Private Provider Association of Texas (PPAT) Annual Conference
Doubletree Hotel Austin, Texas

STAR+PLUS: MCOS' GUIDANCE TO ADDRESSING SERVICE BARRIERS & RESOLUTIONS

NOVEMBER 16, 2017

Topics to Cover

- **What is STAR+PLUS?**
  - Tenets of Service Coordination
- **How to resolve issue(s) with an MCOs**
  - Filing a complaint
  - Appeals and Fair Hearings
- **Who to call or outreach for Assistance?**
  - MCO Contact Information
- **What is a Member Advocate?**

Member/Provider Services

- **When do I call Member Services?**
  - ✓ Verifying eligibility, benefits and prior authorizations on file
  - ✓ Processing member changes to their PCP
  - ✓ Providing assistance with the website & secure Member Portal
  - ✓ Call to get in contact with a Member Advocate or their assigned Service Coordinator
  - ✓ Get a member ID card
  - ✓ Need assistance with Medical Transportation Program (MTP)

Member/Provider Services (continued)

- **When do I Call Provider Services?**
  - ✓ Assisting providers and connecting to the correct departments
  - ✓ Verifying claims receipt or review claims status
  - ✓ Providing assistance with the public website & secure Provider Portal
- **How does the Member Advocates help?**
  - ✓ Help locate doctors and specialists who are able and familiar with serving members with IDD
  - ✓ Help arrange for transportation, if Member is needing assistance
  - ✓ Help members file and/or Appeal or answer questions about the status of an Appeal

Service Coordination

- Service Coordination is the cornerstone of the STAR+PLUS program
- Promote and advocate " One Call" resolution
- Each member is assigned a Service Coordinator (e.g. Licensed Social Worker, Licensed Vocational Nurse (LVN) Registered Nurse (RN) or Nurse Practitioner (NP)
- Identify and address any unmet needs
- Assistance with transportation to medical appointments
- Service Coordinator is responsible for coordinating Members' acute and health care needs

Service Coordination (continued)

- Assist member and caregivers with Long Term Services and Supports Planning
- Service Coordinator works with a multi-faucet inter-disciplinary team of physicians, caregivers, family members, Legal Authorized Representative, Behavioral Health and Long Term Supports and Services (LTSS) providers
- Assist with Inpatient (IP) Discharge Planning and Transition back to the community
- Assist in developing an individualized person-centered Service Plan or Plan of Care addressing the member's preference and needs with dignity, respect and linguistic and cultural manner

Complaints

- **Why submit a complaint?**
  - ✓ When you can't get an issue resolved, file a complaint. We want to help.
  - ✓ All complaints must be resolved within 30 days

- **Who is my first source for resolving an issue or filing a Complaint**
  - ✓ Determine the MCO the member is enrolled with
  - ✓ Recommend outreach to the MCOs' field-based Provider Support Representative for issue resolution
  - ✓ If you still need to file a complaint, process is detailed in the MCOs' Provider Manual is located online on each MCOs' website

- **Providers may file a complaint with HHSC after exhausting complaint procedures**
  - HPM_Complaints@hhsc.state.tx.us or
  - Texas Health and Human Services Commission
    Health Plan Management – H-320
    P.O. Box 85200
    Austin, TX 78708-5200

- **For reporting abuse, neglect or exploitation**
  - For reporting abuse, neglect, or exploitation of children, the elderly or people with disabilities, please visit the Texas Abuse Hotline website at www.txabusehotline.org or call 1-800-252-5400

Appeals and Fair Hearings

What is the process to file an Appeal?

- An appeal is filed based upon the decision to deny or reduce Medicaid covered services based upon lack of medical need. These are also called 'actions' or 'adverse determinations'
- A doctor or someone else can file appeal on the members behalf an appeal an action.
- Members have sixty (60) days from the date of the denial letter to appeal the decision. An acknowledgement of the appeal within five (5) business days of receipt and complete appeal within thirty (30) calendar days. This can be extended up to fourteen (14) calendar days if more time is needed to gather facts about the requested service
- If a service that is being ended, suspended or reduced the appeal must be filed no later than ten (10) days following mailing of the denial letter or the intended effective date if requesting services to continue during the appeal process
- Expedited appeals can be request if member believes based upon the condition of their health a decision must be made quickly and could jeopardize their life or health.

Appeals and Fair Hearings (Continued)

- **What is the process to file a Fair Hearing?**
  - ✓ A Fair Hearing can be requested once the appeal through is completed.
  - ✓ The member or their representative must ask for a Fair Hearing within ninety (90) days of the date on the letter on the decision on the appeal
  - ✓ Services that are denied or reduced must be filed no later than ten (10) days following mailing of the appeal decision letter if requesting services to continue during the fair hearing process
  - ✓ Fair Hearings are processed and scheduled by the states Fair Hearing office

How to Reach Us Superior Health Plan

Superior Contacts	Phone Number
STAR+PLUS Member Services	1-866-516-4501 (TDD/TTY) 1-800-735-2989 or 711
Provider Services	1-877-391-5921
Behavioral Health Crisis Hotline	1-866-516-4501
Complaints	1-866-516-4501
Service Coordination	1-877-277-9772
Utilization Management (acute care services)	1-800-218-7508
Provider Credentialing	1-866-702-4831

www.superiorhealthplan.com

CIGNA-HEALTHSPRING STAR+PLUS - PROVIDER WEBSITE INFORMATION

- **The Cigna-HealthSpring Texas Medicaid STAR+PLUS website is available at:**

  http://starplus.cignahealthspring.com

- **The website includes much of the information included in today's presentation and allows Providers to download numerous additional, more informative resources as well, such as:**

  - ✓ **STAR+PLUS Provider Manual**
  - ✓ **STAR+PLUS Quick Reference Guide**
  - ✓ **STAR+PLUS Provider Directory**
  - ✓ **STAR+PLUS LTSS Billing Guidelines**
  - ✓ **Clinical Practice Guidelines**

Important Numbers - Amerigroup

Amerigroup Member Services	1-800-600-4441 (TTY 711)
Amerigroup Provider Services	1-800-454-3730
Behavioral Health Crisis Hotline	1-800-600-4441 (TTY 771)

IDD/BH Service Coordinator Phone Number and Extension		
All Service Areas	1-866-696-0710	36171

STAR Kids Service Coordinator Phone Number and Extension		
All Service Areas	1-866-696-0710	36171

STAR+PLUS Service Coordinator Phone Number and Extension		
Service Area	Phone Number	Extension
Bexar	1-800-589-5274	35764
El Paso	1-877-405-9871	35762
Harris and Jefferson	1-800-325-0011	35760
Lubbock	1-877-405-9872	35763
Tarrant	1-800-839-6275	35761
Travis	1-800-315-5385	35765
WRSA	1-800-839-6275	35761

Provider Portal Address: https://providers.amerigroup.com

Molina Key Contacts

Molina Contacts	Phone Number
Molina STAR+PLUS Member Services	1-866-449-6849
Service Coordination	1-866-409-0039
Member Advocate	1-866-449-6849
Nurse Advice Line (Available 24 hours per day/7 days)	1-888-275-8750 (English) 1-866-648-3537 (Spanish)
Provider Services	1-855-322-4080
Provider Credentialing and Contracting Request	TexasExpansionContracting@MolinaHealthCare.Com
Utilization Management (acute care services)	1-866-449-6849

Quick Reference Phone List – United Community Plan

Customer Service	888-887-9003
STAR+PLUS Service Coordination Hotline	800-349-0550
STAR+PLUS Prior Authorization	866-604-3267
Credentialing	877-842-3210
Physician Advocates	866-574-6088
LTSS Provider Advocates	888-787-4107
Prescription Prior Authorization	800-310-6826
Behavioral Health Hotline	888-887-9003

- UHCCommunityPlan.com

Questions