INTRODUCTION

Long-term care services and support (LTSS) is a component of STAR Kids, a Texas Medicaid program servicing pediatric members with special needs.

LTSS are services provided on a long-term basis, not acute care as previously discussed in prior chapters.
Personal Care Services
Personal Care Services (PCS) are available to BCBSTX STAR Kids members based on medical and functional necessity and are provided in the home and community setting. Services include assistance with activities of daily living, household chores and nursing tasks that have been delegated by a registered nurse.

Adaptive Aids and Medical Supplies/Custom DME
Adaptive aids and medical supplies are specialized medical equipment and supplies including devices, controls and appliance that enable individuals with functional impairments to perform activities of daily living or perceive, control or communicate with the environment in which they live. BCBSTX is responsible for payment even if BCBSTX is not the MCO who authorized the service.

Private Duty Nursing
Private Duty Nursing (PDN) includes but is not limited to the assessment and evaluation of a member’s healthcare needs in the home or community environment and the direct delivery of nursing tasks, treatments and procedures ordered by a physician.

Minor Home Modifications
Home modifications are services that provide adjustments and/or improvements to a member’s home based on healthcare needs to enable them to reside in their residences. These modifications ensure safety and accessibility for the eligible member. BCBSTX is responsible to pay for minor home modifications approved by a prior MCO.

Respite Care Services
Respite Care Services provides temporary relief to persons caring for pediatric members with special needs on an in-home and out-of-home basis.
Occupational, Physical and Speech Therapy Services

Occupational, physical and speech therapy services include the evaluation, examination and treatment of physical, functional, speech and hearing disorders or impairments.

Consumer Directed Services/Financial Management Services (FMSA)

Consumer Directed Services (CDS) enables members with disabilities to self-direct their care. This includes the hiring, managing and termination of an individual providing personal care services. CDS can be performed by the member, their Legal Authorized Representative (LAR) or by FMSA. In order to participate as a BCBSTX CDSA, the Provider must be specifically identified to perform CDS by HHSC.

Employment Assistance

Employment assistance (EA) is provided as an MDCP waiver service to a member to help the member locate competitive employment or self-employment. Providers must develop and update a quarterly plan for delivering these services.

Supported Employment

Supported Employment (SE) services provide assistance as an MDCP waiver service to a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which members without disabilities are employed. Providers must develop and update a quarterly plan for delivering these services.

Program Objectives

The program will provide services that allow children to remain safely in their homes, offer cost-effective alternatives to placement in nursing facilities and hospitals and support families in their roles as the primary caregivers for their children living with disabilities and other medical conditions.
The Role of the RN Service Coordinator for LTSS

The RN Service Coordinator’s responsibilities will include:

• Development of a cost-effective Individual Service Plan (ISP), using a person-centered/family-centered approach, that enables the member to live safely in their homes and the community.

• Determine the annual cost limit for each member’s budget ensuring that the plan of care doesn’t exceed the member’s cost limit.

• Educate the member, their family or LAR regarding the Consumer Directed Services (CDS) option.

• Ensure that the need for minor home modifications and adaptive aids are addressed in the assessment process and the member’s care plan.

• Determine that the member meets the disability and medical necessity criteria to participate in the MDCP program on an annual basis and attend all required training

• Sessions, initially and ongoing.

Provider Responsibilities for Long Term Services and Supports

Long Term Services and Supports (LTSS) providers deliver a continuum of care and assistance ranging from in-home and community-based services for children and youth who get additional services through MDCP. LTSS providers have certain responsibilities for the STAR Kids program and the members they serve. This includes, but is not limited to:

• Contacting BCBSTX to verify member eligibility and/or authorizations for service.

• Providing continuity of care.

• Coordinating with Medicaid and Medicare.

• Notifying BCBSTX of any change in member’s physical condition or eligibility.

LTSS providers are required to provide covered health services to members in accordance with their BCBSTX agreement and their licensure.
Community First Choice (CFC)

Provider Responsibilities

- The CFC services must be delivered in accordance with the Member’s service plan.
- The program provider must maintain current documentation which includes the member’s service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable).
- The HCS or TxHmL program provider must ensure that the rights of the Members are protected (ex. e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the Member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the Member that are required to ensure the Member’s health, safety, and welfare. The program provider must maintain documentation of this training in the Member’s record.
- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (ex. e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the Member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline. (1-800-647-7418).
- The program provider must address any complaints received from a Member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the Member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, Member (or someone on behalf of a Member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- The program provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver’s license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.
- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must ensure that any additional training requested by the Member/LAR of CFC PAS or habilitation (HAB) service providers is procured.
• The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
• The program provider must adhere to the MCO financial accountability standards.
• The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a Member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.
• The program provider must prevent financial impropriety toward a Member, including unauthorized disclosure of information related to a Member’s finances and the purchase of goods that a Member cannot use with the Member’s funds.

Provider Responsibilities for Employment Assistance (EA) and Supported Employment (SE)

EA services include, but are not limited to, the following:
• Identifying a member’s employment preferences, job skills, and requirements for a work setting and work conditions;
• Locating prospective employers offering employment compatible with a member’s identified preferences, skills, and requirements; and
• Contacting a prospective employer on behalf of a member and negotiating the member’s employment.

SE provides the supports necessary in order to sustain paid employment. SE Services include, but are not limited to, the following:
• Employment adaptations, supervision, and training related to a member’s diagnosis; and
• If the member is age 21 or under, ensure provision of SE, as needed, if the services are not available through the local school district.

The Provider must develop and update quarterly a plan for delivering EA/SE including documentation of the following information:
• Name of the member.
• Member’s employment goal.
• Strategies for achieving the member’s employment goal, including those addressing the member’s anticipated employment support needs.
• Names of the people, in addition to the member, whose support is or will be needed to ensure successful employment placement, including the corresponding level of support those persons are providing or have committed to providing.
• Any concerns about the effect of earnings on benefits, and a plan to address those concerns,
  – Progress toward the member’s employment goal
  – If progress is slower than anticipated, an explanation of why the documented strategies have not been effective, and a plan improve the effectiveness of the member’s employment search.
Claims Filing for LTSS Providers

All Providers rendering LTSS services, with the exception of atypical providers, must use the CMS 1500 Claim Form or the HIPAA 837 Professional Transaction when billing claims. Providers will bill and report LTSS in compliance with the STAR Kids LTSS Health Care Common Procedure Codes (HCPC) and STAR Kids Modifiers Matrix (Matrix). The billing requirements will be made on the BCBSTX website at http://www.bcbstx.com/provider/medicaid/index.html.

Atypical providers are LTSS providers that render non-health or non-medical services to STAR Kids members. Examples of atypical providers include pest control services, home modification services, etc. Atypical providers will submit appropriate documentation to BCBSTX to accurately populate an 837 Professional Encounter.

Some STAR Kids members receive LTSS services that are not covered by BCBSTX and should be submitted to the appropriate payer. For a list of eligible LTSS services and the appropriate payer, please refer to the reference grid on the following page.

Important Information for LTSS Service Providers

In summary, LTSS Service providers are required to:

- Verify member eligibility and obtain necessary referrals and authorizations prior to the provision of services.
- Bill and report LTSS services with compliant coding. Refer to the LTSS required billing codes and modifiers on the next page.
- Notify service coordinator if there is a change in the member’s physical or mental condition.
- Coordinate Medicare and Medicaid benefits appropriately.

1915(i) Home and Community Based Services- Adult Mental Health (HCBS-AMH)

Home and Community Based Services-Adult Mental Health (HCBS-AMH) is a state-wide program that provides home and community-based services to adults with serious mental illness. The HCBS-AMH program provides an array of services, appropriate to each need, to enable him or her to live and experience successful tenure in their chosen community. Services are designed to support long term recovery from mental illness.
Refer to the sample LTSS Billing Matrix on Page 301 for details.

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<td>Financial management services</td>
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### LTSS Benefits Covered by BCBSTX

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<th>YES Waiver Dual Eligible</th>
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Submit Claims to DADS for IDD Waiver Services

Submit Claims to DSHS for YES Waiver Services
ELECTRONIC VISIT VERIFICATION (EVV)

What is EVV?
EVV is a telephone and computer-based system that electronically verifies service visits and documents the precise time service provision begins and ends.

EVV is a method by which a person, including but not limited to, a personal care attendant, who enters a STAR Kids member’s home to provide a service will document their arrival time and departure time using a telephonic or electronic small alternative device provided by the EVV vendor. This visit information will be recorded and used as an electronic version of a paper time sheet for an attendant and used to support claims to BCBSTX for designated EVV services.

Can a member or provider elect not to use EVV?
The use of EVV is mandatory in Texas Medicaid for those services noted below, with some exceptions. All providers must select an EVV vendor from one of two options.

EVV will be required to document delivery of the following STAR Kids services:
- Personal care services (PCS)
- Community First Choice attendant care and habilitation (PAS/HAB)
- MDCP In-Home Respite
- MDCP flexible family support services

Is EVV required for CDS employers?
CDS employers are not required to use EVV.

If you are a CDS Employer, there are three EVV options:
- No EVV Participation: If you do not have access to a computer, assistive devices, or other supports, or you do not feel you can fully participate in EVV, you may choose to use a paper time sheet to document service delivery.
- Phone and Computer (Full Participation): The telephone portion of EVV will be used by your Consumer Directed Services (CDS) Employee(s) and you will use the computer portion of the system to perform visit maintenance.
- Phone Only (Partial Participation): This option is available to CDS Employers who can participate in EVV, but may need some assistance from the FMSA with visit maintenance. You will use a paper time sheet to document service delivery. Your CDS Employee will call-in when they start work and call-out when they end work. Your FMSA will perform visit maintenance to make the EVV system match your paper time sheet.

Will there be a cost to the provider for the access and use of the selected EVV vendor system?
EVV transaction costs will be paid by BCBSTX through direct contracts with the EVV vendors. No EVV transaction costs will be passed on to service providers or to members.
Do providers have a choice of EVV vendors?

Yes, providers have choice of EVV vendor.

- Provider selection of EVV vendor
  - During the contracting and credentialing process with BCBSTX, a copy of the Provider Electronic Visit Verification Vendor System Selection Form should be provided in the application packet. Forms are located at [http://www.bcbstx.com/provider/medicaid/forms.html](http://www.bcbstx.com/provider/medicaid/forms.html).

- Provider EVV default process for non-selection
  - Mandated providers that do not make an EVV vendor selection or who do not implement use of their selected vendor, are subject to contract actions and are defaulted to a selected vendor by HHSC. The provider will receive a default letter detailing out the vendor that they have been defaulted to and when they are required to be implemented with the vendor.

When can a provider change EVV vendors?

- A provider may change EVV vendors 120 calendar days after the submission request by completing the Medicaid EVV Provider System Selection Form.
- A provider may change EVV vendors twice in the life of their contract with BCBSTX.

How do providers with assistive technology (ADA) needs use EVV?

If you use assistive technology, and need to discuss accommodations related to the EVV system or materials, please contact the HHSC-approved EVV vendors.

DataLogic (Vesta) Software, Inc.

<table>
<thead>
<tr>
<th>Contact:</th>
<th>Email:</th>
<th>Phone:</th>
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</thead>
<tbody>
<tr>
<td>Sales &amp; Training</td>
<td><a href="mailto:info@vestaevv.com">info@vestaevv.com</a></td>
<td>1-(888)-880-2400</td>
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<tr>
<td>Tech Support</td>
<td><a href="mailto:support@vesta.net">support@vesta.net</a></td>
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<tr>
<td><a href="http://www.vestaevv.com">www.vestaevv.com</a></td>
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MEDsys Software Solutions, LLC

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<td>Texas Dedicated Support and Sales Number</td>
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<td>Website:</td>
<td><a href="http://www.medsyshcs.com">www.medsyshcs.com</a></td>
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EVV use of small alternative device (SAD) process and required SAD forms.

- The SAD process is found at: http://www.dads.state.tx.us/evv/docs/ProviderAlternativeDeviceNotification_3-2015.pdf
- SAD forms can be found at http://www.bcbstx.com/provider/medicaid/forms.html
- Where do I submit the SAD agreement/order form?
  - The form is submitted to the provider-selected EVV vendor.
    a. DataLogic - email form to: tokens@vestaevv.com or send secure efax to 1-956-290-8728
    b. MEDsys - email form to: tokens@medsysnhcs.com or send secure fax to 1-888-521-0692
    c. Equipment provided by an EVV contractor to a provider, if applicable, must be returned in good condition.

EVV Compliance

All providers providing the EVV mandated services must use the EVV system and must maintain compliance with the following requirements:

- Providers must enter Member information, Provider information, and service schedules (scheduled or non-scheduled) into the EVV system for validation either through an automated system or a manual system.
- Provider Agencies must ensure that attendants providing services applicable to EVV are trained and comply with all processes required to verify service delivery through the use of EVV.
- Provider agencies maintain 90% adherence to HHSC’s EVV Initiative Provider Compliance Plan
  - HHSC EVV Initiative Provider Compliance Plan – A set of requirements that establishes a standard for EVV usage that must be adhered to by Provider Agencies under the HHSC EVV initiative.
  - Provider Agencies must achieve and maintain an HHSC EVV Initiative Provider Compliance Plan Score of at least 90 percent per Review Period.
  - Reason Codes must be used each time a change is made to an EVV visit record in the EVV System
  - The HHSC Compliance Plan is located at: http://www.dads.state.tx.us/evv/complianceplan/HHSCEVVProviderCompliancePlan.pdf
- Provider agencies must maintain adherence to the BCBSTX compliance plan which can be found at www.bcbstx.com/starkids.
- The Provider Agency must ensure quality and appropriateness of care and services rendered by continuously monitoring for potential administrative quality issues.
- The Provider Agency must systematically identify, investigate, and resolve compliance and quality of care issues through the corrective action plan process.
- Providers should notify BCBSTX, or HHSC, within 48 hours of any ongoing issues with EVV vendors or issues with EVV Systems.
- Any Corrective action plan required by BCBSTX must be submitted by the Network Provider to BCBSTX within 10 calendar days of receipt of request.
- Provider Agencies may be subject to termination from the network for noncompliance and may also be subject to corrective action plans or liquidated damages.
Will training be offered to providers?
Yes, BCBSTX will offer training on EVV as a component of STAR Kids provider training. Topics covered in this training will include services requiring EVV, EVV vendor selection, and compliance requirements. Providers will also receive systems training from the EVV vendors. EVV vendor training materials can be found on each EVV vendor website.

Will claim payment be affected by the use of EVV?
- Providers must submit Electronic Visit Verification data before claims are submitted. This must be done in a timely manner since provider claims cannot be paid until verification of a visit has been completed.
- Submission of EVV data does not guarantee claims payment. Clean claims must still be submitted to BCBSTX within 95 calendar days of the EVV visit.
- Provider agencies must complete any and all required visit maintenance in the EVV system within 60 days of the visit (date of service). Visit maintenance not completed prior to claim submission is subject to claim denial or recoupment. No visit maintenance will be allowed more than 60 days after the date of service and before claims submission, unless an exception is granted.
- Providers must adhere to EVV guidelines in the Provider compliance plan when submitting a claim.

Each time visit maintenance is needed on a visit, providers must explain the specific reason a change was made to an EVV visit record using reason codes. Providers must associate the most appropriate reason code with each change made and enter any required free text in the comment section. A single visit may have more than 1 reason code associated with it. The list of current reason codes can be found at https://www.dads.state.tx.us/evv/reasoncodes.html

Reason codes fall into 1 of 2 categories:
- Preferred Reason Codes that document visit maintenance necessitated by a situation in which providers are delivering and documenting services in accordance with HHSC expectations.
- Non-Preferred Reason Codes that document visit maintenance that is necessitated by a situation in which providers are not delivering and documenting services in accordance with HHSC expectations.

EVV Complaint Process
Provider complaints regarding the EVV process should be submitted in accordance with the procedures set forth in the following BCBSTX Medicaid Managed Care Provider Complaint/Appeal Process section.

Providers may also submit complaints regarding an EVV vendor to Electronic_Visit_Verification@hhsc.state.tx.us.
What if I need assistance?
For questions, please call Provider Relations and Network Management at 1-855-212-1615.

Adult Transition Planning
BCBSTX will help to assure that teens and young adult members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their 21st birthday. BCBSTX is responsible for conducting ongoing transition planning starting when the member turns 15 years old. BCBSTX must provide transition planning services as a team approach through the named service coordinator if applicable and with a transition specialist within the Member Services Division. Transition specialists will be an employee of BCBSTX and wholly dedicated to counseling and educating members and others in their support network about considerations and resources for transitioning out of STAR Kids. transition specialists must be trained on the STAR+PLUS system and maintain current information on local and state resources to assist the Member in the transition process. Transition planning must include the following activities:

1. Development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model without a break in service.

2. Prior to the age of 10, BCBSTX will inform the member and the member’s LAR regarding LTSS programs offered through the Department of Aging and Disability Services (DADS) and, if applicable, provide assistance in completing the information needed to apply. DADS LTSS programs include CLASS, DBMD, TxHmL, and HCS.

3. Beginning at age 15, BCBSTX will regularly update the ISP with transition goals.

4. Coordination with DARS to help identify future employment and employment training opportunities.

5. If desired by the member or the member’s LAR, coordination with the Member’s school and Individual Education Plan (IEP) to ensure consistency of goals.

6. Health and wellness education to assist the member with self-management.

7. Identification of other resources to assist the member, the member’s LAR, and others in the member’s support system to anticipate barriers and opportunities that will impact the member’s transition to adulthood.

8. Assistance applying for community services and other supports under the STAR+PLUS program after the member’s 21st birthday.

9. Assistance identifying adult health care providers.
Coordination with Non-Managed Care (Non-BCBSTX) Medicaid Covered Services

The State of Texas has chosen to provide certain member services under individual contracts with different vendors and providers. While BCBSTX is not financially responsible for these services, BCBSTX will work closely with those providers and vendors to assure that members receive all medically appropriate and necessary services.

PCPs coordinate health services for their members, no matter where the services originate. The PCP is responsible for arranging and coordinating appropriate referrals to other providers and specialists and for managing, monitoring, and documenting the services of other providers.

The following Texas programs, services, or benefits have been excluded from BCBSTX STAR Kids Covered Services. Members may be eligible to receive these services on another basis, such as a fee-for-service basis or through a dental MCO (for most dental services). These services are described in the Texas Medicaid Provider Procedures Manual (TMPPM):

- Texas Health Steps dental (including orthodontia);
- Texas Health Steps environmental lead investigation (ELI)
- Early Childhood Intervention (ECI) case management/service coordination;
- Early Childhood Intervention Specialized Skills Training;
- Case Management for Children and Pregnant Women;
- Texas School Health and Related Services (SHARS);
- Department of Assistive and Rehabilitative Services (DARS) Blind Children’s Vocational Discovery and Development Program;
- Tuberculosis services provided by DSHS-approved Providers (directly observed therapy and contact investigation);
- DADS hospice services;
- DADS or DSHS HCBS Waiver programs, authorized under Social Security Act § 1915(c), including Youth Empowerment Services (YES), Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Texas Home Living (TxHmL), and Home and Community-based Services (HCS);
- Court-Ordered Commitments to inpatient mental health facilities as a condition of probation; and
- Nursing facility services and intermediate care facility (ICF) services.
- PASRR screenings, evaluations, and specialized services
- Health and Human Services Commission’s Medical Transportation Program (MTP);
Summary of MTP Services

Medical Transportation Program (MTP) provides non-emergency transportation (NEMT) to Medicaid-eligible STAR members who need help getting to medical appointments, dental appointments and the pharmacy, providing that the member:

- Has a current Medicaid identification (ID) card or Medicaid Verification Letter?
- Has no other means of transportation?
- Receives prior authorization from MTP, if required.

To obtain transportation, STAR members should call MTP at 1-877-633-8747 (877-MED-TRIP) between the hours of 8 a.m. and 5 p.m., Monday through Friday (except on federal holidays). Upon calling to schedule transportation, members will be asked to provide the following information:

- Member’s nine-digit Medicaid number
- Medical physician or other professional’s name, address and phone number
- Date and time of the medical appointment, as well as service being provided

If STAR Kids BCBSTX members are not able to get transportation services through MTP they may access the BCBSTX VAS NEMT services through Medical Transportation Management (MTM). For more information on our VAS NEMT services through MTM see the VAS information in Chapter 3 of this manual.

Although BCBSTX is not responsible for paying or reimbursing the services above, BCBSTX is responsible for educating members about the availability of these services, and for providing appropriate referrals for Members to obtain or access these services. BCBSTX Providers must submit claims for the services above to HHSC’s claims administrator for reimbursement. BCBSTX will not reimburse providers for any of these services performed for BCBSTX STAR Kids members.

Full-risk Broker (FRB) Vendors are vendors that receive capitation payment to provide a full array of transportation services to clients in a specified geographic area. HHSC has contracted with two full-risk brokers: Medical Transportation Management (MTM), Inc. provides service in the Houston/Beaumont area, and Logisticare, LLC provides service in the Dallas/Fort Worth area. Since BCBSTX is in the Travis Service Area these FBV’s are not providing services, the services are provided by the HHSC MTP program.