# Rights and Responsibilities

## New medical procedures review

You have benefits as a member. One of them is that we look at new medical advances. Some of the are like new equipment, tests, and surgery. Each situation is looked at on a case-by-case basis. Sometimes we use a special review to make sure that it is right for you. For more information call member services at 1-866-959-2555.

## If you are too sick to make decisions about your medical care

### What if I am too sick to make a decision about my medical care?

You have the right to accept or refuse medical care.

### What are Advance Directives?

Advance Directives, or living wills, are a set of instructions that you write down in case you are not able to talk or write to give instructions about your medical care. This set of instructions protects your rights and wishes. They tell people what you want your doctor or family to do if you ever have a bad injury or illness and are not able to talk or write. This set of instructions will make it easier on your family. It also helps the doctor know what you want.

### How do I get an Advance Directive?

If you already have an Advance Directive, please let your primary care provider know. If you want information about how to put your instructions in writing, call Member Services toll-free at 1-866-959-2555.

## Release of information

Texas Children's Health Plan is not permitted to give any information to anyone other than the person that filled out the Medicaid application for enrollment. If you filled out the application for enrollment and want to give information to someone other than yourself, call Member Services toll-free at 1-866-959-2555.

## Information you can ask for and receive from Texas Children's Health Plan each year

As a member of Texas Children's Health Plan, you can ask for and receive the following information each year:

- Information about network providers—at a minimum primary care doctors, specialists, and hospitals in our service area. This information will include names, addresses, phone numbers, and languages spoken (other than English) for each network provider plus identification of providers that are not accepting new patients.
- Any limits on the member's freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, appeal, and fair hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration, and scope of benefits. This is designed to make sure you know the benefits to which you are entitled.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from out-of-network providers and/or limits to those benefits.
- How you get after-hours and emergency coverage and/or limits to those benefits, including:
  - What makes up emergency medical conditions, emergency services, and post-stabilization services.
  - The fact that you do not need prior authorization from your primary care provider for emergency care services.
  - How to get emergency services, including instructions on how to use the 9-1-1 phone system or its local equivalent.
  - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
  - A statement saying you have a right to use any hospital or other settings for emergency care.
  - Post-stabilization rules.
- Policy on referrals for specialty care and for other benefits you cannot get through your primary care provider.
- Texas Children's Health Plan's practice guidelines.

## Medicaid and private insurance

### What if I have other health insurance in addition to Medicaid?

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

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

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

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

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

## Physician incentive plans

**If the MCO offers a physician incentive plan:** The MCO cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Members.
Texas Children's Health Plan cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Members. You have the right to know if your primary care provider (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can Member Services toll-free at 1-866-959-2555 to learn more about this.

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

## Your privacy

Texas Children's Health Plan takes the confidentiality of your personal health information—information from which you can be identified—very seriously. In addition to complying with all applicable laws, we carefully handle your personal health information (PHI) in accordance with our confidentiality policies and procedures. We are committed to protecting your privacy in all settings.
We use and share your information only to give you health benefits.
Our Notice of Privacy Practices has information about how we use and share our members' PHI. A copy of our Notice of Privacy is included with your member handbook and is on our website at www.TexasChildrensHealthPlan.org. You may also get a copy of our Notice of Privacy by calling Member Services toll-free at 1-866-959-2555.
If you have questions about our notice, call Member Services.

## When you are not satisfied or have a complaint

### What is a complaint?

A complaint is when you are not happy with your health care or services provided by your doctor, his or her office staff, or the Texas Children's Health Plan staff.

### What should I do if I have a complaint? Who do I call?

We want to help. If you have a complaint, please call us toll-free at 1-866-959-2555 to tell us about your problem. A Texas Children's Health Plan Member Services Advocate can help you file a complaint. Just call 1-866-959-2555. Most of the time, we can help you right away or at the most within a few days.

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

Texas Health and Human Services Commission
Health Plan Operations - H-320
P.O. Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

If you can get on the Internet, you can send your complaint in an email to HPM_Complaints@hhsc.state.tx.us.

### Can someone from Texas Children's Health Plan help me file a complaint?

A Texas Children's Health Plan Member Advocate can help you file a complaint. Just call us toll-free at 1-866-959-2555. Most of the time, we can help you right away or at the most within a few days.

### If you would like to make your complaint in writing, send it to:

Texas Children's Health Plan
Attention: Member Services Complaints
PO Box 301011, NB 8360
Houston, TX 77230

Be sure to include your name and member ID number from your member ID card.

**What are the requirements and timeframes for filing a complaint?**
You can file a complaint at any time. You will get a letter within 5 days telling you your complaint was received.

**How long will it take to process my complaint?**
Within 5 business days of receiving your oral or written complaint, Member Services will send you a letter. It will confirm the day we received your complaint. Texas Children's Health Plan will review the facts and take action within 30 days of receiving your complaint. A resolution letter will be sent to you.

**The letter will:**
- Describe your complaint.
- Tell you what has been or will be done to solve your problem.
- Tell you how to ask for a second review of your complaint.

**How do I file a complaint with HHSC, once I have gone through Texas Children's Health Plan's complaint process?**
Once you have gone through Texas Children's Health Plan's complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989.

**If you would like to make your complaint in writing, send it to the address below:**

Texas Health and Human Services Commission
Health Plan Operations—H-320
PO Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

You can also send your complaint in an e-mail to HPM-Complaints@hhsc.state.tx.us.

## Appeals

If you would like to file an appeal about how we solved your problem, including a denial of payment of service in whole or in part, you must tell us within 30 days of getting your complaint resolution letter.

**What is an appeal?**
An appeal is the process you or someone acting on your behalf can ask for when you do not agree with Texas Children's Health Plan's action and you want a review. An action means the denial or limited authorization of a requested service. It includes the:
- Denial in whole or part of payment for a service.
- Denial of a type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Failure to give services in a timely manner.
- Failure to act within regulatory timeframes.

**How will I find out if services are denied?**
We will send you a letter if a covered service requested by your doctor is denied, delayed, limited, or stopped.

**What can I do if my doctor asks for a service or medicine for me that's covered but Texas Children's Health Plan denies it or limits it? Can someone from Texas Children's Health Plan help me file an appeal?**
You have the right to ask for an appeal if you are not satisfied or disagree with the action. Call Member Services toll-free at 1-866-959-2555. A Member Advocate can help you file your request for an appeal. You can also allow someone like a friend, family member, or your doctor to ask for an appeal on your behalf. You will need to give your consent in writing to have them act on your behalf. Your request for an appeal must be filed within 30 calendar days from the receipt of the notice of the action.

To keep receiving currently authorized services, you must file the appeal on or before the later of 10 days following Texas Children's Health Plan mailing the letter telling you of the action or the intended effective date of the proposed action. You can ask that your services continue until a decision is made. If the final decision is to uphold Texas Children's Health Plan's action, then you can be asked to pay back what it cost to continue your services.

Each appeal is promptly investigated. Texas Children's Health Plan will send you a letter within 5 business days to let you know that we received your appeal request. The letter will list all the information we will need to receive to review the appeal. If you make a verbal request for an appeal, a form will also be enclosed with your letter. You will need to sign and return the form to confirm your request for an appeal.

Texas Children's Health Plan will answer you in writing with a decision about your appeal within 30 days of when we receive your appeal request. You or your representative can ask for an extension of 14 days. Texas Children's Health Plan can also ask you for an extension if we need to get additional information. If we ask for an extension you will receive a letter explaining the reason for the delay.

If your appeal is denied, the answer will explain the reason why it was denied and tell you how to appeal to the next level.

If you appeal the action a second time, the Texas Children's Health Plan Complaint and Appeal Panel will meet to hear your second-level appeal. This panel is made up equally of Texas Children's Health Plan staff, Members and providers. You have the right to make your appeal in person or through family or friends. Texas Children's Health Plan will answer you in writing with a decision about your appeal within 30 days of when we receive your second appeal request.

## What is a fair hearing?

A fair hearing is a chance for you tell the reasons why you think the services you asked for and couldn't get should be allowed.

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

If you, as a member of Texas Children's Health Plan, disagree with the health plan's decision, you have the right to ask for a fair hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A doctor or other medical provider may be your representative. If you want to challenge a decision made by Texas Children's Health Plan, you or your representative must ask for the fair hearing at any time up until 90 days of the date on the health plan's letter with the decision. If you do not ask for the fair hearing within 90 days, you may lose your right to a fair hearing.

**To ask for a fair hearing, you or your representative should either send a letter to the health plan or call:**

Texas Children's Health Plan
Attention: Appeals Department NB8390
PO Box 300709
Houston, TX 77230
Fax: 832-825-8796
Phone: 832-828-1001 or 1-866-959-2555
TDD 1-800-735-2989 (Texas Relay) or 7-1-1

You have the right to keep getting any service the health plan denied or reduced, at least until the final hearing decision is made if you ask for a fair hearing by the later of: (1) 10 days from the time you get the health plan's decision letter, or (2) the day the health plan's letter says your service will be reduced or end. If you do not request a fair hearing by this date, the service the health plan denied will be stopped.

If you ask for a fair hearing, you will get a packet of information letting you know the date, time, and location of the hearing. Most fair hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

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

If you need help filing a request for a fair hearing you can call Member Services and ask a Member Advocate to help you.

### What is an expedited HMO appeal?

An expedited appeal is when Texas Children's Health Plan has to make a decision quickly based on the condition of your health, and taking the time for a standard appeal could jeopardize your life or health.

### What happens if the health plan denies the request for an expedited appeal? What are the timeframes for an expedited appeal?

Requests for expedited appeals can be oral or written. When we get your request for an expedited appeal we will decide if your appeal requires a fast review. If we decide that your appeal does not need a fast review, we will let you know by phone or mail within 2 calendar days. Your appeal will then be a regular appeal. That means we will finish it in 30 days.
If we decide that your appeal does need a fast review, the appeal will be reviewed and resolved within 3 business days. In cases of an ongoing emergency or denial of continued hospitalization, a decision will be made in 1 business day after receipt of the expedited appeal request.

You or your representative can ask for an extension of 14 days. Texas Children's Health Plan can also ask you for an extension if we need to get additional information. An extension is not applicable to cases of an ongoing emergency or denials of continued hospitalization.

We will call you promptly with the decision. We will also send you a letter within 2 business days of the decision.

**How do I ask for an expedited appeal? Does my request have to be in writing? Who can help me in filing an expedited appeal?**
You can call Member Services toll-free at 1-866-959-2555 and ask for help requesting an appeal. A Member Advocate is ready to help you. Your request does not have to be in writing. Your child's doctor can request this type of appeal on your behalf.

## What are my rights and responsibilities?

**Member rights**

1. 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.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   - Be told how to choose and change your health plan and 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.
3. You have the right to ask questions and get answers about anything you don't 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.
4. 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 or your child regardless of cost or benefit coverage.
   - Say yes or no to the care recommended by your provider.
5. You have the right to use available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, and 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.
   - Get a timely answer to your complaint.
   - Use the plan's appeal process and be told how to use it.
   - Ask for a fair hearing from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   - Have telephone access to a medical professional 24 hours a day, 7 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.
   - A right to receive information about the organization, its services, it practitioners and providers and member rights and responsibilities.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you don't want to do or is to punish you.
8. You have the right to know the doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you pay copayments or any other amounts for covered services.
10. You have the right to make recommendations regarding the organization's member rights and responsibilities policy.

**Member responsibilities**

1. 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.
2. 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 can not keep them.
   - Always contact your primary care provider first for 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.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
   - 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.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
   - 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.
5. You must follow plans and instructions for care that you have agreed to with your provider.

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

**What if I need durable medical equipment (DME) or other products normally found in a pharmacy?**

Some durable medical equipment (DME) and products normally found in a pharmacy are covered by Medicaid. For all members, Texas Children's Health Plan pays for nebulizers, ostomy supplies, and other covered supplies and equipment if they are medically necessary. For children (birth through age 20), Texas Children's Health Plan also pays for medically necessary prescribed over-the-counter drugs, diapers, formula, and some vitamins and minerals.

Call 1-866-959-2555 for more information about these benefits.

## Fraud and abuse

**Do you want to report waste, abuse, or fraud?**

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

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

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

- Call the OIG Hotline at 1-800-436-6184 or
- Visit https://oig.hhsc.state.tx.us/ and pick "Click Here to Report Waste, Abuse, and Fraud" to complete the online form.
- You can report directly to your health plan:
  Texas Children's Health Plan
  Fraud and Abuse Investigations
  PO Box 301011, NB 8302
  Houston, TX 77230
  832-828-1320 or toll-free at 1-866-959-2555

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

When reporting about a provider (a doctor, dentist, counselor, etc.) include:

- Name, address, and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it.
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and the 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.

## Abuse, Neglect, and Exploitation

**What are Abuse, Neglect, and Exploitation?**

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

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

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

**How do I report suspected abuse, neglect or exploitation?**

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

**Reporting Abuse, Neglect, and Exploitation.**

The law requires that you report suspected Abuse, Neglect, or Exploitation, including unapproved use of restraints or isolation that is committed by a provider. Call 9-1-1 for life-threatening or emergency situations.

**Report by Phone (non-emergency); 24 hours a day, 7 days a week, toll-free.**

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

- Nursing facility;
- Assisted living facility;
- Adult day care center;
- Licensed adult foster care provider; or.
- Home and Community Support Services Agency (HCSSA) or Home Health Agency.

Suspected Abuse, Neglect or Exploitation by a HCSSA must also be reported to the Department of Family and Protective Services (DFPS). Report all other suspected abuse, neglect, or exploitation to DFPS by calling 1-800-252-5400.

**Report electronically (non-emergency)**

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

**Helpful Information for Filing a Report**

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