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

Refer to: The Medicaid and CHIP Programs page of the HHS website at hhs.texas.gov.

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 and dental maintenance organizations (DMOs) that are contracted by HHSC to provide services for Medicaid managed care clients. The Medicaid managed care MCOs and DMOs provide most of the same benefits that Texas Medicaid provides for Medicaid fee-for-service clients. Some plans may also offer value-added services.

Refer to: Subsection 8, "Carve-Out Services" in this handbook.

The principal objectives of Medicaid managed care are early intervention and improved access to quality care, which significantly improve health outcomes for clients, with a special focus on prenatal and well-child care.

In Medicaid managed care, clients assume responsibility for their personal health care by choosing a health plan and primary care provider and by making use of preventive primary care services. Eligible clients may also choose a DMO 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.

Medicaid managed care uses MCOs to cover services in 13 service areas (SAs).

Medicaid managed care consists of the following programs:

- The STAR program uses MCOs to cover acute care services for children, newborns, pregnant women, and some families. STAR is available statewide, and clients have the choice of at least two STAR MCOs in each SA. The STAR program operates under a federal 1115 waiver.
- The STAR Kids program uses MCOs to cover integrated acute care and long-term services and supports (LTSS) for children and adults who are 20 years of age or younger and have a disability. STAR Kids is available statewide, and clients have the choice of at least two STAR Kids MCOs in each SA. The STAR Kids program operates under a federal 1115 waiver.
- The STAR+PLUS program uses MCOs to cover integrated acute care and LTSS for adults who are 65 years of age or older (including those who are dually eligible for Medicare and Medicaid) and adults who are 21 years of age or older and have a disability. STAR+PLUS also serves those who are

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eligible for Medicaid for Breast and Cervical Cancer (MBCC). The STAR+PLUS program is available statewide, and clients have the choice of at least two STAR+PLUS MCOs in each SA. The STAR+PLUS program operates under a federal 1115 waiver.

- The STAR Health program uses one MCO to deliver health-care and dental services to children who are in foster care throughout the state. STAR Health is administered by Superior HealthPlan and operates under federal 1915(a) authority. The STAR Health program manages the health and dental care of most children in foster care.
- Children's Medicaid dental services are administered by DMOs that process dental authorization requests and claims for most Medicaid fee-for-service and Medicaid managed care clients who are 20 years of age or younger regardless of their medical benefit plan.

Refer to: Section 7, "Children's Medicaid Dental Services" in this handbook for exceptions and additional information.

The Medicaid Managed Care page of the Provider section of the TMHP website at www.tmhp.com for a current list of managed care service areas.

2.1 Managed Care Services

MCOs and DMOs administer most of the services that are rendered to Medicaid managed care clients, including, but not limited to:

- 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 or younger.
- Orthodontia services.
- Services rendered to Medicaid managed care SSI clients.
- Value-added services that an individual MCO or DMO elects to provide.

Administrative procedures, such as prior authorization, precertification, referrals, and claims/encounter data filing may differ from traditional Medicaid (fee-for-service) and from MCO to MCO. Providers should contact the client's specific MCO for details.

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.

Refer to: Section 8, "Carve-Out Services" in this handbook.

2.1.2 Prescription Drug/Pharmacy Services

The client's MCO administers and pays for pharmacy services.

Pharmacy providers must first be enrolled by the Medicaid or Children's Health Insurance Program (CHIP) Vendor Drug Program before they can enroll with an MCO.

Refer to: Subsection 2.2, "Provider Enrollment and Responsibilities" in this handbook.

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

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Refer to: The MCO that administers the client's Medicaid managed care benefits for information about prescription drug and pharmacy benefits.

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

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

The MCOs must:

- 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.
- Provide e-prescribing abilities to:
  - Verify client eligibility.
  - Review medication history.
  - Review formulary and PDL information.
- Process correct pharmacy claims that are 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 of 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 butit 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.

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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 or 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.

Refer to: 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.

2.1.3 Service and Care Coordination

Texas Medicaid has different types of service and care coordination. Clients who are enrolled in Medicaid may receive service or care coordination from MCOs or providers.

2.1.3.1 Service Coordination in STAR Kids and STAR+PLUS

In STAR Kids and STAR+PLUS, service coordination is specialized care management. Service coordination is provided by STAR Kids and STAR+PLUS MCOs and is available to all clients.

MCO service coordinators:

- Identify physical health, mental health, and LTSS needs and develop a service plan.
- Help clients get timely access to providers and covered services.
- Coordinate covered services with non-managed care programs, such as FFS waivers.

2.1.3.2 Service Coordination in STAR and CHIP

In STAR, service coordination is an administrative service that is provided by STAR and CHIP MCOs. Service coordination is available to STAR and CHIP clients who have special health care needs.

MCO service coordinators:

- Work with clients to develop a service plan and coordinate services with the client's primary care provider, specialty providers, and non-medical providers.
- Help clients get access to and use appropriately medically necessary covered services, services with non-managed care programs, such as FFS waivers, and other services and supports.

2.1.3.3 STAR Health Service Coordination and Service Management

In STAR Health, service coordination and service management have distinct functions that are different from the other managed care programs.

STAR Health defines service coordination and service management as follows:

- Service coordination is an administrative service that helps caregivers manage information, such as medical information for court hearings, and coordinate services with non-managed care programs, such as FFS waivers. Service coordination is available to STAR Health clients who have a medical or behavioral need or as requested.

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- Service management is a clinical service that is provided to clients who have a complex medical or behavioral need. Service management helps the client implement a service plan, and it coordinates services between the client's primary care provider and specialty care providers to ensure that the client has access to and appropriately uses medically necessary covered services. Service management may also be requested.

2.1.3.4 Provider Administered Care Coordination

Several types of care coordination are administered at the provider level. These services do not duplicate the service coordination or service management provided by MCOs.

Care coordination services include targeted case management for:

- Early Childhood Intervention (ECI).
- Individuals with intellectual or developmental disabilities.
- Clients who have a mental illness.
- Children and pregnant women.
- Community Living Assistance and Support Services (CLASS) and Deaf Blind with Multiple Disabilities (DBMD).
- Home- and Community-Based Services (HCBS)-Adult Mental Health (AMH) recovery management.

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.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

Subsection 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

2.2.1 Enrollment, Contracting, and Credentialing

Providers must be enrolled in Texas Medicaid before they can be enrolled by an MCO or DMO. Individual MCOs and DMOs have their own guidelines for contracting providers.

All Medicaid MCOs must use the Texas Association of Health Plans' (TAHP's) contracted credentialing verification organization (CVO) as part of its credentialing and recredentialing process regardless of membership in the TAHP.

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

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Providers must refer all questions about enrollment to the MCO or DMO that administers the clients' managed care benefits. TMHP does not have access to the enrollment requirements for the individual MCOs and DMOs.

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 enroll in Medicaid MCOs and DMOs.*

Refer to: Section 8, "Carve-Out Services" in this handbook for a list of services that are carved out of the Medicaid Managed Care program.

Subsection 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

2.2.2 Online Provider Lookup (OPL)

Clients can search for providers using a particular county, SA, or name to find providers who participate in a managed care area. Providers that participate in MCOs and DMOs are responsible for declaring themselves as managed care providers on the OPL. Clients can search for providers that are enrolled in Medicaid managed care on the OPL. The OPL has links to the websites of the MCOs and DMOs, which allows clients to search each MCO's and DMO'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 DMO 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 DMOs will also be terminated.

To reactivate an NPI that has been terminated, the provider must complete the Texas Medicaid Provider Re-enrollment Application.

2.2.4 Excluded Entities and Providers

Title 42 Code of Federal Regulations (CFR) §1003.400(a)(2) states that civil monetary penalties may be imposed against MCOs 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 MCO for any items or services directed or prescribed by an excluded physician or other authorized person if the MCO 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 DMOs 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.

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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 DMO over another.
- Providers must inform clients of all Medicaid managed care health plans and DMOs 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 DMOs 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 client'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 DMO as long as they do not indicate anything more than "(health plan or DMO) is accepted or welcomed here" (provided the sticker meets Medicaid/CHIP Marketing Guide- lines regarding size limitations).
- Providers may display state-approved, health-related marketing materials in their offices, provided it is done equally for all MCOs and DMOs in which they participate. MCO and DMO providers cannot give out or display plan-specific marketing items or giveaways to clients.

Important: ***[Revised]*** *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 Texas Provider Marketing Guidelines document on the HHS website.*

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 primary care provider or a DMO and main dentist or both. The managed care enrollment date is generally separate from the Medicaid eligibility date. In most cases, Medicaid managed care enrollment is not retroactive.

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Refer to: Section 3, "STAR Program" in this handbook.

Section 4, "STAR Kids Program" in this handbook.

Section 5, "STAR+PLUS Program" in this handbook.

Section 6, "STAR Health Program" in this handbook.

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 DMO for managed care services).

If a client loses Medicaid eligibility and then regains eligibility within a certain amount of time, the client is automatically reassigned to the same health plan and primary care provider or DMO that the client had before the client lost Medicaid eligibility.

Refer to: Subsection 2.4, "Primary Care Provider/Main Dentist Guidelines for Medicaid Managed Care Clients" in this handbook.

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

2.3.1 Client Enrollment in Managed Care Programs

Each MCO contracts with primary care providers, hospitals, and other providers to create a healthcare delivery network. Medicaid clients who are eligible for STAR, STAR Kids, or STAR+PLUS choose an MCO and a primary care provider, those eligible for STAR Health choose only a primary care provider, and those eligible for Children's Medicaid Dental Services choose a DMO and a main dentist.

To maximize enrollment, clients may enroll in Medicaid managed care in any of the following ways:

Method of Enrollment	Description
Telephone	STAR, STAR Health, STAR+PLUS, Children's Medicaid Dental Services: 800-964-2777 STAR Kids Helpline: 877-782-6440 (TTY 711 or 800-735-2989) Telecommunications device for the deaf (TDD): 800-267-5008 The Help Line (enrollment broker) is available 8 a.m. to 6 p.m., Central Time, Monday through Friday. A customer care representative will provide essential education about the program and details needed for enrollment.
Mail	Clients can enroll by completing an enrollment form and sending the form to the address on the postage-paid, self-addressed envelope provided with the form. Enrollment forms are mailed to all eligible mandatory clients along with a brochure explaining the program and provider listings for each health plan.
Onsite	Clients can meet with a Medicaid customer care representative at any of the following locations: • Local HHSC offices • Women, Infants, and Children (WIC) classes • Community facilities • Enrollment events

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Method of Enrollment	Description
Default	Clients may be enrolled through an assignment process. If a client does not exercise the right to choose an MCO and primary care provider, the client will be assigned to a health plan and primary care provider. The following factors are considered when processing a default enrollment: • Client's past claims history, taking into account an established relationship with a participating primary care provider • Client's age, sex, and geographic proximity to the primary care provider If a client does not exercise the right to choose a DMO and main dentist, the client will be assigned to a DMO. After the default assignment is made, the DMO will assign the client a Main Dentist.

2.3.1.1 Managed Care Enrollment Timeline

Example 1

Benefits under Medicaid managed care usually begin on the first day of the next month following the client's selection of a managed care plan and primary care provider. The following example shows the managed care enrollment date for a client who selects a health plan and primary care provider 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 primary care provider (before the 15th of the month)	January 10
Managed care benefits begin	February 1

Example 2

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

Task	Date
Client certified for Texas Medicaid	January 10
Medicaid benefits begin	January 10
Client selects health plan and primary care provider (after the 15th of the month)	January 20
Managed care benefits begin	March 1

2.3.1.2 Eligibility Verification Resources

The provider must verify the client's eligibility before providing services except in cases of emergency. If emergency care is provided, the provider should determine the client's MCO and primary care provider as soon as possible. The provider must also verify and abide by the prior authorization and administrative requirements established by the MCO or DMO.

STAR MCOs provide their clients with an MCO identification card. Providers should check the MCO identification card and the Your Texas Benefits Medicaid card to determine whether the client is a managed care client.

Refer to: "Section 4: Client Eligibility" (*Vol. 1, General Information*) for more information.

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The client's MCO and DMO enrollment information can be verified by:

- Checking the client's MCO or DMO ID card (if applicable).
- Visiting the client's Medicaid MCO or DMO's website.
- Calling the client's MCO or DMO.
- Visiting TexMedConnect, accessing the Medicaid Client Portal for Providers, or calling the TMHP Contact Center at 800-925-9126.

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

- The TMHP Automated Inquiry System (AIS) at 800-925-9126.
- Third-party software that uses the TMHP EDI Gateway.
- National Council for Prescription Drug Programs (NCPDP) Eligibility Verification (E1) transaction. The E1 transaction is submitted through a 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.

2.3.2 Enrollment in Managed Care for Specific Groups

2.3.2.1 Expedited Enrollment of Pregnant Women (Program Type 40)

If a pregnant woman applies for program type 40 and is eligible for Medicaid managed care, she has 15 days from the date on which the Enrollment Broker receives the eligibility determination to choose an MCO that participates in her managed care program. If she does not choose an MCO, one will be chosen for her.

The Enrollment Broker contacts the client to begin the enrollment process and helps the client select an MCO. The client can also contact the Enrollment Broker directly. To protect continuity of care and client choice, the Enrollment Broker will work with each pregnant woman to select an MCO 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 to obtain the name of the client's health plan. However, client eligibility should always be verified at the time the service is rendered.

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

There are exceptions to this rule:

- Women who are certified at any time in their estimated month of delivery will be enrolled in managed care on the first day 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 managed care on the first day of the following month (prospective enrollment).
- Women who are not identified as a candidate for program type 40 within three days of certification after her enrollment has been processed will be enrolled in managed care prospectively.

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- In cases where the Medicaid effective date is a future date, prospective enrollment rules will be used.

Important: *Providers must verify the client's plan and primary care provider 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
Managed care start date	August 1

Example 2: Woman Certified in Her 6th Month	
Client certified for Texas Medicaid	August 12
Medicaid benefits begin as fee-for-service	August 1
Managed care start date	September 1

Example 3: Woman Certified in Her 9th Month	
Client certified for Texas Medicaid	August 5
Medicaid benefits begin as fee-for-service	August 1
Managed care start date	September 1

Note: *Expedited enrollments of pregnant women (program type 40) into Medicaid managed care may be retroactive.*

2.3.2.2 Newborn Enrollment

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 that file claims for services provided to newborns are still responsible for meeting the Medicaid filing deadlines, which, in most cases, is within 95 days of the date of service.

MCOs must pay providers for labor- and delivery-related inpatient and professional services that are rendered to mothers for:

- Up to 48 hours following an uncomplicated vaginal delivery.
- Up to 96 hours following an uncomplicated Caesarian delivery.

MCOs must provide neonatal care for newborn clients until the time of discharge. Prior authorizations and primary care provider assignments cannot be a reason to deny claims.

MCOs must notify providers involved in the care of mothers and newborn clients, including out-of-network providers and hospitals, of the MCO's prior authorization requirements. MCOs cannot require prior authorization for services provided to a mother or newborn client for a medical condition that requires emergency services, regardless of when the emergency condition arises.

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.*

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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 clients.

STAR Example

Enrollments of newborns born to mothers who are 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)

Children born to STAR+PLUS or STAR Kids clients will be automatically enrolled with the STAR MCO in the SA operated by the same STAR+PLUS or STAR Kids MCO, if available. If the STAR+PLUS or STAR Kids MCO does not also operate a STAR MCO in the SA, the newborn will be enrolled in Texas Medicaid fee-for-service, and the mother will be given the opportunity to choose a STAR MCO for the newborn. Children born to STAR Health clients will be automatically enrolled in the STAR Health MCO. The effective date of the newborn's enrollment is the same as the newborn's date of birth. The newborn will remain enrolled for at least 90 days following the date of birth unless the mother requests a plan change as a special condition.

2.3.2.2.1 Timely Notification and Assignment of Medicaid ID for Newborns

There may be a delay of up to several months from the DOB for a newborn to receive a Medicaid ID number. Providers should check with each MCO to determine the claim filing requirements for newborns who do not yet have a Medicaid client number. Medicaid MCOs must adjudicate claims for services provided to newborns in accordance with HHSC's claims processing requirements using the proxy ID number or state-issued Medicaid ID number. The MCO cannot deny claims based on a provider's non-use of state-issued Medicaid ID number for a newborn. The MCO must accept provider claims for newborn services based on the mother's name or Medicaid ID number with accommodations for multiple births, as specified by the MCO.

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

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).*

2.3.2.3 Breast Pump Claims Filing for MCO Services

Texas Medicaid and CHIP cover breast pumps and equipment after a baby is born when they are medically necessary.

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Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage & billing
STAR	STAR	STAR	STAR covers breast pumps when medically necessary for mothers or newborns. Breast pump equipment may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps when medically necessary for newborns when the mother does not have coverage under CHIP. The breast pump must be billed under the newborn's Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps when medically necessary for CHIP Perinatal newborns. Breast pump equipment must be billed under the newborn's CHIP Perinatal ID.
STAR Kids	STAR Kids	Medicaid FFS or STAR**	Medicaid FFS, STAR, STAR Kids, and STAR+PLUS cover breast pumps when medically necessary for mothers or newborns. Breast pump equipment may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR+PLUS	STAR+PLUS	Medicaid FFS or STAR**	Medicaid FFS, STAR, STAR Kids, and STAR+PLUS cover breast pumps when medically necessary for mothers or newborns. Breast pump equipment may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.

*** CHIP Perinatal clients who have household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the pregnant woman an Emergency Medicaid application 30 days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.**

**** These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn's Medicaid ID if the mother does not have coverage.**

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Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage & billing
STAR Health	STAR Health	STAR Health	STAR Health covers breast pumps when medically necessary for mothers or newborns. Breast pump equipment may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps when medically necessary for the newborn when the mother does not have coverage. The breast pump must be billed under the newborn's Medicaid ID.

*** CHIP Perinatal clients who have household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the pregnant woman an Emergency Medicaid application 30 days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.**

**** These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn's Medicaid ID if the mother does not have coverage.**

Refer to: Section 3, "Breastfeeding Support Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information about breast pump coverage.

2.3.2.4 Medicaid for Transitioning Foster Care Youth (MTFCY) and Former Foster Care Children (FFCC)

Medicaid for Former Foster Care Children (FFCC) covers Medicaid clients who are 18 years of age or older and were receiving Medicaid when they aged out of foster care, but would otherwise not be eligible to continue Medicaid coverage. FFCC clients are automatically enrolled in STAR Health through the last day of the month in which they turn 21 years of age. FFCC clients may opt out of STAR Health for STAR, which allows clients to choose their MCO.

Medicaid clients who were receiving Medicaid and SSI when they aged out of foster care are automatically enrolled in STAR Kids.

Eligibility for STAR Health and STAR Kids ends on the last day of the month in which they turn 21 years of age and then coverage transfers to STAR unless the client is eligible for STAR+PLUS.

Medicaid for Transitioning Foster Care Youth (MTFCY) covers former foster care youth who were not receiving Medicaid when they aged out of foster care at 18 years of age. MTFCY clients are eligible through the last day of the month in which they turn 21 years of age to receive services through the fee-for-service or managed care models.

2.3.3 Client Rights

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

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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 primary care provider (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 primary care providers in their areas.
  - Be informed of how to choose and change health plans and primary care providers.
  - Choose any health plan that is available in their area and choose a primary care provider.
  - Change their primary care provider at any time for any reason.
  - Change health plans without penalty.
  - Be educated about how to change health plans or primary care providers.
  - 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.

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- 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.

2.3.3.1 Advance Directives

Federal and state law require providers and MCOs 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 client'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.

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2.3.4 Client Responsibilities

Medicaid managed care health plans and primary care providers 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 primary care provider.
  - Make any changes in their health plan and primary care provider 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 primary care provider first for nonemergency medical needs.
  - Be sure they have approval from their primary care provider 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 primary care provider and become fully informed about service and treatment options. That includes the responsibility to:
  - Tell their primary care provider 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.
  - Talk to their provider about all of their medications.

2.4 Primary Care Provider/Main Dentist Guidelines for Medicaid Managed Care Clients

In Medicaid managed care, eligible Medicaid clients choose a primary care provider 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 primary care provider/main dentist is responsible for the following:

- Furnishes primary-care related services

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- 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

Refer to: 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 specialist providers and other services. The primary care provider 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. Primary care providers/main dentists can choose to contract with various MCOs or DMOs.

Although primary care providers are encouraged to help clients access these services, Medicaid managed care enrollees may self-refer for the following services:

- Emergency services
- Family planning services
- THSteps medical services
- Immunizations
- Early Childhood Intervention (ECI)
- 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 Primary Care Provider 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 DMOs for enrollment information.

The following provider types are eligible to serve as primary care providers:

- Pediatricians
- Family/general practitioners
- Internists
- Obstetrician/gynecologists
- Advanced Practice Registered Nurses (APRNs) under the supervision of a physician who qualifies as a primary care provider
- Certified nurse-midwives (CNM) practicing under the supervision of a physician
- Physician assistants (PAs) practicing under the supervision of a physician who qualifies as a primary care provider
- Rural health clinics (RHCs)

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- 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 main dentists:
- General dentist
- Pediatric dentist
- Rural health clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

2.4.2 Primary Care Provider 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 primary care provider 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.

Refer to: Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about billing an exception-to-periodicity checkup

Subsection 4.3.7, "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 3.2.13.1, "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 Primary Care Provider and Main Dentist Changes

Primary care provider and main dentist changes may be requested or initiated by any of the following:

- A client who is enrolled in a Medicaid MCO or DMO may request a primary care provider or main dentist change at any time and for any reason.
- The MCO or DMO may reassign the client to another primary care provider or main dentist for any of the following reasons:
  - The primary care provider or main dentist is sanctioned by HHSC.
  - The primary care provider or main dentist exhibits a documented pattern of unacceptable quality of care.
  - The primary care provider 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 primary care provider or main dentist for any of the following reasons:
  - The client is not included in the primary care provider's or main dentist's scope of practice.
  - The client is noncompliant with medical or dental advice.

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- The client consistently displays unacceptable office decorum.
- The client's relationship with the primary care provider or main dentist is not mutually agreeable.

Any request by a provider to reassign a client to another primary care provider or main dentist must be processed through the applicable Medicaid MCO or DMO. 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 DMO staff. The MCO or DMO 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 DMO.

The MCOs and DMOs can affect a primary care provider 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 primary care provider 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 primary care provider's or main dentist's office or through on-call arrangements with another office or service. Clients should be informed of the primary care provider'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

Primary care providers 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 primary care provider, 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 primary care provider, main dentist, or another provider designated by the primary care provider 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 primary care provider, 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.

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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.

Providers must 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 Medicaid services to which they are legally entitled.

Meeting the requirements of Title VI may require the primary care provider 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 DMOs arrange interpreters).
- Develop written policies and procedures regarding interpreter services (MCOs or DMOs 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.

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 DMO 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.languageline.com or call 800-752-6096.

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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 https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/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 DMO is determined by the MCO or DMO. Providers should contact the MCO or DMO for additional information.

Note: *The MCOs and DMOs 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 DMOs.*

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)

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*) for additional information.

2.6.3 Out-of-Network Reimbursement

MCOs must ensure their clients have access to covered services on a timely basis. They are required to have a defined network of providers to meet client needs, and to provide support to clients who need help finding a doctor or setting up appointments. MCOs must maintain access to network providers based on federal and state requirements. If an in-network provider is not available, the MCO is still required to locate a willing provider to ensure clients have access to medically necessary and appropriate services.

If medically necessary covered services are not available through in-network providers, MCOs must allow a referral to an out-of-network Medicaid provider. The referral must be requested by an in-network provider and within the time appropriate to the circumstances relating to the delivery of the services and the condition of the client but no longer than five business days after the request.

The MCO must fully reimburse the non-network provider in accordance with the out-of-network methodology for Medicaid as defined by HHSC in 1 TAC § 353.4.

MCOs must allow pregnant clients, past the 24th week of pregnancy to remain under their current OB/GYN's care through the client's postpartum checkup, even if the OB/GYN provider is, or becomes, out-of-network.

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For newly enrolled clients, MCOs must pay the existing out-of-network Medicaid providers for medically necessary covered services for up to 90 days, until the client's records and care can be transferred to an in-network provider, or until the client is no longer enrolled with the MCO.

MCOs are not responsible for payment for unauthorized nonemergency services by out-of-network providers, except when that provider is an Indian Health Care Provider (IHCP) enrolled as a FQHC.

2.7 Managed Care Plan Changes

The MCO or DMO changes can be initiated by clients, MCOs, or DMOs.

2.7.1 Client-Initiated Plan Changes

Clients have the right to change plans. Clients must call the Enrollment Broker at 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 primary care providers within their assigned STAR Health MCO.

2.7.2 Plan Administrator-Initiated Changes

Each health plan and DMO 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 DMOs 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 primary care provider 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, DMO'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 clients 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 DMO 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.

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Health plans, DMOs, 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.
- Claims for services that were paid by an MCO and then recouped must contain the recoupment EOB from the MCO for consideration of payment. The claims must meet the 95-day deadline from the recoupment disposition date.

Note: *Letter requests for refunds will not be accepted. A recoupment EOB with a disposition date is required.*

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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.

Refer to: Subsection 6.4.2.9, "Attachments to Claims" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

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

MCOs must have a process in place that allows prior authorizations eligible for recertification to be submitted by providers and reviewed by the MCO within the timeframes as outlined in Section 5: Fee-for-Service Prior Authorizations.

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

Health plan prior authorizations do not automatically transfer with a client who moves to another plan.

When a client or provider notifies the new MCO that there is an existing prior authorization, the new MCO must ensure that the client gets a continued authorization of those services for the same amount, duration, and scope. The new MCO must get the continued authorization within the shortest of the following time periods:

- Within 90 Days of the transition to a new MCO
- Until the end of the current authorization period
- Until the MCO has evaluated and assessed the client and issued or denied a new authorization

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If a client who is transitioning from FFS to managed care was receiving a service that did not require a prior authorization in FFS, but does require one in the new MCO, the MCO must ensure that the client receives services for the same amount, duration, and scope. The continued authorization must last for the shortest period of the following:

- Within 90 days of the transition to the new MCO
- Until the MCO has evaluated and assessed the client and issued or denied a new authorization

Dental prior authorizations may transfer from one DMO to another.

2.9 Claims Filing for Managed Care Services

Claims for services administered by an MCO or DMO must be submitted to the client's MCO or DMO. Providers may submit directly to the appropriate MCO or DMO using the methods established by the MCO or DMO.

Providers must contact the appropriate MCO or DMO for information about filing electronic or paper claims directly to the MCO or DMO.

MCOs may also subcontract with behavioral health organizations (BHOs) and pharmacy benefit managers (PBMs). Providers must contact the client's MCO to verify the claims process.

Refer to: The TMHP website at www.tmhp.com/topics/managed-care for additional information, including MCO and DMO contact information.

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

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

Reminder: *Claims for Medicaid managed care clients must be submitted to the MCO or DMO in which the client is enrolled at the time of service. Providers can contact the client's MCO or DMO for additional details. Claims for hospital facility charges for inpatient hospital stays for Medicaid managed care clients must be submitted to the program, MCO, or DMO in which the client is enrolled at the time of admission. The responsible party will pay the hospital facility charge until the earlier of either the date of discharge from the hospital, date of transfer, or loss of Medicaid eligibility. Providers must submit the claims with the corresponding prior authorizations for the hospital facility charge to the appropriate entity for reimbursement. Providers can contact the appropriate MCO or DMO for additional details. If Medicaid managed care clients receive other services during an inpatient hospital stay, including hospital professional charges, claims for these services (from the date of hospital admission to the date of release) are submitted to the program, MCO, or DMO in which the client is enrolled at the time of the requested service. The MCO or DMO, 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.*

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*) for additional information.

The TMHP Medicaid Managed Care web page at www.tmhp.com/topics/managed-care for additional information.

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2.9.1 Filing Deadlines

The following table summarizes the filing deadlines that apply for MCO and DMO 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 DMO)	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 DMO within 95 days of the date of service. If the claim is not received by the MCO or DMO 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 DMO), 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 DMO 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 DMO within 95 days from the date of disposition by the other insurance resource. The MCO or DMO 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 DMO.

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

Refer to: Subsection 2.9, "Claims Filing for Managed Care Services" in this handbook for details about managed care claims.

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for information about MCO claims processed by TMHP and not the client's MCO.

2.10 MCO/DMO Appeals, Complaints, and Fair Hearings

Providers can submit their appeals directly to the MCO or DMO that administers the clients' managed care benefits.

Claims that were originally submitted to TMHP for routing to the appropriate MCO or DMO 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 DMO. Providers are encouraged to exhaust the complaints or grievance process with their MCO or DMO before filing a complaint with HHSC.

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Refer to: The respective MCO or DMO 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 DMO's complaints or grievance process has been exhausted, complaint requests may be sent to HHSC.

Complaints about STAR, STAR+PLUS, STAR Kids, STAR Health, and DMO can be:

- Emailed to HHSC at HPM_Complaints@hhsc.state.tx.us.
- Mailed to HHSC at:

Health and Human Services Commission
MCCO Research and Resolution
PO Box 149030
MC: 0210
Austin, TX 78714-9030

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.

3.1 STAR Program Clients

Most clients in Texas Medicaid get their coverage through the STAR Program. STAR provides primary care, acute care, behavioral health care, and pharmacy services for pregnant women, newborns, and children and parents with limited income. Some former foster care children and youth are eligible for the STAR Program as well.

STAR is available statewide in 13 service areas (SAs). STAR Medicaid clients can select from at least two MCOs in each service area.

Refer to: Subsection 2.3.2.4, "Medicaid for Transitioning Foster Care Youth (MTFCY) and Former Foster Care Children (FFCC)" in this handbook.

3.2 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
- Waiver of the $200,000 individual annual limit on inpatient services

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3.2.1 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 are already not limited to the 30-day spell of illness.

3.2.2 Prescriptions

STAR clients who are 21 years of age or 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 or younger already receive unlimited medically necessary prescription drugs.

4 STAR Kids Program

The STAR Kids Program is designed to improve access to care, coordinate care across service areas, improve ease of program participation for clients, managed care organizations, and providers, and achieve cost efficiency and cost containment. The STAR Kids program integrates acute care and long-term services and supports (LTSS) into a Medicaid managed care delivery system for children and adults who are 20 years of age or younger and have a disability.

STAR Kids also provides Medically Dependent Children's Program (MDCP) services for eligible clients.

Refer to: The STAR Kids website at www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/star-kids.

4.1 STAR Kids Clients

STAR Kids is available statewide in 13 service areas (SAs). STAR Kids Medicaid clients can select from at least two MCOs in each service area.

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)

Children and youth who receive SSI or SSI-related Medicaid or are enrolled in MDCP receive all of their Medicaid services through the STAR Kids program.

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Children and youth who receive services through other 1915(c) waiver programs receive their basic Medicaid health services through STAR Kids, while receiving their LTSS through their waiver program.

Children who are dually eligible receive most of their acute care services through Medicare but receive LTSS and service coordination through STAR Kids.

4.2 STAR Kids Benefits

STAR Kids Program clients receive all the benefits of Texas Medicaid fee-for-service, including Texas Health Steps and Comprehensive Care Program services. STAR Kids clients who have an assessed need for LTSS, identified by the STAR Kids Screening and Assessment Instrument (SK-SAI), may receive services through their STAR Kids MCO.

4.2.1 Spell-Of-Illness

No spell-of-illness limitation exists for THSteps-eligible clients who are 20 years of age or younger when a medically necessary condition exists.

4.2.2 Prescriptions

All Medicaid clients who are 20 years of age or younger receive unlimited medically necessary prescription drugs.

4.2.3 Service Coordination

Refer to: Subsection 2.1.3, "Service and Care Coordination" in this handbook.

The STAR Kids Handbook page of the HHS website at hhs.texas.gov.

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 services and supports (LTSS) into a Medicaid managed care delivery system for SSI-eligible Medicaid clients.

The STAR+PLUS Program serves adults with a disability, clients age 65 and older (including those dually eligible for Medicare and Medicaid), as well as women in the Medicaid Breast and Cervical Cancer Program.

5.1 STAR+PLUS Program Clients

Medicaid clients who are 21 years of age or older and enrolled in any of the following HHSC programs must enroll in STAR+PLUS for acute care benefits, unless the member is dual-eligible for Medicaid and Medicare:

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

Enrollment in the STAR+PLUS program is required for clients of Medicaid who meet one or more of the following criteria:

- Receive Supplemental Security Income (SSI) benefits or SSI-related Medicaid
- Qualify for STAR+PLUS Home and Community-Based Waiver Services

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- Are 21 years of age or older and receive Medicaid because they are in a Social Security Exclusion program and meet financial criteria for STAR+PLUS Home and Community-Based Services Program
- Are 21 years of age or older and reside in a nursing facility
- Qualify for Medicaid for Breast and Cervical Cancer (MBCC)
- Former Foster Care Children (FFCC) clients who are 21 years of age through the end of the month of their 26th birthday, who are dual eligible, and who reside in a community-based ICF-IID or receive services under the following Medicaid 1915(c) waivers:
  - HCS
  - CLASS
  - TxHmL
  - DBMD

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

Refer to: Subsection 4.8, "Medicaid for Breast and Cervical Cancer (MBCC)" in "Section 4: Client Eligibility" (*Vol. 1, General Information*) for more information about the MBCC Program.

After selecting an MCO, STAR+PLUS Program clients who are not dual-eligible are required to select a primary care provider from the MCO provider directory.

5.1.1 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
- Program of All-Inclusive Care for the Elderly (PACE)
- 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
- Clients who receive limited Medicaid benefits and do not qualify for participation in the VDP

5.2 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
- Waiver of the $200,000 individual annual limit on inpatient services

Refer to: Subsection 3.2.2, "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.*

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5.2.1 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.

5.2.2 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.
- The client is not eligible for Medicare and is admitted to an inpatient facility with a diagnosis of bipolar disorder, major depressive disorder, recurrent depressive disorder, schizoaffective disorder, or schizophrenia.

For confirmation of spell-of-illness limitation contact the client's MCO.

5.2.3 Service Coordination

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.

Refer to: Subsection 2.1.3, "Service and Care Coordination" in this handbook.

6 STAR Health Program

The STAR Health program ensures that children and youth in state conservatorship are able to receive all services they need immediately upon entry into conservatorship. Benefits under STAR Health begin the date the client is placed in conservatorship.

HHSC has selected Superior HealthPlan as the MCO for this program. Superior HealthPlan is responsible for assigning a to clients when they are enrolled in the STAR Health Program. Foster care families are given the opportunity to change their primary care provider 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 with the Texas Juvenile Justice Department

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- 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 Children (FFCC) 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 FFCC program	18 through 20 years of age (Eligibility for STAR Health ends the month of their 21st birthday, and then coverage transfers to STAR unless the client is eligible for STAR+PLUS)

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

Refer to: Subsection 2.3.2.4, "Medicaid for Transitioning Foster Care Youth (MTFCY) and Former Foster Care Children (FFCC)" in this handbook.

Subsection 2.3.2.2, "Newborn Enrollment" in this handbook.

6.2 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.

Refer to: Subsection 2.1.3, "Service and Care Coordination" in this handbook.

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

Refer to: 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.

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For general provider information or authorizations, from STAR Health subcontractors, contact Superior Health Plan.

6.2.1 Spell-Of-Illness

No spell-of-illness limitation exists for THSteps-eligible clients who are 20 years of age and younger when a medically necessary condition exists.

6.2.2 Prescriptions

All Medicaid clients who are 20 years of age and younger receive unlimited medically necessary prescription drugs.

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.*

Refer to: Subsection 4.10, "Health Insurance Premium Payment (HIPP) Program" in "Section 4: Client Eligibility" (*Vol. 1, General Information*) for more information about the HIPP program.

Subsection 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

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 DMOs. Each Medicaid managed care DMO 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 DMO are required to select a DMO 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 DMO to provide a dental home to clients 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. RHCs and FQHCs are also eligible to serve as a Main Dentist.

The First Dental Home Initiative is included in this model.

Refer to: Subsection 3.2.9, "First Dental Home" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

7.3 Client Eligibility

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

Populations that will not receive services through the children's Medicaid managed care DMOs are:

- Medicaid recipients who are 21 years of age or older.

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- Recipients who reside in an institution (i.e. nursing homes, state supported living centers, or ICF-IID).
- Recipients in the STAR Health Program.

7.4 Client Enrollment

Clients choose a DMO 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 DMO by calling 800-964-2777 (telecommunications device for the deaf (TDD): 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 DMO. After the default assignment is made, the DMO will assign the client a Main Dentist.

7.5 Authorizations for Children's Medicaid Managed Care Dental Services (Non-orthodontia Services)

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

If a client is new to a DMO and has an open authorization for covered dental services from TMHP or another HHSC-contracted Medicaid managed care DMO, the DMO 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 DMO.

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.*

7.6 Children's Medicaid Dental Orthodontia Services

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

TMHP will continue to process claims and claims adjustments for orthodontia services claims for clients who are ICF-IID residents.

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If a Medicaid client is enrolled in a DMO for at least one month, is receiving orthodontic treatment, and either ages out of the program or loses eligibility, the DMO is responsible for completion of the course of treatment. The only exception is if the client is disenrolled with cause but is still Medicaid-eligible. For example, if a client goes into a State Supported Living Center, the DMO will no longer be responsible for services rendered.

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 rather than an MCO or DMO.

The following tables shows the services that are partially or completely carved out of the MCO and DMO managed care program:

Carve Out	STAR	STAR Kids	STAR+PLUS	STAR Health
Nutritional products through WIC	TMHP	TMHP	TMHP	TMHP
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
Texas School Health and Related Services (SHARS)	TMHP	TMHP	TMHP	TMHP
Elevated lead investigation services	TMHP	TMHP	TMHP	TMHP
DSHS TB providers	TMHP	TMHP	TMHP	TMHP
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	MCO	MCO	MCO	MCO
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
Home and Community Based Services Adult Mental Health (HCBS-AMH)	TMHP	TMHP	TMHP	TMHP
*** CFC services are carved out for STAR Kids clients who receive services through CLASS, DBMD, HCS, or TxHmL.**				

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Dental Carve Out	Children's Medicaid Dental	STAR Health
THSteps Dental	DMO	MCO
Orthodontia for most clients who are 20 years of age and younger	DMO	MCO
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 DMO.*

Providers must submit authorization requests and claims for services that are carved out of the managed care program to TMHP according to the fee-for-service guidelines that are established for the same service.

Refer to: "Section 6: Claims Filing" (*Vol. 1, General Information*) for more information about 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 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 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 the Sterilization Consent Form 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.*

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

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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 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.

Refer to: 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.

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9 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 DMO:

- Healthy Texas Women (HTW) program - HHSC/TMHP
- HHSC Family Planning Program contracted services - HHSC/TMHP
- Medicaid Medical Transportation Program (MTP)
- CHIP Perinatal—CHIP Perinatal provides prenatal care to the unborn children of pregnant women who have an income of up to 202 percent of the federal poverty level and who are not eligible for other Medicaid programs or traditional CHIP. CHIP Perinatal covered services include prenatal care, labor with delivery, and two postpartum visits.
  - For CHIP perinates in families that have an income at or below the Medicaid eligibility threshold, facility charges associated with labor and delivery are covered by Emergency Medicaid, and professional charges associated with labor and delivery are covered by the CHIP Perinatal MCO.
  - For CHIP perinates in families that have an income above the Medicaid eligibility threshold, the facility and professional charges associated with labor with delivery are covered by the CHIP Perinatal MCO.
- Health Insurance Premium Payment (HIPP) Program—The HIPP Program reimburses clients for the cost of medical insurance premiums when Medicaid finds it more cost-effective to reimburse a Medicaid client's group health insurance premiums than to reimburse the client's medical bills directly through Medicaid.

Refer to: Subsection 6.19, "Children's Health Insurance Program (CHIP) Perinatal Claims" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

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

Subsection 4.10, "Health Insurance Premium Payment (HIPP) Program" in "Section 4: Client Eligibility" (*Vol. 1, General Information*).

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

10 Dual-Eligible Members in Managed Care

Some STAR+PLUS, STAR Kids, and STAR Health clients are eligible for both Medicare and Medicaid. These clients are called dual-eligible clients. Dual-eligible clients who enroll in Medicaid managed care programs receive most acute care services through their Medicare provider. Dual-eligible clients also receive LTSS and Medicaid-only acute care services through their Medicaid MCO. Medicaid MCOs may also provide additional services, such as value-added services.

Providers must bill:

- Medicare acute care services to the client's Medicare MCO or Medicare FFS insurer, following the rules of the Medicare insurer.
- Medicaid-covered services to the client's Medicaid MCO, following Medicaid billing rules.

If a client enrolls in both a Medicare MCO and a Medicaid MCO, the client uses the Medicare primary care provider. In this situation, the client chooses a Medicaid MCO but does not choose a Medicaid primary care provider. For Medicare-covered services, providers follow the Medicare MCO's medical management requirements, including authorization and concurrent review. For Medicaid-covered

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services, providers follow the Medicaid MCO's medical management requirements, including authorization and concurrent review. Providers must deliver Medicaid services in the same amount, duration, and scope as defined in the *Texas Medicaid Provider Procedures Manual*.

Refer to: Subsection 4.9, "Medicare and Medicaid Dual Eligibility" in "Section 4: Client Eligibility" (Vol. 1, General Information) for more information.

10.1 Medicare Advantage Dual Eligible Special Needs Plan – STAR+PLUS Only

A Dual Eligible Special Needs Plan (D-SNP) is a Medicare managed care delivery model designed for dual-eligible clients. A D-SNP:

- Provides Medicare-covered services in accordance with a contract between the D-SNP and the Centers for Medicare & Medicaid Services.
- Pays providers Medicare cost sharing for dual-eligible clients in accordance with a contract between the D-SNP and HHSC.
- Coordinates both Medicare-covered services and Medicaid-covered services for dual-eligible clients.

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/DMO	Contact the client's health/DMO.
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 clients of STAR+PLUS, STAR, STAR Kids, STAR Health, and Children's Medicaid dental services	800-252-8263
TMHP Contact Center	800-925-9126

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