiving emergency care. Providers are not required to notify Cook Children's Health Plan Care Management about emergency care services.

If Cook Children's Health Plan receives a request for authorization of post-stabilization treatment, the health plan must respond to the emergent/urgent facility within one hour. If the facility does not receive a response within one hour, the post-stabilization services shall be considered authorized in accordance with Texas Department of Insurance statutes. The Provider shall notify Cook Children's Health Plan of all post-stabilization treatment requests.

Special Billing

The following value added services require special billing as follows:

School Physicals	These services do not need to be provided by the Member's Primary Care Provider. However, services must be provided by an In Network Provider. Claims for these services are billed to Cook Children's Health Plan using diagnosis code: Z02.5.
Increased Frame Allowance and Vision Services	Claims for these services should be filed directly to National Vision Administrators LLC and questions on how to file these claims should be directed to NVA at 888-830-5630.
Prepared Childbirth Classes	Claims for these services are billed to Cook Children's Health Plan listing the Member's ID Number, name, classes taken and billed amount. This should be sent to Cook Children's Health Plan, PO Box 21271 Eagan, MN. 55121-0271

Co-payments

Medicaid Managed Care Members do not have a co-payment responsibility.

Billing Members

Cook Children's Health Plan reimburses from the Texas Medicaid & Healthcare Partnership fee schedule. Cook Children's Health Plan Providers have agreed to accept the reimbursement as payment in full for services rendered to Medicaid Members.

Members must not be balance billed for the amount above which is paid by the health plan for covered services. In addition, Providers may not bill a Member if any of the following occurs:

- Failure to timely submit a claim, including claims not received by us
- Failure to submit a claim to us for initial processing within the ninety-five day filing deadline
- Failure to submit a corrected claim within the ninety-five day filing resubmission period
- Failure to appeal a claim within the one hundred and twenty day administrative appeal period
- Failure to appeal a utilization review determination within thirty calendar days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission or the appeal process

A Member cannot be billed for failing to show for an appointment. Providers may not bill Cook Children's Health Plan Members for a third party insurance copayment. Medicaid Members do not have an out of pocket expense for covered services. Providers may not bill for or take recourse against a Member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program.

If a Provider furnishes services to a Medicaid Member that are not covered, including services that are not medically necessary, he or she must obtain the Member's signature on a Member Acknowledgement Statement which informs the Member of his or her financial responsibility. The Member Acknowledgement Statement form and Private Pay Agreement form are included in the Appendix section of this Provider Manual.

Providers are allowed to bill Members if retroactive eligibility is not granted. If the Member does become retroactively eligible, the Member should notify the Provider of his or her change in status. Ultimately, the Provider is responsible for timely filing of Medicaid claims. If the Member becomes eligible, the Provider must refund any money paid by the Member

when a Medicaid claim is filed.

Member Acknowledgement Statement (Explanation of Use)

A Provider may bill a Cook Children's Health Plan Member for a service that has been denied as not medically necessary or not a covered benefit only if **both** of the following conditions are met:

- The Member requests the specific service or item
- The Provider obtains and keeps a written Member Acknowledgment Statement signed by the Member that states:
    - "I understand that, in the opinion of (*Provider's name*), the services or items that I have requested to be provided to me on (*dates of service*) may not be covered under the Texas Medical Assistance program as being reasonable and medically necessary for my care. I understand that HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services are determined not to be reasonable and medically necessary for my care."

A sample of the Member Acknowledgement Statement is located in the Appendix section of this Provider Manual.

Private Pay Statement

A Provider is allowed to bill the following to a Member without obtaining a signed Member Acknowledgment Statement:

- Any service that is not a benefit of Texas Medicaid (i.e., cellular therapy).
- All services incurred on non-covered days because of eligibility or spell-of-illness limitation
    - Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the non-covered days
    - Spell-of-illness limitations do not apply to medically necessary stays for Medicaid clients who are twenty years of age and younger
- All services provided as a private pay patient. If the Provider accepts the Member as a private pay patient, the Provider must advise the Member that they are accepted as private pay patient at the time the service is provided and will be responsible for paying for all services received
    - In this situation, HHSC strongly encourages the Provider to ensure that the patient signs written notification so there is no question how the patient was accepted
    - Without written, signed documentation that the Texas Medicaid client has been

properly notified of the private pay status, the Provider cannot seek payment from an eligible Texas Medicaid client

- The patient is accepted as a private pay patient pending Texas Medicaid eligibility determination and does *not* become eligible for Medicaid retroactively
    - The Provider is allowed to bill the client as a private pay patient if retroactive eligibility is not granted
    - If the client becomes eligible retroactively, the client notifies the Provider of the change in status
    - Ultimately, the Provider is responsible for filing timely claims
    - If the client becomes eligible, the Provider must refund any money paid by the client and file claims to Cook Children's Health Plan or Texas Medicaid for all services rendered

A Provider who attempts to bill or recoup money from a Cook Children's Health Plan Member in violation of the above situations may be reported to the appropriate fraud and abuse unit and excluded from the Texas Medicaid Program. Providers are prohibited from including in the contract with their covered Members language that limits the Member's ability to contest claim payment issues, or that binds the Member to the insurer's interpretation of the contract terms.

A sample of the Private Pay statement is located in the Appendix section of this Provider Manual.

Out-of-Network Claims Submission

Clean claims for non-participating Providers located in Texas must be received by Cook Children's Health Plan within ninety-five days of service. Clean claims for non-participating Providers located outside of Texas must be received by us within three hundred and sixty-five days of the date of service.

To submit claims for services provided to STAR Kids Members, Providers must have an active Texas Provider Identifier on file with TMHP, the state's contracted administrator.

Precertification

Non-participating Providers must obtain precertification for all non-emergent services except as prohibited under federal or state law for in network or out of network facility and physician services for a mother and her newborn(s) for a minimum of forty-eight hours following an uncomplicated vaginal delivery or ninety-six hours following an uncomplicated delivery by Cesarean section. We require precertification of maternity inpatient stays for any portion in excess of these timeframes.

Reimbursement

Non-participating Providers are reimbursed in accordance with a negotiated case rate or, in absence of a negotiated rate, as follows:

For STAR Kids we reimburse:

- Out of network, in area service Providers at no less than the prevailing Medicaid FFS rate, less five percent
- Out of network, out of area service Providers at no less than one hundred percent of the Medicaid FFS rate

Section 6: Claim Denials and Appeals

Reconsideration of a Claim Denial

Reconsideration is a second review of a service request when a claim was denied because additional information is needed to adjudicate the claim. This level of review is not an element of the Medicaid or CHIP Appeal or Complaint Processes but provides a means of resolving an administrative or medical necessity denial without accessing the Complaint or Appeal Process. If the denial is upheld, the Provider, Member or Member's representative may pursue the appropriate Complaint or Appeal Process. Example components that a Provider may send for Claim Reconsideration include:

- Change in Member eligibility
- The attachment of a Primary Insurance Explanation of Benefits
- The attached of an invoice or MSRP

Submitting a Claim Reconsideration

Request for reconsideration must be submitted in writing and received by the health plan within one hundred twenty calendar days of the printed disposition date on the Explanation of Payment.

Supporting documentation may include but is not limited to:

- Letter from the Provider stating why they feel the claim denial is incorrect (required)
- Copy of the original claim
- Copy of the health plan explanation of payment
- MSRP or invoice
- Primary Insurance explanation of benefits

Providers should submit claim reconsiderations via the Secure Provider Portal located at cookchp.org. Claim Reconsiderations may be faxed to 682-885-8404 or mailed to:

Cook Children's Health Plan
Attention: Claim Reconsiderations
P.O. Box 2488
Fort Worth, TX 76113-2488

Note: Changes or errors in CPT codes are not available for claim reconsideration.

Corrected claims should be resubmitted to the health plan with a notation of corrected claim.

Provider Appeals Process

Appealing a Claim Denial

A Claim Appeal is defined as a written request by the Provider to further consider the original claim reimbursement decision **based on the original claim information received.**

Providers should make the initial attempt to resolve a claim issue by calling Cook Children's Health Plan Claims Department at 888-243-3312. A Provider may appeal any disposition of a claim. An appeal is a claim that has been previously adjudicated as a clean claim and the Provider is appealing the disposition through written notification to the health plan in accordance with the appeal process.

All appeals of denied claims must be received by Cook Children's Health Plan within one hundred twenty days from the date of disposition (the date of the Explanation of Payment on which the claim appears). Payment is considered to have been paid on the date of issue of a check for payment and its corresponding Explanation of Payment to the Provider by health plan, or the date of electronic transmission if payment is made electronically. Any appeal received after the above stated timely filing day period will be denied for failure to file an appeal within the required time limits. Resolution should be received within thirty calendar days from our receipt of the written appeal.

Telephone communication related to the Provider appeal will be documented on an appeal communication log. Email and fax documentation related to the appeal will be retained by the health plan for a period of seven years.

Submitting a Claim Appeal

Provider appeals must be submitted in writing and received by the health plan within one hundred twenty calendar days of the printed disposition date on the Explanation of Payment. Supporting documentation may include but is not limited to:

- Letter from the Provider stating why they feel the claim payment is incorrect (required)
- Copy of the original claim
- Copy of the health plan explanation of payment
- Explanation of payment from another insurance company
- Prior authorization number and/or form or fax documenting the prior authorization determination
- Eligibility verification documentation
- Electronic acceptance reports confirming the claim was received by the health plan

- Overnight or certified mail receipt as proof of filing received date by the health plan

Providers should submit appeals online through our Secure Provider Portal located on our website cookchp.org. Complete the Customer Service request by selecting the Topic: Submit a Claim Appeal; supporting documentation can be uploaded using the add files feature. Written appeals may be faxed to 682-885-8404 or mailed to:

Cook Children's Health Plan
Attention: Appeals
P.O. Box 2488
Fort Worth, TX 76113-2488

Note: Changes or errors in CPT codes are not considered payment appeals. Corrected claims should be resubmitted to the health plan with a notation of corrected claim.

Section 7: Care Management and Service

Cook Children's Health Plan's Care Management and Service Coordination Program encompasses:

- Medical management
  - Utilization management, case management, service coordination, disease management and population health management
- Population management
  - Predictive modeling, risk assessments/health screenings, preventive care reminders

The Care Management/Service Coordination program leverages the integration of all program functions to deliver a "Member-centric" model of care management.

Disease Management

Disease Management services are designed to assist physicians and other health care Providers in managing Members with chronic conditions. Disease Management services utilize a Member-centric, holistic approach. We tailor our Disease Management interventions based on a Member's risk factors, including Social Determinants of Health that impact a Member's ability to access care or adhere to their treatment plan. Currently we offer Disease Management programs for our Members with asthma, diabetes, and perinatal depression.

Our Disease Management program model includes:

- Proactive identification of Members for enrollment in a Disease Management program
- Evidence-based national guidelines as the foundation of each program's design
- Utilization of the Patient Activation Measure® (PAM®), a validated tool which assesses whether a Member has the knowledge, skills and confidence to manage their health and health care
- Interventions tailored to individual Member needs
- Self-management education tailored to the Member's activation level
- Ongoing communication and collaboration with a Member's physician and service Providers in treatment planning for a Member
- Individual and program outcomes measurement
- Registered Nurse Disease Management Case Managers and Certified Community Health Workers

Members have the right to opt-out of a Disease Management program at any time. If a Member elects to opt-out of a Disease Management program, their other benefits are not affected. Before enrolling a Member into a Disease Management case management level of intervention, the Member must consent to receiving case management services.

Baby Steps Program

Our Baby Steps is a proactive care management program for all expectant mothers and their newborns. It identifies pregnant women as early in their pregnancies as possible through the following methods:

- Review of state enrollment files
- New Member telephonic screenings
- Medical management program referral (e.g., utilization review)
- Discharge planner referral
- Member or caregiver referral
- Practitioner referral

Once Members are identified, Cook Children's Health Plan initiates telephonic outreach within five business days to assess obstetrical (OB) risk and ensure the Member's enrollment in the appropriate intervention level of the Baby Steps program.

All Members enrolled in the Baby Steps program receive written information about Baby Steps program services, how to use the services, a copy of the Baby Basics Book (available in English and Spanish) from the What to Expect Foundation, information about Text4Baby (free text messages on their cell phones through their pregnancy and the baby's first year of life), and Helpful Resources for Women Resource List.

Experienced Nurse Case Managers enroll Members with the highest risk in case management with Member consent. Case Managers work with Members and their OB Providers to develop a care plan to ensure they have access to necessary services.

Our high risk OB case management program offers:

- Individualized, one-on-one case management support
- Care coordination support
- Educational materials and information on community resources
- Incentives to keep prenatal and postpartum checkups and well-child visits after the baby is born
- Depression screening (Edinburgh Postnatal Depression Scale) and referral to a behavioral health Case Manager or Care Coordinator, if appropriate, as well as the appropriate treating Provider.

Service Coordination Teams

Cook Children's Health Plan employs a team approach to Service Coordination to ensure our Members receive the most effective level of support through a coordinated approach to care.

Service Coordination Teams include nurses, social workers, behavioral health specialists and integrated case management specialists.

Utilization Management - Specialty Provider Referral

Cook Children's Health Plan does not require notification to the health plan of in network Provider referrals. The Primary Care Provider is responsible for coordinating referrals to network Specialty Care Providers as needed and documenting all referrals in the Member's medical record.

All out of network Specialty Provider referrals require documentation of medical necessity to be submitted for prior approval of the Cook Children's Health Plan Medical Director. Member eligibility must be confirmed.

Members may self-refer for the following services:

- Obstetrics & Gynecology Services (OB/GYN)
    - Female Members may self-refer to a participating OB/GYN or GYN specialist to obtain obstetrical or gynecological related care
    - Cook Children's Health Plan Members may also access their Primary Care Provider for these services
- Behavioral Health Services
    - Members may access behavioral health services by contacting a network Behavioral Health Provider
- Emergency Care
    - Members are instructed to call their Primary Care Provider as soon as possible after receiving emergency care
    - The Primary Care Provider is not required to send notification to the Care Management Department

Observation Stays

Observation stays are for hospital short stays of less than forty-eight hours. Prior authorization is not required.

High Risk Pregnancy Notification

Cook Children's Health Plan requests notification when Members are diagnosed with a high risk pregnancy.

Delivery Notification

All deliveries exceeding routine length of stay and/or routine DRG per the Texas Medicaid Provider Procedures Manual must be reported to the Care Management Department within one business day. An authorization will be required for these scenarios. Routine deliveries do not require prior authorization.

Service Coordination Description

Service Coordination provides the Member with initial and ongoing assistance identifying, selecting, obtaining, coordinating, and using covered services and other supports to enhance the Member's well-being, independence, integration in the community, and potential for productivity. MCO must ensure that Service Coordination is used to:

- Provide a holistic evaluation of the Member's individual dynamics, needs and preferences
- Educate and help provide health-related information to the Member, the Member's LAR, and others in the Member's support network
- Help identify the Member's physical, behavioral, functional, and psychosocial needs
- Engage the Member and the Member's LAR and other caretakers in the design of the Member's Individual Service Plan (ISP)
- Connect the Member to covered and non-covered services necessary to meet the Member's identified needs
- Monitor to ensure the Member's access to covered services is timely and appropriate
- Coordinate covered and non-covered services
- Intervene on behalf of the Member if approved by the Member

Role of Service Coordinator

The purpose of a Service Coordinator is to maximize a Member's health, wellbeing, and independence. Service Coordination should consider and address the Member's situation as a whole, including his or her medical, behavioral, social, and educational needs.

The Service Coordinator must work with the Member's Primary Care Provider to coordinate all covered services, non-capitated services, and non-covered services available through other sources. This requirement applies regardless of whether the PCP is in the MCO's network. In order to integrate the Member's care while remaining informed of the Member's needs and condition, the Service Coordinator must actively involve the Member's Primary and Specialty Care Providers, including Behavioral Health Service Providers, and Providers of non-capitated services and non-covered services.

When families request information regarding a referral to a Nursing Facility or other long-term care facility, the MCO must inform the Member and family about options available through home and community-based service programs, in addition to facility-based options.

The MCO may allow a Member to receive service coordination through an integrated Health Home if the individual providing service coordination and the service coordination structure meet STAR Kids program requirements. The MCO must reimburse a Health Home that provides service coordination to its Members through an enhanced rate structure, a per-Member-per-month fee, or other reasonable methodology agreed to between the MCO and Health Home.

The MCO must employ Service Coordinators who are experienced in meeting the needs of vulnerable populations who have chronic or complex conditions. Service Coordination personnel and management must have expertise in pediatric care and pediatric developmental challenges, in addition to physical and behavioral health challenges.

Service Coordinators that serve STAR Kids Members must be solely dedicated to serving STAR Kids Members. The MCO must pair a Member with a Service Coordinator who has appropriate experience relating to the individual Member's needs.

Cook Children's Health Plan Service Coordinators may be reached by calling 844-843-0004 and follow the prompts.

Purpose of Service Coordination

Service Coordination provides the Member with initial and ongoing assistance identifying, selecting, obtaining, coordinating, and using covered services and other supports to enhance the Member's well-being, independence, integration in the community and potential for productivity.

Service Coordination must be used to:

- Provide a holistic evaluation of the Member's individual dynamics, needs and preferences

- Educate and help provide health-related information to the Member, the Member's legally authorized representative (LAR), and others in the Member's support network
- Help identify the Member's physical, behavioral, functional, and psychosocial needs
- Engage the Member and the Member's LAR and other caretakers in the design of the Member's Individual Service Plan (ISP)
- Connect the Member to covered and non-covered services necessary to meet the Member's identified needs
- Monitor to ensure the Member's access to covered services it timely and appropriate
- Coordinate covered and non-covered services
- Intervene on behalf of the Member if approved by the Member

Our mission is to inform, educate and support our Members, and ensure coordinated care. Our model is centered on the Member's personal goals and desires, and the interventions needed to maximize independence and promote health.

Service Coordination Levels

A named Service Coordinator is furnished to a Member when the health plan determines one is required through an assessment of the Member's health and support needs. Additionally, a named Service Coordinator is furnished to all Members who request one.

Cook Children's Health Plan provides three levels of service coordination to its Members. Service Coordination levels are designated by the Member's service needs, medical complexity, and psychosocial needs/issues with our most clinically complex Members receiving the most intensive level of service coordination to meet their needs.

Because a Member's health status may change, the Service Coordination Teams are designed to service a Member at any level of need, but coordination levels are designated and tracked in our comprehensive care coordination system to ensure appropriate tracking and service delivery by service level and identified Member needs.

Cook Children's Health Plan provides the following for all STAR Kids Members:

- A description of Service Coordination
- A phone number to contact if the Member needs Service Coordination or is experiencing problems with Service Coordination
- The name of their Service Coordinator, if applicable
- The phone number and email address of their named Service Coordinator or information on how to reach a Service Coordinator if the Member does not have a named Service Coordinator
- The minimum number of contacts the Member will receive every year

- The types of contacts the Member will receive and instructions on how to request additional Service Coordination assistance at any time
- How to access a Member Advocate if the Member has complaints about a Service Coordinator.

If the named Service Coordinator changes, Cook Children's Health Plan notifies Members or their LARs within five business days of the name and phone number of their new Service Coordinator. Within this same time period, the health plan posts the new Service Coordinator's information on the portal or website Members use to obtain plan information.

Members and LARs have the option of requesting the health plan assign a different Service Coordinator to the Member. If the Member or LAR express a concern or dissatisfaction with a Service Coordinator, the appropriate Manager or Team Lead of Service Coordination will assure the Member or LAR that their concerns will be investigated and to expect a follow-up call the next business day. The Member or LAR will be provided the Manager or Team Lead's contact information should they need further assistance. Finally, the Member or LAR will be offered the ability to file a formal complaint at any time and offered assistance by the Member CareAdvocate in doing so.

Cook Children's Health Plan allows Members to receive service coordination through an integrated health home. The individual providing service coordination and the service coordination structure must meet the STAR Kids program requirements. Cook Children's Health Plan maintains responsibility for ensuring the competency of Service Coordinators employed by health homes through required training and competency assessments ongoing.

Service Coordinators must meet the following requirements as outlined below for each service coordination level and must possess knowledge of the principles of most integrated settings, including federal and state requirements.

Level One Member Types

- MDCP STAR Kids Members
- Members with complex needs or a history of developmental or behavioral health issues
- Multiple outpatient visits, hospitalization, or institutionalization within the past year
- Members with Serious Emotional Disturbance (SED) or Serious Persistent Mental Illness (SPMI)
- Members at risk for institutionalization
- Youth Empowerment Service (YES) waiver recipients

All Level One Members receive a minimum of four face-to-face Service Coordination

contacts annually, in addition to monthly phone calls, unless otherwise requested by the Member or Member's LAR.

Level Two Member Types

- Members who do not meet the requirements for Level One classification but receive Personal Care Services (PCS), Community First Choice (CFC), or Nursing Services
- Members the MCO believes would benefit from a higher level of service coordination based on results from the STAR Kids SAI and additional MCO findings
- Members with a history of substance abuse
    - Multiple outpatient visits, hospitalization, or institutionalization within the past year)
- Members without SED or SPMI, but who have another behavioral health condition that significantly impairs function

All level two Members receive a minimum of two face-to-face and six telephonic Service Coordination contacts annually unless otherwise requested by the Member or Member's LAR.

Level Three Member Types

- Members include those who do not qualify as Level one or Level two
- Members have access to service coordination services

All level three Members receive a minimum of one face-to-face visit annually and receive at least three telephonic service coordination outreach contacts yearly.

Screening and Assessment Instrument

The STAR Kids Screening and Assessment Instrument (SAI) is designed as an assessment for all children on SSI and in specified waiver programs. The SAI contains trigger items that advance children into various, more extensive modules.

The modules of the SAI are:

- The Core
- The personal care services module (PCAM)
- The nursing services module (NCAM)

The SAI contains flags for further follow-up by the Managed Care Organizations on issues such as the need for Durable Medical Equipment (DME), behavioral health services, and other therapies. Information gathered using the SAI is used to create an individual service plan (ISP) for each Member, as well as generate potential referrals for additional services the individual might need.

For individuals seeking a medical necessity determination for MDCP or Medicaid state plan Community First Choice services (CFC), the SAI is used to gather the information used to make that determination. The SAI contains a module for MDCP clients and potential clients (MDCP Module) that includes items used exclusively to determine an individual's service cost limit (budget), based on Resource Utilization Group III (RUG) modeling.

A Registered Nurse, Advance Practice Nurse, Physician Assistant, Social Worker (MSW, LBSW, or LCSW), or Licensed Vocational Nurse (with a minimum of one year of previous service coordination or case management experience with pediatric clients) must administer the SAI Core Module and PCAM, if needed, and these modules may not be provided by any contracted entity that is or will be providing direct services to the Member.

A Registered Nurse or Advance Practice Nurse must administer the SAI NCAM and MDCP module, if needed. The MCO must train all individuals that will administer the SAI using a training module required by HHSC before the individuals administer the SAI. For quality monitoring purposes, the MCO must submit data collected through the SAI to the HHSC Administrative Services Contractor in the format prescribed by HHSC.

The SAI must be completed initially, annually for reassessment, and any time the individual or Legally Authorized Representative (LAR) report a significant change in condition that might impact her or her need for services. The SAI will assist in determination of the Member's required level of service coordination and how their needs will potentially be met through service coordination.

Individual Service Plan (ISP)

Each STAR Kids MCO must create and regularly update a comprehensive Person- Centered Individual Service Plan (ISP) for each STAR Kids Member, unless the Member or Member's LAR declines the STAR Kids Screening and Assessment Process as described in Section 8.1.39.

The purpose of the ISP is to articulate assessment findings, short and long-term goals, service needs, and Member preferences.

The MCO must use the ISP to communicate and help align expectations between the Member, their LAR, the MCO and key Service Providers. The MCO must use the ISP to measure Member outcomes over time.

The MCO must ensure that all ISPs must contain the following information:

- A summary document describing the recommended service needs identified through the STAR Kids Screening and Assessment Process
- Covered Services currently received

- Covered Services not currently received, but that the Member might benefit from
- A description of non-covered services that could benefit the Member
- Member and family goals and service preferences
- Natural strengths and supports of the Member including helpful family Members, community supports, or special capabilities of the Member
- With respect to maintaining and maximizing the health and well-being of the Member, a description of roles and responsibilities for the Member, their LAR, others in the Member's Support Network, key Service Providers, the Member's Health Home, the MCO, and the Member's school, if applicable
- A plan for coordinating and integrating care between Providers and covered and non-covered services
- Short and long-term goals for the Member's health and well-being
- If applicable, services provided to the Member through YES, TxHmL, DBMD, HCS, CLASS, or third-party resources, and the sources or Providers of those services
- Plans specifically related to transitioning to adulthood for Members age fifteen and older
- Any additional information to describe strategies to meet service objectives and Member goals

The MCO must ensure that the ISP is informed by findings from the STAR Kids Screening and Assessment Process, in addition to input from the Member; their family and caretakers; Providers; and any other individual with knowledge and understanding of the Member's strengths and service needs who is identified by the Member, the Member's LAR, or the MCO.

To the extent possible and applicable, the MCO must ensure that the ISP accounts for school-based service plans and service plans provided outside of the MCO. The MCO is encouraged to request, but may not require the Member to provide a copy of the Member's Individualized Education Plan (IEP).

Service Planning and Authorization Requests

Service planning for a STAR Kids Member begins with the service coordination team’s review of any existing and active services and any current Individual Service Plan (ISP). This review is documented in the care management software system. Any existing acute care and Long Term Services and Supports are continued until the STAR Kids Assessment Instrument (SAI) is completed.

Next, an in home assessment is conducted by a Cook Children’s Health Plan service coordination team assessor (RN, LMSW, LBSW or LVN) using the STAR Kids Assessment Instrument. The SAI informs a new individual service plan (ISP.), The ISP is coordinated for approval review with the Member’s Primary Care Provider / medical home and the Member

and/ or their Legally Authorized Representative (LAR.) Services are then coordinated with the Service Provider(s) and authorization is communicated to the Service Provider(s). The ISP is provided to the Member's Primary Care Provider/medical home and to the Member and/or their LAR.

The SAI is conducted at least annually, upon Member/LAR request and anytime the Member has a significant change in their condition. Completion of a new SAI leads to adjustments to the Member's service plan and additional services are approved or services not needed are stopped. This process involves the Primary Care Provider/ Medical Home and the Member and/or LAR. Updated ISPs are provided to the Member's Primary Care Provider/Medical Home and to the Member and/or their LAR.

Episodic services requiring prior authorization must be reviewed by Cook Children's Health Plan for medical necessity prior to the provision of services to the Member. Providers must submit an authorization request through our Secure Provider Portal located on our website cookchp.org.

Service Authorization Requests

Services requiring Prior Authorization must be reviewed by Cook Children's Health Plan for medical necessity prior to the provision of services to the Member. To determine if a covered service requires a prior authorization Providers may use the Prior Authorization Lookup tool located on our website at cookchp.org. Providers must submit prior authorization requests through our Secure Provider Portal located on our website cookchp.org.

The following categories of services require prior authorization:

- Out-of-Network Services*
- Inpatient Admissions**
- Home Health Services; Hospice
- Non-Emergency Ambulance transport
- Plastic/Reconstructive/Cosmetic Procedures
- Radiation Therapy
- Transplants
- Emergency Dental Treatment for Dental Trauma
- Services that do not require prior authorization but exceeds the TMPPM limitations, billing requirements, and/or diagnosis

*All out of network services require prior authorization except STAR Kids Family Planning, Texas Health Steps services performed by those with valid Texas Health Steps Provider Identifier, Emergency Care and physician services for uncomplicated deliveries, and services provided by an Indian Health Care Provider enrolled as a FQHC.

**All Inpatient admissions excluding routing vaginal deliveries <3 days and routine cesarean deliveries <5 days.

Included in the prior authorization process are:

- Verification of eligibility
- Determination of medical necessity and benefits.
- Referral of a Member to case or disease management programs when appropriate
-

Prior Authorization Determinations

Episodic (Utilization Management) Case Managers process service requests in accordance with the clinical immediacy of the requested service. If priority is not specified on the referral request, the request will default to routine status.

Severity Type	Turnaround Time
Routine	Within three business days after receiving the request
Urgent	Within one business day after receiving the request
Inpatient (Concurrent)	Within one business day after receiving the request
Emergent/Life Threatening	Within one hour after receiving the request

Prior Authorization is not a guarantee of payment

All services are subject to the plan provisions, limitations, exclusions, and Member eligibility at the time the services are rendered. Services requiring prior authorization are not eligible for reimbursement by Cook Children's Health Plan if authorization is not obtained and cannot be billed to the Member. The decision to render medical services lies with the Member and the treating Provider.

Prior Authorization Not Required response does not indicate that the service is a covered benefit

A response from Cook Children's Health Plan either through the online search functionality or when receiving a response from the health plan upon prior authorization request submission is not to be construed as a statement of benefit coverage for the requested service. Providers should review and understand STAR Kids covered benefits.

Additionally, it remains the Providers responsibility to review services per the Texas

Medicaid Fee Schedule.

Inpatient Authorization and Levels of Care

Cook Children's Health Plan Episodic Case Mangers perform timely review of hospital stays and communicates authorization status to the requesting facility within contractual requirements.

Observation level of care does not require authorization.

All inpatient stays require authorization by the health plan. Facilities are expected to communicate concurrently when the authorized level does not match the facilities' billing level. Level of care appeals received after claims submission are considered payment disputes and are processed per Cook Children's Health Plan Claim policies.

Medically Necessary Services

Medically necessary means:

- For Medicaid Members birth through age twenty the following Texas Health Steps services:
    - Screening, vision and hearing services
    - Other health care services necessary to correct or ameliorate a defect or physical or mental illness or condition; a determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:
        - Must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid Managed Care Program as a whole
        - May include consideration of other relevant factors, such as the criteria described in parts 2)(b-g) and 3)(b-g) of this paragraph
- For Medicaid Members over age twenty, non-behavioral health-related health care services that are:
    - Reasonable and necessary to prevent illnesses or medical conditions or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a Member, or endanger life
    - Provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions
    - Consistent with health care practice guidelines and standards endorsed by professionally recognized health care organizations or governmental agencies
    - Consistent with the Member's diagnoses

- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency
- Not experimental or investigative
- Not primarily for the convenience of the Member or Provider

- For Medicaid Members over age twenty , behavioral health services that:
  - Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder
  - 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
  - Are the most appropriate level or supply of service that can safely be 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

Cook Children's Health Plan provides medically necessary and appropriate 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 health care services.

Medical Necessity Screening Criteria

InterQual® Criteria are utilized by Utilization Management staff to determine medical necessity and appropriateness for medical inpatient concurrent review, inpatient site of service appropriateness, home health, inpatient rehabilitation, and procedures. The Texas Medicaid Provider Procedures Manual and internally developed criteria are also used to determine medical necessity and appropriate level of care. All criteria are based upon recognized standards of care. All criteria are reviewed and approved at least annually by Physicians through the Cook Children's Health Plan Medical Management and Quality Committees. Criteria utilized in the medical necessity review of a service request are available upon request by email, fax or mail.

Medical Necessity Appeals

Cook Children's Health Plan maintains an internal appeal process for the resolution of medical necessity appeal requests. Cook Children's Health Plan will send a letter that informs the Member and the servicing Provider, and the service Provider of appeal rights, including how to access expedited and Independent Organization Review appeals processes at the time a service is denied. The Member or the Member's representative may appeal an adverse benefit determination (medical necessity denial) orally or in writing.

Medicaid Member Appeal Process

How will I find out if services are denied?

Notice of Adverse Benefit Determination (Denials)

Cook Children's Health Plan must notify Members and Providers when an Adverse Benefit Determination is issued. An adverse benefit determination includes the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; or the denial, in whole or in part, of payment for a service. Only the Cook Children's Health Plan Medical Director or the Physician Designee may render a denial for lack of medical necessity (adverse benefit determination).

What can I do if the health plan denies or limits the Member's request for a covered service?

When Cook Children's Health Plan denies or limits a covered service, the Member or his or her authorized representative may file an appeal within sixty days from receipt of the Notice of Adverse Benefit Determination. The Member may request that any person or entity act on his or her behalf with the Member's written consent. A Health Care Provider may be an authorized representative.

Can someone from the health plan help the Member file an appeal?

A representative from the health plan can assist the Member in understanding and using the appeal process. If the Member needs help in filing an appeal, they can contact the Member Services Department and a Member Advocate will assist them. The health plan representative can also assist the Member in writing or filing an Appeal and monitoring the health plan appeal through the process until the issue is resolved. Appeals are accepted orally or in writing. Within five business days of receipt of the appeal request, Cook Children's Health Plan will send a letter acknowledging receipt of the appeal request.

Continuity of Current Authorized Services

The Member may continue receiving services during the appeal if the appeal is filed within ten business days of the Notice of Action or prior to the effective date of the denial, whichever is later. The Member is advised in writing that he or she may have to pay for the services if the denial is upheld. If the appeal resolution reverses the denial, Cook Children's Health Plan will promptly authorize coverage. The Member must request to continue services during the appeal process.

Timeframes for the Appeals Process

The Standard Appeal Process must be completed within thirty calendar days after receipt of the initial written or oral request for appeal. The timeframe for a standard appeal may be extended for a period of up to fourteen calendar days if the Member or his or her representative requests an extension or if Cook Children's Health Plan shows there is need for additional information and how the delay would be in the best interest of the Member. Cook Children's Health Plan provides the Member or his or her authorized representative with a written notice of the reason for the delay.

Appeals are reviewed by individuals who were not involved in the original review or decision to deny and are health care professionals with appropriate clinical expertise in treating the Member's condition or disease. Cook Children's Health Plan provides a written notice of the appeal determination to the Appellant.

Members Option to Request an External Medical Review

If the appeal decision upholds the original decision to deny a service, Members receive information regarding their right to request an External Medical Review. The Member may request an External Medical Review no later than one hundred twenty days after the health plan mails the appeal decision notice.

Members Option to Request Only a State Fair Hearing

If the appeal decision upholds the original decision to deny a service, Members receive information regarding their right to request a State Fair Hearing. The Member may request a State Fair Hearing no later than one hundred twenty days after the health plan mails the appeal decision notice.

Member Expedited Appeal

How to request an emergency appeal?

Members or their authorized representatives may request an emergency appeal either orally or in writing.

Timeframes for the Emergency Appeal Process

Within sixty days (or ten business days to ensure continuation of currently authorized services) from receipt of the Notice of Action or the intended effective date of the proposed action.

Can someone from the health plan help the Member file an appeal?

A representative from the health plan can assist the Member in understanding and using the emergency appeal process. If the Member needs help in filing an appeal, they can contact the Member Services Department and a Customer Care Representative will assist them. The health plan representative can also assist the Member in writing or filing an appeal and monitoring the health plan appeal through the process until the issue is resolved.

What happens if the health plan denies the request for an Emergency Appeal?

If Cook Children's Health Plan denies a request for an Emergency Appeal, the health plan transfers the appeal to the standard appeal process, makes a reasonable effort to give the Appellant prompt oral notice of the denial, and follows up within two calendar days with a written notice. Investigation and resolution of expedited appeals relating to an ongoing emergency or denial of a continued hospitalization are completed:

- In accordance with the medical or dental immediacy of the case
- Not later than one business day after receiving the Member's request for Expedited Appeal

Except for an expedited appeal relating to an ongoing emergency or denial of continued hospitalization, the time period for notification to the Appellant of the appeal resolution may be extended up to fourteen calendar days if the Member requests an extension or Cook Children's Health Plan shows that there is a need for additional information and how the delay is in the Member's best interest. If the timeframe is extended, the health plan will provide the Member with a written notice for the delay if the Member had not requested the delay.

When the timeframe is extended by the Member, the health plan sends a letter acknowledging receipt of the expedited appeal request and the request for an extension. An individual who was not involved in the original review or decision to deny and is a health care professional with appropriate clinical expertise in treating the Member's condition or disease renders the appeal determination. Cook Children's Health Plan provides the Appellant a written notice of the appeal resolution. If the appeal decision upholds the original decision to deny a service, Members receive information regarding their right to request an External Medical Review.

State Fair Hearing Information

Can a Member ask for a State Fair Hearing?

If a Member, as a Member of the health plan, disagrees with the health plan's decision, the Member has the right to ask for a State Fair Hearing. The Member may name someone to

represent them by 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 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 one hundred twenty 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 one hundred twenty 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 call the health plan at 800-862-2488 or send a letter to:

Cook Children's Health Plan
Attention: Denial and Appeal Coordinator
PO Box 2488
Fort Worth, TX 76101-2488

If the Member asks for a State Fair Hearing within ten 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 ten 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.

Health and Human Services Commission will give the Member a final decision within ninety days from the date the Member asked for the hearing.

External Medical Review Information

Can a Member ask for an External Medical Review?

If a Member, as a Member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an external medical review. An external medical review (EMR) 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 one hundred twenty 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 one hundred twenty 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 Cook Children's Health Plan by using the address or fax number at the top of the form.;
- Call Cook Children's Health Plan at 800-862-2247
- Email Cook Children's Health Plan at CCHPDenialandAppeal@cookchildrens.org;
- Go in-person to a local HHSC office.

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

- In writing, via United States mail, email or fax
- Orally, by phone or in person

An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

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

If the Member continues with the State Fair Hearing, the Member can also request the Independent Review Organization be present at the State Fair Hearing. The Member can make both of these requests by contacting the Cook Children's Health Plan at 800-862-2247, emailing CCHPDenialandAppeal@cookchildrens.org or the HHSC Intake Team at EMR_Intake_Team@HHS.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, it is the State Fair Hearing decision that is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

Can a Member ask for an emergency External Medical Review?

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

Adult Transition Planning

Care Transition (Discharge Planning) and Youth to Adult

Cook Children's Health Plan Service Coordinators work collaboratively with facility discharge planners and Case Managers to assure a seamless transition from hospital based care to home, sub-acute care or long term services and supports. Cook Children's Health Plan requests that facilities arrange post hospital services from in network Providers for all Member discharges. This is required for Members with Cook Children's Health Plan as primary coverage and it is requested for those with presumed secondary coverage by the health plan. This practice assures the best outcome should coverage change unexpectedly due to the family electing to maintain Cook Children's Health Plan coverage rather than enrolling the child in other commercial insurance or if coverage ends due to loss of job or eligibility. Using in network Providers also assists our health plan Members with primary commercial coverage when using their Cook Children's Health Plan coverage for balances for high cost services co-pay/deductibles and when benefit maximums are reached.

Cook Children's Health Plan has adopted the Got Transition gottransition.org best practice model to facilitate youth Members to adult care. In network Providers are encouraged to adopt this best practice model.

STAR Kids Only

Cook Children's Health Plan will help to assure that teens and young adult Members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their twenty-first birthday. Each MCO is responsible for conducting ongoing transition planning starting when the Member turns fifteen years old. The MCO must provide transition planning services as a team approach through the named Service Coordinator if applicable and with a Transition Specialist within the Member Services Division.

Role of Transition Specialist

Transition Specialists must be an employee of the MCO and wholly dedicated to counseling and educating Members and others in their support network about considerations and resources for transitioning out of STAR Kids. Transition Specialists must be trained on the STAR+PLUS system and maintain current information on local and state resources to assists the Member in the transition process.

Transition planning must include the following activities:

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

Continuity of Care Transition Plan

The Member's Case Manager/Service Coordinator establishes a transition plan for those

Members who have ongoing care needs at the time eligibility terminates. The transition plan includes coordination of care with other health plan case managers/ service coordinators as appropriate and with the Member's/family's consent; identification of community resources available to meet the medical and/or psychosocial needs of the Member when the Member will not have a funding source/insurance; and, communication of transition plan to the Member's Primary Care Provider.

Providers are encouraged to call the Cook Children's Health Plan Care Management Department at 888-243-3312 for assistance with any continuity of care/transition of care issues. Providers may refer to the covered services section of this Provider Manual for additional information related to Continuity of Care.

Section 8: Quality Management Program (QMP)

The purpose of Cook Children's Health Plan's Quality Management Program is to assure that attributes of care such as accessibility, quality, effectiveness, and cost are measured periodically for accuracy and adequacy. The goal is to provide beneficial feedback to physicians, other Providers and Members so that Cook Children's Health Plan can positively influence the quality of healthcare services provided to our Members. The Quality Management Program also evaluates non-clinical services that influence Member and Provider satisfaction with Cook Children's Health Plan.

The Cook Children's Health Plan Quality Management Committee reviews the performance of the Quality Management Program at least quarterly, using performance data obtained from internal and external sources based on a reporting calendar. The scope of monitoring includes health plan performance, and clinical and service performance in institutional and non-institutional settings, primary care, and major specialty services including mental health care. The method and frequency of data collection are defined specifically for each indicator. The integrity of the data is protected to ensure its validity, reliability, accuracy and confidentiality.

Specific goals and data collection sources are standardized throughout the Cook Children's Health Plan whenever possible and include, but are not limited to, the following areas:

- Continuous Quality Management Indicators
- Performance Improvement Projects
- Clinical Practice Guidelines
- Utilization Management Data
- Service Accessibility Assessments
- Drug and Biological Utilization Data.
- Provider Profiling Reports.
- Quality of Care Occurrence Reports Member Satisfaction Surveys
- Member Complaints, Grievances and Appeals
- Member Services Performance
- Medical Record and Office Site Visit Reviews.
- Credentialing and Recredentialing
- Provider Satisfaction Surveys
- Delegation Audit and Oversight Reports
- Results of Quality Management Improvement Plans
    - Sometimes referred to as "corrective action plans" imposed upon contracted entities, through delegation oversight

Practice Guidelines

Cook Children's Health Plan relies on the use of evidence based clinical practice and medical necessity guidelines to evaluate the quality of care, and to identify opportunities for clinical improvement. These guidelines are adapted from national guidelines for practice. All are reviewed, modified if appropriate, and approved by participating Providers and the Cook Children's Health Plan Medical Management Committee and Quality Improvement Committee, which are composed of Primary Care Providers and a variety of specialists. Clinical Practice Guidelines can be printed from the website at cookchp.org, or you may call 888-243-3312 to receive a printed copy.

Performance Improvement Projects (PIPs)

Cook Children's Health Plan is required to conduct at least two focus studies or Performance Improvement Projects per year based on state requirements; projects typically last two years but may extend to three years depending on the nature of the undertaking. Cook Children's Health Plan utilizes national standards, whenever possible, to measure the success of the projects. Provider participation is often a critical component to the success of these projects.

Reports on active PIPS are provided to QMC for quarterly review. The QMC maintains accountability and authority to review the results, issue recommendations, recommend the allocation of resources relative to PIPs, and reports these to the Cook Children's Health Plan Board of Trustees no less than annually.

PIPs are prioritized based upon the following principles:

- Relevance to the Cook Children's Health Plan business plan, mission, or vision and potential contribution to the achievement of the strategic goals of CCHCS
- Relevance to high volume and/or high risk administrative and/or clinical practices
- Potential to improve the health of enrolled populations
- Relevance to quality of clinical care provided
- Relevance to Provider and/or Member satisfaction
- Potential to produce measurable results
- Relevance to state and federal regulatory agency requirements and/or nationally recognized standards

Quality Indicators

Each year Cook Children's Health Plan evaluates the effectiveness of its Quality Improvement Program based on standards for service and quality of care established by the National Committee for Quality Assurance (NCQA).

The following measures are a subset Healthcare Effectiveness Data and Information Set (HEDIS) measures of quality of health care developed by the NCQA. In addition are measures created internally to supplement HEDIS studies and are broken out in two groups, clinical and service studies.

Clinical

- Well-child visits in the first thirty months of life
- Well-child visits ages three through twenty
- Adolescent well-care visits
- Childhood Immunization Status
- Adolescent Immunization Status
- Lead Screening in Children
- Appropriate Testing for Children With Pharyngitis
- Weight Assessment and Counseling for Nutrition and Physical Activity
- Chlamydia Screening in Women
- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Follow-up Care for Children Prescribed ADHD Medication
- Prenatal and Postpartum Care
- Metabolic Monitoring for Patients on Antipsychotic Medications
- Provider Satisfaction
- Member Satisfaction
- Geographical Access Study
- Access and Availability Study
- Primary Care Access Study
- Behavioral Health Care Access Study
- Improving Medical Check-Up visits within ninety days of enrollment
- Potentially Preventable Admissions
- Potentially Preventable Readmissions
- Potentially Preventable Emergency Room Visits

Utilization Management Reporting Requirements

The primary responsibility for monitoring appropriate use of health services is vested with the Medical Director of Cook Children's Health Plan. The Medical Director will establish Utilization Management requirements that may be revised from time-to-time to assure the delivery of quality care in a cost-effective manner. The Medical Director will be assisted by Registered Nurse Case Managers who will act on behalf of the Medical Director in communicating with participating Providers. Specific requirements for the process are as follows:

Review Process

Prospective Review

A method for reviewing and authorizing elective procedures/tests, both inpatient and outpatient, to determine if the case meets established medical quality criteria, and is being provided in the most efficient and cost-effective manner.

Concurrent Review

A method of reviewing and authorizing current ongoing medical care to ensure that the level of care is appropriate, that the care meets established quality criteria, and that the care is being delivered in the most efficient and cost effective setting.

Retrospective Review

A method of reviewing medical care provided prior to the date of review to determine if care was provided in accordance with established medical quality criteria in the most appropriate and cost effective setting.

Section 9: Complaints and Appeals

Provider Complaint Process

Provider Complaint Process to Cook Children's Health Plan

A complaint means a dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Adverse Benefit Determination. The complaint process does not include appeals related to medical necessity or disenrollment decisions. A complaint does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up a misunderstanding to the satisfaction of the complainant.

Providers that wish to file a complaint about Cook Children's Health Plan or one of our Members can do so by submitting their complaint in writing. Upon receipt of the complaint the health plan will send an acknowledgement letter to the Provider within five business days. Cook Children's Health Plan will fully and completely respond to all Provider complaints within thirty calendar days of receiving the complaint. Telephone communication related to the complaint will be documented in a complaint log. Email and fax documentation related to the complaint will be retained by the health plan for a period of seven years.

Providers may submit a written complaint as follows:

- Faxing a written complaint to: 682-303-0276
- Submitting a written complaint by email to: CCHPCompliance@cookchildrens.org
- Submit online via our Secure Provider Portal by selecting Customer Service topic: Submit a Provider Complaint
- Mailing a written complaint to:

Cook Children's Health Plan
Attn: Compliance
PO Box 2488
Fort Worth, TX 76113-2488

Provider Complaint Process to Health and Human Services Commission

If the Provider is not happy with the resolution of the complaint, they have the right to file a complaint with the Health and Human Services Commission. When filing a complaint with HHSC, Providers must send a letter within sixty calendar days of receiving Cook Children's Health Plan's resolution letter. The letter must explain the specific reasons you believe Cook

Children's Health Plan's complaint resolution is incorrect.

The complaint should include:

- All correspondence and documentation sent to Cook Children's Health Plan, including copies of supporting documentation submitted during the complaint process
- All correspondence and documentation you received from Cook Children's Health Plan
- All R&S reports of the claims/ services in question, if applicable
- Provider's original claim/billing record, electronic or manual, if applicable
- Provider internal notes and logs when pertinent
- Memos from the state or health plan indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the complaint
- Other documents, such as certified mail receipts, original date-stamped envelopes, in service notes, or minutes from meetings if relevant to the complaint. Receipts can be helpful when the issue is late filing

When filing a complaint with Health and Human Services Commission, Providers must submit a letter to the following address:

Texas Health and Human Services Commission
Re: Provider Complaint
Health Plan Operations, H-320
PO Box 85200
Austin, TX 78708

Member Complaint Process

Member's Right to File Complaints to Cook Children's Health Plan

A Member, or the Member's authorized representative, has the right to file a complaint either orally or in writing. Cook Children's Health Plan will resolve all complaints within thirty calendar days from the date the complaint is received. If the Member needs help in filing a complaint, they can contact the Member Services Department and a Customer Care Representative will assist them.

Members can file a complaint with Cook Children's Health Plan by calling 682-303-0004 or toll free at 844-843-0004 or in writing to:

Cook Children's Health Plan
Attn: Compliance
PO Box 2488
Fort Worth, TX 76113-2488

Member's Right to File Complaints to Health and Human Services Commission

If the Member is not satisfied with the resolution of the complaint, they may also file a complaint directly with the Health and Human Services Commission. The Member can call HHSC at toll-free 1-866-566-8989.

If making a Complaint in writing, the Member must send a letter to:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, Texas 78711-3247

If the Member has access to the internet, they can submit their complaint at: HHSC Ombudsman Managed Care Help

Provider Appeal Process to HHSC (related to claim recoupment)

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

Providers may appeal claim recoupments 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 to grant an authorization for the exact items that were approved by the plan
    - The EOB showing the recoupment and/or the plan's "demand" letter for Recoupment
- If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB
- Completed clean claim
    - All paper claims must include both the valid NPI and TPI number
- In cases where issuance of a prior authorization (PA) is needed, the Provider will be contacted with the authorization number and the Provider will need to submit a corrected claim that contains the valid authorization number

- **Note:** Label the request **"Expedited Review Request"** at the top of the letter to ensure the appeal request is reviewed prior to eighteen months from the date of service

Mail Fee-for-Service related appeal requests to:

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

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

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

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

- Member eligibility changed from one Managed Care Organization (MCO) to another on the Date-of-Service
- Providers may appeal claims payment recoupments and denials of services by submitting the following information to the appropriate MCO to which the Member eligibility was changed on the date of service:
    - A letter indicating that the appeal is related to a managed care disenrollment/ recoupment and that the Provider is requesting an Exception Request
- The explanation of benefits (EOB) showing the original payment
    - **The EOB showing the recoupment and/or the MCO's "demand" letter for recoupment** must identify the client name, identification number, DOS, and recoupment amount
    - The information should match the payment EOB
- **Documentation must identify** the client name, identification number, DOS, and recoupment amount, and other claims information
- **Note:** Label the request **"Expedited Review Request"** at the top of the letter to ensure the appeal request is reviewed prior to eighteen months from the date of service

Submit appeals to Cook Children's Health Plan online at cookchp.org via the Secure Provider Portal.

Mail Fee-for-Service related appeals to:

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

No Retaliation

Cook Children's Health Plan will not retaliate against any person filing a complaint against the health plan or appealing a decision made by the health plan.

Cook Children's Health Plan will not punish a child or other person for:

- Filing a complaint against Cook Children's Health Plan or
- Appealing a decision made by Cook Children's Health Plan

Section 10: Behavioral Health Services

Cook Children's Health Plan manages the delivery of mental health and substance use disorder services for STAR Kids Members.

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 Cook Children's Health Plan Members receive timely access to clinically appropriate behavioral health care services, Cook Children's Health Plan believes that quality clinical services can achieve improved outcomes for our Members.

Improved health outcomes can be achieved by providing Members with access to a full continuum of mental health and substance use services through our network of contracted Behavioral Health Providers.

Definition of Behavioral Health

Behavioral Health is defined 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 the American Psychiatric Association.

Behavioral Health Scope of Services

Cook Children's Health Plan will coordinate the behavioral health services, which include, but are not limited to, the services listed in the STAR Kids covered services section. These services include acute, diversionary and outpatient services.

Cook Children's Health Plan will work with participating behavioral health care practitioners, Primary Care Providers, medical/surgical specialists, organizational Providers and other community and state resources to develop relevant primary and secondary prevention programs for behavioral health.

These programs may include:

- Educational programs to promote prevention of substance use
- Parenting skills training
- Developmental screening for children
- Attention Deficit Hyperactivity Disorder (ADHD) screening
- Postpartum depression screening

Primary Care Provider Requirements for Behavioral Health

Primary Care Providers may provide behavioral health services within the scope of their practice. Primary Care Providers are responsible for coordinating the Member‘s physical and behavioral healthcare, including making referrals to Behavioral Health Providers when necessary. Primary Care Providers should submit claims to Cook Children’s Health Plan for consideration.

Primary Care Providers are responsible for identifying and referring any Member three years or older suspected of having a developmental delay or developmental disability, severe emotional disturbance (SED), mental illness or chemical dependency.

Primary Care Providers are required to utilize valid screening and assessment instruments to identify and refer children to Providers specializing in evaluations to determine whether a child or young adult has a developmental disability, or is at risk for or has SED or another type of mental illness

Valid screening and assessments are located at cookchp.org

If applicable Primary Care Providers will refer the Member or young adult to a Provider specializing in evaluations to determine whether the child or young has a developmental disability or is at risk for or has a serious emotional disturbance or mental illness.

This section does not apply to STAR Kids Dual Eligible Members

Role of a Health Home

Cook Children’s Health Plan is committed to providing a consistent and integrated source of healthcare for our STAR Kids Members through a person centered Health Home. Primary Care Providers coordinate with Members, caregivers, other Providers, STAR Kids Service Coordinators, and state and non-state entities to assure that the Member’s medical and behavioral health needs are met. Other Primary Care Provider requirements include screening, identification, and referral to medically necessary or functionally necessary covered services and assessment and coordination of non-clinical services that impact the Member’s health.

Primary Care Provider Referral

Cook Children’s Health Plan Members can self-refer to any in network Behavioral Health Provider for initial evaluation for behavioral health treatment. All behavioral health services which require prior authorization must be coordinated through Cook Children’s Health Plan.

The following circumstances indicate that a referral to a physician is recommended:

- Member is receiving psychoactive medication for an emotional or behavioral problem or condition
- Member has significant medical problems that impact his/her emotional well-being
- Member is having suicidal and/or homicidal ideations
- Member has delirium, amnesia, a cognitive disorder, or other condition for which there is a probable medical (organic) etiology
- Member has a substance use disorder such as substance-induced psychosis, substance induced mood disorder, substance induced sleep disorder, etc.
- Member has or is likely to have a psychotic disorder, major depression, bipolar disorder, panic disorder, or eating disorder
- Member is experiencing severe symptoms or severe impairment in level of functioning or has a condition where there is a possibility that a pharmacological intervention will significantly improve the Member's condition
- Member has another condition where there is a significant possibility that somatic treatment would be of help. Conditions include dysthymia, anxiety, adjustment disorders, post-traumatic stress disorders, and intermittent explosive disorders
- Member has a substance abuse problem

Prior Authorization

Prior authorization may be required prior to seeing a Behavioral Health Provider. To determine if a covered service requires a prior authorization Providers may use the Prior Authorization Lookup tool located on our website at cookchp.org. Providers must submit prior authorization requests through our Secure Provider Portal located on our website cookchp.org

Member Consent for Disclosure of Information

The Primary Care Provider is required to obtain consent for disclosure of information from the Member to permit the exchange of clinical information between the Behavioral Health Provider and the Member's Primary Care Provider. If the Member refuses to release the information, they will sign the consent for disclosure of information that indicates their refusal to release the information. The Provider will document the reason(s) for declination in the medical record. An Authorization for Behavioral Health and Primary Care Provider to Share Confidential Information form is located at cookchp.org.

Covered Services

The following is a non-exhaustive, high-level listing of acute care covered services included under the STAR Kids Program. For a complete listing of the limitations and exclusions that apply to each Medicaid benefit category, Providers should refer to the current Texas Medicaid Provider Procedures Manual at tmhp.com. These services are subject to modification based on federal and state mandates.

A Primary Care Provider referral is not required to access behavioral health services.

STAR Kids covered behavioral health services include, but are not limited to, medically necessary:

- Inpatient mental health services
- Acute inpatient mental health services for adults
- Outpatient mental health services for children and adults
    - When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity
    - Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination
    - A Qualified Mental Health Provider – Community Services (QMHP-CS) is defined by the Texas Department of State Health Services (DSHS) in Title25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be Providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards
        - Those services include individual and group skills training (which can be components of interventions, such as day treatment and in home services), patient and family education, and crisis services
    - Does not require Primary Care Provider referral
- Psychiatry services
- Counseling Services for adults (twenty-one years of age and over)
- Outpatient Substance Use Disorder Treatment Services, including:
    - Assessment
    - Detoxification services
    - Counseling treatment
    - Medication-assisted therapy
- Residential Substance Use Disorder Treatment Services including:
    - Detoxification services
    - Substance use disorder treatment (including room and board)

These services are not subject to the quantitative treatment limitations that apply under traditional, fee-for-service Medicaid coverage.

The services may be subject to Cook Children's Health Plan's non-quantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008.

- Emergency services
- Hospital services, including inpatient and outpatient
    - Cook Children's Health Plan may provide inpatient services for acute psychiatric conditions in a free-standing psychiatric hospital in lieu of an acute inpatient hospital setting
    - Cook Children's Health Plan may provide substance use disorder treatment services in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting

Behavioral health services that are offered to STAR Kids are:

- Reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder
- In accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care
- Furnished in the most appropriate and least restrictive setting in which services can be safely provided
- The most appropriate level or supply of service that can safely be provided;
- Could not be omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered
- Not experimental or investigative, and not primarily for the convenience of the Member or Provider

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.
- Primary Care Provider may refer a Member to a Behavioral Health Provider
- Coordination between behavioral health and physical health services
- Member has the right to obtain a second opinion
- Medical records and referral information must be documented using the most current edition of DSM classifications
- Authorization to release confidential information, such as medical records regarding treatment, should be signed by the patient or guardian prior to receiving care from a Behavioral Health Provider
- Members under the age of twenty-one will be provided inpatient psychiatric services, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction

- Coordination will be conducted with the Local Mental Health Authority (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 the state psychiatric facility
- Assessment documents for behavioral health will be made available for the use of Primary Care Providers
- Cook Children's Health Plan works to ensure that quality behavioral health services are provided to all Members. This approach includes focus studies and utilization management reporting
- Providers will make contact with the Member within twenty-four hours of a missed appointment for the purposes of rescheduling
- Members who are discharged from an inpatient psychiatric facility will have a follow-up appointment within seven days from the date of discharge by the Provider

Non Covered Services

Members may access local community resources for behavioral health services that are not covered. Services may be sought through the local office of the Texas Department of State Health Services (DSHS) or located through the Texas 211 website at 211texas.org.

Members may also receive services through the Local Mental Health Authority (LMHA). The LMHA accepts patients with chronic mental health disorders (i.e. schizophrenia, bipolar disorder, severe major depression). In the event that a Cook Children's Health Plan STAR Kids Member will need to access services through the local mental health authority, the health plan staff will assist the Member through the LMHA system of care.

Accessible Intervention and Treatment

Cook Children's Health Plan promotes early intervention and health screening for identification of behavioral health problems and patient education. Providers are expected to:

- Screen, evaluate, treat and/or refer (as medically appropriate) any behavioral health problem. Primary Care Providers may treat for mental health and/or substance use disorders within the scope of their practice and bill using the DSM codes
- Inform Members how and where to obtain behavioral health services
- Understand that Members may self-refer to any Behavioral Health Provider without a referral from the Member's Primary Care Provider

Providers who need to refer Members for further behavioral health care and need assistance should contact Cook Children's Health Plan. Cook Children's Health Plan continuously evaluates Providers who offer services to monitor ongoing behavioral health conditions, such as regular lab or ancillary medical tests and procedures.

Service Coordination

Behavioral Health Service Coordinators serve as the primary Service Coordinators for Members with a primary behavioral health diagnosis, and are responsible for coordination across the continuum of care. Behavioral Health Service Coordinators are dedicated to the STAR Kids Membership.

Emergency Services

Emergency services are those physician and outpatient hospital services, procedures, and treatments, including psychiatric stabilization and medical detoxification from drugs or alcohol, needed to evaluate or stabilize an emergency medical condition. The definition of an emergency medical condition follows:

Covered inpatient and outpatient services furnished by a Provider that is qualified to furnish such services under the contract and that are needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition, including post-stabilization care services. The Provider should direct the Member to call 911 or go to the nearest emergency room or comparable facility if the Provider determines an emergency behavioral health condition exists.

Emergency Screening and Evaluation

Members must be screened for an emergency medical condition by a qualified behavioral health professional from the hospital emergency room, or by an Emergency Service Program (ESP). This process allows Members access to emergency services as quickly as possible and at the closest facility or by the closest crisis team.

After the emergency evaluation is completed, the facility or program clinician should request prior authorization from Cook Children's Health Plan Providers may request prior authorization via the Secure Provider Portal. Clinical documentation should be provided with the request.

The facility/program clinician is responsible for locating a bed but may request Cook Children's Health Plans assistance. The facility/ program may contact an out of network facility in cases where there is not a timely or appropriate placement available within the network. In cases where there is no in network or out of network psychiatric facility available, Cook Children's Health Plan will authorize boarding the Member on a medical unit until an appropriate placement becomes available.

Outpatient Benefits

Outpatient behavioral health treatment is an essential component of a comprehensive health care delivery system. Cook Children's Health Plan Members may access outpatient mental health and substance use services by self-referring to a network Provider, by calling Cook Children's Health Plan, or by referral through acute or emergency room encounters. Members may also access outpatient care by referral from their Primary Care Provider; however, a Primary Care Provider referral is never required for behavioral health services.

Inpatient Benefits

Cook Children's Health Plan is responsible for authorizing inpatient hospital services, which includes services provided in freestanding psychiatric facilities for STAR Kids Members.

Attention Deficit Hyperactivity Disorder

Treatment of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), including follow-up care for children prescribed ADHD medication, is covered as outpatient mental health services. Cook Children's Health Plan will reimburse Providers for the treatment of ADHD in children who are eligible Members as well as for any follow-up visits with children for whom they have prescribed medications to treat ADHD.

Cook Children's Health Plan requests that the Primary Care Providers or another Provider with prescriptive authority complete a visit with a Member prescribed ADHD medications within thirty days of starting the medication to evaluate efficacy and assess adverse side effects before prescribing further medication. Additionally, children and adolescents on ADHD medication should have at least two follow-up visits in the nine months following the initial thirty day visit.

Coordination, Treatment and Scope of Services

Coordination of Care

Behavioral health service Providers are expected to communicate at least quarterly and more frequently, if necessary, regarding the care provided to each Member with other behavioral health service Providers and Primary Care Providers. Behavioral health service Providers are required to refer Members with known or suspected and untreated physical health problems or disorders to their Primary Care Provider for examination and treatment.

Copies of prior authorization forms, referral forms and other relevant communication between Providers should be maintained in both Providers' files for the Member. Coordination of care is vital to ensuring Members receive appropriate and timely care.

Coordination between Physical and Behavioral Health

Cook Children's Health Plan is committed to coordinating medical and behavioral care for Members who will be appropriately screened, evaluated, treated and/or referred for physical health, behavioral health or substance use, dual or multiple diagnoses, mental retardation, or developmental disabilities. Cook Children's Health Plan will designate behavioral health Service Coordination, Care Coordination, or Case Management personnel to facilitate coordination of care and case management efforts.

Coordination for Members with Substance Use Disorder

Providers must work with the health plan, facilities and Members to coordinate care for Members with substance use disorders to ensure Members have full access to the continuum of covered services (including without limitation assessment, detoxification, residential treatment, outpatient services, and medication therapy) as medically necessary and appropriate.

Coordination with the Local Behavioral Health Authority

Cook Children's Health Plan will coordinate with the Local Mental Health Authority (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 the state psychiatric facility. Cook Children's Health Plan will comply with additional behavioral health services requirements relating to coordination with the Local Mental Health Authority and care for special populations.

Covered services will be provided to Members with Severe and Persistent Mental Illness (SPMI) Severe Emotional Disturbance (SED) when medically necessary, whether or not they are receiving targeted case management or rehabilitation services through the Local Mental Health Authority.

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. Cook Children's Health Plan is required to provide inpatient psychiatric services as a condition of probation to Members under the age of twenty one, 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.

Cook Children's Health Plan will not deny, reduce or controvert the medical necessity of inpatient psychiatric services provided pursuant to a Court-Ordered Commitment for Members under age twenty-one. Any modification or termination of services will be presented to the court with jurisdiction over the matter for determination. A Member who has been ordered to receive

treatment under the provisions of the Texas Health and Safety Code cannot appeal the commitment through Cook Children's Health Plan's complaint or appeals process.

Cook Children's Health Plan will comply with utilization review of chemical dependency treatment. Chemical dependency treatment must conform to the standards set forth in the Texas Administrative Code.

Members Discharged from Inpatient Psychiatric Facilities

Cook Children's Health Plan requires that all Members receiving inpatient Psychiatric Services must be scheduled for outpatient follow up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. The Provider must follow up with the Member and attempt to reschedule missed appointments. Behavioral Health service Providers must contact Members who have missed appointments within twenty-four hours to reschedule appointments.

Transitioning Members from One Behavioral Health Provider to Another

If a Member transfers from one Behavioral Health Provider to another, the transferring Provider must communicate the reason(s) for the transfer along with the information above (as specified for communication from Behavioral Health Provider to Primary Care Provider), to the receiving Provider.

Treatment Record Reviews

Cook Children's Health Plan reviews Member records and uses data generated to monitor and measure Provider performance in relation to the Treatment Record Standards and specific quality initiatives established each year. The following elements are evaluated:

- Use of screening tools for diagnostic assessment of substance use, and Attention Deficit Hyperactivity Disorder (ADHD)
- Continuity and coordination with primary care Providers and other treatment Providers
- Explanation of Member rights and responsibilities
- Inclusion of all applicable required medical record elements as listed below
- Allergies and adverse reactions; medications; physical exam

Cook Children's Health Plan may conduct chart reviews on site, at a Provider facility, or may ask a Provider to copy and send specified sections of a Member's medical record to the health plan. HIPAA regulations permit Providers to disclose information without patient authorization for the following reasons: "oversight of the health care system, including quality assurance activities." Cook Children's Health Plan chart reviews fall within this area of allowable disclosure.

Screening for Depression

Documentation in the medical record is required to demonstrating the use of a nationally recognized standardized screening instrument AND the outcome of the screen.

Although it is expected the instrument will be used most frequently in Primary Care, it is accepted if the standardized instrument is used in another clinic. Approved screening instruments include:

- PRIME-MD (2 question screen used by Whooley & colleagues)
- MOS Depression items (recommended for patients under age sixty (60)
- CEB-D (5 item brief version developed as screening instrument for patients age sixty (60) and over)
- SSDS-PC
- PHQ-2 & PHQ-9
- CESD (5, 10, or 20 item version)
- BDI-S (13 item version)
- BDI (21 items)
- Hamilton Rating Scale for Depression
- DSM criteria for MDD
- Williams et al one-item screener

Targeted Case Management and Mental Health Rehabilitative Services

Definition of Severe and Persistent Mental Illness (SPMI):

Mental illness with complex symptoms that require ongoing treatment and management, most often consisting of varying types and dosages of medication and therapy

Definition of Severe Emotional Disturbance (SED):

A serious emotional disturbance means a diagnosable mental, behavioral, or emotional disorder that severely disrupts a child's or adolescent's ability to function socially, academically, and emotionally, at home, in school, or in the community, and has been apparent for more than a six month period

Member Access to and Benefits of MHR and TCM

Mental Health Rehabilitative Services (MHR) and Mental Health Targeted Case Management (TCM) are available to STAR Kids recipients who are assessed and determined to have:

- A severe and persistent mental illness such as schizophrenia, major depression, bipolar disorder or other severely disabling mental disorder
- Children and adolescents ages three through seventeen years with a diagnosis of a mental illness or who exhibit a serious emotional disturbance

Targeted Case Management

- Must be face to face
- Include regular, but at least annual, monitoring of service effectiveness
- Proactive crisis planning and management for individuals

Provider Requirements

- Training and certification to administer Adult Needs and Strengths Assessment (ANSA) can be found at Adult Needs & Strengths Assessment
- Training and certification to administer Child and Adolescent Needs and Strengths (CANS) can be found at Child & Adolescent Needs & Strengths Assessment
- Providers must follow current Resiliency and Recovery Utilization Management Guidelines (RRUMG) found at Utilization Management Guidelines & Manual
- Attestation from Provider entity to MCO that organization has the ability to provide, either directly or through sub-contract, the Members with the full array of MHR and TCM services as outlined in the RRUMG
- Provider must review a Members plan for Mental Health Rehabilitative Services to determine conditions or needs warrants a reassessment or change in service.
- HHSC established qualification and supervisory protocol, this criteria is located in Chapter 15.1 of the HHSC Uniform Managed Care Manual

Providers must also complete the Mental Health Rehab and/or Targeted Case Management Request forms located at cookchp.org and submit them to Cook Children's Health Plan. All authorizations and claims processing must be submitted to Cook Children's Health Plan via the Secure Provider Portal.

Focus Studies and Utilization Reporting Requirements

Cook Children's Health Plan 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 health plan Members.

Cook Children's Health Plan routinely monitors inpatient and outpatient data, including claims, medical records, and supplemental data, to improve both behavioral health outcomes and physical health outcomes resulting from behavioral health integration into the Member's overall

care.

Cook Children's Health Plan also routinely monitors 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.

Behavioral Health Quality Improvement Studies

Formal quality improvement studies for behavioral health are designed with input from a multi-disciplinary team/committee to ensure valid findings. Data is collected from an administrative database, medical record reviews, surveys and office site visits. Clinical and preventive service studies will in most instances be based on measurement against clinical guidelines.

In additions, both clinical and service indicators will be trended and reported. Performance Improvement Projects (PIP) such as HEDIS Follow-Up after Hospitalization for Mental Illness will be conducted on an annual basis. The findings from these reviews will be communicated to Providers, as applicable. Questions may be directed to Cook Children's Health Plan Quality Management Department toll free at 888-243-3312.

Programmatic success is dependent upon the development of a strong neighborhood Provider, hospital and ancillary Provider network that actively interacts with Behavioral Health Providers to meet the needs of the Cook Children's Health Plan Members. Through both formal and informal interaction with Providers on the results of studies, Provider data sharing, availability of resource information and timely feedback on areas for improvement, Cook Children's Health Plan will provide support in delivering the highest quality of care and service to Members. Cook Children's monitors Member satisfaction via satisfaction surveys, complaints, grievances, and feedback from the Community/Member Advisory Committee. Cook Children's Health Plan has the opportunity to meet and exceed the needs of the communities that it serves.

Notifying Cook Children's Health Plan Of Reportable Events

Reportable events (also known as Critical Incidents) are incidents or outcomes involving Cook Children's Health Plan Members seeking or receiving services from in network Providers that may require further analysis. They also include events that occur during a Member's transition to home or an alternative level of care. Tracking of reportable events is a contractual requirement for our Providers, so it is important to report an occurrence promptly.

Notification to the health plan that a reportable event has taken place must be documented on the Cook Children's Health Plan Reportable Event Form, located on our website cookchp.org and sent to the Quality Improvement Department via email to CCHPQualityImprovement@cookchildrens.org or by fax to 682-885-8494 as soon as

reasonably possible, but ideally within one business day of the date you became aware of the event. Written supplemental notes or a copy of clinical records may be requested.

Reportable Events include but are not limited to the following events occurring within any treatment setting:

Event	Serious Reportable Events (SREs)	Trending Events (TEs)
Suicide attempt	Attempted suicide while inpatient (or at any Provider site) or if needed emergent care and last discharge was within (seven) days	Attempted suicide at any other level of care than inpatient with no apparent Provider culpability
Completed or attempted homicide	Completed homicide while in any level of treatment	Attempted homicide in any level of care with no apparent Provider culpability
Death by any cause	Death by suicide at any level of care, death by any cause while inpatient for psychiatric/substance use treatment, or death by an unknown cause while in any other level of care Death of any consumer while at a Provider site (regardless of whether or not the consumer is a Cook Children's Health Plan Member)	Death by any cause while in any other level of care
Allegations of sexual or physical abuse/neglect/exploitation	Allegations of sexual or physical abuse/neglect/exploitation by a Provider or non-consensual sex between consumers while at a Provider site or where services are rendered Rape, abuse, or assault by staff that is considered founded (witnessed by staff	Allegations of sexual or physical abuse/ neglect/exploitation by non-Provider (occurring at a Provider site or within the Member's home) and consensual sex between consumers at a Provider site or where services are rendered

Event	Serious Reportable Events (SREs)	Trending Events (TEs)
	or other consumers, involving an admission by the perpetrator, involving clinical evidence, etc.) regardless of whether or not a Cook Children's Health Plan Member was involved or present	
Assault within a facility or Provider site	Assaults while in a facility that require serious medical treatment (urgent/emergent care, such as Emergency Department or Urgent Care visit)	Assaults while in a facility that require minor or no medical treatment (such as first aid, assessment/monitoring by on-site medical staff)
Absent without leave for longer than two (2) hours	Absent without leave from residential Provider for longer than two hours and at risk to self or others	Absent without leave from a residential Provider for longer than two hours with no apparent serious risk and did not return with any contraband, illicit substances, etc. This does not include adults leaving voluntary residential treatment if they have been assessed to not be at risk to self or others.
Undesirable events inconsistent with routine patient care	Undesirable events inconsistent with routine patient care of a serious nature (adverse medical complications, inebriation, etc.)	Undesirable events inconsistent with routine patient care of a moderate nature
Breach of confidentiality	Breach of Confidentiality	

Event	Serious Reportable Events (SREs)	Trending Events (TEs)
Parent/guardian taking child AMA from residential setting with child at risk Adult leaving treatment voluntarily while at serious risk	Parents or guardian taking child AMA from any inpatient setting with child at risk due to AMA (kidnapping, etc.) or adult leaving treatment voluntarily while at serious risk for incarceration or hospitalization (such as demonstrating suicidal ideation or unstable mental or physical health status)	
Accidental injuries at a Provider site requiring medical treatment more than first aid	Serious accidental injuries either in a facility or a Provider site (wherever services are rendered) requiring urgent/emergent life-saving care or skilled nursing (such as Emergency Department or Urgent Care visit)	Non-serious accidental injuries either in a facility or at a Provider site (wherever services are rendered) requiring medical treatment more than first aid (First aid includes assessing a condition, cleaning a wound, applying topical medications, and applying simple bandages)
Medication/treatment errors	Medication /treatment errors causing severe or potentially severe harm or distress to the Member	Medication/treatment errors not resulting in severe or potentially severe harm or distress to the Member
Adverse reactions to medication/treatment	Adverse reactions to medication/treatment causing severe or potentially severe harm or distress to Member (NMS, etc.)	Adverse reactions to medication/treatment of a moderate or minor nature
Fire setting or property damage Emergency services summoned to facility other than false alarm	Any time emergency services (fire department, police, EMS, etc.) are summoned to a facility for any reason, such as fire setting, property damage, commitment of a crime, etc.	Fire setting or property damage that does not result in summoning emergency services but does require immediate action or repairs to ensure Member safety. False alarms are not reportable.

Event	Serious Reportable Events (SREs)	Trending Events (TEs)
Temporary closure of facility	Any condition that results in temporary closure of a facility, regardless of whether or not a Cook Children's Health Plan Member is affected by the closure.	
Possession of deadly weapon with the *threat of use by Member* at Provider site	Possession of a deadly weapon and the threat of use of the weapon by Member while in any facility, at a Provider site, or wherever services are rendered	
Outbreak of serious communicable disease	Outbreak of a serious communicable disease, regardless of whether or not a Cook Children's Health Plan Member is present at the time of the notification.	
Other Member safety concern	Other	Other
Any real or threatened litigation in a case against a Provider or Cook Children's Health Plan	ANY real or threatened litigation in a case against Cook Children's Health Plan or a Provider involving a Cook Children's Health Plan Member/family	Any real or threatened litigation against a Provider not involving a Cook Children's Health Plan Member/family
Administrative discharge		Administrative Discharge
Restraint	Restraint while in a facility or at a Provider site (or wherever services are rendered) that requires serious medical treatment (urgent/emergent care, such as Emergency Department or Urgent Care visit) OR restraint that is unauthorized/used improperly/applied	Restraint while in a facility that requires minor or no medical treatment (such as first aid, assessment/monitoring by on-site medical staff)

Event	Serious Reportable Events (SREs)	Trending Events (TEs)
	incorrectly. A restraint not approved in the individual support plan or one that is not a part of an agency's emergency restraint procedure is considered unauthorized.	
Self-injuries behavior	Self-Injurious Behavior that occurs at a Provider site (or wherever services are rendered) and is potentially life threatening or requires serious medical treatment (urgent/emergent care, such as Emergency Department or Urgent Care visit)	Self-Injurious Behavior that occurs at a Provider site (or wherever services are rendered) requiring medical treatment more than first aid (First aid includes assessing a condition, cleaning a wound, applying topical medications, and applying simple bandages) Or, Self-Injurious Behavior that demonstrates a new behavioral pattern of concern
Media contact	An occurrence that involves contact with the media: presence or inquiry by newspaper, news station, media outlet, etc. with the possibility that a public communication will be distributed.	

If you are in doubt that a critical incident has occurred, please notify the Quality Improvement Department so that the information can be reviewed.

Section 11: Glossary of Terms

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

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

Community Living Assistance and Support Services (CLASS) Waiver Program

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

Deaf Blind with Multiple Disabilities (DBMD) Waiver Program

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

Dual-Eligible

Medicaid recipients who are also eligible for Medicare.

Home and Community-based Services (HCS) Waiver Program

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

Long Term Services and Supports (LTSS)

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

Medical Dependent Children Program Waiver Program

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

Texas Home Living Waiver Program

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

Youth Empowerment Services Waiver Program

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

Section 12: Appendix

1. Specialist Acting as a PCP Request Form
2. High Risk Pregnancy Notification
3. Delivery Notification
4. Provider Information Change Form
5. STAR Kids Member ID Card
6. STAR Kids Value Added Services
7. Member Acknowledgement Statement
8. Private Pay Agreement
9. Notice of Hearing Form 4803

CookChildren's Health Plan

Tarrant Service Area

Denton, Hood, Johnson, Parker, Tarrant, Wise

TEXAS Health and Human Services

TEXAS STAR Kids

Your Health Plan ★ Your Choice