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Medicaid for Breast and Cervical Cancer Program Provider Information Session

Medicaid and CHIP Services Department
Summer 2017

Overview

At the end of this presentation you will be able to answer the following questions:

- What is Medicaid for Breast and Cervical Cancer?
- What is managed care?
- What is STAR+PLUS?
- What is required of providers?
- How do clients pick a health plan?
- What is the timeline for the transition?



Background

- The 83rd Texas Legislature directed HHSC to move remaining Medicaid fee-for-service clients to Medicaid managed care.
- Currently, women in the Medicaid Breast and Cervical Cancer program get Medicaid services through Medicaid fee-for-service.
- Most MBCC clients will move to STAR+PLUS managed care **Sept. 1, 2017**.



What is MBCC?

- MBCC provides Medicaid to women diagnosed with breast or cervical cancer, or certain pre-cancer conditions.
- A woman can get MBCC services if she is:
 - Uninsured
 - Between age 18 until the month she turns 65
 - A US citizen or qualified immigrant
 - A Texas resident
 - Financially eligible



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What is MBCC? (cont.)

- Women in the MBCC program continue to receive full Medicaid benefits as long as they are eligible and every six months:
 - Submit of proof of active treatment for breast or cervical cancer from the treating doctor (Form H1551, Treatment Verification) and
 - Complete and submit MBCC Renewal (Form H2340).



What is Managed Care?

- Managed care is healthcare provided through a network of doctors, hospitals and other providers responsible for managing and delivering quality, cost-effective care.
- The state pays a health plan a set rate for each member enrolled, rather than paying for each unit of service provided.



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What Are The Goals of Managed Care?

- Emphasize preventive care
- Establish a medical home through a primary care provider
- Improve access to care
- Make sure people receive the right amount of services
- Improve client and provider satisfaction
- Promote care in least restrictive, most appropriate setting
- Improve health outcomes, quality of care and cost-effectiveness



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Managed Care Programs in Texas

- STAR
- STAR+PLUS
- STAR Health
- STAR Kids
- Texas Dual Eligible Integrated Care Project
 - Called the Dual Demonstration
- CHIP
- CHIP and Children's Medicaid Dental



How Many People Get Medicaid?

Estimates for April 2017 show:

- 4,052,290 people enrolled in Texas Medicaid.
 - 3,721,169 of them are in managed care.
 - STAR – 2,961,227
 - STAR+PLUS – 520,844
 - STAR Health – 31,802
 - STAR Kids – 164,607
 - Dual Demonstration – 44,689
 - 331,122 clients enrolled in Medicaid fee-for-service



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What Is A Health Plan?

- Health plans provide a medical home through a primary care provider and referrals for specialty services as needed
 - Exception: Clients who get Medicare and Medicaid (dual eligible) get acute care services through Medicare.
- Health plans may offer extra services, also called “value-added services”
 - Respite
 - Extra dental services
 - Extra vision services
 - Health and wellness services



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What is STAR+PLUS?

- STAR+PLUS is a Texas Medicaid managed care program for certain populations.
- STAR+PLUS delivers basic care and long-term services and supports.
- As of Sept. 1, 2017, most women in MBCC will get Medicaid services through STAR+PLUS.



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Who is in STAR+PLUS Today?

- Adults who:
 - Are in a waiver program and don't have Medicare or certain facilities
 - Most people who reside in a nursing facility
 - Most people who reside in a intermediate care facility
 - Qualify for Supplemental Security Income (SSI) or SSI-related Medicaid
 - Qualify for Medicaid because they meet a nursing facility level of care and need STAR+PLUS Home and Community Based Services



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What are STAR+PLUS Benefits?

- Traditional Medicaid benefits
- Unlimited prescriptions
- A primary care provider
- Service coordination
 - Includes development of a service plan and coordination of services
- Value-added services
 - Extra services offered by the health plan such as respite and extra vision care



STAR+PLUS Long-Term Services and Supports

- Nursing facility services
- Personal assistance services
- Day activity and health Services
- Community First Choice
- STAR+PLUS Home and Community Based Services program



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What Is Service Coordination?

- A specialized care management service performed by a health plan service coordinator who is usually a nurse, social worker or other professional with the necessary skills to coordinate care.
- Identify and address a member's physical, mental or long-term care needs through a person-centered service plan.
- Help members and families to understand benefits and services.
- Arrange or coordinate community supports including those that may be non-medical, or not covered by Medicaid, such as medical transportation.



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What is Service Coordination? (cont.)

- Members can get more or less service coordination based on their needs.
- At a minimum, women in MBCC receive:
 - A single, identified clinician as their assigned service coordinator.
 - At least one face-to-face visit and one phone call every year.
 - Help with MBCC Medicaid eligibility renewal.
 - Help getting any long term services and supports they might need.
 - Help moving to another program, if needed.

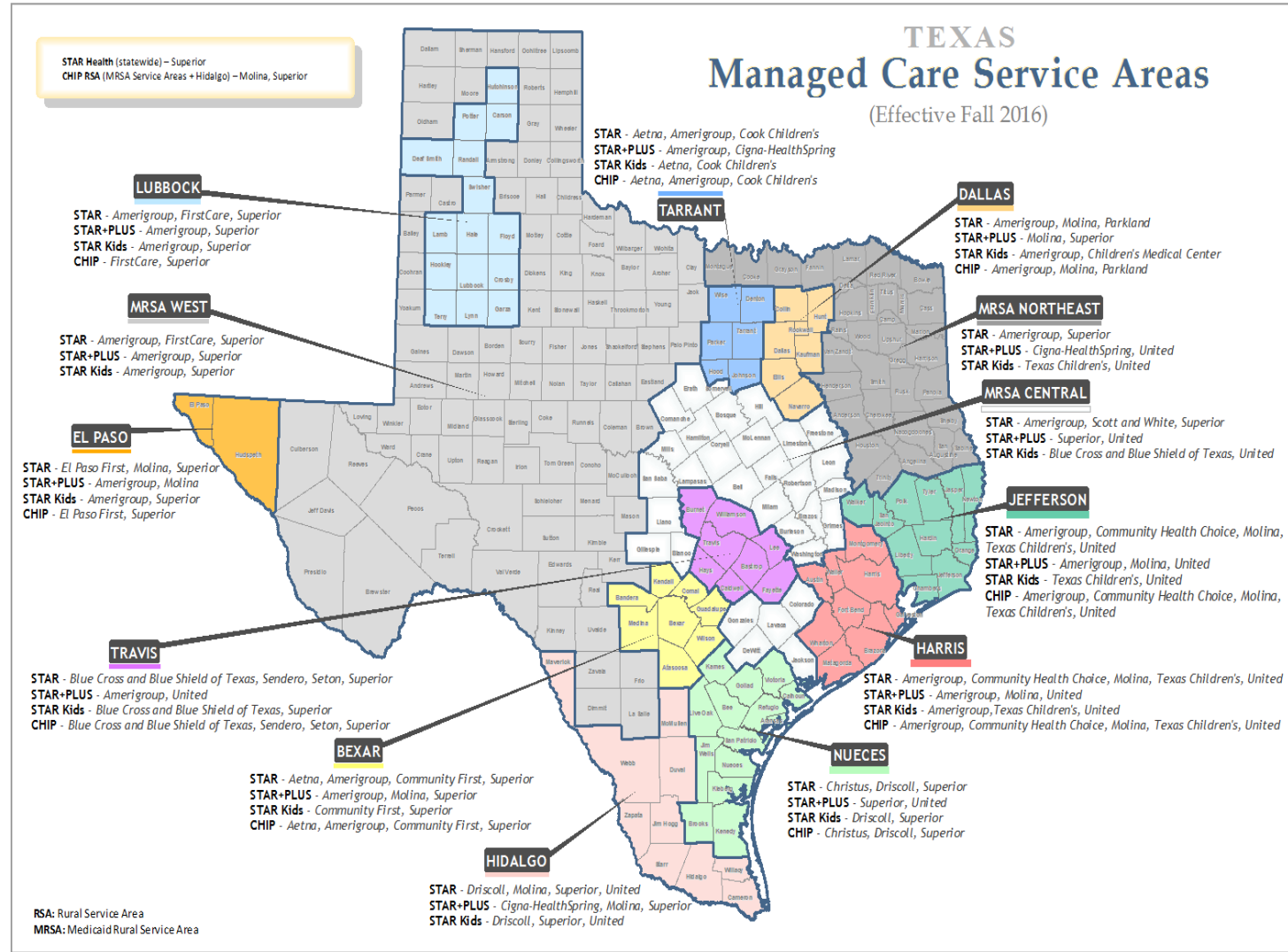


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Managed Care Service Areas



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How Will I Know What Plan My Patients Are In?

- All STAR+PLUS members get a health plan ID card, in addition to a Your Texas Benefits Medicaid card from the state.
- The health plan ID card includes:
 - Member's name and Medicaid ID number
 - Medicaid program
 - Health plan name
 - Primary care provider name and phone number
 - Toll-free phone numbers for member services, service coordination, and behavioral health services hotline
 - Other information may be provided such as date of birth, service area and primary care provider address)



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Continuity of Care

- The state requires STAR+PLUS health plans to provide “continuity of care.”
 - Authorizations for basic care such as specialist visits, medical supplies, etc., are honored for 90 days, until the authorization expires or until the health plan issues a new one.
 - Authorizations for long-term services and supports are honored for six months or until a new assessment is completed.



Continuity of Care (cont.)

- The state requires STAR+PLUS health plans to provide “continuity of care.”
 - During the transition period, members can keep seeing current providers, even if they are out of the health plan’s network.
 - Providers don’t need to resubmit authorization requests to the health plans if an authorization is already in place.



Will Current Services Be Covered In Managed Care?

- Approved and active prior authorizations for covered services will be forwarded to the STAR+PLUS health plans prior to Sept. 1, 2017.
- These prior authorizations are subject to the ongoing care requirements discussed before.
- Providers don't need to resubmit authorization requests to the health plans if an authorization is already in place.



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Provider Contracting

- Providers must contract and be credentialed with a health plan to provide Medicaid managed care services.
- Rates are negotiated between the provider and the health plans.
- Authorization requirements and claims processing might be different between health plans.



Significant Traditional Providers

- A significant traditional provider is a provider who has served Medicaid fee-for-service clients.
- Health plans must offer significant traditional providers the chance to be part of the contracted health plan network.
- Health plans will reach out to significant traditional providers.
 - The providers may initiate the contact.
- Significant traditional providers and health plans must agree on the conditions for contracting and credentialing.



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What if The Provider is Out-of-Area?

- Health plans must have an adequate network of providers and provide services members need inside their service area.
- Health plans may also pay providers outside their service area in certain situations:
 - Emergency services
 - To maintain ongoing care with an existing provider.



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Out-of-Network Providers

- If providers choose not to contract with health plans in the service area, the providers won't be part of the health plans' provider networks.
- Sometimes, the health plans might be willing to sign a single-case agreement or enter a limited contractual relationship.
 - This allows the provider to treat a single Medicaid patient.



Provider Claims

- Providers, including long-term service and support providers, must file claims within 95 days of the date of service.
- Health plans must adjudicate most claims within 30 days.
 - 18 days for electronic pharmacy claims
 - 10 days for nursing facility claims



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Appeals and Fair Hearings

- Members and providers may appeal to the health plans and file a fair hearing request with the state if services are denied, reduced or terminated.
- Services may continue during the review of the appeal or fair hearing when requested on time and the member asks for continued services pending the appeal.



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Provider Complaints

- Providers must contact the health plan to file a complaint and exhaust the health plan's resolution process before filing a complaint with HHSC.
- Appeals, grievances, or dispute resolution is the responsibility of the health plans.
- Providers may file complaints with HHSC if they feel they do not receive full due process from the health plan or if they are not satisfied with the health plan's determination.
- Providers can email:

HPM_complaints@hhsc.state.tx.us



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Complaints and Appeals

- Health plans must use appropriately trained providers when reviewing all medically-based member appeals, such as:
 - Member appeals regarding a benefit denial or limitation
- Health plans also have to resolve your complaints
- Common complaints:
 - Quality of care or services
 - Accessibility or availability of services
 - Claims processing – providers



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Complaint Contacts for Providers

HHSC

HPM Complaints

P.O. Box 85200, MC H-320

Austin, TX 78758

HPM_Complaints@hhsc.state.tx.us

Remember to follow HIPAA guidelines and always send patient information securely.



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Next Steps

- Get to know the health plans operating in counties where you deliver services.
- Begin the contracting and credentialing process with the health plans as quickly as possible.
- Prepare to negotiate rates with the health plans.
- Become familiar with your health plans' policies and procedures for prior authorization and billing.



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How Clients Choose A Health Plan?

- MBCC clients moving to STAR+PLUS will get a packet in the mail with facts about the health plans in their area.
- Everyone will be able to pick from at least two health plans.
- Each health plan has a list of providers for clients to pick from.
- If clients don't pick, HHSC will assign an health plan and a primary care provider.
- Members can change their health plan at any time. Changes take 15-45 days to take effect.



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Enrollment Activities

- May 2017 – Clients get introduction letters.
- June 2017 – Clients get enrollment packets.
- July 2017 – Clients who haven't picked a health plan get reminder letters.
- Aug. 14, 2017 – Clients who do not pick a health plan are assigned to one.
 - Clients may change health plans at any time by contacting the enrollment broker
- Sept. 1, 2017 – MBCC clients will begin getting their services through a STAR+PLUS health plan.



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What If I Have Questions?

- Learn more about the transition of MBCC clients to STAR+PLUS and sign up for updates at:
<https://hhs.texas.gov/mbcc>
- Learn more about managed care at:
<http://hhs.texas.gov/services/health/medical-and-chip/provider-information/expansion-managed-care>
- Send questions to:
Managed_Care_Initiatives@hhsc.state.tx.us



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