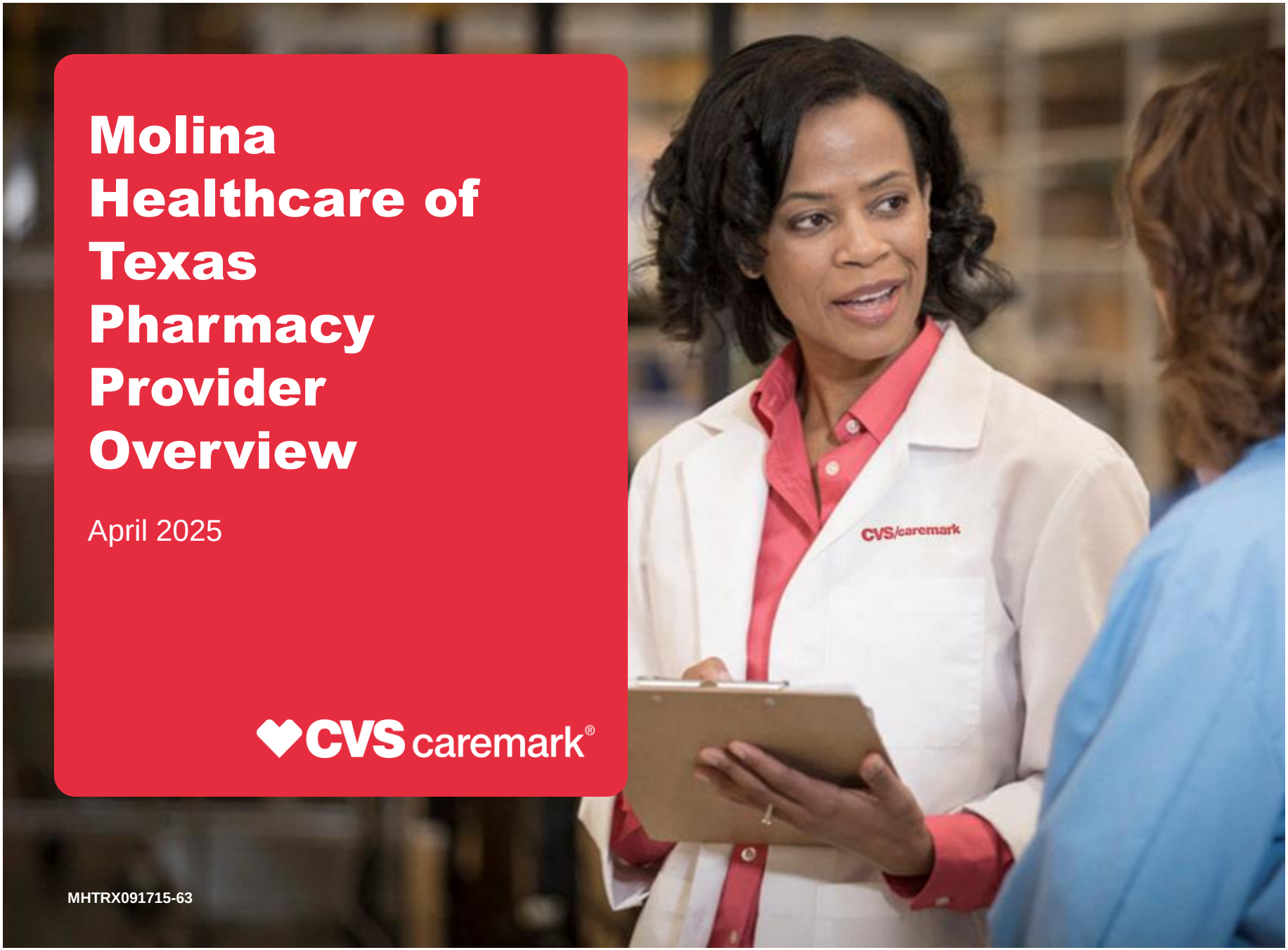
Molina Healthcare of Texas Pharmacy Provider Overview

April 2025



MHTRX091715-63

STATE OF TEXAS STAR, STAR+PLUS AND CHIP PROGRAM

Molina Healthcare of Texas Pharmacy Provider Overview

April 2025

Molina Healthcare of Texas

Provider Network Services
CVS Caremark

Overview and Training Goals

- Pharmacy Network Participation
  - Participation in CVS Caremark Networks
  - Other Participation Requirements
  - Cultural Competency Training
- Understanding Molina Healthcare of Texas Service Areas
- Claims submission and processing information
  - Primary & Medical Claim Requirements
  - Cancellation of Product Orders
  - Coordination of Benefits/Payer Sheet Information
  - Required Claim Fields (NPI, Origin Code)
  - Eligibility
  - Children's Health Insurance Program (CHIP) Coverage & Education
  - Healthy Texas Women Program Information
- Benefit plan design
  - Copayments and Maximum Benefit
  - Emergency 72-hour override
  - Prior Authorization
- Clinical Formulary
  - Formulary & Preferred Drug Coverage
  - Home Health & Durable Medical Equipment and Supplies
  - Comprehensive Care Program
  - Tamper-proof Prescription Pads
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  - DUR Conflict Codes and Messages
- Pharmacy Payment and Contact Information
  - Pharmacy Payment
  - Provider Complaint/Appeal Process
  - MAC Pricing
  - Contact Information

Molina Healthcare of Texas Pharmacy Network Participation

Participation in CVS Caremark Networks

Requirements

Cultural Competency Training

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Pharmacy Participation in CVS Caremark Networks Serving Molina Healthcare of Texas Members

- Program became effective March 1, 2012
- Pharmacy must be enrolled as a Texas Medicaid and/or CHIP pharmacy provider using the Texas Medicaid & Healthcare Partnership (TMHP) Provider Enrollment and Management System (PEMS) tool at the following link.
- Molina Healthcare of Texas is the managed care organization that provides prescription drug benefit to selected State of Texas STAR, STAR+PLUS and CHIP plan members
  - Caremark will administer/process claims on behalf of Molina Healthcare of Texas
  - By participating in Caremark's national pharmacy networks, you automatically participate in the pharmacy network
    Molina Healthcare of Texas will be using for its state of Texas STAR, STAR+PLUS and CHIP program members
  - Caremark's national network is National Choice

Pharmacy Participation in CVS Caremark Networks

- It is important to update pharmacy contact information to ensure accurate Provider Directories and the Medicaid Online Provider Lookup.
- Updates to contact information must be sent in writing, within 10 business days of the change. Provider must send such notification to Caremark by either:

(1) fax to 480-661-3054;

(2) mail to:

CVS Caremark

Attn: Provider Enrollment, MC 129

9501 E. Shea Boulevard

Scottsdale, AZ 85260

(3) Submit an online “Pharmacy Change Form” located on Caremark.com/For Pharmacists and Medical Professionals/Pharmacy Enrollment Self Service/Pharmacy Change Form

- And the pharmacy will also need to update their contact information in the TMHP PEMS tool located here

Other Pharmacy Participation Requirements

Even though your pharmacy participates in Caremark's national networks, your pharmacy also must meet the following requirements in order to serve Texas STAR, STAR+PLUS and CHIP members:

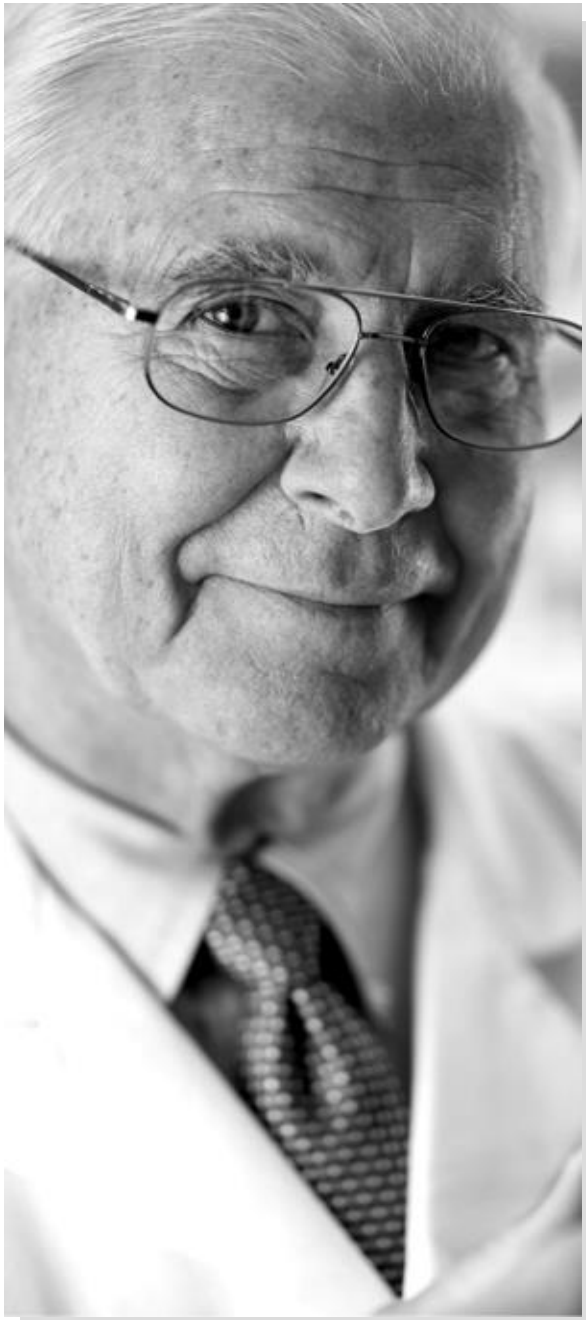
- Your pharmacy must be in good standing with the Texas Health and Human Services Commission's Office of Inspector General (OIG)
- Your pharmacy must participate in the Texas Vendor Drug Program (VDP)
  - If you currently do not participate in the VDP and would like to apply for participation you can apply using the Texas Medicaid & Healthcare Partnership (TMHP) Provider Enrollment and Management System (PEMS) tool at the following link: https://www.tmhp.com/topics/provider-enrollment/pems/start-application

Out of Network Pharmacy Requirements

- 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.

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 https://thinkculturalhealth.hhs.gov/ and select E-learning Programs to register for the Guide to Culturally Competent Care training.



Molina Healthcare Of Texas Service Areas

Bexar Service Area

Dallas Service Area

El Paso Service Area

Harris Service Area

Hidalgo Service Area

Jefferson Service Area

Tarrant Service Area

Medicaid Rural Service Area (RSA) – Northeast Texas Region

CHIP Rural Service Area (RSA)

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Molina Healthcare of Texas Service Areas

Molina Healthcare of Texas Service Areas	STAR	STAR+Plus	CHIP & CHIP Perinate
Bexar Counties: Atascoda, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson		X	
Dallas Counties: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall	X	X	X
El Paso Counties: El Paso, Hudspeth	X	X	
Harris Counties: Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton	X	X	X
Hidalgo Counties: Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata	X	X	X *Hidalgo CHIP is covered under CHIP RSA
Jefferson Counties: Chambers, Harden, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker	X	X	X
Tarrant Counties: Denton, Hood, Johnson, Parker, Tarrant, Wise		X	
Medicaid RSA - Northeast Texas Region Counties: Anderson, Angelina, Bowie, Camp, Cass, Cherokee, Cooke, Delta, Fannin, Franklin, Grayson, Gregg, Harrison, Henderson, Hopkins, Houston, Lamar, Marion, Montague, Morris, Nacogdoches, Panola, Rains, Red River, Rusk, Sabine, San Augustine, Shelby, Smith, Titus, Trinity, Upshur, Van Zandt, Wood		X	
CHIP Rural Service Area (RSA) Counties: 174 rural counties (shown on next slide)			X

CHIP Rural Service Area (RSA) County Listing

Anderson	Donley	King	Robertson
Andrews	Duval	Kinney	Runnels
Angelina	Eastland	Knox	Rusk
Archer	Ector	La Salle	Sabine
Armstrong	Edwards	Lamar	San Augustine
Bailey	Erath	Lampasas	San Saba
Baylor	Falls	Lavaca	Schleicher
Bell	Fannin	Leon	Scurry
Blanco	Fisher	Limestone	Shackelford
Borden	Foard	Lipscomb	Shelby
Bosque	Franklin	Llano	Sherman
Bowie	Freestone	Loving	Smith
Brazos	Frio	Madison	Somervell
Brewster	Gaines	Marion	Starr
Briscoe	Gillespie	Martin	Stephens
Brown	Glasscock	Mason	Sterling
Burleson	Gonzales	Maverick	Stonewall
Callahan	Gray	McCulloch	Sutton
Cameron	Grayson	McLennan	Taylor
Camp	Gregg	McMullen	Terrell
Cass	Grimes	Menard	Throckmorton
Castro	Hall	Midland	Titus
Cherokee	Hamilton	Milam	Tom Green
Childress	Hansford	Mills	Trinity
Clay	Hardeman	Mitchell	Upshur
Cochran	Harrison	Montague	Upton
Coke	Hartley	Moore	Uvalde
Coleman	Haskell	Morris	Val Verde
Collingsworth	Hemphill	Motley	Van Zandt
Colorado	Henderson	Nacogdoches	Ward
Comanche	Hidalgo	Nolan	Washington
Concho	Hill	Ochiltree	Webb
Cooke	Hopkins	Oldham	Wheeler
Coryell	Houston	Palo Pinto	Wichita
Cottle	Howard	Panola	Wilbarger
Crane	Irion	Parmer	Willacy
Crockett	Jack	Pecos	Winkler
Culberson	Jackson	Presidio	Wood
Dallam	Jeff Davis	Rains	Yoakum
Dawson	Jim Hogg	Reagan	Young
Delta	Jones	Real	Zapata
DeWitt	Kent	Red River	Zavala
Dickens	Kerr	Reeves	
Dimmit	Kimble	Roberts	

Claims Submission Information

Claim Submission Requirements for Primary Claims

Medical Claim and Prior Authorization Submission Requirements

Cancellation of Product Orders

Coordination of Benefits

Prescriber NPI

Prescription Origin Code

Eligibility

Children's Health Insurance Program (CHIP) Coverage for Contraceptives

CHIP Program Education

Healthy Texas Women Program Information

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Claim Submission Requirements for Primary Claims

- RXBIN: 004336
- RXPCN: MCAIDADV
- RXGRP: RX0824, RX0825, or RX0826

- Other member-level required elements for claims submission:
  - Member ID number

- Please ask the member to see their ID card
- Pharmacies are not allowed to deny processing a claim due to reimbursement amounts.
- A Provider must submit a claim to Caremark no later than the 95th day after the date the Provider provides health care services.

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.

Coordination of Benefits

- Online coordination of benefits (COB) is supported through POS claims processing.
- COB segment is required
- The following information is required when submitting secondary claims:

Claim	RXBIN	RXPCN	RXGroup	Comments	Other Coverage Code
Secondary to Commercial Insurance	013089	COMADV	RX0824 (CHIP) RX0825 (STAR) RX0826 (STAR+PLUS)	OPAP Billing	Ø2, Ø3, Ø4
Secondary to Medicare Part B	013089	COMADV	RX0833 (Dual Eligible)	OPAP Billing	Ø2, Ø3, Ø4
Secondary to Medicare Part D	012114	COBADV	RX0833 (Dual Eligible)	OPAP Billing	Ø2, Ø3, Ø4

Coordination of Benefits

- COB Payer sheets with additional details are located at www.caremark.com/pharminfo (under NCPDP Payer Sheets)
- Remember, Medicaid is the “payer of last resort”, which means other forms of insurance coverage (e.g., Medicare Part B or D, commercial insurance, etc.) should be submitted before the state of Texas STAR, STAR+PLUS and CHIP programs
- Patients who have Medicare, including Part D, Medicaid or any state or federal prescription insurance can only use a pharmacy discount card if they choose not to use their government-sponsored drug plan for their purchase. Pharmacy discount cards are not valid in combination with these programs.
- Prescriptions reimbursed by Medicare Part D (Medicare Rx) are not eligible for additional reimbursement through Medicaid
- State of Texas STAR and STAR+PLUS plan members should always walk out of the pharmacy with their prescribed medications with no out-of-pocket expense
- CHIP Members may have a copayment*

**Plan member qualifies for a level of coverage with applicable copayments*

Coordination of Benefits

- The information provided will assist you with accurately submitting Coordination of Benefits for Texas Medicaid/CHIP members. If you receive the following or similar reject:

- REJECT 41 <<Submit bill to other processor or Primary Payer>>

Ask member if they have other prescription coverage

- Use the information provided in the charts below to submit the claim
- The OPAP field (Other Payer Amount Paid) should be populated
- Use Other Coverage Codes 02, 03, 04
- Remember, 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 Texas STAR; STAR+PLUS; and CHIP.
- 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	MCAIDADV	RX0824 RX0825 RX0826
Scenario #2	Medicare Part D Plan	Texas Medicaid	012114	COBADV	RX0833
Scenario #3	Commercial Insurance Plan/ Medicare Part B Plan	Texas Medicaid	013089	COMADV	RX0824 RX0825 RX0826 RX0833

Other Required Claim Elements – Prescriber NPI

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

Other Required Claim Elements – 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

Eligibility

- Eligibility Inquiries
  - Pharmacies may submit eligibility inquiries in the NCPDP E1 HIPAA-compliant format and all claims and remittance transactions in the 837/835 HIPAA-compliant format
  - Claim transactions for pharmacy services must be in the NCPDP B1/B2 HIPAA-compliant formats; all others must be in the 837/835 HIPAA-compliant format.
  - Check the plan specific contact list for more further resources
  - Molina Eligibility Contact numbers

    1-855-322-4080 or by Web address
- Newborns
  - VDP Eligibility verification https://provider.txvdpportal.com/
    A newborn needs an ID to process claims. If one is not provided, you must call the Molina Eligibility help line to obtain one on:

    1-855-322-4080 or by Web address

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.
- Claims submitted for family planning drugs will reject with the following or similar message:
  - REJECT 75: << Prior Authorization Required>>

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.

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:
- HHS - Information for Providers regarding Healthy Texas Women Services, Patient Enrollment and Eligibility, Payments, and More
- Texas Medicaid & Healthcare Partnership (TMHP) – Healthy Texas Women program
- Healthy Texas Women Cost Reimbursement Manual link

Healthy Texas Women (HTW) Provider 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.

Healthy Texas Women (HTW) Provider Resources

- Contact Information

  TMHP Contact Center:

  800-925-9126

  (Option 5)

- Email: HealthyTexasWomen@hhsc.state.tx.us or healthytexaswomen@tmhp.com

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.

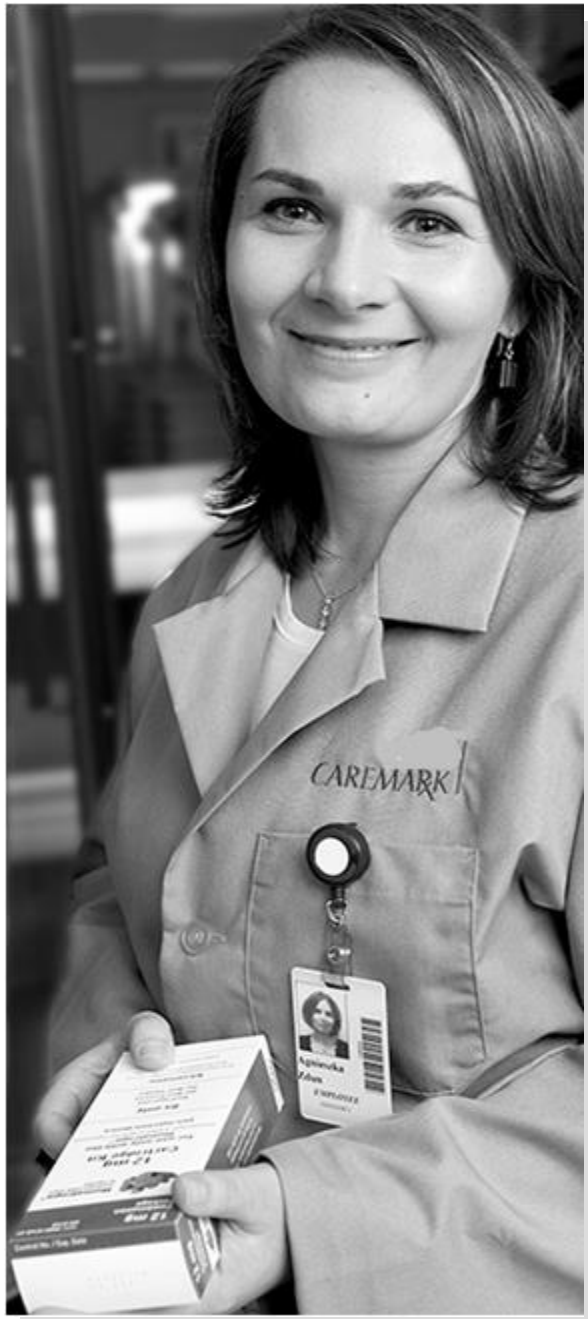
Healthy Texas Women (HTW) Benefits

HTW Benefits

- HTW currently provides a wide variety of women's health and core family planning services, including:
- Pregnancy testing
- Pelvic examinations
- Sexually transmitted infection services, including HIV screening
- Breast and cervical cancer screenings, including clinical breast examination and mammograms
- Screening and treatment for cholesterol, diabetes and high blood pressure
- HIV screening
- Family planning services, including: long-acting reversible contraceptives; oral contraceptive pills; permanent sterilization; and other contraceptive methods such as condoms, diaphragm, vaginal spermicide, and injections
- Screening and pharmaceutical treatment for postpartum depression

Healthy Texas Women (HTW) Plus Benefits

- The HTW program has developed an enhanced postpartum care service package for women enrolled in the HTW program called HTW Plus. To qualify for HTW Plus benefits, HTW clients must have been pregnant within the last 12 months.
- HTW Plus services will focus on treating major health conditions recognized as contributing to maternal morbidity and mortality in Texas, including:
- Postpartum depression and other mental health conditions
  - Services include individual, family and group psychotherapy services; and peer specialist services.
- Cardiovascular and coronary conditions
  - Services include imaging studies; blood pressure monitoring; and anticoagulant, antiplatelet, and antihypertensive medications.
- Substance use disorders, including drug, alcohol and tobacco use
  - Services include screening, brief intervention, and referral for treatment (SBIRT), outpatient substance use counseling, smoking cessation services, medication-assisted treatment (MAT), and peer specialist services.
- Click **here** to view a table containing the procedure codes that will be effective for dates of service beginning September 1, 2020
- 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: link



Benefit Plan Design

Copayments

Emergency 72-hour Override

Prior Authorization

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Copayments and Prescription Maximums Per Month

- For Texas STAR and STAR+PLUS programs
  - There are no prescription drug copayments
  - There is no maximum number of prescriptions
  - May receive up to a 34-day supply from a retail pharmacy or from a mail pharmacy
- 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 $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 $35 for all other drugs***
Cost-sharing Cap	5% (of family's income)**

  - CHIP members may receive up to a 90-day-supply of a drug from a retail pharmacy of from a mail pharmacy.
  - Pharmacies cannot deny a CHIP member's prescription, even if a member cannot pay their copay.
- Balance Billing is not permitted.

*CHIP Perinates and Chip Perinate newborns do not pay these copays, nor do CHIP members who have met their annual limit.

Emergency 72-Hour Override

- 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 nonpreferred 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 when warranted; this procedure should not be used for routine and continuous overrides
- This process is subject to audit
- For further details on the 72-hour emergency supply requests, please use this link to the State VDP website www.txvendordrug.com

Emergency 72-Hour Override

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*

*Nonbreakable package sizes should be dispensed in the smallest package size available (see Provider Manual for details)

*Prior Authorization Emergency 72-hour overrides should not be used to bypass prior authorization requirements for non-emergency medications

Pharmacy Prior Authorization Forms

- When a claim rejects for prior authorization, submit electronically with the Pharmacy Prior Authorization Forms

<<Prescriber should call 855-322-4080 or Fax 888-487-9251 or RPh should submit 72 HR emergency Rx if emergency and DR is not available >>

- Please call or fax the prescriber with the above information so the prescriber can initiate a prior authorization
  - Please include any supporting medical records that will assist with the review of the prior authorization request.
  - For all Medicaid requests allow 24 hours to complete the authorization process. For CHIP allow 72 hours
- Pharmacist should submit 72-hour Emergency Rx if prescriber not available and medication is an emergency
- Pharmacies are allowed to fill an emergency 72-hour supply without delay if the PA is not available
- If the PA is:
  - Approved, Molina will enter the PA and fax the prescriber with the outcome
  - Denied, Molina will deny the PA and fax the prescriber with the outcome

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Clinical Formulary

Formulary & Preferred Drug List

Formulary Drugs & Product Search

Limited Home Health Supplies (LHHS)

Durable Medical Equipment and Supplies

Comprehensive Care Program

Tamper-proof Prescription Pads

E-prescribing

DUR Conflict Codes and Messages

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Formulary & Preferred Drug List

- Covered outpatient drug benefits can be found on the Texas Vendor Drug Program formulary.
- The formulary covers more than 33,000 NDCs including single source and multisource (generic) products, some brand products, biological products, certain limited home health supplies, and vitamins and minerals.
  - Some benefit drug exclusions may apply by plan (e.g. CHIP – Oral contraceptives)
  - Vitamins and minerals are only covered for members through the month of their 21st birthday for certain diagnosis
  - Members who have Medicare as their primary insurance may only have a limited wrap-around formulary that covers non-Part D drugs and some Part B co-pays
- The Vendor Drug Program only reimburses pharmacy providers for outpatient prescription drugs
- The Formulary and Preferred Drug List (PDL) is located at www.txvendordrug.com or Epocrates drug information system at https://online.epocrates.com/home

Formulary & Preferred Drug List

- Preferred Drug List
  - Preferred drugs will be available without prior authorization unless a clinical Prior Authorization is also required
    - The Clinical PA Assistance Chart is located at www.txvendordrug.com for drugs that require a Clinical PA
  - Nonpreferred drugs will require prior authorization
  - Only the prescribing physician or one of their staff representatives can request a prior authorization
  - 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.

Formulary Drugs & Product Search

- **Understanding Coverage:**
  - Formulary drugs are covered under pharmacy benefits.
  - Formulary-preferred vitamins & minerals in Drug Search are covered for all ages.
  - Vitamins and minerals listed on the state formulary Product Search as "VM" are only covered for members through the month of their 21st birthday for certain diagnosis.
- **Formulary Drug Search vs. Product Search:**

Product Search (Non-Drug Items)

- Includes vitamins and minerals, mosquito repellents, influenza vaccines, diabetic supplies, COVID-19 vaccines, COVID-19 test kits, Medicare Part B cost-share products, and Medicare Part D wrap-around products.
- These items are covered but are NOT categorized as formulary drugs.
- Coverage is based on eligibility criteria (e.g., age, medical necessity).

Drug Search (Prescription Medications)

- on-preferred drugs and those needing clinical prior authorization (see Molina specific clinical prior authorizations).
- Examples: family planning drugs, drugs requiring 90% use before a refill, over-the-counter drugs, long-acting contraception drugs, injectable drugs, Medicare Part B cost-share products, and Medicare Part D wrap-around products.
- For more information, visit: Texas Vendor Drug Program (VDP)

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.
- In addition, Molina Healthcare will have certain LHHS products designated as preferred. Refer to the Preferred Diabetic Supplies List located here

  Other formulary diabetic supplies may be covered through the prior authorization process.

Limited Home Health Supplies (LHHS)

LHHS Items:

- Aerosol Chambers
- Diabetic Lancets and Test strips
- Hypertonic Saline's
- Insulin Needles and Syringes
- Oral Electrolytes
- Spring-Powered Lancets
- Talking Monitors
- Please keep the following in mind when submitting a LHHS claim:
  - A Title XIX form is not required for LHHS dispensed through a pharmacy. A prescription (faxed, written, or electronic) is required.
  - Claims must be submitted in accordance with the most current NCPDP pharmacy billing standard.

Durable Medical Equipment 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

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 application 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

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

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

E-prescribing

- E-prescribing with “brand medically necessary” requirements:
  - If the pharmacy receives an e-prescription requiring “dispense as written” by the prescriber, there must be a “Brand Medically Necessary” indication in the Notes to Pharmacy field” (usually a free-form text field); although, some systems may use a separate field to choose a reason why the prescription is DAW
  - If an e-prescription is received by a pharmacy with DAW indicated but without the free text message or additional note, the pharmacist must contact the prescriber for a new prescription
  - Pharmacy should enter “1” in “Dispense as Written” (Field 4Ø8-D8)
  - Pharmacy should enter “3” in “Prescription Origin Code” (Field 419-DJ)
  - Failure of the pharmacy to produce electronic records that indicate the proper DAW and “Brand Medically Necessary” in the free text message for the prescription will result in the claim subject to recoupment
  - A pharmacist may substitute a generically equivalent drug for the brand prescribed unless the prescriber writes in his/her own handwriting the words "Brand Necessary" or "Brand Medically Necessary" on the face of the prescription (42 C.F.R. § 447.331 and 22 Tex. Admin. Code § 309.3). For electronic prescriptions, the MCO must follow the NCPDP standard designation for “Dispense as Written (i.e., DAW = 1).” The prescriber must indicate on the electronic prescription that DAW = 1 and in the “Notes to the Pharmacy,” the prescriber must type “Brand Medically Necessary.” If the electronic prescription is received by the pharmacy with DAW = 1 without the corresponding message, the pharmacist must contact the prescriber for a new prescription. DAW = 1 is not required when the brand is preferred and the generic equivalent is non-preferred.

DUR Conflict Codes and Messages

- All DUR messages appear in the claim response and pharmacies must view all screens necessary to receive the message detail, and act upon all such messages subject to the professional judgment of the provider
- 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
- 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)

Pharmacy Payment and Contact Information

Pharmacy Payment

Provider Complaint/Appeal Process

Maximum Allowable Cost (MAC) Pricing

Contact Information

CVS caremark®

Pharmacy Payment

- Pharmacies will receive payment for Molina Healthcare of Texas claims adjudicating as paid on a weekly basis from Caremark in accordance with prompt pay regulations

- Pharmacies will continue to receive their remittance advice (paper) or 835 file (electronic) as they normally do from Caremark

- Molina Healthcare of Texas claims will appear with an RxBin/PCN/Group combination that differentiates claims from all other claims appearing in the paper/electronic data

- From time to time, Caremark may adjust paid claims to correct errors, or offset for discrepant claims or other charges for noncompliance and audit-related costs

- 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.

Provider Complaint/Appeal Process

- Issues regarding the handling of a Medicaid complaint should be reported to Molina Healthcare at following address: Appeals can be submitted to the following address as well.

  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 by:
  - Mailing to:

    Texas Health and Human Services Commission
    Ombudsman for Managed Care
    P.O. Box 13247
    Austin, TX 78711-3247
    Call: 866-566-8989, 8 a.m. - 5 p.m., Monday - Friday

  - Submitting the Online Question or Complaint Form - https://heartbep-ext.hhs.state.tx.us/omcatLandingPage

- The Right for the External Review Process
  - Member has the right to request an immediate review by an independent/external review for life threatening condition.
  - Member or someone acting on the member's behalf and the provider of record has the right to request a review by an independent/external review organization when Molina denies the appeal

Provider Claims/Appeal Process

- 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

- Appeals Process
  - Provider must submit a Medicaid/CHIP claims appeal to Caremark no later than the 120th day after the date Provider provides health care services.

Maximum Allowable Cost (MAC) Pricing

Background

- Caremark's analytical process to establish a maximum allowable cost (MAC) is at a product level for generics and multi-source brand products. The analytical process involves a review of marketplace dynamics, product availability, and different pricing sources. Pricing sources may include Medi-Span (or any other similar nationally recognized reference), wholesalers, MAC lists published by CMS, and retail pharmacies. MAC prices are subject to change, which can occur at least on a weekly basis, if not more often, and are based on marketplace trends and dynamics, and price fluctuations. MAC pricing is not applied to any preferred brand name drugs. Caremark's complies with Texas Government Code 533.005(a)(23)(K).

Web Portal MAC Price Access

- With respect to Pharmacy Services provided to Texas Medicaid and CHIP enrollees, Caremark has provided Texas Medicaid and CHIP pharmacies with the following process for pharmacies to access MAC prices.
  - Pharmacy Portal Texas MAC Price Look Up: https://rxservices.cvscaremark.com

MAC Challenge Process

- Network pharmacy providers may submit a MAC challenge and Caremark shall respond to the provider within fifteen (15) days after the challenge is made.
  - Chain and affiliation (PSAO) pharmacies should submit MAC paid claim appeals through their respective Chain or PSAO headquarters, which will then submit appropriate data to Caremark.
  - Independent pharmacies (those which are not affiliated with a PSAO for contracting purposes) should submit MAC paid claim appeals through the Pharmacy Help Desk.

Contact Information

Reason	Phone Number	Website
Molina Healthcare of Texas Prior Authorization	Call 1-855-322-4080 Fax 1-888-487-9251	http://www.molinahealthcare.com
Caremark Pharmacy Help Desk (Point of service/ adjudication issues)	For STAR and STAR+PLUS Call 1-877-874-3317 For CHIP Call: 1-833-252-6651	www.caremark.com/pharminfo
Eligibility	Call 1-855-322-4080	http://www.molinahealthcare.com
Texas Vendor Drug Program (For pharmacies only)	Call 1-800-435-4165 Fax 1-512-730-7483	www.txvendordrug.com