

## STAR Kids Frequently Asked Questions for Providers

### Contracting and Credentialing

**Q: How do I contract with a STAR Kids managed care organization (also called a MCO or health plan)?**

A: For STAR Kids contracting opportunities, please click [here](#). STAR Kids MCOs are actively contracting with providers. If you have not heard from the STAR Kids MCOs in your area, please contact the provider relations staff. Be prepared to negotiate your contract rates. The MCOs are not required to pay the same rates as traditional Medicaid. The rates they offer may be higher, the same, or lower than the FFS rate.

**Q: What will happen if I choose not to contract with a STAR Kids MCO?**

A: You can keep seeing your current clients, even if you do not join their health plan's network, for six months after the change to STAR Kids in November 2016.

If you choose not to contract with a MCO in your service area, you will not be part of the MCO's provider network. The MCO generally will not be required to reimburse you for rendered Medicaid services. There are a few exceptions where MCOs must reimburse out-of-network providers for Medicaid services (e.g., emergency services, service unavailable in the network, to meet continuity of care requirements). For requirements regarding out-of-network providers, see [1 TAC § 353.4](#).

In certain situations, a MCO may be willing to sign a single-case agreement or limited contractual relationship.

**\*Q: If I do not join a health plan's provider network, how will authorizations and payment work for that first six-month period?**

A: Your client's MCO will reach out to you after November 1 to ensure that you have the information you need to continue providing services and have a way to bill the MCO.

**Q: Can I contract with only one MCO in my service area, or do I have to contract with all MCOs in my service area?**

A: If you are a significant traditional provider (STP), the STAR Kids MCOs in your service area must offer you a contract. You should be prepared to negotiate rates with the MCOs, however, you are not required to contract with all of the MCOs in your service area. If you contract only with one MCO, be aware that Medicaid clients choose which MCO they want, and can switch MCOs at any time. Your Medicaid clients may choose to receive services from a MCO you do not have a contract with or may choose to switch to a MCO you are not contracted with. In these situations, you might not be reimbursed for rendering Medicaid services. Click here for exceptions.

**Q: If I do not sign a MCO contract, will my STAR Kids Medicaid patient be required to see another provider?**

A: STAR Kids members are generally required to see contracted in-network providers, but some exceptions apply.

**Q: I am located outside the MCOs service area, but provide services to children all over the state. Can I contract with MCOs outside my service area?**

A: Yes, this is an option. STAR Kids MCOs have multiple contracting options, such as single-case agreements, that allow them to contract with certain providers outside their service areas. To maintain member continuity of care, a MCO may contract with a provider outside its designated service areas.

**Q: Can a MCO "drop" a provider from its provider network?**

A: STAR Kids MCOs must offer contracts to "significant traditional providers" (STPs), such as primary care providers, specialists, long-term care providers, and pharmacy providers identified by HHSC as having provided a significant level of care for traditional Medicaid clients. In the first three operational years of STAR Kids (November 1, 2016 - October 31, 2019), the MCO is required to offer contracts to all Medicaid STPs identified by HHSC, and a MCO may terminate a provider contract with a STP only after demonstrating, to the satisfaction of HHSC, good cause for termination (such as fraud, waste, or abuse).

When contracting with a MCO, providers negotiate and agree to accept the MCO's reimbursement rate, maintain enrollment as a Medicaid provider, and meet MCO credentialing requirements.

To learn more about the credentialing process, reach out to your [provider contacts](#).

**Q: I am an ordering, referring, or prescribing provider only. Do I have to contract with a MCO? Do I have to enroll in Medicaid?**

A: If you are a provider who currently prescribes drugs, or orders or refers services for Medicaid clients, but you are not enrolled in Medicaid, you are not required to contract with a STAR Kids MCO. However, based on new federal requirements, to continue prescribing, ordering, or referring services for Medicaid clients, you must complete a [shortened application](#) to order, refer, or prescribe services or medications that will be reimbursed by Medicaid. For more information, visit the [TMHP provider re-enrollment page](#).

**Q: What is credentialing and how long does it take?**

A: To be credentialed, a provider will be required to submit information to the MCO, such as education history, certification, or licensing documentation. A provider must meet the MCO's credentialing requirements in order to be a provider in that MCO's network. The MCO must complete the credentialing process for a new provider and its claim systems must be able to recognize the provider as a network provider no later than 90 calendar days after receipt of a complete application. To learn more about the credentialing process, see Section 8.1.4.2 of the [STAR Kids Contract](#), or reach out to your [STAR Kids provider contacts](#).

[Significant Traditional Providers \(STPs\)](#)

**Q: What is a significant traditional provider (STP)?**

A: STPs are providers identified by HHSC as having provided a significant level of care to Medicaid clients who will be served by STAR Kids starting November 1, 2016. The STAR Kids managed care organizations (MCOs) must offer STPs an opportunity to be a part of the contracted MCO provider network. STPs must accept the MCOs' conditions for contracting, credentialing, and reimbursement to participate in managed care.

**Q: How long will the MCOs be required to maintain STPs within their provider networks?**

A: The MCO will maintain the STP enrollment requirements for the first three operational years of STAR Kids (November 1, 2016 through October 31, 2019). The MCO may not terminate a network provider agreement with a STP unless the MCO demonstrates, to the satisfaction of HHSC, good cause for early termination.

**Q: I think I should be a STP, but have been told I'm not on the STAR Kids STP list -- what should I do?**

A: For three years following the operational start date of STAR Kids (November 1, 2016 through October 31, 2019), providers who believe they meet the STP requirements may contact [HHSC](#) and request HHSC's consideration for STP status.

**Q: I am a provider for Individuals with Developmental Disabilities (IDD), and these services will not be provided through the STAR Kids MCOs. Why am I getting calls from MCOs asking me to contract as a STAR Kids provider?**

A: The MCOs may be anticipating identifying children who are not currently receiving services through an IDD waiver who could qualify for Community First Choice ([CFC](#)). The MCOs want to ensure they have the most appropriate providers in their networks to provide the CFC benefit and could consider you a STP for this service.

To learn more about the Community First Choice benefit, visit the [HHSC CFC webpage](#). The CFC webpage provides general information about the benefit and is not specific to STAR Kids.

### Medicaid Re-enrollment

**Q: What is Medicaid re-enrollment?**

A: As a requirement of the Patient Protection and Affordable Care Act (PPACA), state Medicaid agencies must revalidate the enrollment of all providers in state Medicaid programs. This means Texas Medicaid providers, including ordering, referring, and prescribing providers, who have not met revalidation requirements, must complete the re-enrollment process.

To avoid a potential disruption in payment, providers must submit a Medicaid re-enrollment application on or before June 17, 2016, to be revalidated by September 24, 2016. To learn more about Medicaid re-enrollment, and to avoid a disruption in payment, visit the [TMHP provider re-enrollment page](#).

**Q: I am an ordering, referring, or prescribing (OPR) provider only. Do I need to complete the same application as other providers for Medicaid re-enrollment?**

A: Ordering, referring, or prescribing providers must complete a [shortened application](#) to order, refer, or prescribe services or medications that will be reimbursed by Medicaid.

**Q: Does enrolling in Medicaid mean an OPR provider must see all Medicaid patients?**

A: Enrolling as an OPR provider:

- Does not obligate you to see Medicaid patients;
- Only requires the submission of a shortened application and does not require an application fee;
- Does not mean you will be listed as a Medicaid provider for patient assignment or referral;
- Does not require an annual renewal - OPR providers will be required to renew every five years and will receive a reminder notification;
- Allows you to continue to see Medicaid patients without billing the Medicaid program if you so choose; and,
- Helps ensure that your orders, prescriptions and referrals for Medicaid patients are accepted and processed appropriately.

## Claims and Reimbursements

### **Q: What is the HHSC definition of a clean claim?**

A: A clean claim means a claim submitted by a provider for Medicaid-covered services rendered to a STAR Kids member, with the data necessary for the MCO or subcontracted claims processor to adjudicate and accurately report the claim. For more information, see the [STAR Kids contract](#), and [UMCM Chapter 2.0](#).

### **Q: How many days do I have to submit a claim?**

A: Claims (including claims for MDCP services) must be submitted within 95 days of the date of service. If a claim is not received by the MCO within 95 days, the MCO must deny the claim, with exceptions. For more information, see [UMCM Chapter 2.0](#), or refer to your STAR Kids MCO provider manual(s).

### **Q: I am a Medically Dependent Children's Program (MDCP) provider. How many days do I have to submit a claim?**

A: Currently, MDCP providers have [one year](#) to submit claims. Beginning November 1, 2016, MDCP providers will be required to submit claims to the STAR Kids MCOs **within 95 days of the date of service**.

TMHP will deny MDCP claims for dates of service submitted on or after November 1, 2016. TMHP will continue to pay MDCP claims for services rendered before November 1 2016.

### **Q: How many days does the MCO have to pay a claim?**

A: Once a clean claim is received, the MCO must adjudicate clean claims within 30 days. Pharmacy claims received electronically must be adjudicated within 18 days, and non-electronic pharmacy claims must be adjudicated within 21 days. For more information, see [UMCM Chapter 2.0](#), and [UMCM Chapter 2.2](#), or refer to your MCO provider manual(s).

### **Q: Can I submit claims electronically?**

A: The MCO must offer its providers the option of submitting and receiving claims information through electronic data interchange (EDI) that allows for automated processing and adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. Electronic claims must use HIPAA-compliant electronic formats. For more information, see [UMCM Chapter 2.0](#), or refer to your MCO provider manual(s).

### **Q: I am an LTSS provider. Is there anything special I need to know about STAR Kids LTSS billing?**

A: LTSS providers must bill for and report services using a standard STAR Kids Billing Matrix. The STAR Kids LTSS Billing Matrix can be found on the STAR Kids webpage. MCOs must require all providers rendering LTSS, with the exception of atypical providers to use the CMS 1500 Claim Form or the HIPAA 837 Professional Transaction when billing. Atypical providers will submit appropriate documentation to the MCO.

## Authorizations

### **Q: Will the MCO require authorizations for services? Will authorization requirements be the same across MCOs?**

A: MCOs will require authorizations for certain services. Authorization requirements, including frequency and what services will require authorizations, will vary by MCO. Refer to your MCO provider manual(s) for information on authorization requirements.

**Q: Who will authorize Personal Care Services (PCS), Private Duty Nursing (PDN), Community First Choice (CFC), and Medically Dependent Children's Program (MDCP) services under STAR Kids?**

A: MCOs will be responsible for assessing and authorizing PCS, PDN, and MDCP services. MCOs will also assess and authorize [CFC](#) services, except for individuals who are receiving CFC services through an Individuals with Developmental Disabilities (IDD) waiver (Community Living Assistance and Support Services (CLASS), Deaf-Blind with Multiple Disabilities (DBMD), Home and Community-based Services (HCS), Texas Home Living (TxHmL)).

**Q: Will the MCO deny a claim based on authorization?**

A: If the MCO requires an authorization for a certain service, and the provider does not have authorization for that service, the MCO will deny the claim. For information on how to submit an authorization request, refer to your MCO provider manual(s).

**Q: Will the MCO honor existing authorizations, and if so, for how long?**

A: STAR Kids MCOs must honor existing authorizations for long-term services and supports (like Personal Care Services (PCS), Private Duty Nursing (PDN), Community First Choice ([CFC](#)), or Medically Dependent Children's Program (MDCP) waiver services) for six (6) months, or until the MCO completes a new assessment. Existing authorizations for acute care services (like doctor visits, hospital visits, and labs) must be honored for six months, until the end of the current authorization period, or until the MCO completes a new assessment.

**\*Q: I have heard authorizations are being extended for some services? What does that mean?**

A: If you have an authorization for PDN, PCS, CFC, or therapies that will expire any time in October or November 2016, HHSC will extend it by 90 days to help ensure continuity of care. You and your client will receive a letter explaining this in late October.

**\*Q: I am an MDCP provider and my client received a letter stating that their individual plan of care (IPC) was extended by one year. What does this mean?**

A: This means that your client can keep getting MDCP services they currently receive for one year. These services include: respite, flexible family support services, adaptive aids, minor home modifications, transition assistance services, employment assistance, and supported employment. If your client has a change in condition or needs to change those services, they can ask their MCO service coordinator. This extension does not apply to other services, like PDN.

**Q: How will the authorization process work for dual-eligible members?**

A: When an authorization request for any long-term services and supports, including Personal Care Services (PCS), Private Duty Nursing (PDN), Community First Choice ([CFC](#)), is submitted to a STAR Kids MCO for a dual-eligible member, the MCO must not require providers to submit a Medicare denial for services that are never covered or paid by Medicare. For more information, see [UMCM Chapter 2.0](#), or refer to your MCO provider manual(s).

Under Medicare, referrals to specialists are required for Medicare members with a Medicare health maintenance organization (HMO) plan or a Medicare Special Needs Plan (SNP). Referrals are generally not needed for Medicare members in a preferred provider organization (PPO) plan, or who have "original" Medicare.

**Q: How will authorizations work for long-term services and supports like Personal Care Services (PCS), Private Duty Nursing (PDN), Community First Choice (CFC), or Medically Dependent Children's Program (MDCP) waiver services?**

A: MCOs will assess the need for long-term services and supports and other services through the Screening and Assessment Instrument (SAI). Providers will continue to be responsible for gathering required documentation and requesting authorization in accordance with the MCO's policy.

**Q: Will the prior authorization requirements change for Mental Health Targeted Case Management and Mental Health Rehabilitation Services provided to STAR Kids members?**

A: No. MCOs and providers of these services will follow the procedures described in [UMCM Chapter 15.1](#), Utilization Management. Also refer to your MCO provider manual(s).

## Eligibility

**Q: How do I verify Medicaid eligibility?**

A: Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not necessarily mean the patient has current Medicaid coverage. You must still verify eligibility. There are several ways to do this:

- Swipe the patient's Your Texas Benefits Medicaid card through a standard magnetic card reader, if your office uses that technology.
- Search for the patient using [www.YourTexasBenefitsCard.com](http://www.YourTexasBenefitsCard.com), a secure website with a variety of useful features for Medicaid providers.
- Use TexMedConnect on the [TMHP website](#).
- Call the Your Texas Benefits provider helpline at 1-855-827-3747 (toll-free).
- Call Provider Services at the patient's MCO.

## Screening and Assessment Instrument (SAI) for STAR Kids

**Q: What is the Screening and Assessment Instrument (SAI)?**

A: The Screening and Assessment Instrument (SAI) is a comprehensive, person-centered, needs-based assessment. MCOs must administer the SAI to all members on an annual basis. The purpose of the SAI is to identify members' needs, possible barriers to care, and member and family preferences.

This modular assessment includes triggers that advance children into more extensive modules based on their needs:

- Core module (all STAR Kids members will receive the Core module);

- Personal care assessment module (PCAM), used to assess for attendant care needs;
- Nursing care assessment module (NCAM), used to assess for nursing needs; and
- Medically Dependent Children's Program (MDCP) module, used to determine the MDCP budget.

It also flags items for further follow-up by the MCOs, such as the need for durable medical equipment (DME), behavioral health services, or other therapies. SAI information will be used to inform the individual service plan (ISP).

**Q: Who will complete the SAI?**

A: The SAI will be administered by a nurse or other professional employed by or contracted with the STAR Kids MCO. STAR Kids MCOs will use the SAI to develop individual service plans.

**Q: Can I see a copy of the completed SAI?**

A: Yes. The STAR Kids MCO must share the completed SAI with any contracted provider upon request.

**Q: Can I see a copy of my client's ISP?**

A: Yes. STAR Kids MCOs are expected to share the ISP with providers.

[Readiness Review](#)

**Q: How will HHSC oversee and enforce the access requirements defined in the managed care organization (MCO) contracts to ensure the availability of resources and providers?**

A: HHSC employs a process called "readiness review (RR)" to examine a contracted managed care organization's preparedness and ability to fulfill its obligations under Sections 7, 8.1.1.2, and 8.1.17 of the [STAR Kids Contract](#). During RR, MCOs are required to submit a comprehensive plan for network adequacy that includes a list of all contracted and credentialed providers, in an HHSC-approved format. The plan must include a description of additional contracting and credentialing activities scheduled to be completed before the operational start date. The MCO must submit a listing of all contracted and credentialed providers to be included in the first provider directory 90 days prior to the first enrollment packet mail out, or as otherwise directed by HHSC.

On a continuing basis, MCOs must submit quarterly reports to HHSC. In return, HHSC:

- Evaluates GeoAccess standards
- Analyzes provider data (network panel status reports, provider turnover rates, and enrollment broker reports)
- Considers access to care complaints
- Reviews out-of-network utilization
- Verifies the accuracy of provider directories
- HHSC presentation to the State Medicaid Managed Care Advisory Committee regarding network adequacy (PDF).

**Q: What process will be used to assess readiness for each of the MCOs in their respective service areas? What is being measured to determine readiness prior to implementation?**

A: HHSC employs a process called "readiness review (RR)" to examine a contracted MCO's preparedness and ability to fulfill its obligations under Sections 7, 8.1.1.2, and 8.1.17 of the [STAR Kids Contract](#). Given how MCOs vary in size, experience, and ability, HHSC takes a risk-based approach to RR. This means the RR process may be adjusted based on new member risks and needs. MCOs must satisfy all RR

requirements prior to the operational start date for each applicable MCO program and service area.

Areas reviewed by HHSC include:

- Organizational (corporate background structure, material subcontractor information, etc.)
- Financial (bond documentation, financial update report, affiliate report, etc.)
- Systems (developing, installing, testing of systems; data extracts, transfers, and transmissions; test files for systems and interface testing; demonstration of systems capabilities and adherence to contract specifications; etc.)
- Operations (policies and procedures, network adequacy, claims processing, staff and provider training, etc.)