



Texas Medicaid Provider Procedures Manual

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Provider Handbooks

Medicaid Managed Care Handbook

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.

MEDICAID MANAGED CARE HANDBOOK

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1 General Information

The information in this handbook is intended for Texas Medicaid managed care providers, including providers who are enrolled in a managed care organization (MCO) that is contracted by Texas Medicaid to provide managed care coverage for Texas Medicaid clients.

This handbook provides information about the following managed care programs and services:

- STAR
- STAR+PLUS
- STAR Kids
- STAR Health
- Children's Medicaid Dental Services

Referto: Medicaid managed care website at www.hhsc.state.tx.us/medicaid/managed-care/mmc.shtml.

2 Overview of Medicaid Managed Care

Texas Medicaid, which is administered by the Texas Health and Human Services Commission (HHSC), operates Medicaid managed care under the authority of federal waivers and state plan amendments that were approved by the Centers for Medicare & Medicaid Services (CMS).

Medicaid managed care is administered by MCOs, dental maintenance organizations (dental plans), and BHOs that are contracted by HHSC to provide services for Medicaid managed care clients. The Medicaid managed care MCOs and dental plans cover the same services that Texas Medicaid covers for the Medicaid fee-for-service clients. Some plans may also elect to cover value-added services.

The principle objectives of Medicaid managed care are to emphasize early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for the target population, with a special focus on prenatal and well-child care.

Higher use of medical services occurs when clients obtain nonurgent or emergent acute care through emergency rooms or access duplicate services for the same medical condition. In Medicaid managed care, clients assume more responsibility for their personal health care by choosing a health plan and primary care provider (PCP) and by making use of preventive primary care services. Eligible clients may also choose a dental plan and a main dentist. This collaborative approach to health-care delivery helps to reduce costs by eliminating duplicate services and unnecessary emergency and inpatient care.

Clients who are enrolled in Medicaid managed care may reside in metropolitan or rural areas. Medicaid managed care consists of the following programs:

- The STAR program uses MCOs to cover acute care services in select groupings of counties known as service areas (SAs). STAR is available statewide. The STAR program operates under a federal 1115 waiver.
- The STAR+PLUS program uses MCOs to cover integrated acute and long term services and supports in specific SAs. The STAR+PLUS program operates under a federal 1115 waiver.
- The STAR Health program uses an MCO to deliver health-care services to children who are in foster care throughout the state. STAR Health is administered by Superior HealthPlan Network and operates under a federal 1915(a) waiver. The STAR Health program only manages the health care of some of the children who are enrolled in foster care. Some foster care clients are enrolled in the Permanency Care Assistance (PCA) program and are not considered eligible for enrollment in Medicaid managed care.

- Children’s Medicaid dental services are administered by dental plans that process dental authorization requests and claims for most Medicaid fee-for-service and Medicaid managed care clients who are 20 years of age and younger regardless of their medical benefit plan.

Referto: Section 7, “Children’s Medicaid Dental Services” in this handbook for exceptions and additional information.

2.1 Managed Care Services

MCOs and dental plans administer almost all of the services that are rendered to Medicaid managed care clients, including, but not limited to, the following:

- Professional, inpatient facility, and outpatient facility medical services
- Prescription drug/pharmacy services.
- Children’s Medicaid dental services for most clients who are 20 years of age and younger.
- Orthodontia services.
- Services rendered to Medicaid managed care SSI clients.
- Value-added services that an individual MCO or dental plan elects to cover.

All questions about these services must be directed to the MCO or dental plan that administers the client’s Medicaid benefits. TMHP does not have access to the individual MCO or dental plan authorization and claims information.

2.1.1 Medical Services

Most medical service benefits including professional, inpatient, and outpatient services rendered to Medicaid managed care clients are administered by individual MCOs. Medical services include all those administered by TMHP for fee-for-service clients as well as any value-added services covered by the individual MCOs.

Some services rendered to Medicaid managed care clients are considered “carve-out” services. Carve-out services are administered and paid by TMHP and not by the client’s MCO.

Referto: Section 8, “Carve-Out Services” in this handbook.

2.1.2 Prescription Drug/Pharmacy Services

Pharmacy services rendered to Medicaid managed care clients are administered and paid by the clients’ MCOs according to S.B. 7, 82nd Legislature, First Called Session, 2011.

Pharmacy providers must first be contracted with the Medicaid/Children’s Health Insurance Program (CHIP) Vendor Drug Program before they can contract with the MCOs.

Referto: Subsection 2.2, “Provider Enrollment and Responsibilities” in this handbook.

Generally, there is no monthly prescription limit for managed care clients.

Referto: The MCO that administers the clients Medicaid managed care benefits for information about prescription drug and pharmacy benefits.

Each MCO contracts with one Pharmacy Benefit Manager (PBM). The MCOs and PBMs must adhere to Medicaid preferred drug list (PDL) and HHSC Medicaid and CHIP formularies.

HHSC will manage the Texas Medicaid and CHIP formularies.

The MCOs will:

- Perform drug utilization review for managed care clients.
- Monitor pharmacy providers for compliance.

- Establish help lines for providers and clients.
- Ensure that all clients have access to a minimum of one network pharmacy:
 - Within 15 miles of the client's residence
 - With 24-hour coverage within 75 miles of the client's residence.

Important: MCOs and PBMs cannot require clients to use a mail-order pharmacy.

- Provide e-prescribing abilities to:
 - Verify client eligibility.
 - Review medication history.
 - Review formulary and PDL information.
- Process correct pharmacy claims submitted electronically within 18 days of submission

2.1.2.1 Prescription Drug Prior Authorizations

Prescribers may be required to request prior authorization for a prescription drug. The prescriber must contact the client's MCO or PBM and follow MCO or PBM guidelines and procedures for prior authorization requests.

Important: TMHP does not have access to the MCOs' or PBMs' guidelines and procedures for prior authorizations. The provider must contact the MCOs or PBMs for information. Individual PBMs will have their own PA processes and telephone lines.

The MCO must notify the prescriber's office of a prior authorization approval or denial:

- Within 24 hours of a request submitted by fax or web.
- Immediately for telephone requests.

Prior authorization is required for non-preferred drugs or any drug requiring a clinical prior authorization.

If the pharmacy cannot dispense the client's prescription because prior authorization is required but has not been requested, the pharmacy should contact the MCO or PBM to request prior authorization. The prescribing provider is required to submit certain prior authorization requests including, but not limited to, non-preferred drug prior authorizations.

2.1.2.1.1 Emergency 72-Hour Prescriptions

If the prescribing provider cannot be reached or is unable to request a prior authorization, the pharmacy should submit an emergency 72-hour prescription. The request for an emergency 72-hour prescription claim should not be used for routine and continuous overrides.

A 72-hour emergency prescription will be paid in full to pharmacy providers and does not count toward the three-prescription limit for adults who have not already received their maximum prescriptions for the month.

Reminder: There is no prescription limit for clients who are 20 years of age and younger.

Federal and Texas law allow a 72-hour emergency supply of prescribed medication to be dispensed any time a prior authorization is not available and the prescription must be filled without delay for a medical condition. This rule applies to non-preferred drugs on the Preferred Drug list and any drug for which prior authorization must be requested by the prescribing physician.

2.1.2.1.2 Formulary

The MCOs or PBMs are responsible for informing network providers about how to access the formulary and PDL.

Referto: The Medicaid and CHIP formularies on the VDP website at www.txvendordrug.com and at www.epocrates.com for more information.

MCOs may also selectively contract with pharmacies for specialty drugs.

2.2 Provider Enrollment and Responsibilities

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Referto: “Section 1: Provider Enrollment and Responsibilities” (*Vol. 1, General Information*) for more information about enrollment procedures.

“Appendix B: Vendor Drug Program” (*Vol. 1, General Information*) for more information about pharmacy enrollment.

2.2.1 Enrollment, Contracting, and Credentialing

Providers must be enrolled in Texas Medicaid before they can be contracted and credentialed by an MCO or dental plan.

Individual MCOs and dental plans have their own guidelines for contracting and credentialing providers.

Important: *Enrollment in Texas Medicaid does not guarantee that an MCO or dental plan will contract or credential a particular provider.*

Providers must refer all questions about contracting and credentialing to the MCO or dental plan that administers the clients’ managed care benefits. TMHP does not have access to the contracting and credentialing requirements for the individual MCOs and dental plans.

All questions about Texas Medicaid enrollment can be referred to the TMHP Contact Center.

Note: *Providers who render only carve-out services are not required to contract with Medicaid MCOs and dental plans.*

Referto: Section 8, “Carve-Out Services” in this handbook for a list of services that are carved out of the Medicaid Managed Care Program.

Subsection B.1, “Vendor Drug Program Information” in “Appendix B: Vendor Drug Program” (*Vol. 1, General Information*) for more information about pharmacy enrollment.

2.2.2 Online Provider Lookup (OPL)

Providers that participate in specific MCOs and dental plans are responsible for declaring themselves managed care providers on the OPL. Clients can search for providers using a particular county, service area, or name to find providers who participate in a managed care area.

Clients are able to search for providers contracted with the STAR+PLUS MCOs on the OPL. Links to the websites of the MCOs and dental plans are also provided through the OPL and enable clients to search each MCO's and dental plan's network of participating providers.

2.2.3 Terminated Enrollment

Texas Medicaid monitors provider claim activity. Providers that have not submitted a claim to Texas Medicaid or a Medicaid MCO or dental plan within an 18-month period are notified that their Texas Medicaid enrollment will be terminated at 24 months if they have not submitted any claims.

If a provider's Texas Medicaid enrollment is terminated, the provider's Medicaid managed care contracts with individual MCOs or dental plans will also be terminated.

To reactivate a TPI that has been terminated, the provider must complete the Texas Medicaid Provider Enrollment Application.

2.2.4 Excluded Entities and Providers

The Code of Federal Regulations (CFR) section 1003.102(a)(2) states that civil monetary penalties may be imposed against managed care entities (MCEs) that employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid clients. No Medicaid payments can be made to an MCE for any items or services directed or prescribed by an excluded physician or other authorized person if the MCE either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded.

2.2.5 Accounts Receivable

Providers that have outstanding accounts receivables on their weekly Remittance & Status (R&S) reports must settle them with TMHP even if they no longer submit claims to TMHP.

Payments from the MCOs and dental plans may be held until the debt with TMHP is resolved.

Providers can refund payments to TMHP as follows:

- If the provider no longer receives claim payments from TMHP, the provider must issue a check for the refund amount to TMHP. Payment options may be available. If a refund check is mailed to TMHP, the provider must also submit Form 7.2, "Texas Medicaid Refund Information Form."
- If the provider continues to receive claim payments from TMHP, a recoupment of the funds may be requested through the paper appeal process. If the provider requests a recoupment through the paper appeal process, the provider must not issue a check to TMHP. The refund amounts will be deducted from future payments, and the deductions will appear on the provider's R&S reports.

2.2.6 Educating Clients about Managed Care

Providers cannot enroll Medicaid clients; however, providers are encouraged to educate clients about Medicaid managed care.

Providers that participate in one or more Texas Medicaid managed care plans should follow these rules when educating clients:

- Providers may not influence clients to choose one MCO or dental plan over another.
- Providers must inform clients of all Medicaid managed care health plans and dental plans in which the providers participate.

- Providers and subcontractors may only directly contact potential clients with whom they have an established relationship.
- Providers may inform clients of special services offered by all Medicaid managed care health and dental plans in which the providers participate.
- Providers may inform clients of particular hospital services, specialists, or specialty care available in all plans in which the providers participate.
- Providers may assist a client by contacting a plan (or plans) to determine if a particular specialist or service is available, if the client requests this information.
- Providers may not influence clients based on reimbursement rates or methodology used by a particular plan.
- At the member's request, providers can provide the necessary information for the client to contact a particular plan but cannot promote any plan over another.
- In no instances can providers stock, reproduce, assist in filling out, or otherwise handle the enrollment form. Information can be provided as outlined on the previous page, and clients can be reminded that they can easily enroll over the telephone with the enrollment broker. However, the call must be made by the client, not by the provider or the provider's agent.
- Providers may assist clients with completing the Medicaid application.
- Providers may display stickers that indicate that they participate in a particular Medicaid managed care health or dental plan as long as they do not indicate anything more than "(health plan or dental plan) is accepted or welcomed here" (provided the sticker meets Medicaid/CHIP Marketing Guidelines regarding size limitations).
- Providers may display state-approved, health-related marketing materials in their offices, provided it is done equally for all MCOs and dental plans in which they participate. MCO and dental plan providers cannot give out or display plan-specific marketing items or giveaways to clients.

Important: *Providers must comply with their applicable licensing agency's laws and regulations, including any related to marketing and advertising, and any applicable state and federal laws and regulations, contractual requirements, and other guidance documents. Providers are encouraged to review the [Provider Marketing Guidelines](http://www.tmhp.com) page of the TMHP website at www.tmhp.com.*

2.3 General Information About Client Enrollment in Managed Care

Most of the clients who have been determined to be eligible for Texas Medicaid are first enrolled in fee-for-service. Specific client groups within the Texas Medicaid population are eligible for managed care based on certain established criteria. If the client is eligible for Medicaid managed care, the client will choose an MCO and PCP or a dental plan and main dentist or both. The managed care enrollment date is separate from the Medicaid eligibility date. In most cases, Medicaid managed care enrollment is not retroactive.

Referto: The STAR, STAR+PLUS, and STAR Health sections of this handbook for exceptions.

Claim and authorization transactions for services rendered during the client's fee-for-service eligibility must be submitted to TMHP, and claim and authorization transactions for services rendered during the client's Medicaid managed care enrollment must be submitted to the appropriate entity (i.e., TMHP for carve-out services and the MCO or dental plan for managed care services).

If a client loses Medicaid eligibility and then regains eligibility, the client is automatically reassigned to the same health plan and PCP or dental plan that the client had before the client lost Medicaid eligibility.

Referto: Subsection 2.4, “PCP/Main Dentist Guidelines for Medicaid Managed Care Clients” in this handbook.

“Section 4: Client Eligibility” (*Vol. 1, General Information*).

2.3.1 Managed Care Enrollment Broker

Medicaid clients who are eligible for STAR or STAR+PLUS choose an MCO and a PCP, and those eligible for Children’s Medicaid Dental Services choose a dental plan and a main dentist using the official state enrollment form or by calling the Enrollment Broker.

The Help Line (Enrollment Broker) is available 8 a.m. to 8 p.m., Central Time, Monday through Friday at:

- Telephone: 1-800-964-2777
- Telecommunications device for the deaf (TDD): 1-800-267-5008

2.3.1.1 * Eligibility Verification Resources

The provider is responsible for verifying the client’s eligibility before providing services. The provider must also verify and abide by prior authorization or administrative requirements established by the MCO or dental plan.

Referto: “Section 4: Client Eligibility” (*Vol. 1, General Information*) (*Vol. 1, General Information*) for more information.

The client’s managed care MCO and dental plan enrollment information can be verified by:

- Checking the client’s health plan or dental plan ID card (if applicable).
- Visiting the client’s Medicaid MCO or dental plan’s website.
- Calling the client’s health or dental plan.
- [Revised] Visiting [TexMedConnect](#) or calling the [TMHP Contact Center](#) at 1-800-925-9126.

Note: [Revised] *TMHP Contact Center agents are not able to answer questions regarding eligibility.*

The client’s managed care eligibility can also be verified using:

- The TMHP Automated Inquiry System (AIS) at 1-800-925-9126.
- Third-party software that uses the TMHP EDI Gateway.
- Batched electronic verifications.
- National Council for Prescription Drug Programs (NCPDP) Eligibility Verification (E1) transaction. The E1 transaction is submitted through the pharmacy’s point-of-sale system.
- The Vendor Drug Eligibility Verification Portal (EVP). EVP is a browser-based application that is free for all contracted pharmacy providers.

Referto: Subsection 4.5.3, “Client Eligibility Verification” in “Section 4: Client Eligibility” (*Vol. 1, General Information*) for additional information about verifying client eligibility.

The Texas Medicaid Vendor Drug Program website at www.txvendordrug.com/claims/eligibility-verification.shtml for more information.

2.3.2 Client Rights

In Texas, Medicaid managed care clients have defined rights and responsibilities. Each health plan and PCP share the responsibility to ensure and protect client rights and to assist clients in understanding and fulfilling their responsibilities as plan clients.

Medicaid managed care clients have the right to:

- Be treated fairly and with dignity and respect.
- Know that their medical records and discussions with their providers will be kept private and confidential.
- Request changes to their medical records (if incorrect).
- A reasonable opportunity to choose a health-care plan and PCP (the doctor or health-care provider they will see most of the time and who will coordinate their care) and to change to another plan or provider in a reasonably easy manner. These opportunities include the right to:
 - Be informed of available health plans and PCPs in their areas.
 - Be informed of how to choose and change health plans and PCPs.
 - Choose any health plan that is available in their area and choose a PCP.
 - Change their PCP at any time for any reason.
 - Change health plans without penalty.
 - Be educated about how to change health plans or PCPs.
 - Know that doctors, hospitals, and others who provide care can advise clients about their health status, medical care, and treatment. The health plan cannot prevent them from giving clients this information, even if the care or treatment is not a covered service.”
 - Know that clients are not responsible for paying for covered services. Doctors, hospitals, and others cannot require clients to pay copayments or any other amounts for covered services.
- Ask questions and get answers about anything the client doesn't understand, and that includes the right to:
 - Have their provider explain their health-care needs to them and talk to them about the different ways their health-care problems can be treated.
 - Be told why care or services were denied and not given.
- Consent to or refuse treatment and actively participate in treatment decisions, and that includes the right to:
 - Work as part of a team with their provider in deciding what health care is best for them.
 - Say yes or no to the care recommended by their provider.
- Utilize each available complaint and appeal process through the MCO and through Medicaid, receive a timely response to complaints, appeals, and fair hearings. These processes include the right to:
 - Make a complaint to their health plan or to the state Medicaid program about their health-care, provider, or health plan.
 - Receive a timely answer to their complaint.
 - Access the health plan appeal process and the procedures for doing so.
 - Request a fair hearing from the state Medicaid program and request information about the process for doing so.
- Timely access to care that does not have any communication or physical access barriers. They have the right to:
 - Have telephone access to a medical professional 24 hours a day, 7 days a week in order to obtain any needed emergency or urgent care.

- Receive medical care in a timely manner.
- Be able to get in and out of a health-care provider's office, including barrier free access for persons with disabilities or other conditions limiting mobility, in accordance with the *Americans with Disabilities Act*.
- Have interpreters, if needed, during appointments with their providers and when talking to their health plan. Interpreters include people who can speak in their native language, assist with a disability, or help them understand the information.
- Be given an explanation they can understand about their health plan rules, including the health-care services they can get and how to get them.
- Not be restrained or secluded when doing so is for someone else's convenience, or is meant to force them to do something they are unwilling to do, or to punish them.

2.3.2.1 Advance Directives

Federal and state law require providers to maintain written policies and procedures for informing and providing written information to all adult clients who are 18 years of age and older about their rights under state and federal law, in advance of their receiving care (*Social Security Act* §§1902[a][57] and 1903[m][1][A]). The written policies and procedures must contain procedures for providing written information regarding the client's right to refuse, withhold, or withdraw medical treatment advance directives.

These policies and procedures must comply with provisions contained in 42 *Code of Federal Regulations* (CFR) §§434.28 and 489, SubPart I, relating to the following state laws and rules:

- A client's right to self-determination in making health-care decisions.
- The Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:
 - A client's right to execute an advance written directive to physicians and family or surrogates, or to make a nonwritten directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition.
 - A client's right to make written and nonwritten Out-of-Hospital Do-Not-Resuscitate Orders.
 - A client's right to execute a Medical Power of Attorney to appoint an agent to make health-care decisions on the client's behalf if the client becomes incompetent.
- The Declaration for Mental Health Treatment, Chapter 137, Texas Civil Practice and Remedies Code, which includes a Member's right to execute a Declaration for Mental Health Treatment in a document making a declaration of preferences or instructions regarding mental health treatment.

These policies can include a clear and precise statement of limitation if a participating provider cannot or will not implement a client's advance directive. A statement of limitation on implementing a client's advance directive should include at least the following information:

- A clarification of the provider's conscience objections.
- Identification of the state legal authority permitting a provider's conscience objections to carrying out an advance directive.
- A description of the range of medical conditions or procedures affected by the conscience objection.

A provider cannot require a client to execute or issue an advance directive as a condition for receiving health-care services. A provider cannot discriminate against a client based on whether or not the client has executed or issued an advance directive.

A provider's policies and procedures must require the provider to comply with the requirements of state and federal law relating to advance directives.

2.3.2.2 PCP/Main Dentist and Health/Dental Plan Changes

A client who is enrolled in a Medicaid MCO or dental plan may request a PCP or Main Dentist change at any time and for any reason. PCP or main dentist changes are processed by the MCO or dental plan.

Clients also have the right to change health or dental plans if other options are available in the service area in which the client resides. Plan change requests are processed by the enrollment provider.

Referto: Subsection 2.4.3, “PCP and Main Dentist Changes” in this handbook.

2.3.3 Client Responsibilities

Medicaid managed care health plans and PCPs should help clients understand their responsibilities. These include the responsibility to:

- Learn and understand each right they have under Medicaid. That includes the responsibility to:
 - Learn and understand their rights under the Medicaid program.
 - Ask questions if they do not understand their rights.
 - Learn what choice of health plan is available in their area.
- Abide by the health plan and Medicaid managed care policies and procedures. That includes the responsibility to:
 - Learn and follow their health plan rules and Medicaid rules.
 - Choose their health plan and a PCP.
 - Make any changes in their health plan and PCP in the ways established by Medicaid managed care and by the health plan.
 - Keep their scheduled appointments.
 - Cancel appointments in advance when they cannot keep them.
 - Always contact their PCP first for nonemergency medical needs.
 - Be sure they have approval from their PCP before going to a specialist (except for self-referred services).
 - Understand when they should and should not go to the ER.
- Share information relating to their health status with their PCP and become fully informed about service and treatment options. That includes the responsibility to:
 - Tell their PCP about their health.
 - Talk to their providers about their health-care needs and ask questions about the different ways their health-care problems can be treated.
 - Help their providers get their medical records.
- Actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain their health. That includes the responsibility to:
 - Work as a team with their providers in deciding what health care is best for them.
 - Understand how the things they do can affect their health.
 - Do the best they can to stay healthy.
 - Treat providers and staff with respect.

2.4 PCP/Main Dentist Guidelines for Medicaid Managed Care Clients

In Medicaid managed care, eligible Medicaid clients choose a primary care provider (PCP) or a main dentist who will work with the client to coordinate the client's health care or dental services.

The managed care client's PCP/main dentist is responsible for the following:

- Furnishes primary-care related services
- Arranges for and coordinates referrals for all medically necessary specialty services
- Is available directly or through on-call arrangements 24 hours a day, 7 days a week for urgent or emergency care

Referto: Subsection 2.4.4, "Continuous Access" in this handbook.

Primary care includes ongoing responsibility for preventive health or dental care, health or dental maintenance, treatment of illness and injuries, and the coordination of access to needed specialist providers or other services.

PCPs/main dentists can choose to contract with various MCOs or dental plans.

Provider types who are eligible to serve as a PCP include:

- Pediatricians
- Family/general practitioners
- Internists
- Obstetrician/gynecologists
- Advanced Practice Registered Nurses (APRNs) under the supervision of a physician
- Certified nurse-midwives (CNM) practicing under the supervision of a physician
- Physician assistants (PAs) practicing under the supervision of a physician
- Rural health clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Community Clinics
- Specialists willing to provide medical homes to clients who have special needs

The following provider types are eligible to serve as a main dentist:

- General dentist
- Pediatric dentist
- Federally qualified healthcare center (FQHC)

The PCP or main dentist either furnishes or arranges for most of the client's health-care or dental-care needs, including well-checkups, office visits, referrals, outpatient surgeries, hospitalizations, and health- and dental-related services.

Although PCPs are encouraged to assist clients in accessing these services, Medicaid managed care enrollees may self-refer for the following services:

- Emergency services
- Family planning
- THSteps medical services

- Immunizations
- Early Childhood Intervention (ECI) targeted case management
- Case Management for Children and Pregnant Women
- Obstetric or gynecological services
- School Health and Related Services (SHARS)
- DSHS case management
- HHSC case management
- Behavioral health services (contact client's health plan for specific requirements)
- Vision care (including ophthalmologic or therapeutic optometry)

2.4.1 Enrolling as a PCP or Main Dentist

Various providers may be eligible to enroll in Medicaid managed care as primary care providers or main dentist. Providers must contact the individual Medicaid managed care health plans or dental plans for enrollment information.

2.4.2 PCP Requirements for THSteps Medical Services

THSteps providers must be enrolled with Medicaid to be reimbursed for services provided to clients. THSteps medical services are self-referred. Medicaid MCOs determine how their clients will access THSteps services. The MCO may require the client to go to an in-network THSteps provider or may allow the client to go to any Medicaid THSteps provider, whether or not they are in the MCO's network. Providers that render THSteps services must work in collaboration with the client's PCP to ensure continuity of care.

THSteps providers are required to bill claims as an exception to periodicity when the clients visit is outside of the periodicity schedule because of extenuating circumstances.

Referto: Section 5, "THSteps Medical" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)* for more information about billing an exception-to-periodicity checkup

Subsection 5.3.7, "Exception-to-Periodicity Checkups" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)* for more information about billing an exception-to-periodicity checkup

Subsection 4.2.11.1 *, "Exceptions to Periodicity" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)* for more information about billing an exception-to-periodicity checkup.

2.4.3 PCP and Main Dentist Changes

PCP and main dentist changes may be requested or initiated by any of the following:

- A client who is enrolled in a Medicaid MCO or dental plan may request a PCP or main dentist change at any time and for any reason.
- The MCO or dental plan may reassign the client to another PCP or main dentist for any of the following reasons:
 - The PCP or main dentist is sanctioned by HHSC.
 - The PCP or main dentist exhibits a documented pattern of unacceptable quality of care.
 - The PCP or main dentist inappropriately reduces the client's right to access specialty services covered under Medicaid managed care.
 - The provider leaves Medicaid, retires, or dies.

- A provider may request a client be reassigned to another PCP or main dentist for any of the following reasons:
 - The client is not included in the PCP's or main dentist's scope of practice.
 - The client is noncompliant with medical or dental advice.
 - The client consistently displays unacceptable office decorum.
 - The client's relationship with the PCP or main dentist is not mutually agreeable.

Any request by a provider to reassign a client to another PCP or main dentist must be processed through the applicable Medicaid MCO or dental plan. Before a request for reassignment can be initiated, reasonable measures must be taken to correct the client's behavior. Reasonable measures may include education or counseling by the MCO or dental plan staff. The MCO or dental plan will notify the client of the reassignment if all attempts to remedy the situation have failed. Providers should also notify the client about the reassignment in writing and send a copy of the notification to the MCO or dental plan.

The MCOs and dental plans can affect a PCP or main dentist change immediately if necessary; however, the Medicaid client eligibility verification systems may not immediately reflect the change.

2.4.4 Continuous Access

Continuous access is an important feature of Medicaid managed care. Twenty-four-hour PCP and main dentist availability enables clients to access and use services appropriately, instead of relying on ERs for after-hours care.

Continuous access can be provided through direct access to a PCP's or main dentist's office or through on-call arrangements with another office or service. Clients should be informed of the PCP's or main dentist's normal office hours and should be instructed how to access urgent medical care after normal office hours.

2.4.4.1 After-Hours Guidelines

PCPs and main dentists are required to have at least one of the following arrangements in place to provide 24-hour, 7-day a week access for managed care clients:

- The office telephone is answered after-hours by an answering service, which meets language requirements of the major population groups and which can contact the PCP, main dentist, or another designated provider. All calls answered by an answering service must be returned within 30 minutes.
- The office telephone is answered after normal business hours by a recording in the language of each of the major population groups served, directing the patient to call another number to reach the PCP, main dentist, or another provider designated by the PCP or main dentist. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
- The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, main dentist, or another designated medical practitioner, who can return the call within 30 minutes.

2.4.4.2 Unacceptable Telephone Arrangements

- The telephone answering procedures listed below are not acceptable:
 - The office telephone is only answered during office hours.
 - The office telephone is answered after-hours by a recording that tells clients to leave a message.
 - The office telephone is answered after-hours by a recording that directs clients to go to an Emergency Room for any services needed.
- Returning after-hours calls outside of 30 minutes.

2.5 Cultural Competency and Sensitivity

HHSC values the diversity of the Texas Medicaid population and requires Medicaid managed care to provide programs to support clients from diverse cultural backgrounds:

- Helplines are staffed by both Spanish- and English-speaking customer service representatives who, at any time, may access a multi-language translation service for assistance.
- Articles in the *Texas Medicaid Bulletin* and educational workshops include topics that focus on cultural sensitivity and the need for culturally competent staff in PCP or main dentist offices.

Providers are expected to comply with the laws concerning discrimination on the basis of race, color, national origin, or sex.

2.5.1 Limited English Proficiency

Medicaid providers are required to provide services in the languages of the major Medicaid population groups they serve and to ensure quality appropriate translations. Title VI, section 601, of the *Civil Rights Act* of 1964 states that “no person in the United States shall on the basis of race, color, or national origin, be excluded from participating in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”

HHSC requires Medicaid providers to ensure persons with limited English proficiency have equal access to the medical services to which they are legally entitled.

Meeting the requirements of Title VI may require the PCP or main dentist to take all or some of the following steps at no cost or additional burden to the beneficiary with limited English proficiency:

- Have a procedure for identifying the language needs of patients/clients.
- Have access to proficient interpreters during hours of operation (MCOs or dental plans arrange interpreters).
- Develop written policies and procedures regarding interpreter services (MCOs or dental plans arrange interpreters).
- Disseminate interpreter policies and procedures to staff and ensure staff awareness of these policies and procedures and of their Title VI obligations to persons with limited English proficiency.

In order to meet interpretation requirements, providers may choose to incorporate into their business practice any of the following (or equally effective) procedures:

- Hire bilingual staff. (Does not apply to MCOs.)
- Hire staff interpreters. (Does not apply to MCOs.)
- Use qualified volunteer staff interpreters. (Does not apply to MCOs.)
- Arrange for the services of volunteer community interpreters—excluding the client’s family or friends. (Does not apply to MCOs.)
- Contract with an outside interpreter service. (MCO or dental plan must provide.)
- Use a telephone interpreter service.
- Develop a notification and outreach plan for beneficiaries with limited English proficiency.

It is the provider’s responsibility to ensure that interpretive services are available to his practice to meet requirements on limited English proficiency and communication disabilities. Interpretive services include language and American Sign Language (ASL) interpreters.

Language Line Services operate 24 hours a day, 7 days a week. Language Line Services provides over-the-telephone interpretation, video interpreting, document translation, interpreter testing and training, and other language products as well. Language Line Services charges a fee for the service. For complete details about their billing practices and services, providers should visit the Language Line Services website at www.language-line.com or call 1-800-752-6096.

Complaints and reports of non-compliance with Title VI regulations are handled by the Office for Civil Rights (OCR). Additional information, including the complete guidance memorandum on prohibition of discrimination against persons with limited English proficiency issued by the OCR, can be found on the Internet at www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/index.html.

Note: MCOs are responsible for providing interpreter services.

2.6 Reimbursement

Providers must read and comply with “Section 2: Texas Medicaid Fee-for-Service Reimbursement” (*Vol. 1, General Information*).

Reimbursement for benefits that are administered by a Texas Medicaid MCO or dental plan is determined by the MCO or dental plan. Providers should contact the MCO or dental plan for additional information.

Note: The MCOs and dental plans are not limited to following the Texas Medicaid fee schedules. There may be some differences in reimbursement based on decisions made by the individual health and dental plans.

Texas Medicaid reimburses carve-out services according to the appropriate reimbursement methodology defined in the applicable Texas Medicaid Provider Procedures Manual handbook and the applicable Texas Medicaid fee schedules, which are available on the TMHP website at www.tmhp.com.

2.6.1 Coinsurance and Deductible Payments for Dual-Eligible Clients

Crossover claims for payment for deductibles or coinsurance according to current payment guidelines are processed by TMHP and not the client’s MCO.

For clients who are enrolled in a Medicare Advantage Plan (MAP) and/or Special Needs Plan (SNP), crossover claims for coinsurance and deductible payments are processed by the MAP and/or SNP. These claims are not processed by TMHP.

2.6.2 Third Party Liability (TPL)

Referto: “Section 8: Third Party Liability (TPL)” (*Vol. 1, General Information*) for additional information.

2.6.3 Health Insurance Premium Payment Program

The HIPP Program reimburses for the cost of medical insurance premiums. A Medicaid client is eligible for the HIPP Program when Medicaid finds it more cost effective to reimburse a Medicaid client’s group health insurance premiums than to reimburse his or her medical bills directly through Medicaid.

Note: STAR Health program clients are not eligible to receive HIPP benefits and will continue to receive benefits through the STAR Health program.

Referto: Subsection 4.11, “Health Insurance Premium Payment (HIPP) Program” in “Section 4: Client Eligibility” (*Vol. 1, General Information*).

2.6.4 Providers With Unsatisfied Medicaid Accounts Receivables

TMHP notifies MCOs when a provider has an outstanding accounts receivable balance.

Providers who have an outstanding balance should contact the TMHP Contact Center to make repayment arrangements, even if they are no longer submitting fee-for-service claims.

If providers do not make repayment arrangements, the MCO in which they participate may withhold future payments from them.

2.7 Managed Care Plan Changes

The MCO or dental plan changes can be affected any of the following ways:

- Client initiated.
- Medical or dental plan initiated

2.7.1 Client-Initiated Plan Changes

Clients have the right to change plans. Clients must call the Enrollment Broker at 1-800-964-2777 to initiate a plan change. If a plan change request is received before the middle of the month, the plan change is effective on the first day of the following month. If the request is received after the middle of the month, the plan change will be effective on the first day of the second month following the request, as shown below.

Example	
Request received on or before	Mid-May
Change effective	June 1
Request received after	Mid-May
Change effective	July 1

Note: All plan change requests must be processed by the Enrollment Broker.

The STAR Health Program only has one plan choice available. As a result, clients cannot change plans, but may change PCPs within their assigned STAR Health MCO.

2.7.2 Plan Administrator-Initiated Changes

Each health plan and dental plan has a limited right to request that a client be disenrolled without the client’s consent. HHSC must approve any request for such disenrollment.

Health plans and dental plans may request that a client be disenrolled for the following reasons:

- The client loans his or her Your Texas Benefits Medicaid card to another person to obtain services.
- The client continually disregards the advice of his PCP or main dentist.
- The client repeatedly uses the ER inappropriately.
- Client is disruptive, unruly, threatening, or uncooperative to the extent that client’s membership seriously impairs MCO’s, dental plan’s, or provider’s ability to provide services to the client or to obtain new patients, and the client’s behavior is not caused by a physical or behavioral health condition.
- Client refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow MCO to treat the underlying medical condition).
- For STAR+PLUS MCOs, under limited conditions, the MCO may request disenrollment of members who are totally dependent on a ventilator or who have been diagnosed with End Stage Renal Disease.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the client’s behavior. Reasonable measures may include education or counseling conducted by health plan or dental plan staff. HHSC will notify the client in writing of the disenrollment if all attempts to remedy the situation have failed. HHSC will also notify the client in writing of the availability of appeal procedures and the HHSC fair hearing process.

Health plans, dental plans, and providers can not request a client's disenrollment because of an adverse change in the client's health or the utilization of services that are medically necessary for the treatment of a client's condition.

2.7.3 Managed Care Organization (MCO) Clients Who Transition to Medicaid Fee-For Service (FFS)

When clients transition from an MCO to FFS, providers can request that previously approved authorizations for Comprehensive Care Program (CCP) services, occupational therapy (OT), physical therapy (PT), private duty nursing (PDN), and speech therapy (ST) be transferred from the MCO to FFS.

2.7.3.1 Submission Guidelines

TMHP will consider the reimbursement of claims for services that were rendered on or after the MCO's disenrollment date only when the provider submits a request to TMHP to transfer the previously approved authorization for CCP services. The request to TMHP must be received on or before the end date of the previously approved MCO authorization. Any requests submitted after the MCO's authorization end date will have to meet the regular submission guidelines for the specific service type.

2.7.3.2 Documentation Requirements

All of the requests to transfer the authorizations from the MCO to FFS must include:

- A copy of the previously approved authorization letter.
- All of the documentation that was sent in the original authorization request, including any physician orders that were used to determine the start of care. TMHP will accept the physician orders as the required documentation for the requested services.
- The completed CCP prior authorization form, Special Medical Prior Authorization (SMPA) form, Home Health Plan of Care, or Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form, whichever is applicable for the requested service. The form must include the dates of service and quantities that are being requested from TMHP, which must match the dates of service and quantities that were approved in the original authorization.

Note: It is not necessary to obtain signatures or dates on the forms listed above when submitted to TMHP for the purpose of transferring an authorization from an MCO to FFS Medicaid.

Authorizations for services transferred from an MCO to FFS Medicaid are subject to retrospective review.

TMHP will verify the client's eligibility, the dates of service, and the quantities requested.

TMHP will process reimbursement claims as follows:

- Claims for services that were rendered before the date on which the transfer request was received will be denied as a late submission, and the provider will be notified of their administrative appeal rights through the Health and Human Services Commission (HHSC).
- Claims for services that were rendered on or after the date of receipt use the required information from the transferred authorization and will be processed as if the request was received in a timely manner.

If a request to transfer an MCO authorization is submitted after the end date of the MCO authorization, or the provider does not have an authorization letter from the MCO, TMHP will process the request to transfer the authorization based on established TMHP authorization submission guidelines for CCP services, PDN, OT, PT, and ST.

All new requests for rendered services must meet the documentation requirements.

2.7.3.3 New Services and Extension of Services

For new services that occur after the client's MCO disenrollment change date, the provider is responsible for submitting all TMHP required paperwork and meeting all established submission guidelines for prior authorization.

Requests for the extension of services that occur after the MCO disenrollment change date must include all of the paperwork that is required by TMHP and meet all established submission guidelines for prior authorization.

2.7.3.4 Loss of Eligibility

If an MCO disenrolled a client and the client also loses Medicaid eligibility, providers must anticipate, if and when Medicaid eligibility is restored, that the client will initially be considered a Medicaid FFS client and will have a retroactive eligibility period.

All requests for services that require prior authorization and that occur during the client's retroactive eligibility period, must be submitted to TMHP following the process that is outlined in subsection 5.1.1 *, "Prior Authorization Requests for Clients with Retroactive Eligibility" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*).

If a client is retroactively disenrolled by an MCO, all of the services that are rendered by the provider during this retroactive disenrollment period (specifically from the date on which the client was eligible for FFS to the date of the client's MCO eligibility change) will be denied by TMHP, and the provider will be notified of their administrative appeal rights.

TMHP may consider services for the MCO transition beginning on the date of the client's MCO eligibility change date and going forward. TMHP uses the MCO transition process for the submission of paperwork and the processing of provider requests.

2.8 Authorizations for Managed Care Services

Authorization requests for services administered by the client's MCO or dental plan must be submitted to the client's MCO or dental plan according to the guidelines specific to the plan under which the client is covered.

Health plan prior authorizations do not transfer with a client between plans. For payment to be considered when a client changes plans, providers must obtain prior authorization through the plan under which the client is covered for the date of service.

Dental prior authorizations may transfer from one dental plan to another.

Note: Authorizations and claims for SSI clients who are enrolled in the STAR Program are submitted to the client's MCO or dental plan.

2.9 Claims Filing for Managed Care Services

Claims for services administered by an MCO or dental plan must be submitted to the client's MCO or dental plan. Providers may submit the managed care claims either of the following ways:

- Submit directly to the appropriate MCO or dental plan using the methods established by the MCO or dental plan
- Submit electronically to TMHP for routing to the appropriate MCO or dental plan

Providers who submit claims directly to the MCO or dental plan must follow the guidelines established by the MCO or dental plan for claims submissions. Providers must contact the appropriate MCO or dental plan for information about filing electronic or paper claims directly to the MCO or dental plan.

Referto: The TMHP website at www.tmhp.com/Pages//Medicaid/Medicaid_Managed_Care.aspx for additional information, including MCO and dental plan contact information.

Providers also have the option to submit STAR, STAR+PLUS, STAR Health, and Children's Medicaid Dental Services claims to TMHP using TexMedConnect or the TMHP EDI Gateway. These claims are automatically routed to the appropriate MCO or dental plan based on the client's eligibility on file.

Note: *TMHP will not forward electronic claim submissions for pharmacy benefits, CHIP, or long term care services, and TMHP will not forward any managed care paper claim submissions. These submissions must be submitted directly to the MCO or dental plan that administers the client's Medicaid managed care benefits.*

To submit MCO and dental plan claims to TMHP for proper routing:

- Using TexMedConnect: Log in to the TMHP secure website and submit the claims to TMHP.
- Through EDI: Log in to the claims billing software and submit the claims through EDI to TMHP.

Note: *Each claim must contain services administered by a single entity, either all fee-for-service (including services for fee-for-service clients and carve-out services), all MCO services, or all dental plan services. Fee-for-service procedures and MCO procedures for the same client cannot be billed on the same claim. Each claim may be submitted individually or in a batch. Each batch may contain claims destined for a variety of plans including fee-for-service and managed care.*

Providers receive a message that indicates whether the claim was transmitted successfully or unsuccessfully. The provider can correct the submission and submit the claim until the transmission is successful.

Once the claims have been transmitted successfully, the portal will route each claim to the appropriate entity based on the client's eligibility on file. For MCO and dental plan claims, the provider will receive an electronic claim transmission report that indicates the claim was accepted or rejected by the MCO or dental plan:

- If the claim has been accepted, the provider will receive no more transmissions from TMHP. Notices for payment determinations and all payments will be sent to the provider by the MCO or dental plan according to their individual practices and procedures.
- If the claim has been rejected by the MCO or dental plan, the provider will receive an electronic claim status report, and will be able to correct the submission and submit the claim until the transmission is successful.

Important: *Providers must call the client's MCO or dental plan who processed the claim for information about the MCO's or dental plan's explanation of benefits (EOB), claims payment, claim rejection, how to correct a rejected claim, or any other questions about the MCO or dental plan claim guidelines and processes. TMHP does not have any information about the MCO's or dental plan's claims, benefits, or processes.*

Electronic claims submitted to TMHP require an NPI. If an electronic claim is submitted without an NPI, the claim will be denied. If a claim is submitted electronically with a TPI instead of the NPI, the claim will be denied.

For assistance with enrollment for filing eligible electronic claims to TMHP, providers can contact the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638.

Referto: “Section 3: TMHP Electronic Data Interchange (EDI)” (*Vol. 1, General Information*) for information on electronic claims submissions to TMHP.

Subsection 6.3.4, “National Drug Code (NDC)” in “Section 6: Claims Filing” (*Vol. 1, General Information*) for NDC requirements.

Reminder: *Claims for Medicaid managed care clients must be submitted to the MCO or dental plan in which the client is enrolled at the time of service (or date of admission for inpatient hospital claims). The MCO or dental plan, as a payor of last resort, does not determine payment based on the primary payor’s (i.e., TPR or other primary source of insurance) authorization of services or approval of hospital stays.*

Referto: “Section 8: Third Party Liability (TPL)” (*Vol. 1, General Information*) for additional information.

The TMHP Medicaid Managed Care web page at www.tmhp.com/Pages/Medicaid/Medicaid_Managed_Care.aspx for additional information.

2.9.1 Newborn Claims Filing for MCO Services

Newborns are automatically assigned to the MCO in which the mother is enrolled at the time of the newborn’s birth. The effective date of the newborn’s enrollment is the same as the newborn’s date of birth. Claims for services provided to newborns should be filed with the mother’s MCO. Health-care providers should file newborn claims using the newborn’s Medicaid identification number as soon as the number is made available. Providers filing claims for services provided to newborns are still responsible for meeting the Medicaid filing deadlines, which in most cases is within 95 days of each date of service.

MCOs must pay providers for inpatient and professional services related to neonatal care for up to 48 hours after vaginal delivery and 96 hours after Cesarean delivery. (Prior authorizations and PCP assignment cannot be a reason for denial of claims.)

MCOs may require prior authorizations for hospital and professional services beyond the 48-hour and 96-hour time limits.

Authorization requests, utilization review questions, and claim status inquiries and appeals should be directed to the MCO in which the client is enrolled.

Note: *Telephone numbers and addresses for MCO claims submission and appeals can be found in the appropriate MCO provider policies and procedures manual for the appropriate service area.*

2.9.2 Filing Deadlines

The following table summarizes the filing deadlines that apply for MCO and dental plan claim submissions:

Submission	Filing Deadline
Initial submission submitted to the correct plan	95 days from the DOS
Initial submission submitted to the wrong plan	95 days of the date on the Remittance and Status (R&S) Report from the other (wrong) carrier (documentation of timely filing is required)
Initial submission to TPR (not the Medicaid MCO or dental plan)	95 days from the date of disposition by the other insurance resource
Initial submission for newborns	Submit to the client’s or mother’s MCO within 95 days of the DOS

Claims must be submitted to the appropriate entity whether TMHP or the MCO or dental plan within 95 days of the date of service. If the claim is not received by the MCO or dental plan within 95 days, the claim will be denied.

If the provider files with the wrong plan within the 95 day submission requirement (e.g., State Claims Administrator but not with the MCO or dental plan), the provider must resubmit the claim with documentation that shows the claim was submitted within the appropriate time frame but to the wrong plan. The MCO or dental plan must honor the initial filing date and process the claim without denying the resubmission for the sole reason of passing the filing timeframe. The provider must file the claim with the correct MCO within 95 days of the date on the Remittance and Status (R&S) Report from the other (wrong) carrier.

When a service is billed to other insurance, the claim must be refiled and received by the Medicaid MCO or dental plan within 95 days from the date of disposition by the other insurance resource. The MCO or dental plan will determine, as a part of its provider claims filing requirements, the documentation required when a provider refiles these types of claims with the MCO or dental plan.

MCOs and dental plans are subject to the requirements related to coordination of benefits for secondary payers in the Texas Insurance Code section 843.349 (e) and (f).

Referto: Subsection 2.9, “Claims Filing for Managed Care Services” in this handbook for details about MCO claims processed by TMHP and not the client’s MCO.

2.9.3 System Requirements for MCO and Dental Plan Claim Submissions Through TMHP

Before a claim can be routed to the MCO or dental plan through TMHP’s electronic claims filing system, TMHP must certify that both the system the provider uses to submit the claim and the system the MCO or dental plan uses to receive the claim are compatible with the EDI 5010 standard.

Referto: Subsection 3.7, “Third Party Vendor Implementation” in “Section 3: TMHP Electronic Data Interchange (EDI)” (*Vol. 1, General Information*), for information about EDI 5010 compatibility and certification.

MCOs or dental plans must also complete trading partner testing with TMHP to certify EDI 5010 compatibility and verify that routed claims can be received. Providers that submit claims through TMHP to MCOs or dental plans that have not completed trading partner testing will receive a claim rejection.

If the system requirements are not met, providers must submit claims directly to the MCO or dental plan using the MCO’s or dental plan’s established methods for claims submission. Providers must contact the client’s MCO or dental plan with questions about the MCO’s or dental plan’s billing guidelines and methods.

Note: *Use of TMHP’s electronic claim submission system is optional. Providers may continue to submit claims directly to the appropriate MCO or dental plan. Regardless of submission method, adjudication and reimbursement for managed care services is the responsibility of the appropriate MCO or dental plan and not TMHP.*

2.10 MCO/Dental Plan Appeals, Complaints, and Fair Hearings

Providers can submit their appeals directly to the MCO or dental plan that administers the clients’ managed care benefits.

Claims that were originally submitted to TMHP for routing to the appropriate MCO or dental plan can be appealed to TMHP using TexMedConnect or EDI. The appeals will be routed to the appropriate entity for processing.

2.10.1 Medicaid Managed Care Complaints and Fair Hearings

Medicaid managed care providers may file complaints with HHSC if they find they did not receive full due process from the respective managed care health plan.

Appeals, grievances, or dispute resolution is the responsibility of each MCO or dental plan. Providers must exhaust the complaints or grievance process with their MCO or dental plan before filing a complaint with HHSC.

Referto: The respective MCO or dental plan for information about specific complaint policies and procedures.

The respective health plan’s policies and procedures for information about the MCO appeals and fair hearing process.

Subsection 7.1.5, “Paper Appeals” in “Section 7: Appeals” (*Vol. 1, General Information*) for information about paper appeals.

Once the MCO’s or dental plan’s complaints or grievance process has been exhausted, complaint requests may be sent to HHSC.

STAR, STAR+PLUS, STAR Health, and dental plan complaint requests may be emailed or mailed to HHSC:

- STAR, STAR+PLUS, and dental plan complaints may be emailed to HPM_Complaints@hhsc.state.tx.us.
- STAR Health complaints may be emailed to STAR.Health@hhsc.state.tx.us.
- STAR, STAR+PLUS, STAR Health, and dental plan complaints may be mailed to HHSC at the following address:

Health and Human Services Commission
 Health Plan Management
 4900 N. Lamar Blvd.
 MC H320
 Austin, TX 78751

3 STAR Program

The principal objectives of the STAR Program are to emphasize early intervention and to promote improved access to quality care thereby significantly improving health outcomes for the target populations. The special focus of the STAR Program is on prenatal and well-child care.

In the STAR Program, each MCO contracts with PCPs, hospitals, and other providers to create a health-care delivery network. Eligible clients whose enrollment in the STAR Program is mandatory are required to select a health plan and a PCP. The client selects the PCP from the MCO provider listing.

Referto: The TMHP website at www.tmhp.com/Pages/Medicaid/Medicaid_Managed_Care.aspx for a current list of STAR Program service areas.

3.1 STAR Program Clients

HHSC has targeted these client groups within the Texas Medicaid population for STAR Program enrollment:

Medicaid Base Plan	Medicaid Cat.	Medicaid Type Prog.	Description	SA Group 1	SA Group 2
10	01, 03,04	12	SSI Manually Certified-with Medicare living in a Title XIX facility (also Medicare skilled nursing care)	X	X
10	01, 03, 04	12	SSI Manually Certified without Medicare living in a Title XIX facility (also Medicare skilled nursing care)	X	C
10	01, 03, 04	13	SSI Recipient-with Medicare living in a Title XIX facility (also Medicare skilled nursing care)	X	X
10	01, 03, 04	13	SSI Recipient without Medicare living in a Title XIX facility (also Medicare skilled nursing care)	X	C
10	01, 03, 04	14	MAO and deemed SSI with Medicare in a Title XIX facility	X	X
10	01, 03, 04	14	MAO and deemed SSI without Medicare in a Title XIX facility	X	C
13	1	3	MAO RSDI Increases-with Medicare	X	X
13	1	3	MAO RSDI Increases without Medicare	X	M
13	1	12	SSI Manually Certified-with Medicare	X	X
13	1	12	SSI Manually Certified -without Medicare	X	M
13	1	13	SSI Recipient-with Medicare	X	X
13	1	13	SSI Recipient-without Medicare	X	M
13	1	14	MAO and SSI Clients in 1915 (c) waiver programs-with Medicare	X	X
13	1	14	MAO and SSI Clients in 1915(c) waiver programs - without Medicare	X	M
13	1	18	Disabled Adult / Children denied SSI due to increase in SS benefits-with Medicare	X	X
13	1	18	Disabled Adult/Children denied SSI due to increase in SS benefits - without Medicare	X	M

Medicaid Base Plan	Medicaid Cat.	Medicaid Type Prog.	Description	SA Group 1	SA Group 2
13	1	22	Early Age Widows/Widowers-with Medicare	X	X
13	1	22	Early Age Widows/Widowers without Medicare	X	M
13	1	51	Rider 51 MAO-with Medicare	X	X
13	1	51	Rider 51 MAO-without Medicare	X	M
13	03, 04	3	MAO RSDI Increases-no Medicare (21 and over)	X	M
13	03, 04	3	MAO RSDI Increases no Medicare (Under 21)	X	V
13	03, 04	3	MAO RSDI Increases-Medicare	X	X
13	03, 04	12	SSI Manually Certified-no Medicare Under 21	X	V
13	03, 04	12	SSI Manually Certified-no Medicare 21 and Over	X	M
13	03, 04	12	SSI Manually Certified-Medicare Under 21	X	X
13	03, 04	12	SSI Manually Certified-Medicare 21 and Over	X	X
13	03, 04	13	SSI Recipient-no Medicare - 21 and Over	X	M
13	03, 04	13	SSI Recipient-no Medicare - Under 21	X	V
13	03, 04	13	SSI Recipient-Medicare - 21 and Over	X	X
13	03, 04	13	SSI Recipient-Medicare - Under 21	X	X
13	03, 04	14	MAO and SSI Clients in 1915 (c) waiver programs-no Medicare (21 and Over)	X	M
13	03, 04	14	MAO & SSI Clients in 1915(c) waiver programs no Medicare (Under 21)	X	V
13	03, 04	14	MAO and SSI Clients in 1915 (c) waiver programs-Medicare	X	X
13	03, 04	18	Disabled Adult / Children denied SSI due to increase in SS benefits-No Medicare (21 and over)	X	M
13	03, 04	18	Disabled Adult/Children denied SSI due to increase in SS benefits - No Medicare (Under 21)	X	V

Medicaid Base Plan	Medicaid Cat.	Medicaid Type Prog.	Description	SA Group 1	SA Group 2
13	03, 04	18	Disabled Adult / Children denied SSI due to increase in SS benefits-Medicare	X	X
13	03, 04	19	Transitional SSI-no Medicare	X	V
13	03, 04	19	Transitional SSI-Medicare	X	X
13	03, 04	22	Early Age Widows/Widowers-No Medicare	X	M
13	03, 04	22	Early Age Widows/Widowers-Medicare	X	X
13	03, 04	51	Rider 51 MAO-No Medicare	X	M
13	03, 04	51	Rider 51 MAO-Medicare	X	X
32	2	9	Medical Assistance Only (MAO) Foster Care	X	X
	2	3	MAO RSDI increase	M	M
	2	20	04 months post Medicaid resulting from Child Support	M	M
	2	29	12 months transitional Medicaid following end of state time limited TANF	M	M
	2	37	12 months transitional Medicaid coverage resulting from loss of 90% earned income disregard	M	M
	2	40	Pregnant women	M	M
	2	43	Children under age 1 with income below 198% FPIL	M	M
	2	44	Children age 6-18 with income below 133%FPIL	M	M
	2	45	Children to age 1 born to Medicaid eligible mother	M	M
	2	47	Children ineligible for TANF, TANF-SP, or the age-appropriate medical program due to stepparent or grandparents' applied income, or stepparent's income when included in the case	M	M
	2	48	Children who are age 1-5 with income below 144% FPIL	M	M
	2	61	TANF State Program (TANF-SP)--two parent household eligible for money grant and Medicaid with income below TANF recognized needs	M	M

Medicaid Base Plan	Medicaid Cat.	Medicaid Type Prog.	Description	SA Group 1	SA Group 2
	2	1	Money Grant and Medicaid for caretakers and deprived children with income below TANF recognizable needs	M	M
	2	7	12 months transitional Medicaid resulting from increase in earnings or combined increase in earnings and child support	M	M
	03, 04	88	Medicaid Buy-in for Children with Disabilities No Medicare	X	V
	03, 04	88	Medicaid Buy-in for Children with Disabilities with Medicare	X	X
	1, 3, 4	87	Medicaid Buy-in for Adults No Medicare	X	M
	1, 3, 4	87	Medicaid Buy-in for Adults with Medicare	X	X
C = Conditional, V = Voluntary, M = Mandatory, X = Not Eligible Group 1 SAs- Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, Travis Group 2 SA - Medicaid Rural Service Area (Medicaid RSA)					

Health-care providers must verify eligibility before medical care is provided to STAR Program clients, except in cases of emergency. In situations where emergency care must be provided, the client’s MCO and PCP should be determined as soon as possible.

STAR MCOs provide their clients an MCO identification card. The MCO identification card and the Your Texas Benefits Medicaid card should be required when determining whether or not the client is a STAR Program client.

Referto: Subsection 4.2 *, “Eligibility Verification” in “Section 4: Client Eligibility” (*Vol. 1, General Information*).

3.2 STAR Client Enrollment

Eligible clients in a STAR service area choose an MCO and a PCP. To maximize enrollment, clients may enroll any of the following ways:

Method of Enrollment	Description
Telephone	<p>Clients may call 1-800-964-2777.</p> <p>A customer care representative will provide essential education about the program and details needed for enrollment.</p>
Mail	<p>Clients may complete the STAR Program enrollment form and send the form to the address on the postage-paid, self-addressed envelope provided with the form.</p> <p>Enrollment forms are mailed to all eligible mandatory clients along with a brochure explaining the program and provider listings for each health plan.</p>

Method of Enrollment	Description
Onsite	<p>Clients can meet with a STAR Program customer care representative at any of the following locations:</p> <ul style="list-style-type: none"> • Local HHSC offices • Women, Infants, and Children (WIC) classes • Community facilities • Enrollment events
Default	<p>Clients may be enrolled through an assignment process.</p> <p>If a client does not exercise the right to choose an MCO and PCP, the client will be assigned to a health plan and PCP. The following factors are considered when processing a default enrollment:</p> <ul style="list-style-type: none"> • Client’s past claims history, taking into account an established relationship with a participating PCP • Client’s age, sex, and geographic proximity to the PCP

STAR Example 1

Benefits under the STAR Program usually begin on the first day of the next month following the client’s selection of a managed care plan and PCP. The following example shows the managed care enrollment date for a client who selects a health plan and PCP before the designated cutoff date (approximately the 15th of the month):

Task	Date
Client certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Client selects health plan and PCP (before the 15th of the month)	January 1
Managed care benefits begin	February 1

STAR Example 2

The following example shows the managed care enrollment date for a client who selects a health plan and PCP after the designated cutoff date (approximately the 15th of the month):

Task	Date
Client certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Client selects health plan and PCP (after the 15th of the month)	January 20
Managed care benefits begin	March 1

3.2.1 Expedited Enrollment of Pregnant Women (Program Type 40)

A pregnant woman who applies for program type 40 has 16 days from the date of application to choose a STAR MCO. If she does not choose a STAR MCO, one will be chosen for her.

The Enrollment Broker contacts the client to begin the enrollment process and assists the client in selecting an MCO. The client may also contact the Enrollment Broker directly at 1-800-964-2777 (STAR Help Line). To protect continuity of care and client choice, the Enrollment Broker will work with each pregnant woman to select a health plan that includes her current prenatal care provider or to choose an obstetrical care provider that meets her needs.

Clients will be covered under Texas Medicaid fee-for-service until their Medicaid MCO coverage begins. To ensure proper billing, providers should call the Enrollment Broker at 1-800-964-2777 (STAR Help Line) to obtain the name of the client’s health plan. However, client eligibility should always be verified at the time the service is to be rendered.

Women certified as Medicaid program type 40 may be retroactively enrolled in STAR. Women who are certified as Medicaid program type 40 on or before the 10th of the month will be enrolled in STAR beginning the first of the month of certification. Those who are certified after the 10th of the month will be on Texas Medicaid fee-for-service the month of certification and will be enrolled in STAR beginning the first of the month following the month of certification.

There are two exceptions to this rule:

- Women who are certified at any time in their estimated month of delivery will be enrolled in STAR the first of the following month (prospective enrollment).
- Women who are certified at any time in their actual month of delivery (if known by HHSC before certification) will be enrolled in STAR the first of the following month (prospective enrollment).

Important: Providers must verify the client’s plan and PCP information.

The following examples show when benefits begin in relation to certification:

Example 1: Woman Certified in Her 6th Month	
Client certified for Texas Medicaid	August 1
Medicaid benefits begin	August 1
STAR Program benefits begin	August 1

Example 2: Woman Certified in Her 6th Month	
Client certified for Texas Medicaid	August 12
Medicaid benefits begin	August 1
STAR Program benefits begin	September 1

Example 3: Woman Certified in Her 9th Month	
Client certified for Texas Medicaid	August 5
Medicaid benefits begin	August 1
STAR Program benefits begin	September 1

Within 14 days of enrolling in an MCO, a plan representative will contact the new client to help arrange the first prenatal appointment. Providers should also expect contact from the health plans to facilitate prenatal appointments for new clients. Physicians and other prenatal care providers are encouraged to make prenatal appointments within two weeks.

Note: Expedited enrollments of pregnant women (program type 40) into the STAR Program may be retroactive.

3.2.2 Enrollment of Newborns

In the STAR Program, newborns are automatically assigned to the STAR MCO the mother is enrolled with at the time of the newborn’s birth for at least 90 days following the date of birth unless the mother requests a plan change as a special condition. The effective date of the newborn’s enrollment is the same as the newborn’s DOB. STAR MCOs are responsible for all covered services provided to newborn members.

There may be a delay of up to several months from the DOB for a newborn to receive a Medicaid client number. Providers should check with each STAR MCO for claim filing requirements for newborns who do not yet have a Medicaid client number.

Referto: Subsection 2.9.1, “Newborn Claims Filing for MCO Services” in this handbook.

STAR Example

Enrollments of newborns born to mothers enrolled in STAR are retroactive to the newborn’s date of birth. The following example shows the managed care enrollment date for a newborn:

Task	Date
Client’s date of birth (mother enrolled in STAR)	January 3
Client certified for Texas Medicaid	February 1
Medicaid benefits begin	January 3 (retroactive to DOB)
STAR enrollment begins (mother’s STAR plan at time of birth)	January 3 (retroactive to DOB)

3.2.3 Timely Notification and Assignment of Medicaid ID for Newborns

Hospitals that submit their birth certificate information utilizing the DSHS, Bureau of Vital Statistics (BVS) electronic Certificate Manager software and the Hospital Report (Newborn Child or Children) (Form 7484), receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers involved in newborn care including pharmacies providing outpatient prescription benefits for medically-needy newborns.

For more information or to comment on this process, call 1-512-458-7367.

Note: The enrollment of newborns that are born to mothers who are enrolled in an MCO on the date of birth are retroactive to the newborn’s date of birth (DOB).

3.3 STAR Program Benefits

STAR Program clients receive all the benefits of Texas Medicaid fee-for-service and the following additional benefits:

- Removal of the inpatient spell of illness limitation for adults
- Unlimited medically necessary prescription drugs for adults

3.3.1 Spell of Illness

STAR clients are not limited to the 30-day spell of illness. The spell of illness limitation is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days. All Medicaid clients who are 20 years of age and younger already are not limited to the 30-day spell of illness.

3.3.2 Prescriptions

STAR Program clients who are 21 years of age and older receive unlimited medically necessary prescription drugs. The elimination of the three prescription limit per month for adult clients enrolled in STAR allows the provider greater flexibility in treating and managing a client’s health-care needs. All Medicaid clients who are 20 years of age and younger already receive unlimited medically necessary prescription drugs.

3.3.3 National Drug Code

All STAR providers that submit professional or outpatient claims with physician-administered prescription drug procedure codes are required to use the associated NDC. Drug claims submitted with procedure codes in the “A” code series do not require an NDC. The NDC is only required on outpatient hospital claims and physician claims.

N4 can be entered before the NDC on claims. The NDC is an 11-digit number on the package or container from which the medication is administered.

Referto: Subsection 6.3.4, “National Drug Code (NDC)” in “Section 6: Claims Filing” (*Vol. 1, General Information*).

3.3.4 Behavioral Health Billing

Behavioral health claims for services rendered to STAR clients residing in ICF-IIDs or nursing facilities in the Dallas SA must be submitted to TMHP and processed through Medicaid FFS.

Note: Behavioral health claims for Dallas SA nursing facility residents who are dual eligible for Medicare and Medicaid must continue to be submitted to Medicare first. Medicaid will continue to reimburse providers for the appropriate cost-sharing liabilities.

4 STAR Kids Program

STAR Kids will deliver both basic medical services and long term services and supports (LTSS), such as personal care services (PCS) or private duty nursing (PDN). STAR Kids will also provide Medically Dependent Children’s Program (MDCP) services for eligible clients.

Referto: The STAR Kids website at <https://hhs.texas.gov/services/health/medicaid-and-chip/programs/star-kids>.

4.1 STAR Kids Client Enrollment

Participation in the STAR Kids program is required for Medicaid clients who are 20 years of age or younger and meet at least one of the following:

- Receive Supplemental Security Income (SSI).
- Receive SSI and Medicare.
- Receive services through the Medically Dependent Children Program (MDCP) waiver.
- Receive services through the Youth Empowerment Services (YES) waiver.
- Live in a community-based intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID) or nursing facility.
- Receive services through a Medicaid Buy-In program.
- Receive services through any of the following HHSC intellectual and developmental disability (IDD) waiver programs.
 - Community Living Assistance and Support Services (CLASS)
 - Deaf Blind with Multiple Disabilities (DBMD)
 - Home and Community-based Services (HCS)
 - Texas Home Living (TxHmL)

Clients enrolling in the STAR Kids program will choose a health plan, as well as a primary care physician or clinic who will provide basic medical services, like check-ups, and provide referrals to a specialist when needed.

5 STAR+PLUS Program

The STAR+PLUS Program is designed to improve access to care, provide care in the least restrictive setting, and provide more accountability and control on costs. The STAR+PLUS program integrates acute care and long-term care services and supports into a Medicaid managed care delivery system for SSI-eligible Medicaid clients.

In the STAR+PLUS Program, each MCO contracts with providers and delegated networks to create a health-care provider delivery network.

Referto: The TMHP website at www.tmhp.com/Pages/Medicaid/Medicaid_Managed_Care.aspx for a current list of STAR+PLUS Program service areas.

5.1 STAR+PLUS Program Clients

HHSC has targeted these client groups within the Texas Medicaid population for STAR+PLUS Program enrollment:

Program Type	Description
Enrollment for category 01, 03, 04 (SSI, aged, and blind and disabled clients), and the following program types are mandatory for STAR+PLUS:	
02	Medicaid Buy-In
03	Denied SSI clients who are Medicaid-eligible under Pickle provisions.
12	SSI client
13	SSI client
14	STAR+PLUS Waiver (SPW) clients only <i>Note: Clients in program type 14 who are not determined eligible for the Home and Community-Based Services (HCBS) STAR+PLUS Waiver (SPW) will be excluded from participation in STAR+PLUS.</i>
18	Disabled adult children who are denied SSI coverage due to increase in Social Security benefits
22	Clients who are denied SSI coverage and who receive widow/widower Social Security benefits
Enrollment for category 03 and 04 (SSI blind and disabled children), and the following program type may enroll in a STAR+PLUS MCO.	
19	Medicaid and community-based waiver program for children who are 20 years of age and younger

Clients who are eligible for Medicaid under the SSI Program and who reside in a STAR+PLUS service area can enroll in STAR+PLUS. Enrollment in STAR+PLUS is mandatory for clients who are 21 years of age and older and voluntary for clients who are 20 years of age and younger.

SSI clients who meet the following conditions are required to select a PCP from the MCO provider directory:

- Reside in one of the STAR+PLUS service area counties

- Have selected an MCO
- Are not covered by Medicare

SSI clients who are also covered by Medicare (i.e., dual-eligible clients) must select a STAR+PLUS MCO to receive Medicaid community based long term care services.

Clients enrolled in any of the following HHSC programs can enroll in STAR+PLUS for acute care benefits, unless the client is dual eligible for Medicaid and Medicare:

- Community-based Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)
- Community Living Assistance and Support Services (CLASS)
- Deaf Blind with Multiple Disabilities (DBMD)
- Home and Community-Based Services (HCS)
- Texas Home Living (TxHmL)

Note: Enrollment in STAR+PLUS is mandatory for clients who are 21 years of age and older and voluntary for clients who are 20 years of age and younger.

Exception: Clients who receive Medicare Part B in addition to Medicaid, will remain in FFS for all Medicaid services.

5.1.1 STAR+PLUS Program Dual-Eligible Clients

Many STAR+PLUS clients are eligible for Medicaid and Medicare. STAR+PLUS MCOs are not at risk for the delivery of acute care services needed by dual-eligible clients.

Most STAR+PLUS clients with Medicare and Medicaid are Medicaid Qualified Medicare Beneficiaries (MQMBs). MQMBs receive Medicare benefits through a Medicare risk product (MCO) or Medicare fee-for-service insurance program. To reduce confusion, HHSC has mandated that STAR+PLUS MQMBs continue to receive all their acute care services as they do today, with Medicare being the primary payor and Texas Medicaid fee-for-service, through TMHP, the secondary payor.

MQMB clients qualify for Medicaid benefits that are not covered by Medicare.

Providers are to continue billing for Medicare acute care services through the client’s Medicare MCO or fee-for-service insurer following the rules of the Medicare insurer. If the client is in both a Medicare MCO and a Medicaid MCO, the client uses the Medicare PCP, and providers follow the Medicare MCO’s medical management rules for authorization, concurrent review, etc. MQMBs choose a Medicaid MCO but do not choose a Medicaid PCP.

Referto: Subsection 4.10, “Medicare and Medicaid Dual Eligibility” in “Section 4: Client Eligibility” (*Vol. 1, General Information*) for more information and further MQMB instructions.

5.1.2 Clients Who Are Ineligible For The STAR+PLUS Program

Clients who meet the following criteria are not eligible to enroll in STAR+PLUS and will remain in Texas Medicaid fee-for-service:

- Residents in a State Supported Living Center
- Residents in an ICF-IID who are dual eligible in Medicare and Medicaid
- Residents of state hospitals or institutions for mental diseases
- Frail Elderly (or 1929B) Program clients
- In-Home and Family Support Program Services clients

- Qualified Medicare Beneficiaries (QMBs) that do not receive Medicaid benefits other than Medicare deductible or coinsurance liabilities according to current payment guidelines
- Undocumented aliens
- Clients who receive limited Medicaid benefits and do not qualify for participation in the VDP
- Clients who participate in one of the following Home and Community-Based Waiver programs (other than the Nursing Facility Waiver):
 - Medically Dependent Children’s Program (MDCP) Waiver Program
 - Intellectual or Developmental Disability (IDD) Waiver Program

5.2 STAR+PLUS Client Enrollment

Clients in a STAR+PLUS service area must choose an MCO and a PCP. To maximize enrollment, clients may enroll any of the following ways:

Method of Enrollment	Description
Telephone	<p>Clients may call 1-800-964-2777.</p> <p>A customer care representative will provide essential education about the program and details needed for enrollment.</p>
Mail	<p>Clients may complete the STAR+PLUS Program enrollment form and send the form to the address on the postage-paid, self-addressed envelope provided with the form.</p> <p>Enrollment forms are mailed to all eligible mandatory clients along with a brochure explaining the program and provider directories for each health plan.</p>
Onsite	<p>Clients can meet with a STAR+PLUS Program customer care representative at any of the following locations:</p> <ul style="list-style-type: none"> • Local HHSC offices • Women, Infants, and Children (WIC) classes • Community facilities • Enrollment events
Default	<p>Clients may be enrolled through an assignment process.</p> <p>If a client does not exercise the right to choose an MCO and PCP, the client will be assigned to a health plan and PCP. The following factors are considered when processing a default enrollment:</p> <ul style="list-style-type: none"> • Client’s past claims history, taking into account an established relationship with a participating PCP • Client’s age, sex, and geographic proximity to the PCP

Benefits under the STAR+PLUS Program usually begin on the first day of the next month following the client’s selection of a managed care plan and PCP.

STAR+PLUS Example 1

The following example shows the eligibility dates for a client who selects a health plan and PCP before the designated cutoff date (approximately the 15th of the month):

Task	Date
Client certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Client selects health plan and PCP (before the 15th of the month)	January 1
Managed care benefits begin	February 1

STAR+PLUS Example 2

The following example shows the eligibility dates for a client who selects a health plan and PCP after the designated cutoff date (approximately the 15th of the month):

Task	Date
Client certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Client selects health plan and PCP (before the 15th of the month)	January 20
Managed care benefits begin	March 1

5.2.1 Enrollment of Newborns

Children born to STAR+PLUS clients will be automatically enrolled with the STAR MCO in the service area operated by the same STAR+PLUS MCO if available. The effective date of the newborn’s enrollment is the same as the newborn’s date of birth. If the STAR+PLUS MCO does not also operate a STAR MCO in the service area, the newborn is placed into Texas Medicaid fee-for-service, and the mother is given the opportunity to choose a STAR MCO for the newborn.

***Reminder:** Hospitals that submit the newborn’s birth certificate information using the DSHS Bureau of Vital Statistics (BVS) electronic Certificate Manager software and the Hospital Report (Newborn Child or Children) (Form 7484), receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers involved in newborn care including pharmacies providing outpatient prescription benefits for medically-needy newborns.*

For more information or to comment on the process for expedited assignment of a newborn Medicaid identification number, providers can call 1-512-458-7367.

5.3 STAR+PLUS Program Benefits

STAR+PLUS Program clients receive all the benefits of Texas Medicaid fee-for-service and the following additional benefits:

- Unlimited medically necessary prescription drugs for adults who are not dual-eligible
- A service coordinator

***Referto:** Subsection 3.3.2, “Prescriptions” in this handbook for more information about prescription benefits.*

***Note:** Dual eligible adults continue to be limited to three prescriptions unless they have joined the Medicare MCO also offered by their STAR+PLUS MCO.*

5.3.1 Prescriptions

STAR+PLUS clients who are 21 years of age and older and do not receive Medicare receive unlimited medically necessary prescription drugs. The elimination of the three prescription limit per month for adult clients enrolled in STAR+PLUS allows the provider greater flexibility in treating and managing a client's health care needs. All Medicaid clients who are 20 years of age and younger already receive unlimited medically necessary prescription drugs.

5.3.2 Spell of Illness

The spell-of-illness limitation applies to clients in the STAR+PLUS Program.

A spell-of-illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

An individual may be discharged from and readmitted to a hospital several times, regardless of the admittance reasons, and still be considered to be in the same spell of illness if 60 days have not elapsed between discharge and readmission.

The spell-of-illness limitation does not apply in the following situations:

- A prior-approved solid organ transplant has an additional 30-day spell of illness, which begins on the date of the transplant.
- No spell-of-illness limitation exists for THSteps-eligible clients who are 20 years of age and younger when a medically necessary condition exists.
- The client is enrolled in the Medicaid managed care STAR program.

5.3.3 Service Coordination and Care Management

The MCO must furnish a service coordinator to all STAR+PLUS clients who request one, or when the MCO determines the need for a service coordinator through an assessment. A service coordinator is the person with primary responsibility for providing service coordination and care management to STAR+PLUS clients.

5.3.4 Behavioral Health Billing

Behavioral health claims for services rendered to STAR+PLUS clients residing in ICF-IIDs or nursing facilities in the Dallas SA must be submitted to TMHP and processed through Medicaid FFS.

Note: Behavioral health claims for Dallas SA nursing facility residents who are dual eligible for Medicare and Medicaid must continue to be submitted to Medicare first. Medicaid will continue to reimburse providers for the appropriate cost-sharing liabilities.

6 STAR Health Program

The STAR Health program ensures that children taken into state conservatorship are able to receive all services they need immediately upon entry into conservatorship.

HHSC has selected Superior HealthPlan Network as the MCO administrator for this program. Superior HealthPlan is responsible for assigning a PCP to clients when they are enrolled in the STAR Health Program. Foster care families are given the opportunity to change their PCP after this initial assignment.

6.1 STAR Health Program Clients

All Medicaid clients in foster care are placed in this program with the following exceptions:

- Children adjudicated and placed in a Texas Youth Commission (TYC) or Texas Juvenile Probation Commission (TJPC) facility

- Children from other states who are placed in Texas Children in Medicaid-paid facilities such as children in nursing homes, ICF-IIDs, or State-Supported Living Centers
- Children who are active SSI-related Medicaid clients
- Children who are in state conservatorship who are placed outside of Texas
- Children who are in adoption assistance

Clients who participate in the Medicaid for Transitioning Foster Care Youth (MTFCY) program and the Former Foster Care in Higher Education (FFCHE) program are eligible for the STAR Health program.

The following table shows the age ranges for clients who may be eligible for the STAR Health program:

Group Clients Belong to	Age Ranges
Client under DFPS conservatorship	DFPS can retain conservatorship through the month of the client’s 18th birthday. (Eligibility ends the month conservatorship ends.)
Clients who voluntarily continue in a foster care placement after DFPS conservatorship ends	18 through 21 years of age (Eligibility ends the month of their 22nd birthday.)
Clients who are participating in the MTFCY program	18 through 20 years of age (Eligibility ends the month of their 21st birthday.)
Clients who are participating in the FFCHE program	21 through 22 years of age (Eligibility ends the month of their 23rd birthday.)

STAR Health members can gain eligibility on any day of the month. To ensure the accurate confirmation of STAR Health eligibility, it is essential that all health-care providers verify eligibility by contacting the STAR Health MCO. The STAR Health MCO receives updated eligibility information on a daily basis, so it will have the most current eligibility information.

The Department of Family and Protective Services (DFPS) Form 2085 as well as the Your Texas Benefits Medicaid card may also be used to verify eligibility in the STAR Health Program.

Newborns born to a mother who is enrolled in the STAR Health program are automatically enrolled in STAR Health.

Newborns born to a mother who is enrolled in STAR Health through the Former Foster Care in Higher Education (FFCHE) Program are not eligible to be enrolled in STAR Health.

Newborns that are taken into State conservatorship while still in the hospital will be enrolled in STAR Health on the date the State takes conservatorship.

6.2 STAR Health Client Enrollment

Benefits under STAR Health begin when the client is placed in conservatorship.

STAR Health Example

Task	Date
Client placed in conservatorship	January 26
Client certified for Texas Medicaid	January 26
Medicaid benefits begin	January 26
STAR Health benefits begin	January 26

6.3 STAR Health Program Benefits

STAR Health Program clients receive all the benefits of traditional Texas Medicaid as well as service coordination to assist in making appointments and accessing services; and service management to assist with managing the health care of those with ongoing and serious medical needs.

Referto: “Appendix B: Vendor Drug Program” (*Vol. 1, General Information*) for information about outpatient prescription drugs.

Most Medicaid foster care claims are capitated services and must be submitted to Superior HealthPlan.

Referto: Section 8, “Carve-Out Services” in this handbook for the list of non-capitated services that may be reimbursed by TMHP.

All THSteps dental, medical, vision, and mental health providers should submit claims for services rendered to foster care clients to Superior HealthPlan’s dental, vision, and mental health contractors.

For general provider information, contact STAR Health at 1-866-439-2042.

For authorizations, contact:

Contractor	Contact Information
Physical Health authorizations:	1-800-218-7508 (Fax 1-800-690-7030)
Cenpatico Behavioral Health authorizations:	1-866-218-8263 (Fax 1-866-534-5958)
Total Vision Health Plan (TVHP) vision services authorizations:	1-800-642-9488 (Fax 1-252-451-2140)
DentaQuest authorization:	Prior authorization requests must be sent to the following address: DentaQuest 12121 North Corporate Parkway Mequon, WI 53092 Fax: (262) 241-7150 or 1-888-313-2883 Telephone: 1- 888-308-9345 (provider line).

Note: HIPP program clients who are enrolled in STAR HEALTH should be removed from the HIPP program and continue to receive their benefits under the STAR Health program.

Referto: Subsection 4.11, “Health Insurance Premium Payment (HIPP) Program” in “Section 4: Client Eligibility” (*Vol. 1, General Information*) for more information about outpatient prescription drugs that are provided by VDP contracted pharmacies.

“Appendix B: Vendor Drug Program” (*Vol. 1, General Information*) for information about VDP.

6.3.1 STAR Health Mental Health Rehabilitation Mental Health Claims Submissions

STAR Health providers must submit their mental health rehabilitation claims for Superior HealthPlan foster care clients to Cenpatico at the following address:

Cenpatico Claims
PO Box 6300
Farmington, MO 63640-3806

Providers should submit their electronic claims to one of the clearinghouses that are trading partners with Cenpatico. Information about these clearinghouses can be found on the Cenpatico website at www.cenpatico.com. Click **Providers**, click **Resources**, and then click **Electronic Transactions (EDI)**. Texas mental health providers can use the following:

Clearing House Trading Partner	Payer ID
Availity	68058
Emdeon	68053
Gateway EDI	68053
McKesson	68058
SSI	68053

For more information on the use of other clearinghouses, providers should call Cenpatico at 1-800-225-2573, extension 25525 or visit the Cenpatico website at www.cenpatico.com.

The following procedure codes and modifier combinations must be submitted to Cenpatico for mental health rehabilitation services:

Procedure Code	Modifier
G0177	
G0177	HK
H0034	
H0034	HK
H0034	HQ
H0034	HK and HQ
H0034	HA
H0034	HA and HR or UK
H0034	HA and HQ
H0034	HA and HQ and HR or UK
H2011	
H2011	HK
H2011	HA
H2014	
H2014	HQ
H2014	HA
H2014	HA and HR or UK
H2017	
H2017	HK
H2017	TD
H2017	HK and TD
H2017	HQ
H2017	HK and HQ
H2017	HQ and TD
H2017	HQ and HK and TD
H2017	ET

Procedure Code	Modifier
H2017	HK and ET

The services listed above may be reimbursed when rendered to clients who satisfy the criteria of the mental health priority population and who are determined to need mental health rehabilitation. These services may be provided to a person with a single severe mental disorder (excluding IDD or substance use disorder) or a combination of severe mental disorders as defined in the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* (DSM).

7 Children’s Medicaid Dental Services

7.1 Overview

The principal objectives of children’s Medicaid managed care dental services are to provide quality, comprehensive dental services in a manner that improves oral health of clients through preventative care, health education, and early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for the target populations.

7.2 Children’s Medicaid Dental Services Model

Clients primary and preventive Medicaid dental services are provided statewide through Medicaid managed care dental plans. Each Medicaid managed care dental plan is responsible for contracting with general dentists, pediatric dentists, and dental specialists to create a delivery network. Clients who receive their dental services through a Medicaid managed care dental plan are required to select a dental plan and a Main Dentist (or Main Dental Home provider or Dental Home). The client selects the Main Dentist from a provider directory.

A Main Dentist means a provider who has agreed with a Dental Contractor to provide a Dental Home to Members and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as Main Dental Home Providers are general dentist and pediatric dentist.

The First Dental Home Initiative is included in this model.

Referto: Subsection 4.2.8, “First Dental Home” in the *Children’s Services Handbook (Vol. 2, Provider Handbooks)*.

Services provided through children’s Medicaid dental plans are separate from the medical services provided by the STAR, STAR+PLUS, and STAR Health managed care organizations.

7.3 Client Eligibility

Most children who are 20 years of age and younger will receive their dental services through Medicaid managed care dental plan.

Populations that will not receive services through the children’s Medicaid managed care dental plans are:

- Medicaid recipients who are 21 years of age or older.
- Recipients who reside in an institution, i.e. nursing homes, state supported living centers, or ICF-IID.
- Recipients in the STAR Health Program (Managed Care Foster Care Program)

7.4 Client Enrollment

Clients choose a dental plan and Main Dentist. To maximize enrollment, the children’s Medicaid dental services offer four alternative ways that clients can enroll:

- Telephone Enrollment. A client can enroll in a dental plan by calling 1-800-964-2777 (telecommunications device for the deaf (TDD): 1-800-267-5008) A customer care representative will provide essential education about the program and details needed for enrollment.
- Mail-in Enrollment. If calling is not convenient, a client may enroll by completing the an enrollment form and dropping it in the mail using the postage-paid, self-addressed envelope. Enrollment forms are mailed to all eligible mandatory clients along with information explaining the services and how to choose a Main Dentist.
- Onsite Enrollment. In addition to telephone and mail-in enrollment, clients can enroll by talking with customer care representative at a local HHSC office, at Women, Infants, and Children (WIC) classes, community facilities, or during enrollment events.
- Default Enrollment. The final method of enrollment is through an assignment process. If a client does not exercise the right to choose a dental and Main Dentist, the client will be assigned to a dental plan. After the default assignment is made, the dental plan will assign the client a Main Dentist.

7.5 Children’s Medicaid Dental Plan Choices

Children’s Medicaid dental services benefits are administered by two dental managed care organizations (i.e., dental plans) across the state of Texas.

Medicaid Managed Care Dental Plan	Dental Plan Provider Services
DentaQuest	1-800-685-9971
MCNA Dental	1-855-776-6262

7.6 Authorizations for Children’s Medicaid Managed Care Dental Services (Non-orthodontia Services)

Authorization requests for services administered by the client’s dental plan must be submitted to the client’s dental plan according to the guidelines specific to the plan under which the client is covered.

If a member is new to a dental plan and has an open authorization for covered dental services from TMHP or another HHSC-contracted Medicaid managed care dental plan, the dental plan must accept that authorization and cannot require additional authorization or review.

TMHP authorizes and processes dental and emergent orthodontic services for clients who are 20 years of age and younger but have not yet enrolled in a dental plan.

TMHP also authorizes services for the following clients:

- Dental services for Medicaid clients who are 21 years of age and older
- Dental and orthodontia services for all Medicaid clients, regardless of age, who reside in Medicaid-paid facilities such as nursing homes, state-supported living centers, or ICF-IIDs

Exception: *STAR Health Foster Care Program clients receive dental and orthodontic services through DentaQuest.*

7.7 Children’s Medicaid Dental Orthodontia Services

The Medicaid managed care dental plans will be responsible for prior authorizing, processing, and reimbursing any orthodontic services rendered to Texas Medicaid fee-for-service and managed care clients. Claims for orthodontic services that were initially authorized by TMHP but later transitioned to a managed care dental plan will be processed and reimbursed by the dental plan. Providers should check client eligibility to identify the managed care dental plan in which the client is enrolled.

TMHP will continue to process claims and claims adjustments for:

- Orthodontia services with dates of service on or before February 29, 2012.
- Clients who had orthodontia services that were prior authorized by TMHP and who lost Medicaid eligibility before March 1, 2012.
- Orthodontia services claims for clients who are ICF-IID residents.

8 Carve-Out Services

Some services are “carved out” of one or more of the managed care programs. Carved out services are those that are rendered to Medicaid managed care clients, but are processed for payment consideration by TMHP and not an MCO or dental plan.

The following table shows the services that are partially or completely carved out of the MCO and dental plan managed care program as well as services that are no longer carved out as of March 1, 2012:

Carve Out	STAR	STAR Kids	STAR+PLUS	STAR Health
Nutritional products through WIC	TMHP	TMHP	TMHP	TMHP
DSHS MH rehabilitation	MCO	MCO	MCO	MCO
DSHS MH rehabilitation (w/ Modifier HZ)	TMHP	TMHP	TMHP	MCO
County Indigent Health Care Program (CIHCP)	TMHP	TMHP	TMHP	TMHP
Early Childhood Intervention (ECI) case management	TMHP	TMHP	TMHP	TMHP
ECI specialized skills training	TMHP	TMHP	TMHP	TMHP
Family planning services for Dell Children’s managed care health plan	TMHP	N/A	N/A	N/A
SHARS	TMHP	TMHP	TMHP	TMHP
Elevated lead investigation services	TMHP	TMHP	TMHP	TMHP
DSHS TB providers	TMHP	TMHP	TMHP	TMHP
DSHS targeted case management	MCO	MCO	MCO	MCO
DSHS targeted case management (w/ Modifier HZ)	TMHP	TMHP	TMHP	TMHP
HHSC Blind Children’s Vocational Discovery and Development Program	TMHP	TMHP	TMHP	TMHP
Case Management for Children and Pregnant Women	TMHP	TMHP	TMHP	TMHP
* CFC services are carved out for STAR Kids clients who receive services through CLASS, DBMD, HCS, or TxHML.				

Carve Out	STAR	STAR Kids	STAR+PLUS	STAR Health
Community First Choice (CFC) services*	TMHP	MCO	MCO	MCO
Personal Care Services (PCS)	TMHP	MCO	MCO	MCO
Youth Empowerment Services (YES) Waiver	TMHP	TMHP	TMHP	TMHP
* CFC services are carved out for STAR Kids clients who receive services through CLASS, DBMD, HCS, or TxHmL.				

Dental Carve Out	Children’s Medicaid Dental	STAR Health
THSteps Dental	Dental plan	MCO
Orthodontia for most clients who are 20 years of age and younger	Dental plan	MCO
Orthodontia for clients who turned 21 years of age before March 1, 2012, and whose services were authorized by TMHP before March 1, 2012	TMHP	TMHP
ICF-IID Dental Services	TMHP	TMHP

Note: Authorizations and claims for SSI clients who are enrolled in the STAR Program are submitted to the client’s MCO or dental plan.

Authorization requests for services that are carved out of the managed care program must be submitted to TMHP according to the fee-for-service guidelines that are established for the same service.

Claims filing for services that are carved out of the managed care program must be submitted to TMHP according to the fee-for-service guidelines that are established for the same service.

Providers should refer to the appropriate *Texas Medicaid Provider Procedures Manual* handbook for the applicable authorization request and claims filing guidelines.

8.1 Family Planning Carve-Out Services

Some family planning services are carved-out services for Texas Medicaid clients whose managed care benefits are administered through Dell Children’s Health Plan. These carved out services may be considered for payment by Texas Medicaid through TMHP if the service has been denied by the health plan as a family planning service.

All Dell Children’s Medicaid providers should submit family planning claims using the CMS-1500 paper claim form, or electronic equivalent, to the client’s managed care health plan in order to receive the health plan’s denial.

Important: Services that are denied by the health plan for any other reason will not be considered for reimbursement by Texas Medicaid.

8.1.1 Professional and Outpatient Claims

For affected claims to be eligible for reimbursement through TMHP, providers must do the following:

- 1) Submit the claim to the client’s managed care health plan in order to receive the health plan’s denial. Claims that are submitted electronically using TexMedConnect will automatically be forwarded to the client’s Medicaid managed care plan.
- 2) Submit a paper claim to TMHP upon receipt of the health plan’s denial. All applicable documentation must be included with the paper claim, including, but not limited to:

- The health plan's EOB document that indicates the denial code with its description and the date the EOB was issued. The denial must indicate that the service was denied because it was a family planning service. The EOB date will be used to calculate the filing deadline for the claim submission.
- All documentation for family planning services including Sterilization Consent Forms and Hysterectomy Acknowledgements Forms, and any other documentation that is required by Texas Medicaid.

Note: *A paper claim is required because TMHP automatically forwards electronic claims to the client's health plan without processing. Providers must comply with all filing deadlines unless otherwise specified below in this article.*

Referto: *The Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks) for Texas Medicaid guidelines for family planning services.*

8.1.1.1 Claim Forms for Submission to TMHP

After receiving the health plan's denial, Medicaid family planning services providers should submit paper claim forms to TMHP as follows:

- Providers that contract with the HHSC Family Planning Program should submit claims on a 2017 paper claim form along with the health plan's denial.
- Providers that do not contract with the HHSC Family Planning Program should submit claims on a CMS-1500 paper claim form along with the health plan's denial.

Providers should submit the health plan's EOB document that indicates the denial code with its description and the date that the EOB was issued. The denial must indicate that the service was denied because it was a family planning service. The EOB date will be used to calculate the filing deadline for the claim submission.

Providers must comply with all filing deadlines.

The initial paper claim will be denied by TMHP. TMHP will automatically reprocess for payment consideration any claim that has been denied only with EOB 00081, "Services billed to TMHP in error. Bill HMO."

TMHP will reprocess only those claims that were denied with EOB 00081 as the only EOB message on the claim. If a claim has been denied with other EOB messages in addition to EOB 00081, the provider must resolve the other reasons for denial through the standard appeals process before TMHP can reprocess the claim for payment of the carved-out services.

8.1.2 Inpatient Claims

For affected claims to be eligible for reimbursement through TMHP, providers must do the following:

- 1) Submit the claim to the client's managed care health plan in order to receive the health plan's denial. Claims that are submitted electronically using TexMedConnect will automatically be forwarded to the client's Medicaid managed care plan.
- 2) Submit a paper claim to HHSC Administrative Appeals upon receipt of the health plan's denial. All applicable documentation must be included with the paper claim, including, but not limited to:
 - The health plan's EOB document that indicates the denial code with its description and the date the EOB was issued. The denial must indicate that the service was denied because it was a family planning service. The EOB date will be used to calculate the filing deadline for the claim submission.
 - All documentation for family planning services including Sterilization Consent Forms and Hysterectomy Acknowledgements Forms, and any other documentation that is required by Texas Medicaid.

HHSC Administrative Appeals will send the family planning services inpatient claims to TMHP for reprocessing. Medical portions of the claims will be denied by Texas Medicaid because they are covered under the client's health plan and will not be considered for reimbursement through TMHP. The services that were denied by the health plan as family planning services will be considered for payment according to Medicaid guidelines.

Referto: The *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)* for Texas Medicaid guidelines for family planning services.

“Section 7: Appeals” (*Vol. 1, General Information*) for additional information about administrative appeals.

8.1.3 Provider Working With Clients Enrolled in the Christus Health Plan

Christus Health Plan is entirely owned by a Catholic health system and is bound by the Ethical and Religious Directives for Catholic Health Care Services and will not directly or indirectly provide, arrange, or pay for the following family planning carve-out services:

- Family planning annual exams, outpatient visits, and laboratory and radiology services
- Contraceptive devices and related procedures
- Contraceptive drugs, supplies, and counseling (unless prescribed for purposes other than family planning)
- Sterilization and related procedures
- Abortions

The above carve-out services may be covered through Medicaid when provided by family planning providers that are not contracted through Christus Health Plan. Providers should submit their claims for these carve-out services to Christus Health Plan. The claims are then routed to HealthSmart for processing of the family planning carve-out services.

Referto: The *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)* for family planning services.

9 PCCM and Managed Care Claims Processed by TMHP Before March 1, 2012

On or after March 1, 2012, TMHP will continue to process all transactions for PCCM and managed care claims that were submitted to TMHP before March 1, 2012.

9.1 PCCM Appeals

The following types of managed care claims must be appealed to TMHP and not the MCO or dental plan:

- Services that were carved-out before March 1, 2012
- Other managed care exceptions that were processed by TMHP before March 1, 2012

Providers can find benefit, limitation, and claims filing information in the appropriate Texas Medicaid Provider Procedures Manual or Texas Medicaid website article for the dates of service on the claim.

9.2 PCCM Cost and Reporting

Providers who rendered services to Texas Medicaid PCCM clients on or before February 29, 2012, must continue to prepare one copy of the applicable CMS Cost Report Form along with the required PCCM supplemental worksheets. The PCCM supplemental worksheets include the Inpatient PCCM D-4 worksheet, available from CMS, and the Outpatient PCCM D, Part V worksheet. A sample of the Outpatient PCCM D, Part V is available on the TMHP website at www.tmhp.com.

Hospitals must include inpatient and outpatient costs in the cost reports submitted annually.

Referto: Subsection 2.2.2, “Cost Reimbursement” in “Section 2: Texas Medicaid Fee-for-Service Reimbursement” (*Vol. 1, General Information*).

Subsection 3.7.4, “Provider Cost and Reporting” in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about cost reporting.

9.2.1 PCCM Outpatient Services Cost Reporting

PCCM Outpatient Services are subject to cost report settlements. PCCM outpatient services providers are not required to submit any additional forms or reports, because HHSC has required providers to submit the necessary PCCM supplemental worksheets along with the CMS form number CMS-2552-96, “Cost Report for Electronic Filing of Hospitals,” for hospital cost reports that end on or after October 1, 2007. The PCCM supplemental worksheets include the Inpatient PCCM D-4 worksheet and the Outpatient PCCM D, Part V worksheet.

The interim cost report settlement process will be completed within six months of the date on which the TMHP Medicaid Audit Department receives the workable cost report. The cost settlement is determined by comparing the total Medicaid-allowable costs to the provider’s interim payments for PCCM outpatient hospital services that were delivered during the reporting period. HHSC will then issue a notice of settlement that specifies the amount due to or from the PCCM outpatient hospital.

10 Other State Health-Care Programs

The services available under the following programs are administered by TMHP or other state programs and not by the client’s MCO or dental plan:

- Healthy Texas Women (HTW) program - HHSC/TMHP
- HHSC Family Planning Program contracted services - HHSC/TMHP
- Medicaid Breast and Cervical Cancer (MBCC) - HHSC
- Medicaid Medical Transportation Program (MTP)
- CHIP Perinatal Program - The CHIP Perinatal Program provides prenatal care to the unborn children of pregnant women up to 200 percent of the federal poverty level who are not eligible for other Medicaid programs or traditional CHIP. The professional services are administered by the health plan, and some inpatient services are administered by TMHP.

Referto: Subsection •, “Children’s Health Insurance Program (CHIP) Perinatal Claims” in “Section 6: Claims Filing” (*Vol. 1, General Information*).

Claims and authorization requests for the services listed above must be submitted according to the established guidelines.

11 Contact Information

The following information can be used to communicate with TMHP:

Correspondence	Contact Information
All correspondence for services rendered to clients who are enrolled with a Texas Medicaid health/dental plan	Contact the client’s health/dental plan.
Claims, authorizations, and other TMHP correspondence for transactions that are processed by TMHP.	Volume 1, “Written Communication With TMHP,” for the list of post office box addresses that must be used for specific items.
HHSC contact information for STAR+PLUS, STAR, STAR Health, Children’s Medicaid dental services, and PCCM	1-800-252-8263
Questions about PCCM claims and appeals after March 1, 2012	1-800-925-9126