

# STAR Kids Health Plan Profiles



Aetna Better Health of Texas  
Services Area  
Tarrant

## Key Contacts

Joanna Rhodes

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Mary Downey

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## Link to Online Provider Directory

<https://www.aetnabetterhealth.com/texas/assets/pdf/member/STARKidsproviderdirectory.pdf>

## Continuity

- Existing authorizations for acute care services (like physical, occupational, or speech therapy) will be honored for six months, until the authorization expires or until the health plan conducts a new assessment.
  - Example: Your child is receiving speech therapy services under an authorization that goes through March 31, 2017.
    - If it gets close to March 31 and the health plan has not done an assessment, your providers can work with the health plan to get a new authorization.
    - If the health plan does a new assessment, the health plan will then work with your therapy provider to have them ask for a new authorization.
- Existing authorizations for long-term services and supports (like private duty nursing and personal care services) will be honored for six months or until the health plan conducts a new assessment.
  - Example: Your child is receiving personal care services under an authorization that goes through August 30, 2017.
    - Your health plan will come out to do a new assessment within the first six month period. After the health plan does a new

assessment, the health plan will then work with your home health agency to initiate a new authorization.

- Aetna will extend STAR Kids continuity of care until Oct. 31, 2017 for physician services where an established relationship existed, including hospital-affiliated physicians. Additional services ordered by the out-of-network physician might require prior authorization.
  - Example: You have an appointment with the neurologist on December 3, 2016. That neurologist is not in your health plan's network. You can still go to your appointment and your health plan will work with that provider. Your health plan will provide documentation to make sure that your provider knows that he or she can still see your child.

### Referral Policies

- A referral isn't a requirement for your STAR Kids plan of benefits.
- Aetna Better Health does not require a referral or authorization to any in-network specialists. However there might be services that require prior authorization.
- *Please note that an out-of-network physician must be a valid Texas Medicaid provider to receive payment for services from Aetna Better Health and these services must be Medicaid covered services.*

Here are some examples:

- If the member is seeking services from a new specialist with no existing relationship, Aetna Better Health does not require referral or authorization for an in-network specialist. However, there are services that might need prior authorization.
- If the member is seeking urgent care from a new physician specialist, Aetna Better Health doesn't require referral or authorization for an in-network physician specialist.
- If a member is seeking emergency services from a new physician specialist, Aetna Better Health doesn't require a referral or authorization if the services are a covered Medicaid benefit and are performed by a provider who is qualified to furnish the services and are needed to evaluate or stabilize the emergency medical condition.

(See <https://www.aetnabetterhealth.com/texas/members/starkids/handbook>)

# Amerigroup

## Services Areas

Dallas, El Paso, Harris, Lubbock, MRSA West

## Key Contact

Aron Head

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Phone: 817-861-7700 ext. 57747

## Link to Online Provider Directory

<http://amerigroup.prismisp.com>

## Continuity of Care

- Existing authorizations for acute care services (like physical, occupational, or speech therapy) will be honored for six months, until the authorization expires or until the health plan conducts a new assessment.
  - Example: Your child is receiving speech therapy services under an authorization that goes through March 31, 2017.
    - If it gets close to March 31 and the health plan has not done an assessment, your providers can work with the health plan to get a new authorization.
    - If the health plan does a new assessment, the health plan will then work with your therapy provider to have them ask for a new authorization.
- Existing authorizations for long-term services and supports (like private duty nursing and personal care services) will be honored for six months or until the health plan conducts a new assessment.
  - Example: Your child is receiving personal care services under an authorization that goes through August 30, 2017.
    - Your health plan will come out to do a new assessment within the first six month period. After the health plan does a new assessment, the health plan will then work with your home health agency to initiate a new authorization.
- You may continue to see your existing providers, even if they are out of network, until April 30, 2017, including hospital-affiliated physicians. You may continue to see existing physicians (primary care physicians and specialists) until October 30, 2017.

- Example: You have an appointment with the neurologist on December 3, 2016. That neurologist is not in your health plan's network. You can still go to your appointment and your health plan will work with that provider. Your health plan will provide documentation to make sure that your provider knows that he or she can still see your child.

## Referral Policies

Amerigroup does not require primary care provider referral to network medical or behavioral health specialists. Any member can self-refer to a network medical or behavioral health specialist. Prior authorization is not required for network specialist office visits (for example, evaluation and management (E&M)).

You don't need a primary care provider referral for a network specialist if you're:

- Seeking services from a new specialist where there is no pre-existing relationship.
- You're seeking emergency or urgent services from a new specialist in the network.
- You're seeking services from a current specialist with whom they have an existing relationship.

(See <https://www.myamerigroup.com/TX/Pages/star-kids.aspx>)

## Blue Cross Blue Shield

### Services Areas

Travis, MRSA Central

### Key Contacts

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Nicole Evans, Manager, Public Programs-Medicaid

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Phone: 512-349-4840

### Link to Online Provider Directory

<https://public.hcsc.net/providerfinder/medicaid-search.do?corpEntCd=TX1&custGrp=STARTX&alpha=STK&ntwkdisplayId=STKTX>

### Continuity of Care

- Existing authorizations for acute care services (like physical, occupational, or speech therapy) will be honored for six months, until the authorization expires or until the health plan conducts a new assessment.
  - Example: Your child is receiving speech therapy services under an authorization that goes through March 31, 2017.
    - If it gets close to March 31 and the health plan has not done an assessment, your providers can work with the health plan to get a new authorization.
    - If the health plan does a new assessment, the health plan will then work with your therapy provider to have them ask for a new authorization.
  
- Existing authorizations for long-term services and supports (like private duty nursing and personal care services) will be honored for six months or until the health plan conducts a new assessment.
  - Example: Your child is receiving personal care services under an authorization that goes through August 30, 2017.
    - Your health plan will come out to do a new assessment within the first six month period. After the health plan does a new assessment, the health plan will then work with your home health agency to initiate a new authorization.
  
- For the first 12 months after STAR Kids starts, BCBSTX will allow members to see Medicaid enrolled, out-of-network providers, in or out of the service delivery area, including hospital-affiliated physicians, for Medicaid covered services, including hospital-affiliated physicians. Documentation of referrals isn't required. Referral is a process that one provider uses to recommend a member see another provider or specialist.

- Prior authorization for non-emergency services is required to ensure the provider is loaded in the system and can submit claims. BCBSTX will allow members to see the out-of-network provider and will work with the providers to obtain the prior authorization.
  - Example: You have an appointment with the neurologist on December 3, 2016. That neurologist is not in your health plan's network. You can still go to your appointment and your health plan will work with that provider. Your health plan will provide documentation to make sure that your provider knows that he or she can still see your child.

### Referral Policies

When client is seeking services from a new specialist where there is no preexisting relationship.

- BCBSTX doesn't require documentation of referrals to Medicaid specialists.
- BCBSTX doesn't require prior authorization for in-network specialists.
- BCBSTX will allow members to see out-of-network or out-of-service area Medicaid specialists for medically necessary services. When the provider is out-of-network members will work with their service coordinator to make sure the providers are loaded in our system and that they can file claims.

When client is seeking emergency or urgent services from a new specialist.

- BCBSTX does not require referrals or prior authorizations for emergency care or urgent care for in or out-of-network Medicaid enrolled providers.
- Members are encouraged to call their primary care provider during office hours for urgent care. If they already have a specialist that has treated the child for urgent issues they can contact the specialist directly. The primary care provider might be able to bring the member in for urgent care, or refer the member for urgent care to another provider if the primary care provider can't treat the member and the family does not have another specialist to see.

- BCBSTX does not require documentation of referrals to Medicaid specialists.
- BCBSTX will allow members to see out-of-network Medicaid enrolled specialists for medically necessary services.

When client is seeking services from a current specialist with whom they have an existing relationship.

- If you feel no one in the network can give your child the care he or she needs, and/or you have an existing relationship with a Medicaid enrolled provider, BCBSTX will allow your child to see those providers for medically necessary services for up to a year.
- When the provider is out-of-network members will work with their service coordinator so arrangements can be made to pay the out-of-network provider. We will reach out and attempt to get these out-of-network Medicaid enrolled providers in network.
- We will offer single case agreements for a specialist with whom the member has an existing relationship who isn't willing to join our network, to allow this member to continue to see their existing specialists.

#### Notes

- BCBSTX uses the term "OK" in our Member Handbook and on our Member Website to mean the provider is required to obtain prior authorization.
- The term "referral" is a process that one provider uses to recommend a member to see another provider or specialist. BCBSTX does not require documentation of these referrals.
- Prior authorization is when both BCBSTX and your provider agree ahead of time that the service or care you ask for is medically necessary. This process is also used to obtain information needed to load into our system for claims payment from out of network providers.

(see <http://www.bcbstx.com/starkids/>)



# Children's Medical Center Health Plan

Services Area

Dallas

## Key Contacts

Joshua Malone, Director of Compliance

[Joshua.Malone@childrens.com](mailto:Joshua.Malone@childrens.com)

214-456-0054

Robert Robidou, Vice President of Operations

[Robert.Robidou@childrens.com](mailto:Robert.Robidou@childrens.com)

214-456-1959

214-456-1959

## Link to Online Provider Directory

<https://www.childrensmedicalcenterhealthplan.com/home/find-doctor>

## Continuity of Care

- Existing authorizations for acute care services (like physical, occupational, or speech therapy) will be honored for six months, until the authorization expires or until the health plan conducts a new assessment.
  - Example: Your child is receiving speech therapy services under an authorization that goes through March 31, 2017.
    - If it gets close to March 31 and the health plan has not done an assessment, your providers can work with the health plan to get a new authorization.
    - If the health plan does a new assessment, the health plan will then work with your therapy provider to have them request a new authorization.
  
- Existing authorizations for long-term services and supports (like private duty nursing and personal care services) will be honored for six months or until the health plan conducts a new assessment.
  - Example: Your child is receiving personal care services under an authorization that goes through August 30, 2017.
    - Your health plan will come out to do a new assessment within the first six month period. After the health plan does a new assessment, the health plan will then work with your home health agency to initiate a new authorization.

- For the first 12 months after STAR Kids starts, Children’s Medical Center Health Plan (CMCHP) will allow members to see out-of-network Medicaid providers, including providers outside the service delivery area and, hospital-affiliated physicians, for Medicaid covered services. Authorizations and referrals to see out-of-network Medicaid providers will not be required. Authorizations for services and treatments might still be required. Notification of visit to your service coordinator is advised.
  - Example: You have an appointment with the neurologist on December 3, 2016. That neurologist is not in your health plan's network. You can still go to your appointment and your health plan will work with that provider. Your health plan will provide documentation to make sure that your provider knows that he or she can still see your child.

## Referral Policies

- A referral is not needed for STAR Kids members seeking services from an in-network specialist where there is no pre-existing relationship.
- During the first 12 months of enrollment, continuity of care will be upheld and an authorization won't be needed to see in-network specialist.
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- If an out-of-network specialist is requested to be seen a referral would not be needed from the primary care provider, but the health plan must be notified.
- If a STAR Kids member is seeking emergency or urgent services from a new specialist, a referral isn't needed.
- If a STAR Kids member is seeking services from a current in-network specialist with whom they have an existing relationship, a referral is not needed.
- If their current specialist accepts Medicaid and is out of network, CMCHP will uphold continuity of care during the first 12 months, and an authorization won't be needed to pay the claim. A referral isn't needed from the primary care provider, but the health plan will need to be notified if the specialist is an out of network Medicaid provider.

(see <https://www.childrensmedicalcenterhealthplan.com/home/for-members>)

# Community First

## Services Area

Bexar

### Key Contacts

Kelley Longhofer, STAR Kids Executive Director  
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Martin M. Jimenez  
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Phone: 210-358-6180

[Link to Online Provider Directory](http://www.cfhp.com/find-provider/star-kids/)  
[www.cfhp.com/find-provider/star-kids/](http://www.cfhp.com/find-provider/star-kids/)

### Continuity of Care

- Existing authorizations for acute care services (like physical, occupational, or speech therapy) will be honored for six months, until the authorization expires or until the health plan conducts a new assessment.
  - Example: Your child is receiving speech therapy services under an authorization that goes through March 31, 2017.
    - If it gets close to March 31 and the health plan has not done an assessment, your providers can work with the health plan to get a new authorization.
    - If the health plan does a new assessment, the health plan will then work with your therapy provider to have them request a new authorization.
  
- Existing authorizations for long-term services and supports (like private duty nursing and personal care services) will be honored for six months or until the health plan conducts a new assessment.
  - Example: Your child is receiving personal care services under an authorization that goes through August 30, 2017.
    - Your health plan will come out to do a new assessment within the first six month period. After the health plan does a new assessment, the health plan will then work with your home health agency to initiate a new authorization.

- You may continue to see physician and specialists, , including hospital-affiliated physicians, where you have an existing relationship with that primary care or specialist physician, for up to 12 months after November 1, 2016, without need for an authorization to pay the provider's claim, even if they are out of network and/or out of the Bexar service area.
  - Example: You have an appointment with the neurologist on December 3, 2016. That neurologist is not in your health plan's network. You can still go to your appointment and your health plan will work with that provider. Your health plan will provide documentation to make sure that your provider knows that he or she can still see your child.
- New procedures or tests that are to be performed by your physician might require authorization and your service coordinator can help you and your physician with that information.

### Referral Policies

- Community First Health Plans (CFHP) does not require a referral to see a specialist, but some specialists and primary care providers require or prefer to have a formal "referral."
- CFHP can help the member by working with their primary care provider's office and the specialist's office to communicate any necessary information that either provider needs.
- If the specialist isn't in-network, CFHP will try to recruit the provider, and while that is happening, a Letter of Agreement (LOA)/Single Case Agreement can be signed by the provider if necessary. These agreements can be for one or several visits and lengths of time.

(See <http://www.cfhp.com/pages/referrals-authorizations-continuity-of-care/>)

# Cook Children's Health Plan

## Services Area

Tarrant

### Key Contact

Teresa Hebert

Email: [Teresa.hebert@cookchildrens.org](mailto:Teresa.hebert@cookchildrens.org)

Phone: 682-885-5885

### Link to Online Provider Directory

[www.cookchp.org/SiteCollectionDocuments/StarKids-ProviderDirectory.pdf](http://www.cookchp.org/SiteCollectionDocuments/StarKids-ProviderDirectory.pdf)

### Continuity of Care

- Existing authorizations for acute care services (like physical, occupational, or speech therapy) will be honored for six months, until the authorization expires, or until the health plan conducts a new assessment.
  - Example: Your child is receiving speech therapy services under an authorization that goes through March 31, 2017.
    - If it gets close to March 31 and the health plan has not done an assessment, your providers can work with the health plan to get a new authorization.
    - If the health plan does a new assessment, the health plan will then work with your therapy provider to have them request a new authorization.
  
- Existing authorizations for long-term services and supports (like private duty nursing and personal care services) will be honored for six months or until the health plan conducts a new assessment.
  - Example: Your child is receiving personal care services under an authorization that goes through August 30, 2017.
    - Your health plan will come out to do a new assessment within the first six month period. After the health plan does a new assessment, the health plan will then work with your home health agency to initiate a new authorization.
  
- For the first 12 months after STAR Kids starts, Cook Children's Health Plan will allow members to see out-of-network physicians, including hospital-affiliated physicians, with whom the member has an existing

relationship, including those physicians outside the service delivery area.

- Authorizations and referrals to see such out-of-network physicians won't be required.
- Authorizations for other services and treatments might still be required.
- All providers must be Medicaid approved providers and the services provided must be Medicaid covered services.
- Example: You have an appointment with the neurologist on December 3, 2016. That neurologist is not in your health plan's network. You can still go to your appointment and your health plan will work with that provider. Your health plan will provide documentation to make sure that your provider knows that he or she can still see your child.

### Referral Policies

Cook Children's Health Plan is aware that managed care is a new model of care for STAR Kids members and families, and Cook Children's Health Plan is committed to a "continuity of care" process. As such, Cook Children's Health Plan will respect relationships that STAR Kids members have developed over time with their physicians. This means all physicians who are currently providing services, both primary and specialty services, will continue to be accessible to STAR Kids members without need for authorizations.

In operating the continuity of care process, Cook Children's Health Plan doesn't require referral or authorization to in-network specialists, including behavioral health care. While members may seek specialist services from in-network providers without Cook Children's Health Plan approval, we do encourage members to engage their primary care provider and medical home first, to ensure the specialist is the right one for the illness or condition, the specialist doesn't need information from the primary care provider and the information from the visit is communicated back to the primary care provider.

From Nov. 1, 2016 to Oct. 31, 2017, Cook Children's Health Plan will not require referral or authorization to an out-of-network specialist either in or out of the service area if the member has an established relationship with the specialist. Please note that an out-of-network physician must be a valid

Medicaid provider to receive payment for services from Cook Children's Health Plan and the services must be Medicaid covered services. Below are specific examples:

- If the member is seeking services from a new specialist with no existing relationship, CCHP does not require referral or authorization for an in-network specialist. We might require an authorization for some services that the specialist may perform, such as allergy or psychological testing.
- If the member is seeking urgent care from a new specialist, CCHP doesn't require referral or authorization for an in-network specialist. We encourage members to contact their primary care provider first, to make sure it is appropriate to wait, monitor that the illness doesn't turn into an emergency and facilitate the appointment.
- If a member is seeking emergency services from a new specialist, CCHP does not require referral or authorization if the services are needed to evaluate or stabilize the emergency medical condition and are performed by a provider that is qualified to furnish the emergency services.
- If the Member is seeking services from a specialist with an existing relationship, as noted above, from Nov. 1, 2016 to Oct. 31, 2017, CCHP will not require referral or authorization to an out-of-network specialist either in or out of the service area. We may require authorization for some services that the specialist may perform, such as allergy or psychological testing. Note that out-of-network physicians must be Medicaid providers to receive payment for services and the services must be Medicaid covered services.

(see <http://www.cookchp.org/English/members/star-kids/Pages/Specialty-Care-and-Referrals.aspx>)



## Driscoll

### Services Areas

Hidalgo, Nueces

### Key Contact

Donald A. Well

Director, Provider Relations and Contracting

615 N Upper Broadway, Suite 1621

Corpus Christi, TX 78401

[Donald.well@dchstx.org](mailto:Donald.well@dchstx.org)

Phone: 361-694-4349

Cell: 361-881-1349

### Link to Online Provider Directory

[driscollhealthplan.com/find-a-provider](http://driscollhealthplan.com/find-a-provider)

### Continuity of Care

- Existing authorizations for acute care services (like physical, occupational, or speech therapy) will be honored for six months, until the authorization expires or until the health plan conducts a new assessment.
  - Example: Your child is receiving speech therapy services under an authorization that goes through March 31, 2017.
    - If it gets close to March 31 and the health plan has not done an assessment, your providers can work with the health plan to get a new authorization.
    - If the health plan does a new assessment, the health plan will then work with your therapy provider to have them request a new authorization.
  
- Existing authorizations for long-term services and supports (like private duty nursing and personal care services) will be honored for six months or until the health plan conducts a new assessment.
  - Example: Your child is receiving personal care services under an authorization that goes through August 30, 2017.
    - Your health plan will come out to do a new assessment within the first six month period. After the health plan does a new assessment, the health plan will then work with your home health agency to initiate a new authorization.

- For the first 12 months after STAR Kids starts, you may see a **Medicaid physician specialist** (in-network or out-of-network, including hospital-affiliated physicians) **with whom you have an existing relationship** without a referral, including ones outside the service delivery area, for Medicaid-covered services. These physician specialists need to:
  - Follow all the Driscoll Health Plan (DHP) authorization and referral procedures if the provider needs to send you to another provider with whom you have no preexisting relationship.
  - Provide updates or reports of their treatment to your DHP primary care provider identified on your DHP ID card.

### Referral Policies

- For the first 12 months after STAR Kids starts, you may see a Medicaid physician specialist (in-network or out-of-network) with whom you have an existing relationship without a referral, including ones outside the service delivery area, for Medicaid Covered Services. These physician specialists need to:
  - Follow all the DHP authorization and referral procedures if the provider needs to send you to another provider with whom you have no preexisting relationship.
  - Provide updates or reports of their treatment to your DHP PCP identified on your DHP ID card.
- You may see a Medicaid non-physician provider (in-network or out-of-network) with whom you have an existing relationship, including ones outside the service delivery area, for a Medicaid-covered services covered by an existing state authorization for the shorter of the following three periods:
  - 6 months from Nov. 1, 2016
  - Until the authorization expires.
  - The STAR Kids assessment has been completed by the DHP service coordinator and you, your primary care doctor and the DHP service coordinator have agreed on the new care plan.
  - The State will provide DHP copies of these authorizations. If additional services are desired, the provider must contact your PCP or your DHP Service Coordinator.
- If you are seeking routine services from any new provider with whom you have no pre-existing relationship, you **will** need to get a referral from your primary care provider.

- If you are seeking a one-time emergency or urgent service from a new physician specialist with whom you have no pre-existing relationship, you **won't** need to get a referral.

(see <http://driscollhealthplan.com/programs/star-kids>)

# Superior Health Plan

## Services Areas

Bexar, El Paso, Hidalgo, Lubbock, MRSA West, Nueces, Travis

## Key Contact

Marisa Moreno

Email: [mmoreno@centene.com](mailto:mmoreno@centene.com)

Phone: 800-656-4817 ext. 22907

## Link to Online Provider Directory

<https://providersearch.superiorhealthplan.com>

## Continuity of Care

- Existing authorizations for acute care services (like physical, occupational, or speech therapy) will be honored for six months, until the authorization expires or until the health plan conducts a new assessment.
  - Example: Your child is receiving speech therapy services under an authorization that goes through March 31, 2017.
    - If it gets close to March 31 and the health plan has not done an assessment, your providers can work with the health plan to get a new authorization.
    - If the health plan does a new assessment, the health plan will then work with your therapy provider to have them request a new authorization.
  
- Existing authorizations for long-term services and supports (like private duty nursing and personal care services) will be honored for six months or until the health plan conducts a new assessment.
  - Example: Your child is receiving personal care services under an authorization that goes through August 30, 2017.
    - Your health plan will come out to do a new assessment within the first six month period. After the health plan does a new assessment, the health plan will then work with your home health agency to initiate a new authorization.
  
- For the first 12 months after STAR Kids starts, you may see a Medicaid out-of-network physician specialist, including hospital-affiliated physicians, with whom you have an existing relationship, including providers outside the service delivery area.

- All providers must be Medicaid-approved providers and the services provided must be Medicaid-covered services.
- Authorizations for office visits to see such out-of-network providers are not required.
- Authorizations for services and treatments may still be required.
- Superior does not require referrals for specialists. However, it is common for specialists to require a referral from the member's primary care provider before the initial specialist visit occurs. In the event members have an existing relationship with a specialist, a referral would not be needed.
- Example: You have an appointment with the neurologist on December 3, 2016. That neurologist is not in your health plan's network. You can still go to your appointment and your health plan will work with that provider. Your health plan will provide documentation to make sure that your provider knows that he or she can still see your child.

## Referral Policies

### **What is a referral?**

Your doctor will talk to you about your or your child's needs and will help make plans for you to see a specialist. This is called a referral. Your doctor will work closely with your specialist to coordinate services and make sure you are getting the care you or your child needs.

### **Do I need a referral to see a specialist?**

You do not need a referral from Superior to see a specialist. However, some specialists may require a referral from your primary care provider if you are a new patient. If your child has an existing relationship with a specialist, a referral would not be needed from your primary care provider.

### **What is an authorization? When do I need one?**

Some services or treatments provided in a specialist's office may need approval from Superior. This is called an authorization. Contact Superior to find out what requires prior authorization.

### **What if my child's specialist is not in Superior's network?**

- For six months after STAR Kids starts on Nov. 1, 2016, you or your child can continue to see a out-of-network provider, including

providers outside the service delivery area, for Medicaid covered services.

- Authorizations for office visits are not required. Authorizations for services and treatments may be required. I
- If you/your child receives services from a specialist who is not a Medicaid provider and doesn't accept your primary insurance plan, you might be responsible for the bill.
- Superior will work with you and your specialist to ensure you or your child continues to receive care until the specialist joins the Superior network or you or your child are transitioned to an in-network provider.
- If you see a specialist who is not a Superior provider or doesn't accept Medicaid, you may get a bill from your provider.

### **What if my child needs emergency or urgent services from a specialist?**

No referral or authorization is needed for emergency or urgent services as long as the provider is in Superior's network or accepts Medicaid. If the specialist is not a Superior or Medicaid provider, you may receive a bill. Please note: If emergency or urgent services were provided in an office setting, your provider should contact Superior as soon as possible after the visit because some services require an authorization.

### **My child is already has a specialist or primary care provider and we have Medicare or private insurance. Can we continue to see them?**

Yes. If your child has Medicare or private insurance you don't need a referral or authorization from Superior. Your child can continue to see their primary care provider or specialists as long as they are accepted by your private insurance or Medicare plan. If your provider leaves the network, Superior can help you find a new one.

[\(http://www.superiorhealthplan.com/2016/09/19/star-kids-referrals-and-authorizations-frequently-asked-questions/\)](http://www.superiorhealthplan.com/2016/09/19/star-kids-referrals-and-authorizations-frequently-asked-questions/)

# Texas Children's Health Plan

## Services Areas

Harris, Jefferson, MRSA Northeast

## Key Contact

RosCet Varner

Email: [roscet.varner@tchp.us](mailto:roscet.varner@tchp.us)

832-828-1078

## Link to Online Provider Directory

[www.texaschildrenshealthplan.org/find-a-doctor](http://www.texaschildrenshealthplan.org/find-a-doctor)

## Continuity of Care

- Existing authorizations for acute care services (like physical, occupational, or speech therapy) will be honored for six months, until the authorization expires or until the health plan conducts a new assessment.
  - Example: Your child is receiving speech therapy services under an authorization that goes through March 31, 2017.
    - If it gets close to March 31 and the health plan has not done an assessment, your providers can work with the health plan to get a new authorization.
    - If the health plan does a new assessment, the health plan will then work with your therapy provider to have them request a new authorization.
- Existing authorizations for long-term services and supports (like private duty nursing and personal care services) will be honored for six months or until the health plan conducts a new assessment.
  - Example: Your child is receiving personal care services under an authorization that goes through August 30, 2017.
    - Your health plan will come out to do a new assessment within the first six month period. After the health plan does a new assessment, the health plan will then work with your home health agency to initiate a new authorization.
- Texas Children's Health Plan will allow members to see out-of-network physicians, including physicians outside the service delivery area and hospital-affiliated physicians, for Medicaid covered services for the first 12 months after STAR Kids starts, (Nov. 1, 2016 to Oct. 31, 2017).

- Such out-of-network physicians would need to be valid, attested Medicaid providers if they wish to receive payment for their services from TCHP as the primary payer.
- Authorizations and referrals to see such out-of-network physicians won't be required. Authorizations for services and treatments may still be required.
- Example: You have an appointment with the neurologist on December 3, 2016. That neurologist is not in your health plan's network. You can still go to your appointment and your health plan will work with that provider. Your health plan will provide documentation to make sure that your provider knows that he or she can still see your child.

### Referral Policies

Texas Children's Health Plan has revised its policies regarding continuity of care for STAR Kids.

- Texas Children's Health Plan does not require approval referral, or authorization to in-network physician specialists, including behavioral health care, women's health care or urgent care.
- From Nov. 1, 2016 to Oct. 31, 2017, Texas Children's Health Plan will not require approval, referral or authorization to an out-of-network physician specialist either in or out of the service area. The out-of-network physician must be a valid Medicaid provider to receive payment for services from Texas Children's Health Plan.
- While Members may seek physician specialist services from in-network providers without Texas Children's Health Plan approval, we do encourage Members to engage their primary care provider and medical home first, to make sure:
  - The physician specialist is the right one for the illness or condition.
  - The physician specialist does not require information from the primary care provider.
  - The information from the visit is communicated back to the primary care provider.



Below are specific examples:

- If the member is seeking services from a new physician specialist with no existing relationship, Texas Children's Health Plan does not require approval, referral, or authorization for an in-network physician specialist.
  - From Nov. 1, 2016 to Oct. 31, 2017, Texas Children's Health Plan won't require approval, referral or authorization to an out-of-network physician specialist.
  - An out-of-network physician must be a valid Medicaid provider to receive payment for services from Texas Children's Health Plan.
  - We may require an authorization for some services that the physician specialist may perform, such as genetic or psychological testing.
- If the Member is seeking urgent care from a new physician specialist, Texas Children's Health Plan does not require approval, referral, or authorization for an in-network physician specialist.
- From Nov. 1, 2016 through Oct. 31, 2017, Texas Children's Health Plan will not require approval, referral, or authorization to an out-of-network physician specialist. An out-of-network physician must be a valid Medicaid provider to receive payment for services from Texas Children's Health Plan. We do encourage Member's to contact their primary care provider first, to:
  - Make sure it is appropriate to wait.
  - Monitor that the illness does not turn into an emergency.
  - Facilitate the appointment.
- If a member is seeking emergency services from a new physician specialist, we do not require an approval, referral, or authorization if the services are a covered benefit and are performed by a provider who is qualified to furnish the services and that are needed to evaluate or stabilize the emergency medical condition.
- If the member is seeking services from a physician specialist with an existing relationship, Texas Children's Health Plan doesn't require

approval, referral, or authorization for an in-network physician specialist.

- From November 1, 2016 through October 31, 2017, Texas Children's Health Plan will not require approval, referral, or authorization to an out-of-network physician specialist. An out-of-network physician must be a valid Medicaid provider to receive payment for services from Texas Children's Health Plan. We may require an authorization for some services that the physician specialist may perform, such as genetic or psychological testing.

(see

[http://www.texaschildrenshealthplan.org/sites/default/files/pdf/Banner%20re%20prior%20authorization--PA3\\_0.pdf](http://www.texaschildrenshealthplan.org/sites/default/files/pdf/Banner%20re%20prior%20authorization--PA3_0.pdf))

## UnitedHealthcare

### Services Areas

Harris, Hidalgo, Jefferson, MRSA Northeast, MRSA Central

### Key Contact

Member Services  
(877) 597-7799

### Link to Online Provider Directory

[http://americhoice.com/find\\_doctor/first.jsp?xplan=uhctx&xtitle=Doctor](http://americhoice.com/find_doctor/first.jsp?xplan=uhctx&xtitle=Doctor)

### Continuity of Care

- Existing authorizations for acute care services (like physical, occupational, or speech therapy) will be honored for six months, until the authorization expires or until the health plan conducts a new assessment.
  - Example: Your child is receiving speech therapy services under an authorization that goes through March 31, 2017.
    - If it gets close to March 31 and the health plan has not done an assessment, your providers can work with the health plan to get a new authorization.
    - If the health plan does a new assessment, the health plan will then work with your therapy provider to have them request a new authorization.
  
- Existing authorizations for long-term services and supports (like private duty nursing and personal care services) will be honored for six months or until the health plan conducts a new assessment.
  - Example: Your child is receiving personal care services under an authorization that goes through August 30, 2017.
    - Your health plan will come out to do a new assessment within the first six month period. After the health plan does a new assessment, the health plan will then work with your home health agency to initiate a new authorization.
  
- UnitedHealthcare agrees to allow STAR Kids members to see out of network providers for 12 months, including providers outside of service delivery areas and hospital-affiliated physicians. Referrals will not be required. Medical necessity authorizations may be required for certain services.

- Example: You have an appointment with the neurologist on December 3, 2016. That neurologist is not in your health plan's network. You can still go to your appointment and your health plan will work with that provider. Your health plan will provide documentation to make sure that your provider knows that he or she can still see your child.

## Referral Policies

- If a client is seeking services from a new specialist where there is no pre-existing relationship.
  - We do not require referrals for a member in STAR Kids to see a primary care provider and get a referral before seeing a specialist.
  - Clinical authorizations may be required to determine medical necessity for certain services such as therapies, durable medical equipment, and tube feeding. A list of services requiring prior authorization are found on our website and are not more restrictive than the current state program.
- If a client is seeking emergency or urgent services from a new specialist.
  - We don't require referrals for a member in STAR Kids to see a primary care provider and get a referral before seeing an in-network specialist.
  - Clinical authorizations may be required to determine medical necessity for certain services such as therapies, durable medical equipment, and enteral formula. A list of services requiring prior authorization are found on our website and are not more restrictive than the current program.
- If a client is seeking services from a current specialist with whom they have an existing relationship.
  - We do not require referrals for a member in STAR Kids to see a primary care provider and receive a referral before to seeing a specialist.
  - Clinical authorizations may be required to determine medical necessity for certain services such as therapies, durable medical

equipment, and enteral formula. A list of services requiring prior authorization are found on our website and are not more restrictive than the current program.

(See [http://www.uhccommunityplan.com/tx/medicaid/star\\_kids/member-information.html](http://www.uhccommunityplan.com/tx/medicaid/star_kids/member-information.html))