Frequently Asked Questions and Answers: Managed Care Organizations and HCS/TxHmL Program Providers

Pharmacy/Medication Related Questions:

1) Question: After the initial transition pre-authorization period, how will Home and Community-based Services (HCS) or Texas Home Living (TxHmL) program providers be involved in advance of any potential changes in medications, particularly psychotropic medications that will have a direct impact on the ability of the program providers to deliver care?

Answer: The program provider is responsible for procuring prior authorization requirements for medications from the managed care organization (MCO) so they can anticipate what medications will require prior authorization. The Health and Human Services Commission (HHSC) is advising the program providers to inform the MCOs’ service coordinators (SC) about individuals who have very delicate medication regimens that cannot be altered without risk to the individual. HHSC suggests this information be communicated as soon as possible after the individual enrolls into STAR+PLUS, so this information can be documented by the MCO. If a medication change is made that concerns the program provider, the program provider should discuss their concerns regarding the change in medication with the prescribing practitioner or MCO SC prior to filling the prescription.


For more information, please refer to the DADS Alert dated August 19, 2014: [Steps to Alleviate Delays in Filling Needed Prescriptions for Individuals Affected by the STAR+PLUS Managed Care Expansion of Acute Care Services](http://www.txvendordrug.com/downloads/prescriber-assistance-chart.pdf).

The MCOs have a requirement in their contract to conduct drug utilization reviews. The MCO's Drug Utilization Review should specifically assess prescribing patterns for psychotropic medications as defined by Texas Family Code § 266.001(7). If the MCO identifies patterns outside of the MCO’s parameters for psychotropic medications, or if HHSC notifies the MCO of outlier prescribing patterns, then the MCO must conduct a peer-to-peer discussion on the appropriateness of the drug regimen with the prescriber.

For children, the MCO must model its parameters on the Department of Family and Protective Services (DFPS’s) “Psychotropic Medication Utilization Parameters for Foster Children.” (See DFPS’s website for more information: [http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp](http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp)).

For adults, the MCO must base its parameters for psychotropic medications on a peer-reviewed, industry standard such as the Department of State Health Services (DSHS) Psychotropic Drug
Formulary at http://www.dshs.state.tx.us/mhprograms/Formulary.shtm. The DSHS Psychotropic Drug Formulary provides tables summarizing the recommended dosage ranges for psychotropic drugs for children, adolescents, and adults. These dosage ranges are guidelines and are not intended to replace other references or the clinician's clinical judgment.

2) **Question:** STAR+PLUS plans are required to cover an emergency 3-day supply if medication runs out. Who is responsible for payment of the medication if the 3-day supply runs out and the STAR+PLUS plan has not received a new order? Who is responsible for obtaining a new order?

**Answer:** The program provider is responsible for getting medication prescriptions and ensuring that the individual does not run out of medications. The program provider can solicit the help of the MCO SC if there is difficulty getting a prescription filled. The MCO will pay the pharmacy for approved prescribed medications that are part of the Medicaid formulary. If there are no refills remaining, the program provider should contact the physician and coordinate refill authorizations to the pharmacy. If filling the order is delayed due to need for prior authorization, it would be expected that program providers show documented efforts to coordinate this prior authorization with the MCO well in advance of the 24 hour period allowed for MCOs to make a prior authorization determination. HCS Texas Administrative Code (TAC) reference: §9.174(a)(31). TxHmL TAC reference: §9.555(c).

3) **Question:** When a STAR+PLUS Member loses Medicaid eligibility, who is responsible for payment of medication?

**Answer:** At this time, current processes to obtain medications when a person loses Medicaid Eligibility should be used. For Example: the program provider may ask the pharmacy to delay billing for the medication until Medicaid is restored, or may pay for medications in hopes that the pharmacy will reimburse them once the pharmacy files a claim and is paid for medications during the retroactive period of Medicaid eligibility.

For Additional Information regarding loss of Medicaid Eligibility, see the following PDF and link regarding addition of CARE Screen C63:
http://www.dads.state.tx.us/providers/communications/alerts/alerts.cfm?alertid=1678

**Nursing/Medical Questions:**

4) **Question:** What is a “medically fragile plan”, and who is responsible for developing it?

**Answer:** There is no “medically fragile” plan or program. There are plans and programs developed for individuals who are medically fragile. The program provider Registered Nurse (RN) is required to complete a comprehensive nursing assessment. The RN must also develop the “plan of care” that reflects any nursing tasks that will be provided. It is recommended that program providers share the “plan of care” for individuals who are medically fragile with the
MCO SC. The revised version of the HHSC STAR+PLUS handbook will include requirements regarding information sharing between MCOs and program providers.

5) **Question:** Will communication between the RNs or licensed vocational nurse (LVNs) employed by the HCS or TxHmL program provider and the STAR+PLUS plan be considered billable under the HCS and TxHmL programs?

**Answer:** Billing and Payment Guidelines state that currently it is not allowable for an RN to bill for speaking to another RN or for an RN to bill for speaking to an LVN unless the RN is supervising the work of the LVN. Billing is allowable for participating in service plan team meetings to coordinate and assess an individual’s health status. In addition, an HCS or TxHmL program provider RN/LVN could bill for time spent communicating with a MCO service coordinator only if the communication took place in the context of a service plan team meeting.

**Survey and Certification Questions:**

6) **Question:** Prior to the STAR+PLUS roll out, DADS reviewers could cite a deficiency or impose other punitive action for not completing, or not completing in a timely fashion, orders issued by the physician. Will the HCS and TxHmL program providers still be cited while they are waiting for a service authorization from the STAR+PLUS MCO? Will the HCS and TxHmL program providers be expected to pay for the test, evaluation or service when the MCO denies it while an appeal takes place?

**Answer:** HCS and TxHmL Providers need to work with the physician and MCO to ensure individual’s health and safety. HCS TAC reference: §9.174(a)(31). TxHmL TAC reference: §9.555(c).

As stated in Information Letter 14-81:

If a program provider experiences coordination difficulty with an MCO, each of the health plans has a provider hotline and providers are encouraged to contact the MCO to resolve concerns. Additionally, the provider may elevate the issue to HHSC by emailing HHSC’s complaint mailbox: HPM_complaints@hhsc.state.tx.us. However, as with other situations in which the program provider meets with a challenge to obtaining an acute care service, Waiver, Survey and Certification would expect to see documented attempts to obtain MCO approval for an ordered service or procedure up to and including through the appeal process. If the appeal is denied, the program provider must work with applicable parties, such as a physician or other health care professional, LAR and service planning team to develop an alternative plan to meet the individual’s need.

MCO Service Coordinator Questions:

7) **Question:** Does the MCO SC write a comprehensive service plan for individuals who receive HCS or TxHmL waiver services and are enrolled in STAR+PLUS?

**Answer:** HHSC does not require the MCO SC to write “a comprehensive service plan” for individuals in an IDD waiver. The MCO SC may develop a document, especially for individuals who are medically fragile, that outlines the acute care services to be provided to individuals who receive HCS or TxHmL waiver services. The MCO SC is expected to share information with program providers. The revised version of the HHSC STAR+PLUS handbook will include requirements regarding information sharing between MCOs and program providers. If the program provider has any MCO documents they should consider the content of these documents when developing the individual’s implementation plan.

8) **Question:** For emergent acute care issues, who should be contacted first: the MCO SC or the Local Intellectual Developmental Disability Authority (LIDDA) SC?

**Answer:** If a situation is a true emergency, emergency services should be accessed prior to contacting either the MCO SC or the LIDDA SC. Current policy does not exist that dictates whether the MCO SC or the LIDDA SC should be contacted first. However, since the question specifically asks about emergent acute care services, it may be advantageous to contact the MCO SC first so that the MCO SC can intervene, if necessary, to ensure the individual receives appropriate and timely acute care services.

Payer/Medicaid Eligibility Questions:

9) **Question:** If an individual has Medicaid and private insurance, will the individual enroll with a STAR+PLUS MCO? What is the order of payment responsibility for the MCO, private insurance and waiver program?

**Answer:** Currently the Texas Health and Human Services Commission, Medicaid for the Elderly and People with Disabilities (MEPD) Handbook, Chapter D, Subchapter 7000-3rd Party Resources states that Medicaid is considered the payer of last resort for a person's medical expenses. The private insurance would be billed first and the STAR+PLUS plan is responsible for all acute care Medicaid covered services. The waiver would continue to provide covered waiver services that are not paid by private insurance or included in STAR+PLUS acute care.

10) **Question:** Will individuals be able to maintain participation in the Health Insurance Premium Payment (HIPP) program? Who will be responsible for premium payments, and who will be responsible for copayments and deductibles?

**Answer:** On July 25, 2014, the following information was released in a DADS alert:
To ensure access to long-term services and supports, individuals enrolled in, or eligible for, the STAR+PLUS program may receive coverage through Medicaid and HIPP. Although clients will need to select a Medicaid-enrolled primary care provider (PCP) under STAR+PLUS, clients can
continue to see the PCP and specialists they currently see through their employer-sponsored insurance. (Designation of a STAR+PLUS PCP will not impact designation of PCPs under employer-sponsored insurance.) The client is responsible for all associated cost sharing for non-Medicaid covered benefits or if the PCP and specialist they see are not Medicaid-enrolled providers related to their employer-sponsored insurance.

Beginning on September 1, 2014, some individuals enrolled in a 1915(c) waiver for individuals with intellectual and developmental disabilities (IDD) or residing in a community-based intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID) will begin receiving their acute care services, such as doctor's visits and prescription drugs, through the STAR+PLUS program. The 1915(c) IDD waivers are Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services (HCS) and Texas Home Living (TxHmL). These individuals may also be enrolled in HIPP. Under these circumstances:

- HIPP will reimburse clients for all or part of their employer-insurance premiums,
- STAR+PLUS MCOs will cover cost-sharing related to the employer-sponsored insurance for Medicaid-covered services provided by a Medicaid provider,
- STAR+PLUS MCOs also will cover Medicaid-covered acute care services provided by a Medicaid provider not available through the employer sponsored insurance, and
- The IDD waivers and ICFs-IID will provide long-term services and supports.

11) Question: How can providers and individuals obtain assistance with Medicaid and STAR+PLUS eligibility issues?

Answer: Individuals and program providers can request assistance with eligibility issues from the MCO. Individuals and program providers can also call DADS Help for Texans toll-free line 1-855-937-2372.

Additionally, program providers can contact the Health Plan Management email listed below for assistance with any managed care-related issue, including situations in which Medicaid status is affected because of SSI:

HPM_complaints@hhsc.state.tx.us

In an effort to assist HCS/TxHmL program providers track individuals Periodic Review Dates; DADS has added a new field, Periodic Review Date (PRD) to the CARE Screen C63. The (PRD is the due date for a Medicaid recipient’s annual redetermination. PRD serves as a useful tool to assist HCS/TxHmL program providers in tracking individuals Medicaid eligibility expiration dates. For more information see link below:

http://www.dads.state.tx.us/providers/communications/alerts/alerts.cfm?alertid=1678

Psychiatric Services Questions:

12) Question: How do HCS and TxHmL providers access emergency psychiatric services for individuals when individuals are enrolled in STAR+PLUS? If the MCO
service coordinator is not available, what type of assistance will the 24 hour nursing line be able to provide during a serious psychiatric episode?

Answer: MCO approval for emergency services is not required. If the situation is a true psychiatric emergency, emergency services should be accessed prior to contacting either the MCO SC or the LIDDA SC.

If the MCO offers a nurse line, they are operated 24 hours a day, 7 days a week, and can advise program providers on how to access emergency psychiatric services.

The program provider must take appropriate action to ensure the health and safety of the individual. The program provider is currently responsible for having behavioral support plans in place for individuals whose needs support the behavioral support waiver service. These plans should include what to do if there is a behavioral emergency. Staff should be aware of what these behavioral support plans include, be trained on how to implement them and know who to contact and what to do in case of a behavioral emergency. Program providers are responsible for responding to emergency situations as documented in the behavioral support plan and immediately as the situation requires. A psychiatric crisis may require the program provider to contact the appropriate emergency service and have the individual evaluated. Reference: 9.174(a)(31) for HCS and 9.555(c) for TxHmL.

13) Question: Many program providers use a treatment team approach. Would both the IDD provider psychologist and MCO psychiatrist be able to bill at the same time?

Answer: Yes, both the HCS or TxHmL provider psychologist and the MCO psychiatrist can bill for team meetings. According to the HCS/TxHmL billing guidelines, Section 3720 Multiple Service Providers, No. 1 - Multiple Service Providers of the Same Service Component or Subcomponent with a 15-Minute Unit of Service, subparagraph 1a - Performance of the Same Activity, multiple service providers of the same service component or subcomponent with a 15 minute unit of service, as listed in Section 3510, 15-Minute Unit of Service, may perform an activity at the same time for the same individual if multiple service providers are needed to perform the activity.

According to the HCS and TxHmL billing guidelines HCS and TxHmL program providers can also submit a service claim for service providers of Professional Therapies, Nursing, Day Habilitation, Supported Home Living, Supported Employment, Employment Assistance and Community Support service components and their subcomponents where applicable for participating in service plan team meetings.

Therapies Questions/Concerns:

14) Question: Will the HCS/TxHmL program provider secure prior authorization for therapy services through the STAR+PLUS MCO first to see if they are denied before putting them on the IPC?
The requirements for adding therapy services to the IPC have not changed. Program providers must ensure that therapy services are not covered under STAR+PLUS, or other resources before adding to an IPC. DADS encourages ongoing communication between IDD providers and MCOs. As stated in Information Letter 14-38 (See Above): To facilitate the development of a coordinated service plan, in addition to service planning team members required by the program, consideration should be given to inviting the MCO SC and the LTSS service provider(s), along with others involved in the individual’s life.

**15) Question:** The STAR+PLUS MCO covers acute/rehabilitative therapies, while HCS covers habilitative therapies. What are the processes for resolving disagreements as to whether therapy is considered acute/rehabilitative or habilitative?

**Example:** Someone is discharged from the hospital. There is an order for physical therapy (PT). The MCO denies the request for an evaluation, denies the number of visits requested, and/or approves very few sessions. The IDD provider’s contracted PT believes they need PT or more PT than was authorized.

**Example:** PT services are denied by STAR+PLUS because the MCO considers the IDD waiver service habilitative. Can program providers use PT services through the IDD waiver and be in compliance with DADS rules?

**Answer:** The MCO will send a letter to the member/legally authorized representative (LAR) anytime a service is denied, terminated or reduced. The MCOs have agreed to send a copy of the letter to the program providers and LIDDA SC upon request. The letter also contains information on how to contest the decision through an appeal process with the MCO and/or the fair hearing process through HHSC. If a doctor or service provider of professional therapies orders a set number of therapies and the MCO denies all or a portion of the ordered hours, DADS will consider the MCO denial letter as evidence that the service is not available through the MCO. Once an MCO denial letter is received by the program provider, the service can be added to the individual’s IPC, and the LIDDA SC will update the PDP if necessary. The HCS/TxHmL waiver will continue to provide waiver services that are not covered or are denied by the MCO. HCS TAC reference: §9.154(c) and 9.174(a)(27). TxHmL TAC reference: §9.555(k).

**Value Added Services Questions:**

**16) Question:** How do value added services (VAS) coordinate with IDD waiver services?

**Answer:** VAS are not “acute care services”. They are services or resources not covered through Medicaid offered by an MCO. A clarification regarding the use of VAS is available on the HHSC website: [http://www.hhsc.state.tx.us/medicaid/managed-care/mmc/starplus-expansion/adding-basic-health-services.shtml](http://www.hhsc.state.tx.us/medicaid/managed-care/mmc/starplus-expansion/adding-basic-health-services.shtml)

**17) Question:** What services must the HCS or TxHmL waiver provide before a VAS is used? For example:
a.) Can HCS and TxHmL providers access the non-emergency transportation service in order to transport clients to a medical appointment?
b.) Some MCO’s offer quarterly pest control. Is that available if an individual living in an HCS residential setting chooses an MCO that covers pest control?

Answer:

a) The Medical Transportation Program is not a VAS. According to the HHSC website, “the Medical Transportation Program sets up non-emergency rides for people who have no other way to get to their Medicaid health-care visits.” Some of the MCOs provide transportation services beyond MTP as a VAS. If transportation is included in the service definition for an HCS service that an individual receives or is eligible for, transportation should be provided through that service. Services that include transportation are Residential Supports, Supervised Living, Host Home/Companion Care and Supported Home Living. If an individual is an HCS recipient who lives in their own home or family home, and does not receive transportation through supported home living, the individual may use the Medical Transportation Program or transportation offered by their MCO as a value added service.

b) If pest control is included in the individual’s room and board agreement for a residential setting, it cannot be accessed as a VAS by the individuals living in that home.

18) Question: How should Dental services covered under IDD waivers and dental VAS provided through the MCO be used in relationship to each other?

Answer: VAS are health-related services or resources available through an MCO that are not covered by Medicaid. Each MCO identifies the VAS that MCO will offer for each service delivery area. The VAS must be approved by HHSC. Some MCOs offer dental services (such as $250 for routine cleanings) to adults, since these services are not covered by Medicaid.

An FAQ related to Dental Services and Value Added Services is posted on the HHSC Managed Care website:

http://www.hhsc.state.tx.us/medicaid/managed-care/mmc/starplus-expansion/adding-basic-health-services.shtml

VAS are intended to be a benefit, not a burden, to the STAR+PLUS member. The program provider will not be billing for VAS services. It is possible that in order to access a VAS, a dentist other than the individual’s established dentist may have to be used. Most VAS services are limited in scope and will not cover extensive dental services. The ability and advantages of a STAR+PLUS member accessing a VAS service must be made on an individual basis.

Adaptive Aids Questions:

19) Question: Will DADS require program providers to show additional documentation of Medicaid denial for adaptive aids besides a denial letter for the MCO SC?

Answer: DADS requires a Medicaid or MCO denial before the item is purchased through adaptive aids. Refer to Section 6100 of the HCS and TxHmL billing guidelines for specific
documentation required for adaptive aids. DADS will accept an MCO denial letter for adaptive aids as proof of non-coverage by Medicaid.

20) Question: Is there a list of adaptive aids that must have an MCO denial before they can be added to the IPC?

Answer: The STAR+PLUS MCO is responsible for covering every acute care service that is covered by traditional (fee-for-service) Medicaid. As in fee-for-service Medicaid, the STAR+PLUS MCOs use certain criteria to determine whether a benefit will be provided. If an adaptive aid may be covered by STAR+PLUS, that adaptive aid should be requested through the STAR+PLUS program, and the MCO will determine whether it is a covered benefit. Click here for the list of Adaptive Aids and Medical Supplies covered by Acute Care Medicaid and Adaptive Aids covered in the HCS and TxHmL waiver located in Appendix VII from the HCS Billing Guidelines.

Appeals/Difference of Opinions Questions/Concerns:

21) Question: What are the processes for appeals and decision making when services are delayed? For example:
   a.) Discharge planning after an acute medical hospitalization?
   b.) Placement of an individual after a behavioral/psychiatric crisis?

Answer:
A) The LIDDA SC and program provider should coordinate and communicate with the hospital and MCO SC to ensure that a discharge plan is developed prior to discharge from an acute care hospital. The MCO is responsible for the provision of acute care services. An individual who requires additional inpatient treatment from a rehabilitation facility or nursing facility should not be released from an acute care hospital until admission to the rehabilitation facility or nursing facility is arranged. HCS TAC reference: §9.174(a)(31). TxHmL TAC reference: §9.555(c).

B) The program provider is currently responsible for having behavioral support plans in place for individuals whose need require behavioral supports waiver service. These plans should include what to do in an emergency situation. Staff should be trained on the individual’s behavioral support plan which should include who to contact and what to do in case of a behavioral emergency. The LIDDA SC and program provider should coordinate and communicate an individual’s behavioral health needs with the MCO SC. The MCO is responsible for providing behavioral health services including inpatient psychiatric hospitalization. For individuals in the Dallas service area, the NorthSTAR Managed Care program is responsible for delivery of behavioral health services. HCS TAC reference: §9.178(v). TxHmL TAC reference: §9.580(p).

MCOs are required to have critical elements included in the member handbook, such as the appeal process (Section K) and the Expedited MCO Appeal (required language in Attachment FF) Uniform Managed Care Manual: http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/
22) Question: What are the roles of the MCO SC and LIDDA SC and how do they collaborate with each other?

Answer: MCOs are responsible for the appropriate and timely provision of acute care services. HCS and TxHmL program providers should contact the MCO SC for matters relating to the provision of acute care services. The LIDDA SC is responsible for coordination of HCS and TxHmL waiver services. HCS and TxHmL program providers should contact the LIDDA SC for matters relating to the IHCS and TxHmL waiver services. Please refer to IL 14-38 on the DADS website: http://www.dads.state.tx.us/providers/communications/2014/letters/IL2014-38.pdf

For additional information related to MCOs and HCS/TxHmL, recipients and providers should utilize the following links:

- **DADS HCS & TxHmL Provider Resources** - to access use the link located on the left hand side of the page titled Managed Care Expansion Resources: http://www.dads.state.tx.us/providers/HCS/index.cfm

- **Information Letter 14-81 Program Provider Responsibilities Regarding Acute Care Services**: http://www.dads.state.tx.us/providers/communications/2014/letters/IL2014-81.pdf


- **For more information regarding Health Plan Management inquiries**: HPM_complaints@hhsc.state.tx.us