WELCOME TO THE NETWORK:
PROVIDER ONBOARDING & ORIENTATION

August 27th, 2025

Parkland
Community Health Plan

AGENDA

PARKLAND COMMUNITY HEALTH PLAN (PCHP) INTRODUCTION

Parkland
Community Health Plan

ABOUT PCHP

OUR HISTORY

PCHP is a locally owned and operated Managed Care Organization (MCO), founded by Parkland Health, that has served Medicaid and CHIP members in North Texas since 1999.

OUR PROGRAMS

PCHP coordinates services for STAR and CHIP members in the Dallas Service Area.

STAR (Previously **Parkland HEALTH*first***)

- No-cost coverage for income-eligible children, pregnant women, and families.

TEXAS STAR
Your Health Plan ★ Your Choice

CHIP/CHIP PERINATE (Previously **Parkland KIDS*first***)

- Low-cost coverage for children (0–18) whose families earn too much for Medicaid but not enough for private insurance.
- Includes **CHIP Perinate, CHIP Perinate Newborn**

CHIP

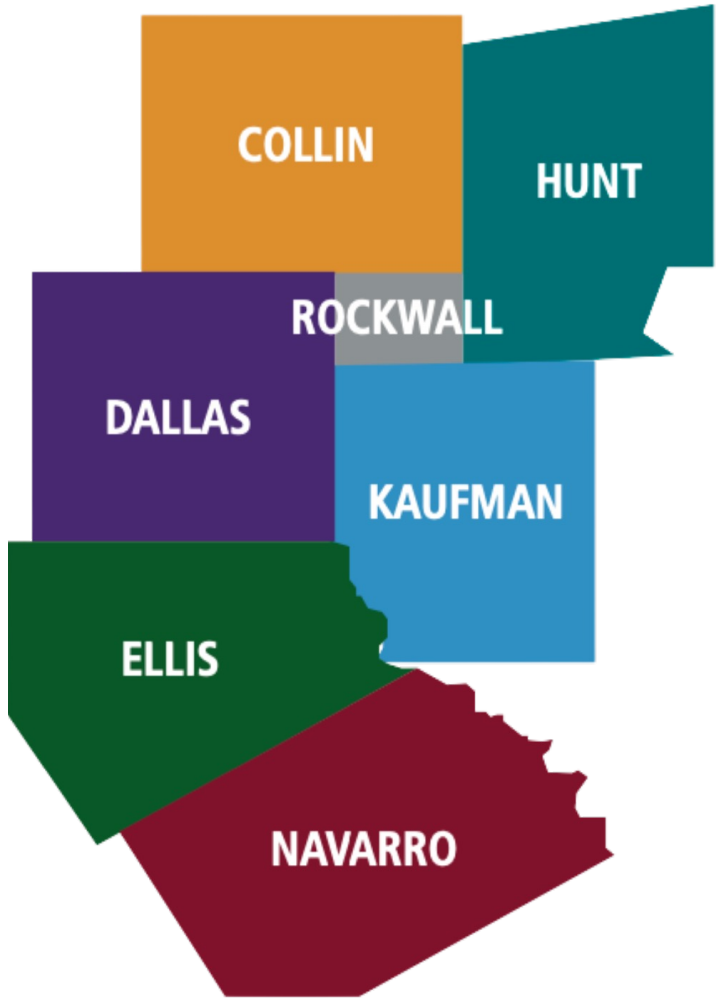
PCHP DALLAS SERVICE AREA

160,000+ Members

9,000+ Providers

40+ Hospitals & Urgent Care Centers

Across 7 Counties



PCHP's Service Area

TRANSITION FROM CARELON TO PCHP

Parkland
Community Health Plan

BEHAVIORAL HEALTH (BH) SERVICES TRANSITION

WHAT IS CHANGING

- **Effective September 1, 2025,** PCHP will directly manage BH services for PCHP STAR and CHIP members.
- This includes but is not limited to claims, authorizations, and provider support—previously handled by Carelon Behavioral Health (Carelon).

KEY TRANSITION DATES

- **Through August 31, 2025**: Carelon continues managing BH services.
- **Starting September 1, 2025**: All BH services, operations, and support transition to PCHP.

WHY THIS MATTERS

- Providers are required to contract and credential with PCHP. A provider interested in joining our network must:
    1. Be enrolled as a Medicaid Provider.
    2. Complete and submit a **Prospective Provider Form**.

KEY TRANSITION DATES

PRIOR AUTHORIZATIONS, POST-SERVICE/RETRO AUTHORIZATIONS, CLAIMS, & APPEALS

	DATE / EVENT	HANDLED BY	NOTES
Outpatient BH Services	Requests submitted for dates of service or **before August 31, 2025**	**Carelon**	PCHP will honor Carelon-approved authorizations issued **before September 1, 2025,** for services occurring after that date.
	Requests submitted for dates of service on or **after September 1, 2025**	**PCHP**	Submit requests directly to PCHP.
Inpatient/ Residential Services	Admissions on or **before August 31, 2025**	**Carelon**	Managed by Carelon **until discharge or October 31, 2025**, whichever comes first.
	Admissions on or **after September 1, 2025**	**PCHP**	Authorization and concurrent review handled by PCHP.
	Continued stay reviews on or **after November 1, 2025**	**PCHP**	PCHP manages continued stay reviews for ongoing cases admitted **prior to September 1, 2025**.
Claims	Service **before September 1, 2025**, if submitted by **December 31, 2025**	**Carelon**	Carelon will process if received **by December 31, 2025**; otherwise, send to PCHP.
	Services with dates of services or admission on or **after September 1, 2025**	**PCHP**	Submit to PCHP **based on date of service (OP) or admission (IP/RTC).**
Clinical & Claim Appeals	Appeals for clinical (auth) or claim determinations rendered by Carelon for dates of service (OP) or dates of admission (IP/RTC) before **September 1, 2025**	**Carelon**	Carelon will process all clinical appeals for service/admission dates noted if received **by December 31, 2025**.
	Appeals for clinical (auth) or claim determinations rendered by PCHP for dates of service (OP) or dates of admission (IP/ RTC) on or **after September 1, 2025**, or for appeals related to Carelon determinations IF submitted on or **after January 1, 2026**	**PCHP**	Send to PCHP for dates of service (OP) or admission (IP/RTC) on or **after September 1, 2025,** or for dates of service (OP) or admission (IP/RTC) if submitted on or **after January 1, 2026**.

BEHAVIORAL HEALTH (BH) SERVICES AND SERVICE COORDINATION

Parkland
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BEHAVIORAL HEALTH (BH) SERVICES

BH INCLUDES BOTH ACUTE AND CHRONIC PSYCHIATRIC CONDITIONS AND * SUBSTANCE USE DISORDERS, AS DEFINED IN THE MOST RECENT DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM).

THE FOLLOWING SERVICES ARE COVERED FOR STAR MEDICAID AND CHIP MEMBERS:

- **Mental Health treatment:**
  - Inpatient mental health services
  - Therapy: individual, family, and group sessions
  - Psychological and neuropsychological testing
  - Mental health targeted case management and rehabilitative services (MHR/TCM)
  - Medication management
- **Substance Use Disorder (SUD) treatment:**
  - Assessment and outpatient (OP) treatment
  - Withdrawal management
  - Residential treatment
  - Screening, Brief Intervention and Referral to Treatment (SBIRT) services, with required provider training and resources available through SAMHSA and outlined in the TMPPM

BEHAVIORAL HEALTH (BH) SERVICES

- **Substance Use Disorder (SUD) Services:** PCHP works with providers, facilities, and members to coordinate care for individuals with substance use disorders (SUD), ensuring members have access to the full continuum of **covered, medically necessary services—including, without limitation:**
  - Assessment
  - Outpatient services
  - Medication therapy
  - Detoxification/withdrawal management
  - Residential treatment

- **SUD treatment** is a covered benefit under Texas Medicaid for individuals who meet diagnostic criteria for a substance use-related disorder, as defined by the current edition of the **Diagnostic and Statistical Manual of Mental Disorders (DSM).**

- **Recommended provider resources:**
  - **Substance Abuse and Mental Health Services Administration (SAMHSA)**
  - **PCHP Clinical Practice Guidelines**

BEHAVIORAL HEALTH (BH) SERVICES

- **Screening, Brief Intervention and Referral to Treatment (SBIRT):** A comprehensive, public health approach used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs in individuals age 10 and older.
  - **Screening** identifies a person's risk level using standardized tools, including but not limited to:
    - Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
    - Drug Abuse Screening Test (DAST)
    - Alcohol Use Disorders Identification Test (AUDIT)
    - CAGE Questionnaire (Cut-down, Annoyed, Guilty, Eye-opener)
    - CRAFFT Questionnaire (Car, Relax, Alone, Forget, Family/Friends, Trouble)
    - Binge drinking questionnaires, BAC results, or toxicology screens
  - **Brief Intervention** involves motivational interviewing to raise awareness and promote behavior change following a positive screen.
  - **Referral to Treatment** is provided when more extensive care is needed, ensuring individuals are connected with appropriate substance use treatment.
    - Members may receive:
      - Up to two screening-only sessions per rolling year
      - Up to four combined screening and brief intervention sessions per rolling year
      - No prior authorization required for SBIRT services within allowable benefit limitations
  - Information on trainings and screening tools is available via the **Substance Abuse and Mental Health Services Administration (SAMHSA).**

BEHAVIORAL HEALTH (BH) SERVICES

- **Opioid Use Disorder (OUD) & MAT Services**
  - **Medication Assisted Treatment (MAT)** combines FDA-approved medications with psychosocial therapies to treat substance use disorders, including Alcohol Use Disorder (AUD) and Opioid Use Disorder (OUD).
  - MAT—including Methadone and non-Methadone therapies—is considered evidence-based best practice and **does not require prior authorization.**

  - **Providers are encouraged to:**
    - Offer as many treatment options as possible (within scope of practice)
    - Educate members with AUD and OUD on the availability and benefits of MAT
    - Ensure members are aware they can receive MAT regardless of where they are receiving SUD services

BEHAVIORAL HEALTH (BH) SERVICES

- **Attention-Deficit/Hyperactivity Disorder (ADHD):** A neurodevelopmental condition marked by persistent inattention, hyperactivity, and impulsivity that interfere with daily functioning or development. It often begins in childhood and can continue into adulthood, impacting academic, occupational, and social outcomes if left untreated or undertreated.
  - **Covered ADHD-related services include, but are not limited to:**
    - Assessment and diagnostic evaluations
    - Outpatient counseling (e.g., coping skills, psychoeducation)
    - Medication management through psychiatric prescribers and PCPs
    - ADHD diagnosis and medication management by PCPs, including discussions around medication efficacy
  - **Additional provider guidance:**
    - A follow-up visit is requested within 30 days of starting ADHD medication to assess effectiveness and monitor for adverse effects.
    - At least two additional follow-up visits are recommended within the 9 months following the initial 30-day visit.
    - Reimbursement is available for eligible ADHD-related services, as outlined in the Texas Medicaid Provider Procedures Manual (TMPPM).
    - Clinical Practice Guidelines are available for reference: ***Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of ADHD in Children and Adolescents | American Academy of Pediatrics.***

BEHAVIORAL HEALTH (BH) SERVICES

- **Applied Behavior Analysis (ABA):** Evidence-based therapy intervention for youth with **Autism Spectrum Disorder (ASD),** focused on improving a youth's cognitive, language, social, and self-help skills through intensive behavior modification and reinforcement strategies. It replaces maladaptive behavior with functional behavior, improving the youth's ability to function successfully in the home, school, and/or community.
- **The ABA benefit** is available to Medicaid-eligible members age 0–20 who are clinically appropriate for ABA and diagnosed with ASD by a practitioner identified in the TMPPM.
    - **Covered ABA services include, but are not limited to:**
        - ABA evaluation
        - Individual and group treatment
        - Parent/caregiver education and training
        - Interdisciplinary team meetings
- ABA services require prior authorization; providers should refer to the TMPPM for the full ABA policy.

IN LIEU OF SERVICES (ILOS) OVERVIEW —
STAR MEMBERS ONLY

ACCESS KEY CRITERIA AND FORMS

ILOS SERVICE	PURPOSE	PROVIDER RESPONSIBILITY
Partial Hospitalization Program (PHP)	Voluntary alternative to inpatient hospitalization	Educate members about PHP; document member consent
Intensive Outpatient Program (IOP)	Step-down care to prevent or reduce inpatient stays	Educate members about IOP; document member consent
Coordinated Specialty Care	Early intervention for first-episode psychosis; diversionary care to prevent or reduce inpatient stays	Notify members of availability; document consent
Inpatient Services at IMD	Specialized inpatient care when clinically appropriate (limited to 15 days per calendar month)	Educate members; document consent; coordinate as needed

KEY REMINDERS:

- **Members must agree** to receive ILOS before services are provided.
- **ILOS must be medically appropriate and cost-effective**; providers must ensure the most clinically appropriate service is offered during each episode of care.
- **Services must be authorized by PCHP** by contacting **Provider Services** at **1-888-672-2277**, or by submitting through the **Provider Portal** or via **fax**.
- All ILOS discussions and agreements **must be documented** in the member's medical record.
- PCHP coordinates with providers to authorize the clinically indicated service.

BEHAVIORAL HEALTH (BH) SERVICES

DIRECT ACCESS

- Members can self-refer into BH services and do not require a referral from their PCP.
- To locate in-network BH providers, members and providers can:
  - Use the **provider lookup tool** on the PCHP website at **ParklandHealthPlan.com.**
  - Call **Provider Services: 1-888-672-2277**

REFERRALS

- Providers—including those offering **physical health, mental health, or substance use treatment**—may refer members to other in-network providers as clinically appropriate.
- **Any provider (including substance use disorder (SUD) treatment providers)** may contact PCHP for assistance with identifying appropriate referral options for members. Referral support is available via the **Provider Services line** listed above and through the **provider lookup tool**.

SUPPORTING BH SERVICES: ROLE OF THE PCP

KEY RESPONSIBILITIES FOR SCREENING, COORDINATION, AND REFERRAL

- PCPs may provide behavioral health services within the scope of their practice. Primary Care Providers are responsible **for coordinating the member's physical and behavioral health care,** including facilitating **referrals to Behavioral Health providers** when necessary. PCPs should **submit claims to PCHP** for consideration.
- PCPs are responsible for **identifying and referring members** age 3 and older who are suspected of having a **developmental delay, developmental disability, Severe Emotional Disturbance (SED), mental illness,** or **substance use disorder (SUD).**
- PCPs must use **validated screening and assessment tools** to evaluate behavioral health needs and refer children for **specialized evaluations** when appropriate.
    - Validated behavioral health screenings tools are available **on the PCHP website.**

MH REHABILITATION & TARGETED CASE MANAGEMENT

TRAINING REQUIRMENTS

All providers—including local and non-local mental health/behavioral health (MH/BH) authorities—who deliver MH rehabilitative services or targeted case management must complete required training prior to delivering services. This requirement applies to all personnel involved in providing these services.

PCHP must ensure providers are compliant with these training requirements on at least an annual basis. While providers may deliver services to children, adults, or both, they must attest to completing all training applicable to the populations they serve. MHR and TCM providers must also meet all other applicable service provision requirements. **PCHP will require provider attestation in order to demonstrate compliance.**

ATTESTATION SUBMISSION

To confirm compliance, providers must submit an annual attestation form. The Mental Health Rehabilitation Services and Targeted Case Management Attestation Form can be obtained by emailing PCHP's Network Development Department at **PCHP.ContractingDepartment@phhs.org**. Completed attestations should be returned by email to PCHP's Network Development Department for submission.

SERVICE COORDINATION AND INTERVENTIONS

SERVICE COORDINATION HELPS ADDRESS THE INDIVIDUAL NEEDS OF MEMBERS WITH PHYSICAL HEALTH AND/OR BEHAVIORAL HEALTH RISKS BY FACILITATING APPROPRIATE, HIGH-QUALITY CARE.

- PCHP's Service Coordination program is part of a comprehensive healthcare management model, offering a continuum of services including service coordination and disease management.
- The program works to reduce barriers by identifying unmet needs and helping members access appropriate resources. This may include:
  - Care coordination
  - Community resource connection
  - Disease-specific education
  - Interventions that support safe, independent living
- Service Coordinators provide initial and ongoing assistance with identifying, selecting, and using covered services and supports to improve well-being and community integration.
- **Key elements include:**
  - Identification through direct referral (self, LAR, provider, UM) or data analytics, stratified by risk level
  - Whole-health assessment to independence determine member needs
  - Individualized service plan developed with the member, providers, PCPs, and supports
  - Coordination of services to meet health needs, including non-medical determinants of health
  - Most interventions are provided telephonically

SERVICE COORDINATION AND INTERVENTIONS

MEMBER ELIGIBILITY FOR SERVICE COORDINATION

All PCHP members are eligible to enroll in the Service Coordination program. Targeted outreach is conducted for members classified as **high-risk** or identified as having **Special Health Care Needs (MSHCN).** Participation is voluntary and requires member consent.

- **Members considered high-risk or having special health care needs may include:**
  - Members receiving Early Childhood Intervention (ECI) services
  - High-risk pregnant women or those with a history of pre-term birth
  - Members with high-cost catastrophic conditions or high service utilization
  - Members with mental illness and co-occurring substance use disorder
  - Members with behavioral health conditions that may impact physical health or treatment compliance, including those with serious emotional disturbance or serious and persistent mental illness
  - Members with serious ongoing illness or a chronic complex condition expected to last long-term and requiring continuous therapeutic or pharmacologic care (e.g., HIV/AIDS, respiratory illness, diabetes, heart disease, kidney disease), or those receiving in-home/facility-based therapy or attendant care

SERVICE COORDINATION AND INTERVENTIONS

SERVICE COORDINATION INTERVENTIONS MAY INCLUDE:

- Comprehensive assessments and individualized, integrated care planning with member-centered goals.
- Assistance accessing physical and behavioral health services, benefits, and community resources.
- Linkages to peer support services.
- Appointment scheduling and transportation assistance.
- Health education to promote self-management and adherence to care.
- Coordination among behavioral health providers, PCPs, health homes, and medical specialists.
- Support during transitions of care to ensure continuity and safety.
- Motivational interviewing to encourage engagement and behavior change.
- Provision of condition-specific self-management tools and coaching.
- Identification of and support addressing non-medical determinant of health needs.

SERVICE COORDINATION AND INTERVENTIONS

HOURS OF OPERATION

Our Service Coordination team of licensed nurses and behavioral health practitioners are available:

Monday – Friday | 8 am – 5 pm (Central Time)

Confidential voicemail is available 24/7.

SERVICE COORDINATION REFERRALS

To refer a member to the Service Coordination team, please provide:

- Member demographics (name, Medicaid ID, authorized representative name and contact info, if applicable)
- Brief reason for referral
- Any identified needs or requested resources

To make a referral, call 214-393-7003 or email PCHPUMCaseManagement@phhs.org.

COORDINATION OF CARE

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SCREENING TOOLS AND TECHNIQUES

PROVIDERS ARE ENCOURAGED TO SCREEN FOR BOTH MENTAL HEALTH AND SUBSTANCE USE DISORDERS USING VALIDATED SCREENING TOOLS INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING:

- PHQ-2, PHQ-9, PHQ A
- GAD-7
- Patient Stress Questionnaire
- MDQ
- C-SSRS
- ADHD Rating Scale-IV
- NICHQ Vanderbilt Assessment Scales
- M-CHART-R
- SCOFF
- PC-PTSD
- PSSI (PTSD Symptom Scale Interview)
- PCL-C (PTSD Checklist – Civilian Version)
- AUDIT-PC
- CAGE-AID
- CRAFFT
- NIDA
- Screening for Obsessive-Compulsive Disorder

NOTE: This is not a comprehensive list. These screening tools may be used by a variety of licensed health care providers.

COORDINATION OF CARE BETWEEN PH & BH PROVIDERS

PROVIDER REQUIREMENTS

- **All BH and PH providers** (including PCPs, OB/GYNs, internists, and other relevant provider types) must **share clinical information** amongst each other regarding members with co-occurring physical and behavioral health conditions, in accordance with federal and state law.
    - A fillable **Coordination of Care Form** is available to support this documentation.
- BH providers must **send initial and quarterly summary reports**—or more frequently if clinically indicated—on the member's behavioral health status to the PCP.
    - These reports require the member's or legal guardian's consent and must be documented in the medical record.

TO SUPPORT OUR BH AND PH NETWORK, PCHP IS COMMITTED TO KEEPING PROVIDERS CURRENT ON COORDINATION OF CARE PRINCIPLES AND QUALITY INITIATIVES. THIS INCLUDES, BUT IS NOT LIMITED TO, PROVIDING EDUCATION AND TRAINING ON:

- **Validated** behavioral health (BH) **screening tools**.
- **New models** of behavioral health interventions.
- **Practice-relevant tools** that support integrated or coordinated care delivery.
- **Strategies** that promote high-quality, whole-person care and help prevent gaps in treatment.

BH PROVIDER EXPECTATIONS: REPORTING & COORDINATION

PROVIDERS MUST:

- Send initial and quarterly (or more frequent, if clinically indicated) summary reports to the member's PCP, with the member or legal guardian's consent.
- Refer members with known or suspected physical health issues to their PCP for evaluation and treatment.
- Be licensed to provide healthcare services.

The **DSM Multi-Axial Classification** must be used when assessing members for BH services, including for both MH and SUD.

Post-hospitalization follow-up:

- Members must be offered an outpatient BH appointment within 7 days of discharge from inpatient psychiatric hospitalization.
- BH providers must contact members who miss appointments within 24 hours to reschedule.

LOCAL MENTAL HEALTH AUTHORITY (LMHA)

COORDINATION WITH LMHA

- PCHP coordinates with **Local Mental Health Authorities (LMHAs**) and **state psychiatric facilities** to support **admission, discharge planning, treatment goals, and projected length of stay** for members committed by a court of law.

- PCHP also complies with behavioral health requirements for **coordination of care**, especially for **members in special populations.**

- Covered services, such as mental health rehab and targeted case management, are provided to members with **Severe and Persistent Mental Illness (SPMI)** or **Severe Emotional Disturbance (SED)**, when medically necessary

TEXAS PROVIDER MARKETING GUIDELINES

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TEXAS PROVIDER MARKETING GUIDELINES

THESE GUIDELINES CLARIFY WHAT PROVIDERS CAN (AND CANNOT) DO WHEN COMMUNICATING WITH STAR AND CHIP MEMBERS.

PROVIDERS MAY:

- Inform patients which Medicaid and CHIP plans they accept.
- Describe services and benefits of MCOs with which they participate.
- Share MCO contact info if requested.
- Distribute and help complete enrollment applications.
- Direct patients to enroll through the Administrative Services Contractor (Maximus)

PROVIDERS MUST:

- Distribute materials from **all** contracted MCOs or **none at all**.
- Ensure all materials:
  1. Meet HHSC content, reading level (6th grade), and size requirements.
  2. Are available in English and Spanish (plus other languages upon request).
  3. Include provider's name and office location.
  4. Do not contain HHSC logos or misrepresent services.
  5. Avoid misleading claims, financial incentives, or negative references to other providers.

The Full **Texas Provider Marketing Guidelines** are available on the Texas HHSC website.

COMPLIANT & NONCOMPLIANT MARKETING ACTIVITIES

PERMISSIBLE	PROHIBITED
Sending marketing materials to every person in a specific zip code, without specifically targeting Medicaid clients	Unsolicited personal contact such as direct mail, telephone, and door-to-door solicitation
Sending an appointment reminder to a Medicaid client	Offering gifts or other incentives designed to influence a client's choice of provider
Participating at a health education event and providing branded giveaways valued at no more than $15 each	Providing giveaways or incentives valued at more than $15 each, or passing out marketing materials
Sharing marketing materials via television, radio, newspaper, internet, or billboard ads.	Sharing marketing materials or making any other communication efforts intended to influence the client's choice of provider
Provider marketing conducted at: • Community-sponsored educational events or health fairs • Outreach activity or similar community event that does not involve unsolicited personal contact or promotion of the provider's practice that is not intended as health education	Sending marketing materials to a client to offer inducements or incentives
Provider marketing for the purpose of: • Providing appointment reminders • Distributing promotional health materials • Providing information about services you offer • Coordinating care	• Unsolicited personal contact at a childcare facility or any other type of facility • Targeting clients solely because they receive Medicaid/CHIP benefits.

**The information provided is not intended to be comprehensive or to identify all applicable state and federal laws and regulations. Providers remain responsible for and must comply with all applicable requirements of state and federal laws and regulations.*

MEMBER RIGHTS AND RESPONSIBILITIES

Parkland
Community Health Plan

MEMBER RIGHTS & PROTECTIONS

STAR MEDICAID AND CHIP MEMBERS HAVE THE RIGHT TO:

- Be treated with respect and dignity.
- Have their personal information protected, in accordance with U.S. law and PCHP policies.
- Receive information that is easy to understand, in a language they know.
- Understand how their health benefits work.
- Know about PCHP services, provider networks, and company information.
- Know their rights and responsibilities as a member.
- Provide feedback about what they believe their rights and responsibilities should be.
- Access care when needed.
- Discuss treatment options with their provider, regardless of cost or coverage.
- Participate in treatment decisions with their provider.
- Refuse treatment, as permitted by law.
- Access care without fear of unnecessary restraint or seclusion.
- Appoint someone to make medical decisions if they are unable.
- Have a representative speak on their behalf.
- Review and request corrections to their medical record, as allowed by law.
- Understand their billing and charges.
- Request reasonable accommodations for disabilities, as required by law.
- Request a second medical opinion.
- File complaints and appeals regarding their care.
- Be treated fairly—even after filing complaints or appeals.
- *STAR Medicaid Only*: Access NEMT services for rides to covered health care appointments when other transportation is not available.

ENSURING MEMBER RIGHTS: YOUR ROLE AS A PROVIDER

PROVIDER REQUIREMENTS FOR MEMBER RIGHTS COMPLIANCE:

1. **Be Familiar**—Understand the Member Rights and Responsibilities and be prepared to support members in exercising them.

2. **Post Notices**—Display a statement of Member Rights and Responsibilities prominently within your facility, in the primary language of the member population. ***Compliance with posting requirements is reviewed during site visits.***

3. **Inform Members**—Explain Member Rights and Responsibilities verbally and in writing at the start of treatment, in the member's primary language. ***Documentation of this discussion is required in the member's medical record and reviewed during chart audits.***

VALUE-ADDED SERVICES (VAS) AND MEMBER BENEFITS

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EXTRA BENEFITS FOR PCHP MEMBERS

VALUE-ADDED SERVICES (VAS) OVERVIEW

These services available at low or no cost, depending on the member's plan. Examples include:

24/7 live nurse line

Support for pregnant and postpartum members, such as:

- Car seats
- Play yards*
- Home-delivered meals

Allowance for eyeglass frames

Additional transportation assistance*

Sports physical

Allowance for dental services*

Members can learn more about these added benefits through the PCHP Benefits & Services webpage, which they can access at **ParklandHealthPlan.com/Members/Benefits.**

*Applies to STAR Medicaid members only.

EXTRA BENEFITS FOR PCHP MEMBERS

HEALTH INCENTIVES PROGRAM – PAID REWARDS

In addition to VAS, members can earn rewards for completing health-focused activities that support physical and behavioral health.

EXAMPLES OF ELIGIBLE BH ACTIVITES:

- Health Risk Assessment (HRA) Completion
- 7-Day Behavioral Health Follow-Up
- 30-Day Behavioral Health Follow-Up
- ADHD Management
- 7-Day Post-Hospitalization Follow-Up
- And more!

The full list of eligible activities is available at **ParklandHealthPlan.com/PaidRewards**

HOW THE PROGRAM WORKS

- Members, or their parents or guardians, can create an account to track earned points and redeem rewards.
- Rewards can be redeemed online or by phone through the **Parkland Rewards Program**.

MemberWell.com/PCHPRewards | **1-855-651-5093 (TTY: 1-844-488-9731)**

PHARMACY – COVERAGE OVERVIEW

PCHP COVERS PRESCRIPTION MEDICATIONS FOR STAR AND CHIP MEMBERS.

- Our plan is administered by **Navitus Health Solutions**.
- CHIP and STAR formularies are still managed by HHSC and are available on the Vendor Drug Program (VDP) website at txvendordrug.com.

Provider Hotline (Pharmacy): 1-877-908-6023

Email: ProviderRelations@navitus.com

Website: www.Navitus.com

REMINDERS FOR PROVIDERS

- Be aware of all medications your patient is taking—including OTC and herbal supplements.
- Encourage **members** to call the **PCHP support line*** for pharmacy questions:
  - **STAR**: 1-888-672-2277
  - **CHIP/CHIP Perinate**: 1-888-814-2352

*Available Monday through Friday from 8 am to 5 pm, excluding state-approved holidays.

EMERGENCY PRESCRIPTION

72-HOUR EMERGENCY SUPPLY

- Pharmacies **must** provide a 72-hour emergency supply of a prescribed drug when:
  - The medication is needed without delay
  - A prior authorization (PA) is required but not immediately available
- This applies to all drugs requiring a PA, including:
  - Nonpreferred drugs on the Preferred Drug List
  - Drugs subject to clinical edits
- The emergency supply should be dispensed when a PA cannot be resolved within 24 hours for a medication on the **Vendor Drug Program (VDP) formulary** that is appropriate for the member's condition.
- The pharmacy should submit an emergency 72-hour prescription if the prescribing provider:
  - cannot be reached or
  - is unable to request a PA
- For more information, call the **72-Hour Emergency Supply Hotline: 1-877-908-6023**

NONEMERGENCY MEDICAL TRANSPORTATION (NEMT)

ELIGIBILTY & PROGRAM OVERVIEW

- PCHP covers NEMT services for STAR Medicaid members, which are scheduled and managed by our partner, **Access2Care (A2C).**
- **NEMT is available for Medicaid covered healthcare services only—it does not include ambulance transport or trips for non-medical needs.**
- Transportation services may include, but are not limited to:
    - Rides to appointments via bus, taxi, van, Lyft/Uber, or airfare
    - Passes or tickets for public transportation
    - Gas cards or direct fuel reimbursement
    - Tickets or passes for public transportation
    - Curb-to-curb or wheelchair-accessible vans
    - Mileage reimbursement for an Individual Transportation Participant (ITP)
    - Meals and lodging for members under 21 who must travel long distances
- Members and providers can arrange transportation directly through A2C.
- A2C may contact provider offices to confirm appointments—please assist with validation when contacted.
- **For help, members and providers can call A2C at 1-833-931-3844.**

INTERPRETER AND TRANSLATION SERVICES

OVERVIEW

Interpreter services are available to meet the needs of our members. If a provider does not have access to a translator prior to a member's appointment, PCHP will coordinate interpreter services—**including sign language and in-person or phone-based interpretation.**

INTERPRETER AVAILABILITY & SCHEDULING

- **All interpreter services** require **4–5 business days** advance notice
- Requests submitted with fewer than 3 days' notice may not be guaranteed
- Interpreter cancellations must be reported to PCHP as soon as possible after the member cancels or reschedules

IMPORTANT: If an interpreter is **NOT** canceled within **24 hours** of the scheduled appointment, the health plan is still charged for the service.

NEED TO REQUEST AN INTERPRETER FOR A FUTURE APPOINTMENT?

- **Call Provider Services** at **1-888-672-2277** → be sure to provide the appointment date and time.
- Email requests securely at **PCHPMemberAdvocate@phhs.org**

EARLY CHILDHOOD INTERVENTION (ECI)

OVERVIEW

The ECI program offers in-home or community-based services for children (ages 0–3) with suspected developmental delays or disabilities. Services may include:

- Screenings
- Physical, occupational, speech, and language therapy
- Other tools to support effective learning

ECI REFERAL PROCESS & REQUIREMENTS

- Providers must refer any child under age 3 to the Texas HHS ECI program **within 7 days of identifying a disability or suspected delay**.
- A medical diagnosis is **not required** for a referral
- To refer families for services, providers may contact the local ECI program, or the **HHS Office of the Ombudsman at 1-877-787-8999 (TTY: 7-1-1); select language and then Option 3.**
- Click **here** for more information about the ECI program and requirements.

STATE-ADMINISTERED PROGRAMS & NON-CAPITATED SERVICES

✪ STAR Medicaid Members Only

Texas HHSC and Partners	✪	THSteps Dental (including Orthodontia)
	✪	THSteps Environmental Lead Investigation (ELI)
	✪	THSteps Personal Care Services (PCS) – for members ages 0-20
		Early Childhood Intervention (ECI) Service Coordination & Specialized Skills Training
	✪	HHSC Hospice Services
	✪	HHSC-contracted providers of service coordination for individuals with intellectual or developmental disabilities
	✪	School Health and Related Services (SHARS)
Department of State Health Services (DSHS)		Tuberculosis Services Provided by DSHS Approved Providers (Directly Observed Therapy and Contact Investigation)
Other State Agencies		Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program
***Special Circumstances**		**Inpatient Facility Charges:** For certain inpatient stays under STAR, facility charges are paid through Fee-for-Service or the prior MCO as defined in the Span of Coverage policy.
		Mental Health Targeted Case Management and Rehabilitative Services: Available for Dual Eligible Members (members eligible for both Medicaid and Medicare) through Non-Capitated Services.

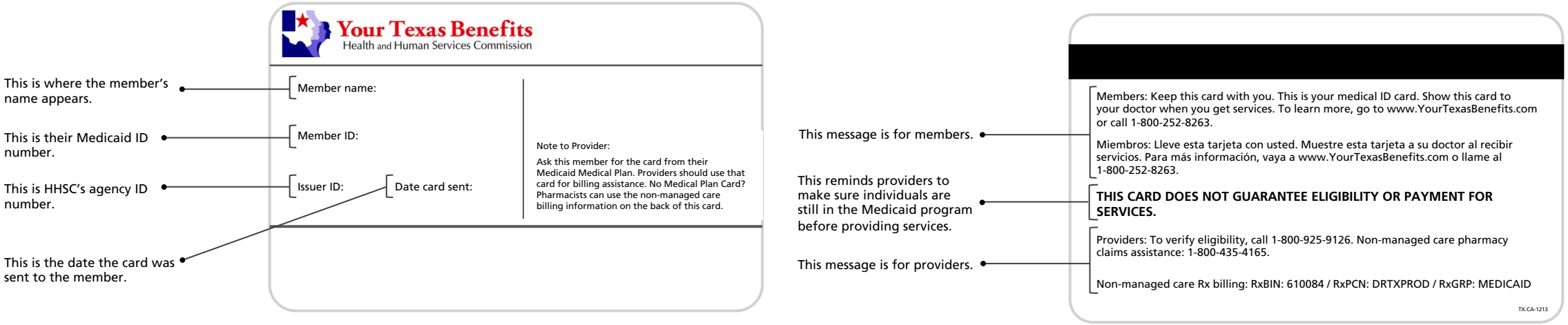
NOTE: *The remaining programs may serve STAR Medicaid members, but they are not exclusive to them. Eligibility criteria vary by service and agency.*

MEMBER ELIGIBILITY

Parkland
Community Health Plan

YOUR TEXAS BENEFITS (YTB) STAR MEDICAID CARD

The **YTB Medicaid card replaces the STAR Medicaid ID letter** (Form 3087) members previously received by mail.



Texas HHSC now uses digital tools, including an online portal, to verify STAR Medicaid eligibility and provide real-time access to a patient's service and treatment history.

PCHP MEMBER ID CARDS

STAR MEDICAID


Parkland Community Health Plan

Plan Type: STAR

TEXAS STAR Your Health Plan • Your Choice | TEXAS Health and Human Services

Name / Nombre:
Member ID / Número de identificación:
DOB / Fecha de nimiento:
Effective Date / Fecha de vigencia:

PCP:
PCP Phone / Teléfono del PCP:
PCP Effective Date / Fecha de vigencia del PCP:

Navitus RxBIN: 610602 | RxPCN: MCD | RxGRP: PCH
Pharmacist use only: 1-877-908-6023

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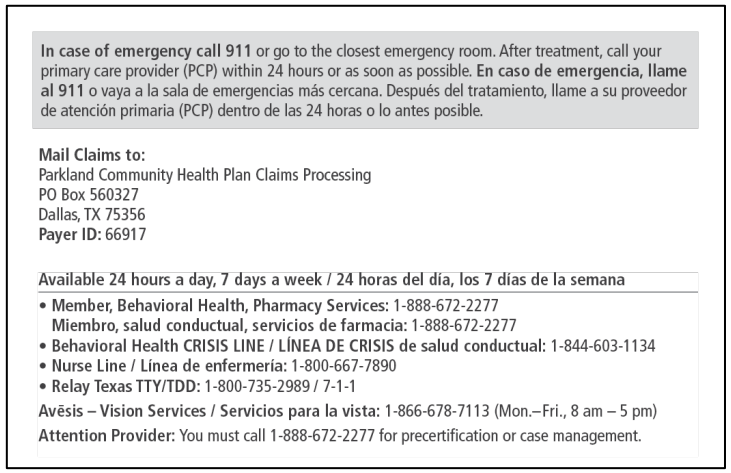
In case of emergency call 911 or go to the closest emergency room. After treatment, call your primary care provider (PCP) within 24 hours or as soon as possible. **En caso de emergencia, llame al 911** o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su proveedor de atención primaria (PCP) dentro de las 24 horas o lo antes posible.

Mail Claims to:
Parkland Community Health Plan Claims Processing
PO Box 560327
Dallas, TX 75356
Payer ID: 66917

Available 24 hours a day, 7 days a week / 24 horas del día, los 7 días de la semana

- **Member, Behavioral Health, Pharmacy Services:** 1-888-672-2277
  Miembro, salud conductual, servicios de farmacia: 1-888-672-2277
- **Behavioral Health CRISIS LINE / LÍNEA DE CRISIS de salud conductual:** 1-844-603-1134
- **Nurse Line / Línea de enfermería:** 1-800-667-7890
- **Relay Texas TTY/TDD:** 1-800-735-2989 / 7-1-1

Avēsis – Vision Services / Servicios para la vista: 1-866-678-7113 (Mon.–Fri., 8 am – 5 pm)
Attention Provider: You must call 1-888-672-2277 for precertification or case management.

CHIP


Parkland Community Health Plan

Plan Type: CHIP

CHIP | TEXAS Health and Human Services

Name / Nombre:
Member ID / Número de identificación:
DOB / Fecha de nimiento:
Effective Date / Fecha de vigencia:

PCP:
PCP Phone / Teléfono del PCP:
PCP Effective Date / Fecha de vigencia del PCP:

Navitus RxBIN: 610602 | RxPCN: MCD | RxGRP: PCH
Pharmacist use only: 1-877-908-6023

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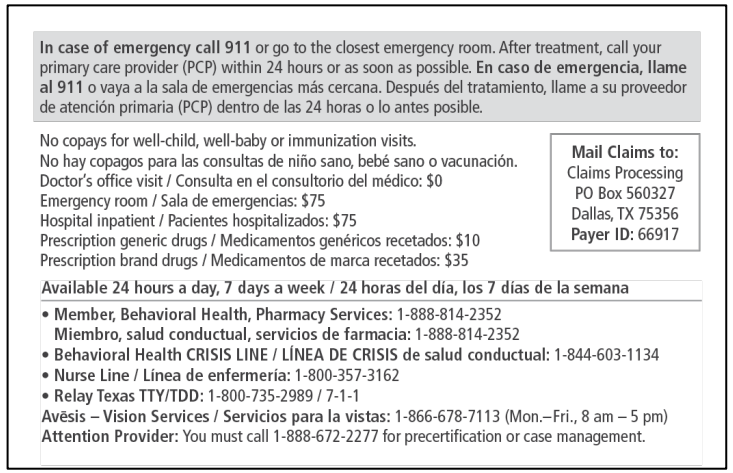
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No copays for well-child, well-baby or immunization visits.
No hay copagos para las consultas de niño sano, bebé sano o vacunación.
Doctor's office visit / Consulta en el consultorio del médico: $0
Emergency room / Sala de emergencias: $75
Hospital inpatient / Pacientes hospitalizados: $75
Prescription generic drugs / Medicamentos genéricos recetados: $10
Prescription brand drugs / Medicamentos de marca recetados: $35

Mail Claims to:
Claims Processing
PO Box 560327
Dallas, TX 75356
Payer ID: 66917

Available 24 hours a day, 7 days a week / 24 horas del día, los 7 días de la semana

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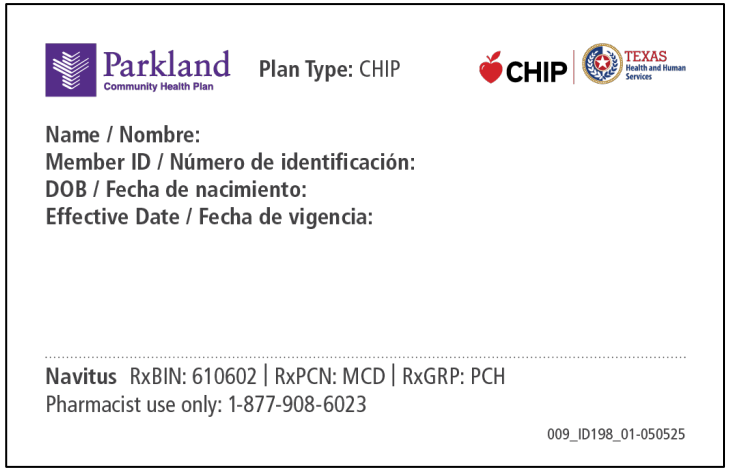
  Miembro, salud conductual, servicios de farmacia: 1-888-814-2352
- **Behavioral Health CRISIS LINE / LÍNEA DE CRISIS de salud conductual:** 1-844-603-1134
- **Nurse Line / Línea de enfermería:** 1-800-357-3162
- **Relay Texas TTY/TDD:** 1-800-735-2989 / 7-1-1

Avēsis – Vision Services / Servicios para la vistas: 1-866-678-7113 (Mon.–Fri., 8 am – 5 pm)
Attention Provider: You must call 1-888-672-2277 for precertification or case management.

PCHP MEMBER ID CARDS

CHIP PERINATE – Below 198% FPL



Parkland Community Health Plan **Plan Type:** CHIP

CHIP | TEXAS Health and Human Services

Name / Nombre:
Member ID / Número de identificación:
DOB / Fecha de nacimiento:
Effective Date / Fecha de vigencia:

Navitus RxBIN: 610602 | RxPCN: MCD | RxGRP: PCH
Pharmacist use only: 1-877-908-6023

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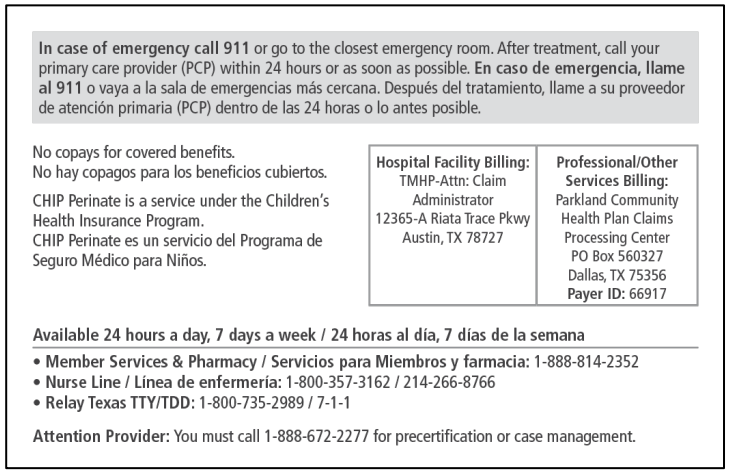

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No copays for covered benefits.
No hay copagos para los beneficios cubiertos.

CHIP Perinate is a service under the Children's Health Insurance Program.
CHIP Perinate es un servicio del Programa de Seguro Médico para Niños.

Hospital Facility Billing:
TMHP-Attn: Claim Administrator
12365-A Riata Trace Pkwy
Austin, TX 78727

Professional/Other Services Billing:
Parkland Community Health Plan Claims Processing Center
PO Box 560327
Dallas, TX 75356
Payer ID: 66917

Available 24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana

- **Member Services & Pharmacy / Servicios para Miembros y farmacia:** 1-888-814-2352
- **Nurse Line / Línea de enfermería:** 1-800-357-3162 / 214-266-8766
- **Relay Texas TTY/TDD:** 1-800-735-2989 / 7-1-1

Attention Provider: You must call 1-888-672-2277 for precertification or case management.

CHIP PERINATE – Above 198% FPL

Parkland Community Health Plan **Plan Type:** CHIP

CHIP | TEXAS Health and Human Services

Name / Nombre:
Member ID / Número de identificación:
DOB / Fecha de nacimiento:
Effective Date / Fecha de vigencia:

Navitus RxBIN: 610602 | RxPCN: MCD | RxGRP: PCH
Pharmacist use only: 1-877-908-6023

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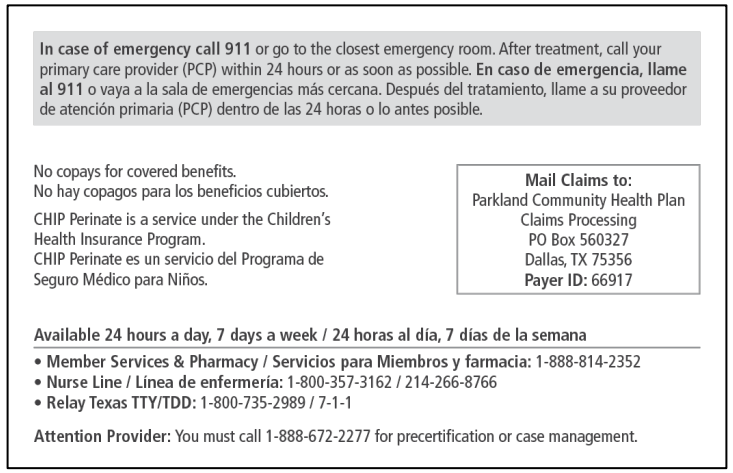

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Mail Claims to:
Parkland Community Health Plan
Claims Processing
PO Box 560327
Dallas, TX 75356
Payer ID: 66917

Available 24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana

- **Member Services & Pharmacy / Servicios para Miembros y farmacia:** 1-888-814-2352
- **Nurse Line / Línea de enfermería:** 1-800-357-3162 / 214-266-8766
- **Relay Texas TTY/TDD:** 1-800-735-2989 / 7-1-1

Attention Provider: You must call 1-888-672-2277 for precertification or case management.

CHIP PERINATE NEWBORN

Parkland Community Health Plan **Plan Type:** CHIP Perinate Newborn

CHIP | TEXAS Health and Human Services

Name / Nombre:
Member ID / Número de identificación:
DOB / Fecha de nacimiento:
Effective Date / Fecha de vigencia:

PCP:
PCP Phone / Teléfono del PCP:
PCP Effective Date / Fecha de vigencia del PCP:

Navitus RxBIN: 610602 | RxPCN: MCD | RxGRP: PCH
Pharmacist use only: 1-877-908-6023

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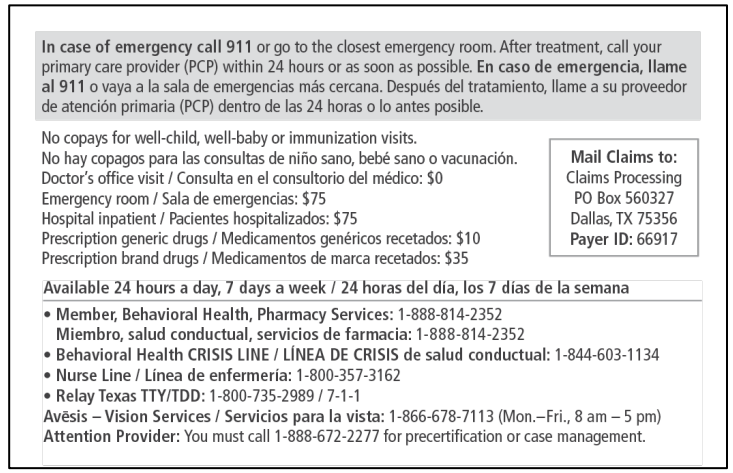

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No copays for well-child, well-baby or immunization visits.
No hay copagos para las consultas de niño sano, bebé sano o vacunación.
Doctor's office visit / Consulta en el consultorio del médico: $0
Emergency room / Sala de emergencias: $75
Hospital inpatient / Pacientes hospitalizados: $75
Prescription generic drugs / Medicamentos genéricos recetados: $10
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Mail Claims to:
Claims Processing
PO Box 560327
Dallas, TX 75356
Payer ID: 66917

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Avēsis – Vision Services / Servicios para la vista: 1-866-678-7113 (Mon.–Fri., 8 am – 5 pm)
Attention Provider: You must call 1-888-672-2277 for precertification or case management.

VERIFYING MEMBER ELIGIBILITY

PROVIDERS SHOULD VERIFY MEMBER ELIGIBILITY *BEFORE* SERVICES ARE RENDERED BECAUSE:

1. **Member eligibility can change at any time**, even if the member presents a valid Medicaid ID card. The card alone does not guarantee active coverage.

2. **Failure to verify eligibility may result in claim denials or non-payment** — services rendered to ineligible members are not reimbursable.

3. **Verifying eligibility ensures:**
   - The member is **actively enrolled with PCHP** on the date of service.
   - The correct MCO is billed.
   - Prior authorization or benefit limits are confirmed in advance.

BEST PRACTICE	ALWAYS VERIFY ELIGIBILITY BEFORE EACH APPOINTMENT AND KEEP DOCUMENTATION (e.g., FORM H1027) IN CASE IT'S NEEDED FOR APPEALS.

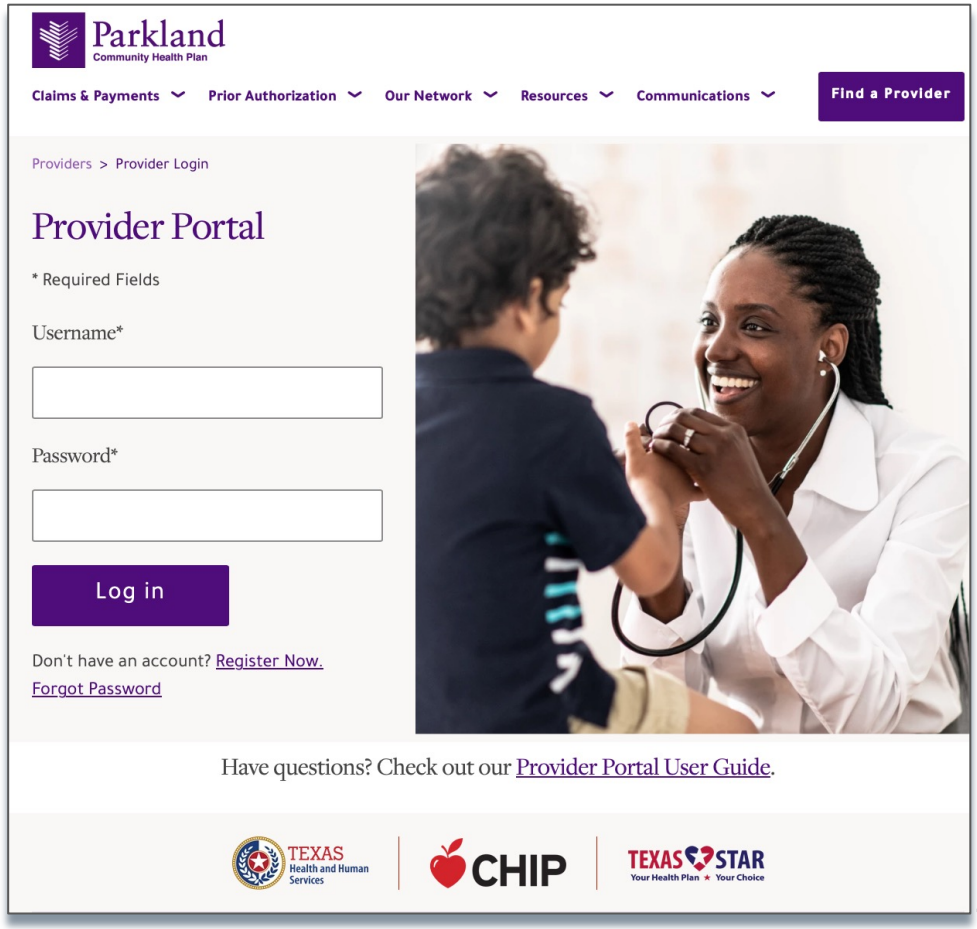
HOW TO VERIFY A MEMBER'S ELIGIBILITY

PROVIDERS CAN VERIFY A MEMBER'S ELIGIBILITY USING ONE OF THE FOLLOWING METHODS:

1. Log into the **PCHP Provider Portal**.

2. Call **Provider Services:** 1-888-672-2277
   - **Select** your **preferred language**
   - **Press 2** for Providers
   - **Press 7** to speak with a representative

3. Use **TexMedConnect** on the TMHP website: **www.tmhp.com**



HIPAA AND PHI COMPLIANCE

Parkland
Community Health Plan

PROTECTED HEALTH INFORMATION (PHI)

PHI INCLUDES ANY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION, SUCH AS:

- Member health conditions, health care provided, or payments made.
- Member identifiers like name, SSN, medical record number, or account number.
- Physical or electronic records, biometric data, and other unique identifiers.

PRIVACY IDENTIFIERS – EXAMPLES		
Name	Email Address	Device and Biometric Identifiers
Address	Social Security Number	Medical Record Number
Phone Number	Health Plan Beneficiary's Phone Number	Full-face photograph(s)

PENALTIES FOR HIPAA VIOLATIONS:

- Fines start at $100 per violation and can escalate up to $1.5 million annually.
- Criminal sanctions may apply for wrongful disclosure or malicious acts.

For more on HIPAA privacy protections and PHI, visit the Privacy Rule Guidance page on HHS.gov.

PROTECTED HEALTH INFORMATION (PHI)

INCLUDES ANY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION RELATED TO:

- A member's past, present, or future physical or mental health conditions
- The provision of health care to a member
- Payment for past, present, or future health care services
- Identification of a member (e.g., name, ID number, address)
- Any information that can reasonably be used to identify the individual
- Protection of electronic and physical data, including system access, building access, and workspace security

PENALTIES FOR MISUSE OR WRONGFUL DISCLOSURE OF PHI:

- Civil fines start at **$100 per violation** and may total up to **$1.5 million per year** for repeated violations
- **Intentional or malicious disclosures** may lead to additional civil penalties and **criminal sanctions** against individuals or entities involved

.Refer to applicable state laws and the PCHP Provider Manual for detailed PHI privacy and security requirements.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) IS A FEDERAL LAW THAT PROTECTS THE PRIVACY AND SECURITY OF INDIVIDUALS' HEALTH INFORMATION:

PRIVACY	SECURITY
Each individual's right to control how their personal health information is used or shared.	Protection of an individual's physical and electronic health data, including access to systems, buildings, and workspaces.

Providers are <u>required</u> to follow HIPAA regulations to protect member information and prevent its unauthorized use or disclosure.

CULTURAL COMPETENCY

Parkland
Community Health Plan

CULTURAL COMPETENCY

WHY IT MATTERS

PCHP is committed to ensuring that our staff and providers are informed of the importance of providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

PCHP RESOURCES

For more information, visit the Provider Resources Page on the PCHP website to review our **Cultural Competency presentation.**

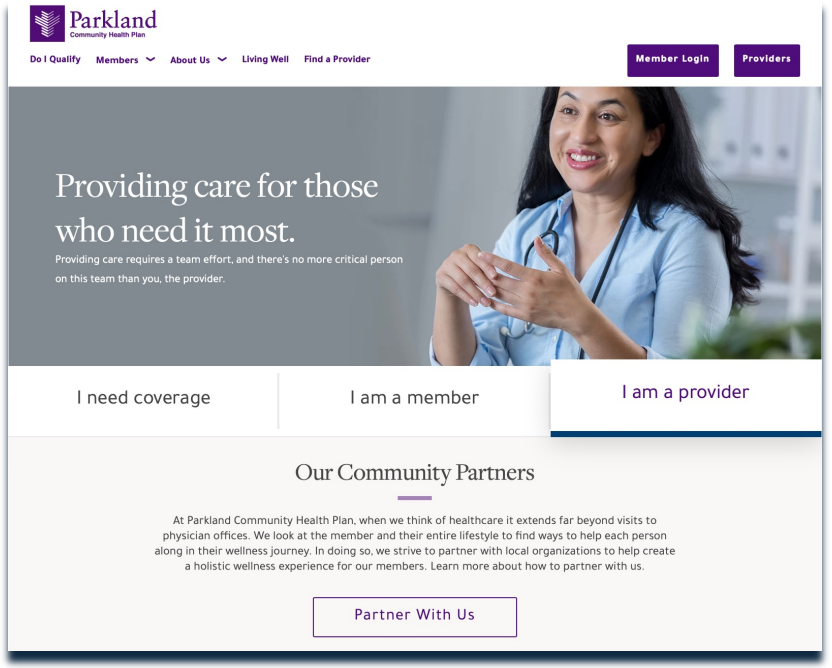
WEBSITE AND ADDITIONAL RESOURCES

Parkland
Community Health Plan

PCHP WEBSITE

AVAILABLE TO PARTICIPATING AND NON-PARTICIPATING PROVIDERS, THE PCHP WEBSITE OFFERS 24/7 ACCESS TO HELPFUL TOOLS AND INFORMATION, INCLUDING:

- Provider manual
- Provider directory and search tool
- Provider newsletters
- Member handbook
- Assistance with member and roster questions
- Secure web portal login
- Forms and provider documents



Visit **Providers.ParklandHealthPlan.com/Login**

PROVIDER PORTAL TOOLS AND ACCESS

THE PCHP PROVIDER PORTAL OFFERS SECURE ACCESS TO TOOLS THAT SUPPORT PATIENT CARE AND DAY-TO-DAY OPERATIONS.

ONCE REGISTERED, BH PROVIDERS CAN:

- Check member eligibility and coverage
- View claims and payment status.
- Submit and track prior authorizations requests.
- Refer members to Case or Disease Management.
- Submit appeals, complaints, and claim disputes.
- Access the provider directory.
- Download provider forms and documents.
- Update your demographic information.
- Access the MAC (Max. Allowable Cost) portal.
- Get answers to general provider questions.

Need Help? Call Provider Services: 1-888-672-2277

PROVIDER RELATIONS REPRESENTATIVES

WHAT IS A PROVIDER RELATIONS REPRESENTATIVE?

Every provider is assigned a dedicated provider relations representative who acts as your main point of contact. They serve as the bridge between PCHP and our provider network, helping ensure you have the support and tools you need to succeed.

HOW WE SUPPORT PROVIDERS:

- Education and training
- Demographic updates
- Help with policies, procedures, and day-to-day operations
- Contract support and clarification
- Assistance with member and roster questions
- Provider Portal assistance

WEBSITE TOOLS AND RESOURCES

QUICK REFERENCE

Parkland Community Health Plan (PCHP) Website

- Provider Home Page
- Provider Portal
- PCHP Provider Manual
- Provider Newsletters
- Provider Network News
- PA Lookup Tool

Questions? Reach out to the PCHP Provider Relations team at PCHP.ProviderRelations@phhs.org

PROVIDER DEMOGRAPHICS AND ENROLLMENT

Parkland
Community Health Plan

PROVIDER INFORMATION & CONTACT UPDATES

WHAT TO UPDATE

- Address
- Phone number
- Group affiliation
- Tax ID (via CAQH and PCHP email)
- Facility/service location changes

WHY IT MATTERS

- Accurate directories
- Reliable search functionality
- Timely communication for claims, PA, referrals
- **Submit updates at least 30 days in advance to PCHP.ContractingDepartment@phhs.org**

PROVIDER ENROLLMENT & MANAGEMENT SYSTEM (PEMS)

OVERVIEW

- **PEMS access** is tied to the provider's **NPI (National Provider Identifier)** or **API (Atypical Provider Identifier)** linked to their TMHP account. Providers must ensure their NPI or API information is current and correct.

IMPORTANT: PEMS accepts only NPIs or APIs. **Legacy identifiers (e.g., TPI)** are no longer valid for enrollment.

- Providers enrolling in Texas health care programs must enroll under one of two categories based on their NPI or API on file with **NPPES: Individual or Organization.**
- An NPI **is not required** for providers of **non-health care services**. However, they must attest that they are not healthcare providers and are **not eligible for an NPI** to receive an API. *This includes QMHPs.*
- For more information about who may not apply for an NPI, refer to **Title 45 CFR §160.103.**
- **Taxonomy codes** must be on file with NPPES to enroll and revalidate in PEMS.
- **Helpful Links:** Enrollment Revalidation Quick Reference | TMHP PEMS

FEDERAL RE-ENROLLMENT REQUIREMENTS

TO STAY COMPLIANT WITH FEDERAL AND STATE REGULATIONS, ALL PROVIDERS MUST REVALIDATE ENROLLMENT EVERY 3 TO 5 YEARS.

- Required under **Title 42 CFR §455.414** and **TAC §371.1015**
- In some cases, revalidation may be required more frequently
- Providers may submit revalidation applications **up to 90 days** before the due date

ADDITIONAL SUPPORT

- **TMHP Contact Center**: 1-800-925-9126 (select Option 3)
- **TMHP-CSHCN Services Program**: 1-800-568-2413 (select Option 2)
- **TMHP Provider Enrollment Webpage**

ACCESS AND AVAILABILITY STANDARDS

Parkland
Community Health Plan

COVERED SERVICES AND ACCESS REQUIREMENTS

THE FOLLOWING SERVICES ARE COVERED FOR MEMBERS, BUT MUST FOLLOW NETWORK AND PRIOR AUTHORIZATION GUIDELINES:

- **Lab and radiology services** – should be performed at contracted/in-network facilities. If out-of-network services are needed, providers must submit a justification to avoid delays or potential adverse determinations.
- **Prescription drugs** – must be on the formulary and filled at a network pharmacy.
- **Inpatient hospitalizations and select outpatient services** – require prior authorization.

DIRECT ACCESS IS AVAILABLE FOR THE FOLLOWING SERVICES:

- **Ob/Gyn care**
- **Vision services** – coordinated through Avēsis Vision
- **Therapeutic optometry** – in-network providers only (excludes surgery)
- **Behavioral health services** – coordinated by PCHP
- **Texas Health Steps exams***
- **Family planning services***

**STAR Medicaid benefit only*

APPOINTMENT ACCESSIBILITY STANDARDS

TYPE OF CARE	APPOINTMENT STANDARD
Urgent Care (Urgent Specialty Care and Behavioral Health Services)	Within 24 hours
Initial Outpatient Behavioral Health Visits (does not apply to CHIP Perinate)	Within 10 business days or 14 calendar days
Initial Outpatient Behavioral Health Visits Upon Discharge From an Inpatient Psychiatric Setting	Within 7 calendar days

It is highly recommended that providers share this information with their appointment schedulers to ensure compliance with the required appointment availability standards.

PREVENTIVE CARE AND PCP STANDARDS

APPOINTMENT TYPE	STANDARD
New Covered Persons	14 days for newborns; 60 days for children and adults
Preventive Visits	14 days for newborns; 60 days for all others
CHIP/CHIP Perinate	Well-child visits per AAP guidelines
STAR Medicaid	Texas Health Steps checkups per schedule (no later than 60 days)

Appointments must be offered as soon as possible and not exceed these timeframes.

24/7 ACCESS AND OFFICE REQUIREMENTS

SERVICE	STANDARD
Referrals	Within 30 calendar days
After-Hours Access	Coverage 24/7, 365 days a year
Call Return Time	Within 30 minutes of after-hours call
In-Office Wait Time	Within 30 minutes of arrival

COMPLIANCE AND NOTIFICATIONS

PROVIDERS MUST NOTIFY PROVIDER RELATIONS IMMEDIATELY IF ANY OF THE FOLLOWING OCCUR:

- **Access Issues:** Unable to meet Access and Availability standards (i.e., temporary or permanent access disruptions)
- **Service Limitations:** Restrictions on treating members (i.e., limited-service hours, service restricted to specific settings)
- **Practice or Demographic Changes:** Changes to provider information (i.e., telephone number updates, suite changes, office relocations)

QUARTERLY SURVEY REQUIREMENTS:

- PCHP conducts a quarterly Access and Availability Survey to monitor network adequacy, as required by State Medicaid, Medicare, and proprietary client contracts.
- Providers must complete the survey at least once per quarter, even if no changes have occurred.
- Results are shared with NCQA and state health plans.
- Data supports access monitoring, network development, and contracting decisions.

Contact the PCHP Provider Relations Team at PCHP.ProviderRelations@phhs.org

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT

PCHP'S QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) PROGRAM ENSURES HIGH STANDARDS IN CLINICAL CARE AND SERVICE DELIVERY ACROSS ALL AREAS OF OUR HEALTHCARE SYSTEM.

PROGRAM HIGHLIGHTS:

- **Member-Centered**: Tailored to age groups, risk status, and disease categories.
- **Compliant**: Meets all state and federal Quality Improvement (QI) requirements.
- **Collaborative**: Guided by a multidisciplinary committee with diverse expertise.

CLINICAL AND UTILIZATION REVIEW PROCEDURES

Parkland
Community Health Plan

PRIOR AUTHORIZATION (PA) REVIEW PROCESS

PRIOR & CONCURRENT PA PROCESS

Participating provider submits Texas Universal Authorization Form or other appropriate form to request services on PA list.

PCHP receives information and reviews eligibility, benefits, and medical necessity and returns authorization to requesting provider.

Rendering provider coordinates, as necessary, with requesting provider.

SUBMIT PA REQUESTS:

- **By Phone (Preferred):** 1-888-672-2277
- **Online: via** PCHP Provider Portal
- **By Fax:** 1-214-266-2064 or 1-844-266-2064 (toll-free)
- **Prior Auth Lookup Tool:** PA Lookup Tool

IMPORTANT POLICY GUIDELINES:

- If a PA request is incomplete, PCHP will notify the requesting provider no later than **3 business days after receipt** (STAR Standard) or more urgently for expedited requests.
- A request for PA is not a guarantee of payment. **Unauthorized services will not be reimbursed.**
- When an authorization is approved, it **does not** necessarily mean **all** services in that authorization request were approved.
- Providers should refer to the TMPPM for the correct form based on the type of request. Forms can be downloaded from the **TMHP website.**
- **NOTE**: BH services cannot be auto-authorized through the PCHP provider portal. This may differ from the previous Carelon portal. All BH authorizations must follow the standard submission process.

PRIOR AUTHORIZATION (PA)

THE FOLLOWING SERVICES REQUIRE PCHP'S PRIOR AUTHORIZATION:

- Inpatient services
- Diversionary/ In Lieu of services (IOP, PHP, CSC)
- Residential Treatment
- Outpatient and IP Withdrawal Management
- Out-of-network services
- EPSDT services

CHECK AUTHORIZAITON REQUIREMENTS

Use the **PCHP Prior Authorization Lookup Tool** to check if a service requires prior approval and visit the **Provider Resources page** for additional tools and support.

AUTHORIZATIONS FOR EXTENDED SERVICE UTILIZATION

PA IS NOT REQUIRED FOR ROUTINE OUTPATIENT TREATMENT.

PCHP **does not** require prior authorization for the following services:

- Routine outpatient services, such as outpatient assessments and therapies
- Psychological or neuro-psychological testing
- SBIRT services
- Health and Behavior Assessment (HBAI) services
- Peer Support or Certified Family Partner services
- Mental Health Rehabilitative or Targeted Case Management services (MHR/TCM)

However, authorization may be required if/when utilization of these services exceeds specific limits. For OP assessments, therapies, SBIRT and HBAI services, Peer Support/Certified Family Partner and psych/neuro psych testing, PCHP utilizes the thresholds as outlined in the TMPPM. For Mental Health Rehabilitative and Targeted Case Management services, PCHP has established benefit guidelines based on the Texas Resilience and Recovery Utilization Management Guidelines.

AUTHORIZATIONS FOR EXTENDED SERVICE UTILIZATION

MENTAL HEALTH REHABILITATIVE AND TARGETED CASE MANAGEMENT SERVICES

- **PCHP does not require prior authorization for MHR/TCM services.**
- PCHP aims to give service providers flexibility to ensure **clinically appropriate utilization** is delivered to members, based on the level of care recommended as part of the **CANS and ANSA assessment process.**
- The following chart defines the **thresholds** PCHP will apply to the MHR/TCM service array. **Utilization that exceeds the thresholds listed will require clinical review.**
- These thresholds were established using the "**high need" unit allowance** and are based on the highest thresholds across all levels of care in the **TRR-UMG for Child and Adolescent Services** or **TRR-UMG for Adult Services.**
    - These thresholds are only meant to provide guidance to providers as to when a clinical review would be necessary.
    - These thresholds **DO NOT** replace or supersede the clinically appropriate / allowable utilization listed in the TRR-UMG for any level of care.
    - Providers are expected to ensure that utilization is aligned with the **unique needs of each member** and level of care recommended by the CANS/ANSA assessment results.
    - **All service utilization is subject to audit.**

EXTENDED UTILIZATION REVIEW — MHR/TCM

SERVICE	CODES	NOTES
Skills Training and Development	CPT: H2014 (--, HA, HA/HQ, HQ)	After 30 units per calendar month
Psychosocial Rehabilitation	CPT: H2017 (--, TD) CPT: H2017 (ET, HQ, HQ/TD)	After 71 units per calendar month After 44 units per calendar month
Targeted Case Management	CPT: T1017 (--, HA, HA/TF, HA/TG, TF)	After 40 units per calendar month
Medication Training and Support	CPT: H0034 (HA, HQ, HA/HQ)	After 25 units per calendar month

Modifier Key:
HA: Individual services for child/youth
HQ: Group services for adults
HA/HQ: Group services for child/youth
TD: individual services rendered by RN
HQ/TD: group services rendered by RN
ET: individual crisis services
TG: Intensive Case Management
TF: Routine Case Management
--: No modifier

**PCHP will provide required notice to providers should any of the limits above change in the future.

MEDICAL NECESSITY CRITERIA

PCHP USES THE FOLLOWING RESOURCES TO DETERMINE MEDICAL NECESSITY FOR BEHAVIORAL HEALTH SERVICES:

- Texas Medicaid Provider Procedures Manual
- InterQual® Behavioral Health Criteria – including Adult and Geriatric Psychiatry, Child and Adolescent Psychiatry, and Behavioral Health Services
- American Society of Addiction Medicine (ASAM)
- Texas Resilience and Recovery (TRR) Utilization Management Guidelines and Manual

AUTHORIZATION REVIEW PROCESS — *PRIOR & CONCURRENT*

CLINICIANS REVIEW AND DOCUMENT CLINICAL INFORMATION TO DETERMINE MEDICAL NECESSITY FOR THE REQUESTED LEVEL OF CARE.

KEY ELEMENTS MAY INCLUDE, BUT ARE NOT LIMITED TO:	
Presenting problem / reason for referral	Functional impairment
Current symptoms (e.g., risk to self/others, psychosis, active substance use, relapse risk)	Family and social supports
Diagnosis	Psychosocial situation and home environment
Current medications / medication changes	Coordination between BH and medical providers
Current treatment plan	Assessment of local delivery system and network access
Response to treatment / barriers to treatment	Discharge plan
Co-occurring conditions (SUD, Medical, IDD)	

When requesting authorization for Court Ordered care, providers must submit a copy of the Court Order to PCHP. If no Court Order is received, PCHP will process the request using appropriate Medical Necessity Criteria.

Requests for SUD services will be reviewed using ASAM criteria. Reviews will be largely structured around the 6 Dimensions. Providers will be expected to identify the level of care requested based on ASAM LOCs.

AUTHORIZATION REQUEST TIMELINES — *PRIOR & CONCURRENT*

STANDARD REQUESTS

- Except for extenuating circumstances (e.g., retro-eligibility), providers must seek authorization for services according to the timelines below.
  - Inpatient requests must be submitted within 24 hours (1 business day) of the admit date to be considered timely.
  - All other requests must be made prior to or on the requested start date of authorization to be considered timely.
  - Requests for continued stay must be submitted on or before the first non-covered day to ensure continuity of care.
- Requests submitted outside of these timelines may be subject to adverse determination.

ADVANCE REQUESTS

- Prior authorization or service authorization requests can be submitted up to 60 days prior to the expiration of the current authorization period.
- Requests must include sufficient clinical information to support a medical necessity determination.
  - This includes evidence that the member's condition is not expected to change between the request date and the requested service start date.

RETRO-ELIGIBILITY & DISCHARGE SCENARIOS

- For members discharged from care:
  - If the hospital stay is 0–14 days, providers may submit a request within 14 days of discharge using the standard clinical review process.
  - If the stay exceeds 14 days, or if the request is submitted more than 14 days after discharge (for a 0–14 day stay), the claim appeal process must be used for reimbursement.
- For members who are still in care when retro-eligibility is established, the clinical review process applies.

PRIOR AUTHORIZATION (PA)

STATUS OF A REQUEST

Providers can check the status of a PA request by:

Logging in to the Provider Portal

Calling Provider Services: 1-888-672-2277

REVIEW PERIODS BY PROGRAM TYPE

PROGRAM	AUTHORIZATION TYPE	TURNAROUND TIME
STAR (Medicaid)	Non-Urgent, Outpatient	Within **3 business days**
	Urgent, Outpatient	Not to exceed **72 calendar hours**
STAR (Medicaid) and CHIP	Inpatient	Within **1 business day** (not to exceed 72 calendar hours)
CHIP Approvals	Outpatient	Within **2 business days**
CHIP Adverse Determinations	Outpatient	Within **3 business days**

Approvals or denials will be communicated based on the urgency of the request.

BILLING AND CLAIMS

Parkland
Community Health Plan

SUBMITTING CLAIMS: FILING DEADLINES & METHODS

TIMELY FILING REQUIREMENTS

MCO	LINE OF BUSINESS	TIMELY FILING REQUIREMENT
Parkland Community Health Plan	STAR & CHIP	Claims must be submitted within 95 days of the date of service (outpatient) or discharge (inpatient).

- **Submit claims promptly** to avoid denials.
- Clean claims are adjudicated **within 30 days** of receipt.
- Appeals must be filed **within 120 days** of the EOP. PCHP will send an **acknowledgment within 5 business days** and **resolve within 30 calendar days** of receipt.

CLAIMS SUBMISSION OPTIONS

SUBMISSION TYPE	INSTRUCTIONS
Paper Claims	**Mail to:** Parkland Community Health Plan P.O. Box 560327 Dallas, TX 75356 ***Fax or Handwritten claims*** *are* ***not*** *accepted.*
Electronic Claims	Submit through the PCHP **Provider Portal** For **EDI submissions**, use **Payer ID: 66917**

CLAIMS DISPUTES, APPEALS, AND COMPLAINTS

CLAIMS RESUBMISSIONS AND DISPUTES

For corrected claim, COB information, proof of timely filing:

Parkland Community Health Plan
ATTN: Claims Resubmissions
P.O. Box 560327
Dallas, TX 75356
Online: PCHP Provider Portal

COMPLAINTS AND APPEALS

Parkland Community Health Plan Claims
ATTN: Appeals and Complaints
P.O. Box 560347
Dallas, TX 75356
Online: PCHP Provider Portal

ONLINE SUBMISSION

PCHP Provider Portal

INQUIRIES MUST INCLUDE:

1. Provider's name
2. Date of the incident
3. Description of the incident
4. Time frames

Submit service inquiries to **Provider Services: 1-888-672-2277**

ADVERSE DETERMINATION APPEAL ON BEHALF OF MEMBER

AUTHORIZATION APPEAL

- A provider may appeal an adverse determination of an authorization on behalf of the member.
- Provider is to obtain approval from the member.
- Appeal must be submitted within 60 days of the adverse determination notification.

SUBMIT REQUESTS:

By Fax (Preferred): 1-844-310-1823

By Phone: 1-888-672-2277

By Mail: ATTN: Appeals and Complaints
P.O. Box 560347
Dallas, TX 75356

EXTERNAL MEDICAL REVIEW (EMR)

- A provider may request an EMR on behalf of the member if they are in disagreement of the appeal determination.
- An EMR is an optional extra step that can be taken to have the appeal decision reviewed before the State Fair Hearing (SFH).
- An EMR with a SFH must be requested within 120 days of the appeal decision notification.

STATE FAIR HEARING (SFH)

- A provider may request a SFH with or without an EMR on behalf of the member if they are in disagreement with the appeal determination.
- A SFH is when HHSC directly reviews our decisions with your medical care.
- A SFH with or without an EMR must be requested within 120 days of the appeal decision notification.

INDEPENDENT REVIEW ORGANIZATION (IRO)

WHAT IS AN IRO?

An external entity contracted with Texas Health and Human Services Commission (HHS) to conduct independent reviews of adverse determinations involving appropriateness of care, medical necessity criteria, level of care, and effectiveness of a requested service.

TIMEFRAMES FOR IRO

- The IRO must complete the EMR and provide determination to PCHP /Member using the following timeframes:
  - Expedited EMR Request: No later than the next business day following receipt of the health plan's records related to the service denial or reduction determination.
  - Standard EMR Request: No later than 10 business days following receipt of the health plan's records related to the service denial or reduction.
- The IRO must ensure that its reviewers are licensed clinical reviewers of the same specialty or area of practice that would generally provide the type of treatment that is the subject of the EMR.

IRO DECISION DETERMINATION

IRO DECISIONS ARE FINAL

The member, authorized representative, and PCHP must be notified by the IRO of its EMR decision in a letter.

- IRO Decision Notice will be sent via mail.
- For expedited EMR requests, the IRO will send the determination of its EMR decision via secure email.

TYPES OF IRO DECISIONS

- **Overturned**: Completely reverse PCHP's decision to deny/reduce/terminate
- **Partially Overturned**: Partially reverse PCHP's decision
- **Denial Upheld**: Sustain the original decision and agree with PCHP's adverse determination

IRO DETERMINATION AND STATE FAIR HEARING PROCESS

- PCHP must process any IRO decision to overturn or partially overturn a denial and notify the member within 72 hours.
- The Denial & Appeal Coordinator will call the member to explain the IRO outcome and review their right to continue with the State Fair Hearing process.
- The member or Legally Authorized Representative (LAR) must choose to either proceed with or withdraw the State Fair Hearing request.
- If a withdrawal is not formally submitted, the hearing process will continue.

BALANCE BILLING

MEMBERS MUST NOT BE BALANCE BILLED FOR THE AMOUNT ABOVE WHICH IS PAID BY THE HEALTH PLAN FOR COVERED SERVICES.

Providers may not bill a member if any of the following applies:

- Claim was not submitted for initial processing within the 95-day filing deadline
- Corrected claim was not submitted within the 95-day submission period
- Claim appeal was not submitted within the 120-day administrative appeal period
- Utilization review appeal was not submitted within 30 calendar days of denial notification
- Claim was incomplete or unsigned
- Errors occurred during claims preparation, submission, or the appeal process

Providers may not bill a member:

- For failing to show for an appointment
- For a third-party insurance copayment

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.

ELECTRONIC FUNDS TRANSFER (EFT) & ELECTRONIC REMITTANCE ADVICE (ERA)

ELECTRONIC FUNDS TRANSFER AND ELECTRONIC REMITTANCE ADVICE OPTIONS

PCHP offers electronic funds transfer (EFT) and electronic remittance advice (ERA) with online viewing capability. Providers may choose to receive payments electronically via direct deposit and select from the following remittance delivery options:

- ERA available online
- HIPAA-compliant data file for direct download into your practice management or accounting system
- Printed and mailed paper remittance

Providers have two options to enroll in EFT:

1. **Enroll in EFT for PCHP *only*** *(no fees):* **Complete PCHP Enrollment**
2. **Enroll in EFT for all payers** using the Settlement Advocate platform *(a fee will apply):* **Complete All-Payer Enrollment**

For assistance with enrollment or payment options, providers can **contact ECHO Health at 1-888-927-6260.**

FRAUD, WASTE, AND ABUSE (FWA)

Parkland
Community Health Plan

FRAUD, WASTE, AND ABUSE (FWA)

DEFINITIONS AND EXAMPLES

FRAUD	WASTE	ABUSE
Any intentional deception, misrepresentation, or omission made by a person who knows it could result in an unauthorized benefit for themselves or another individual. It encompasses any action that violates federal or state laws governing health care programs.	Any practice a sensible person would consider careless or would cause excessive use of resources, items, or services.	Any practice inconsistent with proper fiscal, business, or medical practices and that causes unnecessary program cost.
EXAMPLES	**EXAMPLES**	**EXAMPLES**
Alteration of claim forms	Overutilization of services that are not medically necessary	Denying/limiting access to medically necessary services
Incorrect coding intended to misrepresent services	Duplication of services already provided	Billing members upfront for services that should be covered by Medicaid/CHIP
Billing for services that were not rendered	Preventable hospital readmissions due to inadequate discharge planning	Allowing ineligible individuals to use someone else's Medicaid ID
Substitution of services (billing for one service while providing another)	Complex, redundant billing processes driving administrative costs	Failure to report third-party liability (TPL) coverage

REPORT FRAUD, WASTE, AND ABUSE

CONTACT THE FOLLOWING:

Parkland Community Health Plan

Online: FWA Situation Referral Form
Phone: 1-888-672-2277
Email: PCHPSIU@phhs.org

Mail: Parkland Community Health Plan
Attention: SIU Coordinator
P.O. Box 569005
Dallas, TX 75356-9441

Compliance Hotline: 1-800-403-2498

Texas HHSC — Office of Inspector General

Online: OIG FWA Referral Form
Phone: 1-800-436-6184

To Report a Provider:

Office of Inspector General
General Investigations
Mail Code: 1361
P.O. Box 85200
Austin, TX 78708-5200

To Report a Member:

Office of Inspector Geneal
General Investigations
Mail Code: 1362
P.O. Box 85200
Austin, TX 78708-5200

Texas Attorney General — Medicaid Fraud Control Unit (MFCU)

Online: MFCU
Phone: 1-800-252-8011 or 512-371-4700
Email: mfcu@oag.texas.gov

Mail: Office of the Attorney Geneal
Medicaid Fraud Control Unit
P.O. Box 12548
Austin, TX 78711

PROVIDER RESPONSIBILITIES FOR PREVENTING FWA

PROVIDERS PARTICIPATING IN TEXAS STAR MEDICAID PLAY A CRITICAL ROLE IN PREVENTING FWA. THEIR RESPOSIBLITIES INCLUDE:

Compliance with Medicaid Regulations

- Follow all HHSC and Medicaid & CHIP rules, billing procedures, and policies.
- Stay current on updates to Medicaid provider manuals and applicable state laws.

Accurate Documentation & Billing

- Submit accurate, complete, and truthful claims.
- Ensure billed services were actually provided and are medically necessary.
- Avoid upcoding, unbundling, duplicate billing, and phantom billing.

Protecting Member Identity

- Verify Medicaid eligibility and confirm member identity before billing.
- Report suspected identity misuse (e.g., multiple Medicaid IDs).

Monitoring and Reporting FWA

- Conduct internal audits and monitor for FWA risk indicators.
- Report suspected FWA to:
    - Texas OIG Fraud Hotline
    - Medicaid Fraud Control Unit (MFCU)
    - MCOs, if applicable

Staff Training and Internal Compliance

- Train staff on how to detect, prevent, and report FWA.
- Maintain a written FWA compliance program as required by Texas Medicaid.

QUESTIONS?

Parkland
Community Health Plan

THANK YOU!

Provider Services: 1-888-672-2277

Providers.ParklandHealthPlan.com

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