# Addendum to Provider Manual: Texas Managed Care Medicaid & CHIP

**For Managed Care Organization: Molina Healthcare**

**PROGRAMS SERVING:**

- Texas Medicaid (STAR)
- Texas Medicaid (STAR+PLUS)
- Children's Health Insurance Program (CHIP)

**SERVICE AREAS COVERED:**

**STAR: Dallas, El Paso, Harris, Hidalgo, Jefferson**

**STAR+PLUS: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Tarrant, Medicaid RSA - Northeast Texas Region**

**CHIP: CHIP RSA, Dallas, Harris, Hidalgo, Jefferson**

**Contact/Information Source:**

Caremark Pharmacy Help Desk Number: **1-877-874-3317** (STAR, STAR+PLUS) / **1-833-252-6651** (CHIP)

Caremark Pharmacy Help Desk (and Payer Sheets) Website: http://www.caremark.com/pharminfo

Eligibility Verification Number: **1-855-322-4080**

Eligibility Verification Website: https://availity.com/MolinaHealthcare

Prior Authorization Number: **1-855-322-4080**

Prior Authorization Fax: **888-487-9251**

Eligibility Verification Website: https://www.txvendordrug.com/about/manuals/pharmacy-provider-procedure-manual/p-6-eligibility/pharmacy-verification-eligibility/real-time-eligibility-verification/eligibility-verification-e1-transaction

Texas Vendor Drug Program (VPD) Number: **1-800-435-4165**
(for pharmacy use only – please do not give this number to Medicaid or CHIP clients)

Texas Vendor Drug Program (VPD) Website: http://www.txvendordrug.com

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# I. Introduction

This is an Addendum to your current Caremark Provider Manual and outlines your provider responsibilities when providing Pharmacy Services to qualified State of Texas Medicaid/CHIP program ("Texas Medicaid") recipients ("Eligible Person"), through Molina Healthcare, a managed care organization in the Medicaid Program and CHIP Program, administered by the Texas Health and Human Services Commission. CVS Caremark is the pharmacy benefits manager for Molina Healthcare. You must be a contracted pharmacy provider in Caremark's pharmacy network and participate in the Texas Vendor Drug Program in order to provide outpatient pharmaceutical services to Texas Medicaid/CHIP Eligible Persons. Capitalized terms used in this Addendum shall have the same meaning as in the **Glossary of Terms** in the Provider Manual, except as otherwise defined herein.

**Contact Information:**
CVS Caremark Pharmacy Help Desk: 1-877-874-3317 (STAR, STAR+PLUS) / 1-833-252-6651 (CHIP)

TMHP Contact Center at 1-800-925-9126 or refer to the TMHP website

**Role of Pharmacy:**
The role of the pharmacy is to provide covered services to eligible members according to the terms and conditions of the current Provider Manual and all appropriate Addendum and Pharmacy Communications which may be issued from time to time.

# II. Covered Services

**Member Prescriptions:**
Members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 34-day supply at a retail pharmacy and a 34-day supply from a mail pharmacy. CHIP members may receive up to a 90-day-supply of a drug.

# III. Quality Management

Please refer to your Caremark Provider Manual, but more specifically, section **Credentialing and Quality Management** which states as follows:

**Quality Management**
Provider must comply with credentialing and quality management initiatives required by Caremark, and Provider must provide Caremark with documentation and other information that may be needed in connection with such initiatives including, but not limited to, disclosure of information as set forth in "Disclosure of Information by Providers and Fiscal Agents" (42 CFR Part 455, Subparts B, E) and "Disclosure of Ownership and Control Information" (42 CFR Part 420, Subpart C).

Caremark has the right to reasonably determine in its sole discretion whether or not Provider meets and maintains the appropriate credentialing and quality management standards to serve as a Provider for Caremark and its Plan Sponsors.

We also refer you to the **Clinical Programs, Services and Related Messages** section of the Provider Manual for utilization management programs.

# IV. Provider Responsibilities

**a. Availability:** N/A

**b. Updates to Contact Information:** Providers must send changes of their contact information in writing, within 10 business days of any changes in the documentation and other information provided to Caremark in connection with enrolling as a Provider and in any credentialing or quality management initiatives. Such information, includes but is not limited to, changes in name, address, telephone number, fax number, services, group affiliation or ownership, and must be sent to Caremark by either: (1) fax to 480-661-3054; or (2) mail to:

**Caremark**
Attn: Provider Enrollment, MC 129
9501 E. Shea Boulevard
Scottsdale, AZ 85260

And the pharmacy will also need to update their contact information in the TMHP PEMS tool located here: https://www.tmhp.com/topics/provider-enrollment/pems/start-application

**c. Network Provider:** You must be a contracted pharmacy provider in Caremark's pharmacy network and participate in the Texas Vendor Drug Program in order to provide outpatient pharmaceutical services to Texas Medicaid and CHIP Eligible Persons. Members have the right to obtain medications from any network pharmacy that meets all participation criteria.

**d. Out of Network Provider:** Members can use in network VDP registered mail order pharmacies. In network VDP registered pharmacies can deliver to member's preferred address at no charge. Requests processed at out of network pharmacies require prior authorization review.

**e. Eligibility Verification and Authorizations for Service:** Please refer to your Caremark Provider Manual, sections **Verification of Eligible Persons** and **Identification Cards** which states as follows:

**Verification of Eligible Persons**
Provider will not be paid for providing Pharmacy Services related to Covered Items to an Eligible Person whose eligibility was incorrectly submitted.

Molina Healthcare will provide Eligible Persons with identification cards. Provider must request the identification card from the Eligible Person and utilize the information on the identification card to submit claims through the claims system. If an identification card is unavailable at the point of service, reasonable attempts/efforts should be made to obtain the necessary information for claim submission. Provider will not be paid for providing Pharmacy Services related to Covered Items to an Eligible Person whose eligibility was not correctly submitted.

**Identification Cards**
In most cases, the identification card will be produced in the NCPDP format and will contain the Eligible Person's identification number, the RXBIN, RXPCN, and RXGRP. Some Plan Sponsors produce identification cards that may not include this information.

RXBIN 004336
RXPCN ADV
RXGRP RX0824, RX0825, RX0826

**Verification of Electronic Eligibility:** Provider may submit an NCPDP E1 Transaction to verify eligibility electronically.

**Newborns**
A newborn needs an ID to process claims. If one is not provided or available, you must contact the Eligibility verification team to obtain one. Eligibility contact details are published on the front cover of this addendum.

**f. Pharmacy Records Standards:** Please refer to your Caremark Provider Manual section **Records Maintenance** which states as follows:

**Documentation**
Provider must maintain all documents and records related to Covered Items dispensed to Eligible Persons in accordance with industry standards in a readily obtainable location for a minimum of ten (10) years or such period as required by applicable Law. Such documents and records may include, but are not limited to, original prescriptions; signature logs; daily prescription logs; wholesaler, manufacturer and distributor invoices; Prescriber information; and patient profiles. Refer to the **Professional Audits** of the Provider Manual for more detail on documentation requirements. Provider must maintain and secure records in accordance with HIPAA requirements, including disposing of any records containing Protected Health Information (PHI) in a secure manner in accordance with guidelines issued by the Secretary of Health and Human Services for rendering such records unusable, unreadable or indecipherable to unauthorized individuals.

**g. Formulary and Preferred Drug List Adherence:** Please refer to your Caremark Provider Manual, section **Formularies**. Please also refer to the Texas Health and Human Services Commission's website link Preferred Drugs | Vendor Drug Program (txvendordrug.com) for the most up to date Preferred Drug List (Texas Drug non-PA PDL Search and PDL/PA Status Search) and for the Texas Drug Code Formulary (https://www.txvendordrug.com/formulary/formulary-search). The Texas Medicaid preferred drug list is also available on the Epocrates drug information system. (https://online.epocrates.com/home). Please refer to the Clinical PA Assistance Chart located at https://www.txvendordrug.com/formulary/prior-authorization for drugs that require Clinical Prior Authorization.

**h. General:** Provider shall coordinate with the Prescriber as necessary in performing Provider's Pharmacy Services, and ensure that Eligible Persons receive all medications for which they are eligible. This includes filling all prescriptions under all plans Eligible Persons has prescription benefit coverage under (including public and private sources of coverage).

**i. Coordination of Benefits:** Please refer to your Caremark Provider Manual, section **Coordination of Benefits**, which states as follows:

**Coordination of Benefits (COB)**
Prior to dispensing a Covered Item to an Eligible Person, Provider must inquire whether such Eligible Person has any prescription benefit coverage (including both public and private sources of coverage) in addition to such Eligible Person's benefit under a Plan. If such Eligible Person has additional prescription benefit coverage of any kind, Provider must submit its claim to the appropriate payer as required by and in accordance with any coordination of benefits requirements, and must engage in appropriate coordination of benefits activities to the extent required by Caremark, or applicable by Law.

Plans may indicate if an Eligible Person's eligibility is "supplemental" and Provider may receive the following or similar reject :
Reject 41 <<Submit bill to other processor or primary payer>>

Upon receipt of the reject:

- Ask member if they have other prescription coverage
- Use the information provided in the chart below to submit the claim
- The OPAP field (Other Payer Amount Paid) should be populated
- Use Other Coverage Codes 02, 03, 04

Medicaid is a "payer of last resort", which means other forms of insurance coverage (e.g., Medicare Part B or Part D, commercial insurance, etc.) should be submitted before state of Texas STAR, STAR+PLUS or CHIP program.

Also, please update the member profile with COB information.

| Scenario | If the Primary is… | If the Secondary is… | RXBIN | RXPCN | RXGRP |
|---|---|---|---|---|---|
| Scenario #1 | **Texas Medicaid/CHIP** | N/A | 004336 | ADV | RX0824<br>RX0825<br>RX0826 |
| Scenario #2 | Medicare Part D Plan | **Texas Medicaid** | 012114 | COBADV | RX0833 |
| Scenario #3 | Medicare Part B Plan | **Texas Medicaid** | 013089 | COMADV | Rx0833 |
| Scenario #4 | Commercial Insurance Plan | **Texas Medicaid/CHIP** | 013089 | COMADV | RX0824<br>RX0825<br>RX0826 |

Provider must not hold Eligible Persons, who are dual eligible for both Medicare and Medicaid, liable for Medicare Part A and B cost sharing when Medicaid is responsible for paying such amounts; Provider must accept Caremark's payment as payment in full or bill the appropriate state Medicaid agency.

For complete information on COB, please refer to the payer specification sheet located at www.caremark.com.

**j. Fraud, Waste and Abuse:** The HHSC Office of Inspector General (OIG) investigates waste, abuse, and fraud in all Health and Human Services agencies in the State of Texas. To report waste, abuse or fraud please call 1-800-436-6184 or visit the HHSC OIG website at https://oig.hhsc.state.tx.us/.

Federal law requires all providers and other entities that receive or make annual Medicaid payments of $5 million or more to educate their employees, contractors, and agents about fraud and false claims laws and the whistleblower protections available under those laws.

**k. Cultural Competency Training:** All Caremark contracted pharmacies are encouraged to take cultural competency training. The United States Department of Health and Human Services' Office of Minority Health (OMH) offers a free, computer-based training program on cultural competency for healthcare providers, although it currently does not fully apply to pharmacists. For more information, refer to the OMH Think Cultural Health Web site at www.ThinkCulturalHealth.hhs.gov and select E-learning Programs to register for the Guide to Culturally Competent Care training.

**l. Prescriber NPI:**

- For all claims, including controlled substance prescriptions, providers must use the prescriber's valid and active NPI.
- Provider must maintain the DEA number on the original hard copy for all controlled substances prescriptions in accordance with State and Federal laws.
- Nurses and physician's assistants, etc. may use the NPI of the supervising physician.
- Claims submitted without an appropriate, valid, NPI will be rejected.

# V. Provider Complaint/Appeal Process to Caremark

Please refer to your Caremark Provider Manual, sections **Disputed Claims** and **Claims Adjustment**, for all payment disputes. Also, the **On-Site and Investigational Audit Resolution – Appeals Process** section of the Provider Manual contains information defining the appeals processes for Caremark audits conducted of Providers. Complaints regarding any issue other than payment disputes or audits can be submitted in writing or orally to the Caremark Help Desk. A complaint will be resolved within 30 days. Please refer to the **Pharmacy Help Desk** section in the Caremark Provider Manual or the Pharmacy Help Desk for assistance and guidance. Issues regarding the handling of a complaint should be reported to Molina Healthcare.

**Molina Healthcare of Texas**
PO Box 182273
Chattanooga, TN 37422
Attn: Appeals and Grievances Department
Or call: (866) 449-6849

Any Medicaid issues not resolved to the provider's satisfaction by Caremark or Molina Healthcare can be submitted to the state.

Mail: Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-3247

hhs.texas.gov/managed-care-help
1-866-566-8989

Or submitting the Online Question or Complaint Form http://bit.ly/ComplaintSubmission

Complaints involving CHIP health maintenance organizations (HMOs) claims issues should be directed to the:

**Texas Department of Insurance**
Consumer Protection, Mail Code 111-1A
P.O. Box 149091
Austin, Texas 78714-9091
1-800-252-3439

# VI. Encounter Data, Billing and Claims Administration

Please refer to your Caremark Provider Manual, section **Claims Submission**.

**a. Preferred Brand Name**
Prescription for preferred brand name drug does not require the phrase "Brand Necessary", "Brand Medically Necessary", "Brand Name Necessary", or "Brand Name Medically Necessary" across the face of the prescription. Dispense as written (DAW) is not required for preferred brand name drugs.

**b. Cost Sharing Schedule:**
There are no prescription drug copayments for Medicaid STAR and STAR+PLUS programs.

For Texas CHIP*: The following copayments are dependent upon the level of benefit

| Co-Pays (per visit): | |
|---|---|
| **At or below 151% FPL** | **Charge** |
| Generic Drug | $0 |
| Brand Drug | $5 |
| Cost-sharing Cap | 5% (of family's income)** |
| **Above 151% up to and including 186% FPL** | **Charge** |
| Generic Drug | $10 |
| Brand Drug | $25 for insulin<br>$35 for all other drugs*** |
| Cost-sharing Cap | 5% (of family's income)** |
| **Above 186% up to and including 201% FPL** | **Charge** |
| Generic Drug | $10 |
| Brand Drug | $25 for insulin<br>$35 for all other drugs*** |
| Cost-sharing Cap | 5% (of family's income)** |

**c. Emergency Services Claims:** A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs that require a PA, either because they are non-preferred drugs on the Preferred Drug List or because they are subject to a clinical PA.

For all Medicaid requests, allow 24 hours to complete the authorization process. For CHIP, allow 72 hours. If the Prescriber cannot be reached or is unable to request a PA, Provider should submit an emergency 72-hour prescription. This procedure should not be used for routine and continuous overrides. This process is subject to audit.

Provider can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g. an albuterol inhaler, as a 72-hour emergency supply, but should use the smallest available package size.

Prior Authorization Emergency 72-hour overrides should not be used to circumvent the prior authorization requirements.

For further details on the 72-hour emergency supply requests, please use this link to the State VDP website: Emergency Override | Vendor Drug Program (txvendordrug.com)

**d. Billing Members:** Please refer to your Caremark Provider Manual section **Limitation on Collection** which states as follows:

**Limitation on Collection**
Except for the Patient Pay Amount, Provider cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person for the provision of Pharmacy Services related to a Covered Item in any event, including nonpayment by or bankruptcy of a Plan Sponsor or Caremark or where such amount is disallowed or not permitted by a governmental body. For Claims of Plan Sponsors who are Medicare Advantage organizations providing Medicare Part C services, Provider must not hold any Eligible Person liable for payment of any fees that are the legal obligation of such Medicare Advantage organization.

According to the Texas Medicaid rules and regulations, it is unlawful for a pharmacy provider to withhold medication dispensation to a CHIP member who cannot afford required copayments. For auditing and legal purposes, the pharmacy provider is required to notate and document the balance due upon medication dispensation.

**e. Time Limit for Submission of Claims:** In accordance with Texas Insurance code 843.337, Provider must submit a claim to Caremark no later than the 95th day after the date Provider provides health care services.

**f. Claims Payment:** In accordance with Texas Insurance Code 843.339, a pharmacy claim submitted electronically will be paid by Caremark through electronic funds transfer no later than the 18th day after the date on which the claim was affirmatively adjudicated. A pharmacy claim not submitted electronically will be paid by Caremark no later than the 21st day after the date on which the claim was affirmatively adjudicated.

**g. Compounded Medications:** Please refer to your Caremark Provider Manual section **Compounded Medications** for unique claims submission requirements.

**h. Claims Questions/Appeals:** Please refer to your Caremark Provider Manual, sections **Disputed Claims** and **Claims Adjustment**. The **On-Site and Investigational Audit Resolution – Appeals Process** section of the Provider Manual contains information about the appeals processes for Caremark audits conducted on Providers. Provider must submit an appeal to Caremark no later than the 120th day after the date Provider provides health care services. For MAC paid claim appeals, Provider may appeal the MAC price paid by Caremark at a product level. Refer to the **Maximum Allowable Cost (MAC)** section of the Provider Manual.

**i. List of Covered Drugs and Preferred Drugs:** Please refer to the Texas Health and Human Services Commission's website link http://www.txvendordrug.com for the Formulary and Preferred Drug List. This information is also available via the Epocrates drug information system at https://online.epocrates.com/home. The Medicaid Program also covers certain over-the-counter drugs if they are on the approved drugs list. Like other drugs, over-the-counter drugs must have a prescription written by the member's physician. Check the list of covered drugs at Formulary | Vendor Drug Program (txvendordrug.com). Please refer to the Clinical PA Assistance Chart located at Clinical Prior Authorization Documents | Vendor Drug Program (txvendordrug.com) for drugs that require Clinical Prior Authorization.

**j. Limited Home Health Supplies (LHHS):** The Vendor Drug Program (VDP) covers Limited Home Health Supplies through the outpatient pharmacy benefit. To provide LHHS to CHIP and Medicaid members enrolled with Molina Healthcare of Texas, pharmacies must be contracted with the VDP and with Caremark, our pharmacy benefit manager (PBM). Enrollment as a Durable Medical Equipment (DME) provider is not required. Providers already enrolled as a Medicaid/CHIP DME provider must submit a claim for LHHS through the pharmacy benefit by way of the pharmacy claim system; these items will not be processed under the medical benefit.

**k. Durable Medical Equipment (DME) and Supplies:** Durable Medical Equipment (DME) is equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury, or disability, and is appropriate for use in the home. Pharmacies are encouraged to provide some limited DME and medical supplies to Medicaid STAR; Medicaid STAR+PLUS, and CHIP plan members.

- To participate as a DME provider, pharmacies must enroll with the MCO as a DME medical provider and satisfy all the requirements of the Texas Medicaid and CHIP Vendor Drug Program.
- DME claims (including CCP claims) will be processed under the medical claim benefit – the pharmacy will need to submit a standard CMS 1500 claim to the MCO

**l. Comprehensive Care Program (CCP):** The Medicaid Comprehensive Care Program (CCP) can cover medically necessary drugs and DME supplies that are not available through Vendor Drug for clients from birth through 20 years of age.

Pharmacies must be enrolled as a CCP provider to provide these services
-Pharmacies that want to enroll in the CCP program should complete an pplication at tmhp.com. For assistance contact the TMHP Contact Center at 1-800-925-9126, or e-mail TMHP Provider Relations to request assistance from the local TMHP provider relations representative in your area.
-Pharmacies must also contract with the MCO to participate in the MCO's network.

Pharmacies not enrolled with CCP should direct the client to a CCP provider or to the MCO for assistance in locating a CCP provider. Authorizations for CCP services are handled by the MCO, not Caremark.

CCP claims will be processed under the medical claim benefit and the pharmacy will need to submit a standard CMS 1500 claim to the MCO.

**m. Tamper-proof Prescription Pads:** Prescribing practitioners are required to use tamper-resistant prescription paper when writing a prescription for any drug for STAR and STAR+PLUS recipients. This requirement applies to all STAR and STAR+PLUS prescriptions submitted for payment. The regulation does not apply to prescription orders

transmitted to a pharmacy via telephone, fax, or electronically. The tamper-resistant requirement is only mandatory for prescriptions written for STAR and STAR+PLUS members, it is not a requirement for the CHIP program.

**n. E-prescribing:** Providers engaged in E-prescribing must do so in accordance with all applicable State and Federal laws. Providers are encouraged to utilize E-prescribing practices, the benefits of which include the correct identification of covered, preferred drugs and the subsequent reduction in the need to work with the prescriber to find alternatives.

**o. DUR Conflict Codes and Messages:** Caremark, in accordance with current NCPDP standards, returns up to 9 DUR messages that can be received on the same claim and requires Providers to have the capability to accept up to 9 DUR messages on the same claim.

The Following are some of the most commonly used DUR conflict codes and messages with corresponding descriptions separated into categories as recommended by NCPDP:

| DUR Conflict Codes and Messages | | |
|---|---|---|
| **High Dose (HD)** | **Excessive Utilization - Early Refill (ER)** | **Under Utilization – Late Refill (LR)** |
| **Drug-Drug Interaction (DD)** | **Therapeutic Duplication (TD)** | **Ingredient Duplication (ID)** |
| **Drug-Age Precaution (PA)** | **Drug-Pregnancy Alert (PG)** | **Drug-Disease Precaution (DC)** |

**p. Process for Prior Authorization:** Please refer to your Caremark Provider Manual, section **Prior Authorization** which states as follows:

**Prior Authorization**
For some Plans, certain medications will require prior authorization. For prior authorization, the Prescriber needs to supply additional documentation to Caremark or the Plan Sponsor to determine whether certain criteria are met for the drug to be covered under the Plan.

If a medication is designated for prior authorization, the claim may reject with a message such as:

**Prior Authorization Required:**
**Prescriber should call 855-322-4080 or Fax 888-487-9251 or RPh should submit 72 hr emergency Rx if Dr is not available**

The claims system response typically also provides the correct contact information in the subsequent message.

If the Prescriber feels the drug is medically necessary, he or she will need to call the number listed in the messaging to initiate coverage in order to avoid jeopardizing the health or safety of the Member.

To obtain a prior authorization form you can call 1-855-322-4080 or fax 1-888-487-9251.

Providers can also submit prior authorizations electronically at pharmacy prior authorization forms (molinahealthcare.com) under title Electronic Prior Authorization Information.

Provider must support all clinical programs and services and inform Eligible Persons when a drug designated for prior authorization has been prescribed. Caremark requires that its Network Pharmacy pharmacist make good faith efforts to contact the Prescriber to inform on prior authorization messaging.

**Prior Authorization Process:**

- Federal and Texas law require providers to dispense a 72-hour emergency supply of a prescribed drug when the medication is needed without delay and prior authorization is not available

- Applies to non preferred drugs on the Preferred Drug List and any drug that is affected by a clinical PA needing prescriber's prior approval
- The pharmacy should submit an emergency 72-hour prescription override when warranted; this procedure should not be used for routine and continuous overrides and should not be used to circumvent the prior authorization process. This process is subject to audit.
- If the pharmacy receives a reject for "Prior Authorization Required", and the prescriber is not available, the pharmacy should submit the following information in order to provide the member with an emergency 72-hour supply:

| Field Number | Field Explanation | Pharmacy Should Submit |
|---|---|---|
| Field 461-EU | Prior Authorization Type Code | 8 |
| Field 462-EV | Prior Authorization Number Submitted | 801 |
| Field 405-D5 | Days' Supply | 3 |
| Field 442-E7 | Quantity Dispensed | Dependent on package size* |

***Non-breakable package sizes should be dispensed in the smallest package size available.**

**q. Children's Health Insurance Program (CHIP) Coverage for Contraceptives:** Family planning drugs prescribed for contraception are not covered by the Children's Health Insurance Program (CHIP). Claims submitted for family planning drugs will reject with the following or similar message:

**REJECT 75: << Prior Authorization Required >>**
**Contraception not covered; other uses**

**r. CHIP Member and Provider State Program Education:**

- Molina provides education to the parent and member's Legally Authorized Representative about any other state programs or resources.

- Molina educates Members about family planning programs as follows:
  -Molina Members in CHIP who are aging out of the program receive education about Healthy Texas Women Program services, including Health Texas Women Plus services.
  -All Chip members of child-bearing age receive education about HHSC Family Planning Program services.
  -All Chip Members receive education about HHSC Primary Health Care Program services.

- Molina educates providers on eligibility criteria and services available under the Healthy Texas Women Program, including Healthy Texas Women Plus services; the HHSC Family Planning Program; and the HHS Primary Health Care Program.

**s. Healthy Texas Women (HTW) Program Services:** The Healthy Texas Women (HTW) program offers women's health and family planning services at no cost to eligible, low-income women. These services help women plan their families, whether it is to achieve, postpone, or prevent pregnancy. They also can have a positive effect on future pregnancy planning and general health.

Providers participating in the Healthy Texas Women program can access necessary information regarding policies, billing forms and more online at:

- Healthy Texas Women | Texas Health and Human Services
- Healthy Texas Women (HTW) | TMHP

Healthy Texas Women Cost Reimbursement Manual | Texas Health and Human Services

Healthy Texas Women (HTW) Resources –

- The Texas LARC Toolkit: Texas Medicaid Policy on Providing Long- Acting Reversible Contraception Services
- The Texas Clinician's Postpartum Depression Toolkit: A resource for Texas clinicians on screening, diagnosis and treatment of postpartum depression (PPD). The toolkit also includes coverage and reimbursement options for PPD through Medicaid, CHIP, the Healthy Texas Women program, the Family Planning Program, and other referral options.

Contact Information:

Texas Health and Human Services
Healthy Texas Women, MC 0224
701 W. 51st Street
Austin, TX 78751

Or

PO Box 149347
Austin, TX 78714-9347
Phone: (512) 776-7796
Fax: (512) 776-7203
Email: womenshealth@hhsc.state.tx.us
Verify client eligibility: 1-866-993-9972
Provider inquiries: 1-800-925-9126 (TMHP contact center, pick option 5)

**t. Healthy Texas Women (HTW) Plus Provider Enrollment:**

- There is no additional requirement for current HTW providers to provide HTW Plus services.
- To become an HTW provider, providers must enroll in Texas Medicaid through the Texas Medicaid & Healthcare Partnership (TMHP). Providers can choose one of the following enrollment methods:
- Apply online. Go to TMHP.com and select "providers" in the banner at the top of the page, and then select "Enroll Today!" in the banner at the top of the page. Follow the onscreen instructions.
- Submit a paper application. Go to TMHP.com and follow the instructions above, then go to the Forms page. Scroll down to "Provider Enrollment – Applications" to access and download the enrollment forms for printing.
- Request an enrollment package from TMHP by phone at 800-925-9126, or by mail at:

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

- ***Important:*** *To serve HTW Plus members, providers must first enroll as Medicaid providers by following the steps above, and then be certified by HTW.*

**Contact Information**
To determine if a client is eligible for HTW Plus, call 1-866-993-9972. For HTW Plus questions, call 1-800-925-9126, Option 5.

**u. Healthy Texas Women (HTW) Benefits:** To view pharmacy benefits for HTW and HTW Plus, providers can visit the HHSC Vendor Drug Program website and click on HTW and HTW Plus Program Formulary (Excel) file: www.txvendordrug.com/resources/downloads.

**v. Transaction Fees - Amendments to 2016 Caremark Provider Manual:** Effective September 1, 2015, pursuant to Tex.Ins.Code § 1369.402, and to the extent applicable under the law, Caremark shall not directly or indirectly charge or hold Provider responsible for a fee for any step of or component or mechanism related to the claim adjudication process, including (1) the adjudication of a pharmacy benefit claim; (2) the processing or transmission of a pharmacy benefit claim; (3) the development or management of a claim processing or adjudication network; or (4) participation in a claim processing or adjudication.

**w. Cancellation of Product Orders:**

- If a Network Provider offers delivery services for covered products, such as durable medical equipment (DME), home health supplies, or outpatient drugs or biological products, the Provider is required to reduce, cancel, or stop delivery at the Member's or the Member's authorized representative's written or oral request. The Provider must maintain records documenting the request.
- For automated refill orders for covered products, the MCO's Provider Contract must require the Provider to confirm with the Member that a refill, or new prescription received directly from the physician, should be delivered. Further, the Provider must complete a drug regimen review on all prescriptions filled as a result of the auto-refill program in accordance with 22 Tex. Admin. Code 291.34. The Member or Member's Legally Authorized Representative must have the option to withdraw from an automated refill delivery program at any time.

**x. Prescription Origin Code:** Providers should use the Prescription Origin Code when submitting claims; Original fill Claims submitted without one of the values below will be rejected.
The Prescription Origin Code should be placed in the 419-DJ field, and the following values should be used:
1 = Written
2 = Telephone
3 = Electronic
4 = Facsimile
5 = Pharmacy
The Fill Number should be placed in the 403-D3 field, and the following values should be used:
ØØ = Original dispensing Ø1 to 99 = Refill number

# VII. Reporting 340B Claims

The State of Texas Health and Human Services Commission (HHSC) requires managed care organizations (MCOs) to provide network pharmacies with information on reporting 340B claims (i.e., claims for drugs acquired through the 340B Drug Pricing Program as administered by the Health Resources and Services Administration). Providers must submit an indicator when utilizing medications filled with 340B acquired drugs. This indicator will allow the State of Texas to exclude claims filled with 340B acquired drugs from their Medicaid rebate invoicing.

Effective April 1, 2014, the Texas Health and Human Services Commission (HHSC) amends 1 T.A.C. § 355.8548, which concerns certain Medicaid fee-for-service (FFS) pharmacy provider types who are enrolled in the federal drug pricing discount program, to discontinue the methodology that requires covered entities to submit the actual acquisition cost and instead utilize a reimbursement methodology based upon the drug ingredient costs for pharmacies enrolled in the section 340B drug-pricing program.

Effective August 15, 2014, the Texas Health and Human Services Commission (HHSC) amends Uniformed Managed Care Manual (UMCM) Chapter 2.2, which concerns certain Texas Medicaid/CHIP Vendor Drug Program provider types who are enrolled in the federal drug pricing discount program, to implement the pricing methodology approved by HHSC. ACTION: Accordingly, and effective December 1, 2014, claims filled with 340B drugs for Texas Medicaid/CHIP enrollees will be reimbursed based on the revised 340B methodology described below, if the claim is appropriately submitted by the pharmacy.

When submitting claims filled with drugs acquired through the 340B program, the lower of logic reimbursement formula as detailed in Section 4.3 or Schedule A of the Caremark Provider Agreement, whichever is applicable, shall apply.

The following value must be used in the NCPDP Payer Field to identify drugs acquired at 340B pricing. Providers must use this field to indicate claims for which dispensed drugs were acquired at 340B pricing. Please start working with your software vendors immediately, if needed, to populate this field. Claims are subject to audit.

| Field No. | NCPDP Field Name | Value | | Comments |
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| 420-DK | Submission Clarification Code | 20 = 340B | RW | 20 = Required when designating the product being billed was purchased pursuant to rights as a 34ØB /Disproportionate Share Pricing/Public Health Service item. |

Any claims submitted without the 340B Submission Clarification Code value of ‘20’ indicates that the claim is a non-340B drug.