FirstCare™
HEALTH PLANS
PART OF BAYLOR SCOTT & WHITE HEALTH

TEXAS STAR
Your Health Plan ★ Your Choice

TEXAS
Health and Human Services

ERRATA (CORRECTION) SHEET TO THE
JUNE 2022 FIRSTCARE MEMBER HANDBOOK

Member Rights and Responsibilities

What are my rights and responsibilities?

Member Rights:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
   (a) Be treated fairly and with respect.
   (b) Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and Primary Care Provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   (a) Be told how to choose and change your health plan and your Primary Care Provider.
   (b) Choose any health plan you want that is available in your area and choose your Primary Care Provider from that plan.
   (c) Change your Primary Care Provider.
   (d) Change your health plan without penalty.
   (e) Be told how to change your health plan or your Primary Care Provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   (a) Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   (b) Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   (a) Work as part of a team with your provider in deciding what health care is best for you.
   (b) Say yes or no to the care recommended by your provider.
5. You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
   (a) Make a Complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
   (b) Get a timely answer to your Complaint.
   (c) Use the plan's appeal process and be told how to use it.
   (d) Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   (e) Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   (a) Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   (b) Get medical care in a timely manner.

(c) Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
(d) Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
(e) Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.
10. You have the right to get information and make recommendations about FirstCare's member rights and responsibilities.

Member Responsibilities:

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

(c) Do the best you can to stay healthy.
(d) Treat providers and staff with respect.
(e) Talk to your provider about all of your medications.
(f) Follow plans and instructions for care.

Complaints and Appeals

Complaints

What should I do if I have a complaint?
We want to help. If you have a complaint, please call us toll-free at 1-800-431-7798 (TTY 7-1-1) to tell us about your problem. A FirstCare Member Services Advocate can help you file a complaint. Just call 1-800-431-7798. Most of the time, we can help you right away or at the most within a few days.

FirstCare will acknowledge, investigate, and resolve a complaint within 30 days after the date FirstCare receives your complaint.

What are the requirements and timelines for filing a complaint?
You can file a complaint anytime. A complaint can be done over the phone or in writing:

FirstCare Health Plans
Attn: Complaints & Appeals
1206 West Campus Drive
Temple, TX 76502
Fax: 806-784-4319

You can also file a complaint with FirstCare Self-Service on my.FirstCare.com:

- Log into the portal
- Choose “Send a Message” in the Message Center
- Select “Complaint” under Message Type
- Enter and submit your complaint

Once we receive your complaint, we will send you a letter letting you know we are working to resolve the problem. This letter will be mailed within five business days after we receive your complaint.

How long will it take to process my complaint? What are the requirements and timeframes for filing a complaint?
We will send you a letter telling you about our decision. You will receive this letter within 30 days after we receive your complaint.

If you have a complaint about an ongoing emergency or hospital stay, we will resolve your complaint as soon as we can based on the urgency of your case and no later than one (1) business day from when you got your complaint.

If I am not satisfied with the outcome, who else can I contact?
If you cannot get things worked out to your satisfaction with FirstCare, you can complain to the Health and Human Services Commission (HHSC).

How to file a complaint with HHSC?

Once you have gone through the FirstCare complaint process you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-800-431-7798 (TTY 7-1-1), 7 a.m. to 7 p.m. CST, Monday to Friday. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-3247
Fax: 888-780-8099

If you can get on the Internet, you can submit your complaint at: hhs.texas.gov/managed-care-help. See flyer on page 71 for more information.

Appeals

Coverage Determinations
All denials of services are made by the FirstCare Medical Director(s), after review of medical facts given by your provider. Any person making decisions for services makes them based only on the appropriateness of care and services. No rewards are based on review of services or service denials. FirstCare does not offer money or rewards, to providers or other people making decisions on services.

What can I do if my doctor asks for a service or medicine for me that's covered but FirstCare denies it or limits it?
FirstCare STAR will send you a letter about action on a covered service your doctor asks for. An appeal is the process where you ask for a review of the action. You have the right to request an appeal if you do not agree with the action. An action means the denial or limited approval of the service. It includes the:

- Denial in whole or part of payment for a service.
- Stopped care you think you need;
- Denial of a type of service.
- Reduction or end of a previously authorized service.

What are the requirements and timelines for filing an appeal?
You have sixty (60) days from the date of the denial letter to send us an appeal. You or your provider may appeal verbally or in writing.

We will send you a letter within five (5) business days of receiving your appeal, to let you know that we got it. You can send us proof, or any claims of fact or law that support your appeal, in person or in writing.

We will complete the entire standard Appeal review within thirty (30) days of your request.

If the time frame will be longer, we will give notify you by phone followed by a written notice of the reason for the delay (unless you asked for the delay) within two (2) calendar days. The time frame is extended up to 14 days. If we need more information, we will reach out to your doctor.

If you wish to appeal a denial of a service that is not a covered benefit, then you will need to file a complaint with the State. See "Complaints Process" section above to see how to file a complaint with the state.

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How can I ask for continuation of current authorized services?
If you are receiving services that are being ended, suspended or reduced, you must file an appeal on or before the later of:

- 10 days following the FirstCare's mailing of the notice of the action (using the postage stamp date) or
- The intended effective date of the proposed action for the service to end, suspend, or be reduced
- If you are already getting services, you may ask that they be continued until you find out the results of your appeal. You may have to pay for the services, if the decision is upheld

Does my appeal request have to be in writing?
You can call Customer Service at 1-800-431-7798 (TTY 7-1-1)to let us know you want to appeal an action. You can also submit your appeal in writing. . If you need help, FirstCare can help you write your appeal. Your written appeal should be mailed to:

FirstCare Health Plans
Attn: Complaints & Appeals
1206 West Campus Drive
Temple, TX 76502Fax: 806-784-4319

How will I find out if services are denied?
Each appeal is promptly investigated. You or your representative, and your doctor will get a letter that will explain the final decision of our internal review within 30 calendar days of your request.
If your appeal is denied, the letter will explain the reason why it was denied and tell you how to appeal to the next level.

Can someone from FirstCare help me file an appeal?
Yes. Call FirstCare Customer Service at 1-800-431-7798.

Expedited Appeals

What is an Emergency Appeal?
An Emergency Appeal is when the health plan has to make a decision quickly based on the condition of your health, and taking the time for a standard appeal could jeopardize your life or health.

How do I ask for an expedited appeal?
Call FirstCare Customer Service at 1-800-431-7798 (TTY 7-1-1) if you need help.

Does my request have to be in writing?
You may ask for an Emergency Appeal by phone or in writing.

What are the timeframes for an expedited appeal?
If your Emergency Appeal is about an ongoing emergency or denial to stay in the hospital, FirstCare will review your case and get back to you within one (1) workday after we receive your request. Other emergency appeals will be decided within 72 hours. The appeal process may be extended up to 14 calendar days if you request an extension. Or, if FirstCare shows the need and how the extension is best for you. You will receive a letter if the emergency appeal process is extended.

What happens if FirstCare denies the request for an Emergency Appeal?
If FirstCare decides we do not need to make a decision quickly based on the condition of your health, we will let you know right away. The appeal will still be reviewed, and the decision may take up to thirty (30) days.

Who can help me file an Emergency Appeal?
FirstCare Customer Service can help you with your appeal. Call FirstCare Customer Service toll-free at 1-800-431-7798 (TTY 7-1-1).

State Fair Hearing

Can I ask for a State Fair Hearing?

If you, as a Member of the health plan, disagree with the health plan's internal appeal decision, you have the right to ask for a State Fair Hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter with the internal appeal decision. If you do not ask for the State Fair Hearing within 120 days, you may lose your right to a State Fair Hearing. To ask for a State Fair Hearing, you or your representative should either send a letter to the health plan at:

FirstCare Health Plans
ATTN: Complaints & Appeals
MS A4 144
1206 West Campus Drive
Temple, Texas 76502
1-800-431-7798

or call **1-800-431-7798**.

You have the right to keep getting any service the health plan denied or reduced, based on previously authorized services, at least until the final State Fair Hearing decision is made if you ask for a State Fair Hearing by the later of: (1) 10 calendar days following the date the health plan mailed the internal appeal decision letter, or (2) the day the health plan's internal appeal decision letter says your service will be reduced or end. If you do not request a State Fair Hearing by this date, the service the health plan denied will be stopped. If you ask for a State Fair Hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most State Fair Hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

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

Can I ask for an emergency State Fair Hearing?

If you believe that waiting for a State Fair Hearing will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you or your representative may ask for an emergency State Fair Hearing by writing or calling FirstCare. To qualify for an emergency State Fair Hearing through HHSC, you must first complete FirstCare's internal appeals process.

External Medical Review Information

Can a Member ask for an External Medical Review?
If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed before the State Fair Hearing occurs. The Member may name someone to represent them by contacting the health plan and giving the name of the person the Member

wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative may either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to FirstCare by using the address or fax number at the top of the form.;
- Call the MCO at 1-800-431-7798;
- Email the MCO at Complaints@BSWhealth.org;

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

The Member may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing, the Member can also request the Independent Review Organization be present at the State Fair Hearing. The Member can make both of these requests by contacting the Member's MCO at:

FirstCare Health Plans
ATTN: Complaints & Appeals
MS A4 144
1206 West Campus Drive
Temple, Texas 76502
1-800-431-7798

or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

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

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Can I ask for an emergency External Medical Review?

If you believe that waiting for a standard External Medical Review will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you, your parent or your legally authorized representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling FirstCare. To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHSC, you must first complete FirstCare's internal appeals process.