

Dual Demonstration FAQs

Benefits

- What benefits are available under the Dual Demonstration?
 - Individuals have access to a comprehensive network of acute and long-term care services providers, and access to the same medically necessary Medicare and Medicaid benefits as they do today coordinated under one entity with additional value added services that vary by Medicare-Medicaid Plan (MMP).
 - Under the Dual Demonstration, care coordination services will be available to all enrollees. MMPs will offer a service coordination team to ensure the integration of services to meet the enrollee's medical, behavioral health, long-term services and supports, and social needs. The team's approach will be person-centered and built on the enrollee's specific preferences and goals.
- What are the advantages of participating in the Dual Demonstration for providers?
 - A single managed care entity called a Medicare-Medicaid Plan (MMP) is responsible for contracting and credentialing providers of Medicare and Medicaid services. Additionally, the MMP is responsible for all Medicare and Medicaid claims processing, provider payment, and appeals.
 - Providers will receive payment for covered Medicare and Medicaid services from the MMP, and payment will reflect both Medicare and Medicaid payment amounts without submitting a second bill. In addition, authorization requirements are set by MMP with a timeframe of 3 days instead of 14 days.
 - For nursing facility providers, residents can be admitted under skilled criteria without requiring a 3 day hospital stay, and may also be able to stay within the facility without hospitalization by obtaining authorization from the MMP.

Networks

- What are the network adequacy standards for the Dual Demonstration?
 - MMP's are responsible for managing their own networks. Their network adequacy requirement standards were jointly reviewed by both HHSC and CMS for adequacy. CMS reviewed the networks for Medicare-covered services, and HHSC reviewed them for Medicaid-covered services. In instances where Medicare and Medicaid both cover a service, the more stringent network adequacy standards applied.
- How does a provider contract with an MMP?
 - The MMPs in the Dual Demonstration counties have and continue to outreach to current Medicaid and Medicare providers to offer contracts. Providers may also contact the MMPs directly. If providers reach out to an MMP to inquire about a contract, it is important that the provider ask the MMP specifically about contracting to provide services in the Dual Demonstration since the MMPs operate other products.

Accountable Care Organizations (ACOs)

- Can individuals receiving care from a Medicare ACO enroll in the Dual Demonstration?
 - Dual eligible beneficiaries attributed to a Medicare ACO may also be eligible for enrollment in the Dual Demonstration.

- To preserve the infrastructure of existing ACOs in the counties in which the Dual Demonstration operates (Bexar, Dallas, El Paso, Harris, Hidalgo or Tarrant), beneficiaries in an ACO established by March 1, 2015 with fewer than 9,000 members will receive notification about the option to enroll in the Dual Demonstration, but will not be passively enrolled.
- Dual eligible beneficiaries attributed to an ACO with more than 9,000 members will be eligible for passive enrollment.
- The MMPs are required to develop shared savings arrangements with contracted providers. These arrangements allow providers and MMPs to develop shared savings models that mirror the format and requirements of current ACOs, or the flexibility to develop other innovative arrangements.

Eligibility

- How do providers verify a member's Medicaid eligibility?
 - Providers should verify Medicaid eligibility and managed care enrollment using TexMedConnect on the TMHP website at www.tmhp.com.
 - TexMedConnect/Medicaid Eligibility and Service Authorization Verification (MESAV) will show Medicaid eligibility and the managed care segments for Medicaid or MMP managed care members.
- How will Dual Demonstration members be identified in TIERS?
 - MMPs have their own plan codes which are visible on the managed care screen.
- What are the plan codes for the Dual Demonstration?

Dual Demonstration - STAR+PLUS (Eff. 3/1/15)		
4F	Amerigroup Texas, Inc.	Bexar
3G	Amerigroup Texas, Inc.	El Paso
7Z	Amerigroup Texas, Inc.	Harris
6F	Amerigroup Texas, Inc.	Tarrant
4G	Molina Healthcare of Texas	Bexar
9J	Molina Healthcare of Texas	Dallas
3H	Molina Healthcare of Texas	El Paso
7V	Molina Healthcare of Texas	Harris
H9	Molina Healthcare of Texas	Hidalgo
4H	Superior Health Plan	Bexar
9K	Superior Health Plan	Dallas
HA	Superior Health Plan	Hidalgo
7Q	United Healthcare Texas	Harris
H8	HealthSpring	Hidalgo
6G	HealthSpring	Tarrant

- When a patient presents to a provider's office or facility without an ID card, how will the provider be able to identify an MMP enrollee?
 - The information will appear as it does today for STAR+PLUS members on TMHP.com, with the addition of an identifying MMP Plan Code.
- What address is used to determine if a member is residing in a county participating in the Dual Demonstration?

- A member's residential address is used to determine if they reside in a Dual Demonstration county. HHSC eligibility obtains this information from the Social Security Administration (SSA).

Enrollment

- Is the enrollment into a MMP mandatory?
 - No, enrollment is optional.
- How do members opt in?
 - Members should call the Medicaid enrollment broker, MAXIMUS, to opt in at 1-877-782-6440.
- If a member opts out, do they have to enroll in a Medicare Advantage plan (Part C) or can they get Original Medicare with a Prescription Drug Plan (Part D)?
 - The member can choose either one.
- If an individual opts-in or opts-out of the program, when is the change effective?
 - Requests to opt-in, or disenroll from one MMP and enroll in another MMP will be accepted through the 12th of the month for an effective date of coverage the 1st calendar day of the next month.
 - Requests for opt-ins or MMP plan changes received after the 12th of the month will be processed for an effective date of the 1st of the second month following the request.
 - It is important to note that since enrollment is done by month, a member can't be enrolled or disenrolled mid-month.
 - An individual can opt out of the Dual Demonstration at any time of the month and the change would be effective the first day of the following month. A member can call on the very last day of the month, and be disenrolled from the Demonstration the next day.
- Are dual eligible individuals in an employer-sponsored Medicare retirement plan excluded from the Duals Demonstration?
 - Dual eligible individuals with employer-sponsored Medicare retirement plans are not excluded from the Dual Demonstration, but will not be passively enrolled. These members would have to opt in.
- Will the various enrollment letter mailings be available online in advance?
 - Enrollment letters are available on the HHSC website: <http://www.hhsc.state.tx.us/medicaid/managed-care/dual-eligible/>

Billing, Claims & Payments

- Who do I bill for services provided prior to the Dual Demonstration?
 - If the patient was not enrolled in an MMP at the time of service, providers should bill the appropriate payer (either Medicare or Medicaid) based on dates of service for which they are billing. Providers should bill the program the individual was enrolled in at the time the service was provided.
 - As part of the Dual Demonstration continuity of care provisions, medically necessary covered services must be provided or arranged for during the applicable transition period. Current long term services and supports (LTSS) services will be authorized for up to six months after initial enrollment into an MMP. Current acute care services will be authorized for up to 90 days.
- Will claims automatically crossover from Medicare to the patient's new MCO like they crossover now to TMHP?

- All claims will be paid by the MMP, so there is nothing to cross over. Medicare providers can use HETS to look up which MMP a member is in. Medicaid providers can use the same systems they use today, such as THMHP TexMedConnect Portal/MESAV.
- Will the MMP's use Electronic Funds Transfer (EFT) to pay providers?
 - EFT varies by MMP. Providers should seek information about specific billing practices from the MMP(s) with which they are contracted.
- What are the claims payment requirements for MMPs?
 - The current requirement in Medicare Advantage is to pay 95% of clean claims within 30 days (42 CFR 422.520). The Texas Dual Demonstration improves upon this standard in several ways:
 - In line with current STAR+PLUS requirements for nursing facility services, the MMPs shall process 98% of clean claims within 10 days and 99% within 90 days (TX Contract, section 5.1.9.3).
 - For Medicare Part D claims, the MMPs shall process electronic claims within 14 days or within 21 days for non-electronic claims (TX Contract, Appendix D, Article II, N.2).
 - In line with current STAR+PLUS requirements for non-NF, non-Part D services, the MMPs shall process 98% of clean claims within 30 days and 99% within 90 days (TX Contract, section 5.1.9.3).
- Will the Medicare reimbursement schedule be negotiated with each MMP by the provider or will it coincide with the RUG Schedule with Medicare?
 - Payment levels for in-network providers are dictated by the terms of the contracts that providers establish with the MMPs.
 - Non-contracted providers should bill the MMP during the continuity of care period. After that, if the provider has not entered a contract with the MMP, the MMP may transition the member (with their consent) to an in-network provider.
- Are providers required to submit one bill or separate bills for both acute and long-term care services? If providers are required to submit one bill, what form would providers need to use? What other types of forms would providers use for the Dual Demo?
 - If the services are covered by Medicare (such as hospitals, ancillaries/Comprehensive Out Patient Rehabilitation Facilities (CORFs), Outpatient Rehabilitation Facilities (ORFs) and professional services), providers should follow CMS guidelines and bill on a UB 04.
 - Professional services, including those delivered by non-skilled Medicaid providers, would be billed on a CMS 1500 format.
 - Behavioral health services are a mixture – case management and psychosocial rehab are usually billed on a UB04 Rev Code 100 or 900. Professional services would bill in CMS 1500 format. Hospital would be billed on a UB 04.
 - Home health can bill either on a UB 04 or CMS 1500.
- For providers participating in the Dual Demonstration, is timely filing based on the Medicare time frame of up to 1 year or is it dependent on the individual MMP?
 - In-network providers should refer to the conditions of their contracts with each MMP for timely filing requirements.

Complaints/Grievances, Appeals & Fair Hearings

- What is the member complaint/grievance, appeals and fair hearings process?
 - The complaint, or grievance, is filed either orally or in writing, and acted upon at the MMP level.

- All current Medicare and Medicaid protections remain in place for members, with certain enhancements:
 - Beneficiaries will have the added protection of continued services while an appeal is pending.
 - For Medicaid appeals, members will continue to have an option to appeal directly through the MMP, but will have additional time to do so. Beneficiaries will have 60 instead of 30 days.
- For Medicaid services, the member may appeal to the MMP, but also may request a fair hearing through HHSC within 90s days, consistent with current Medicaid policy.
- Consistent with existing rules, Part D Appeals will be automatically forwarded to the CMS Medicare Independent Review Entity (IRE) if the MMP misses the applicable adjudication timeframe. The IRE for Medicare is MAXIMUS. More information is available at: <http://www.medicareappeal.com/>.
- For overlapping (Medicare and Medicaid) services, the appeal may 1) start at the MMP and then 2a) will be auto-forwarded to the IRE and 2b) the member may also request an HHSC fair hearing at the same time if they choose.
- What is the provider complaint/grievance and appeals process?
 - Provider appeals, grievances, and/or dispute resolution is the responsibility of the MMP.
 - Please note that under managed care, providers should first exhaust the complaints or grievance process with their MMP before filing a complaint with HHSC. If after completing the MMP process, the provider believes they did not receive full due process from the MMP, they may file a Medicaid complaint or inquiry through HHSC's Health Plan Management (HPM) complaints box at: HPM_complaints@hhsc.state.tx.us.

Transportation Services

- Who is responsible for providing non-emergency transportation?
 - MMPs are responsible for contracting with providers to provide non-emergency ambulance transportation. Providers should contact the appropriate MMP to request an authorization prior to providing non-emergency ambulance transportation.
 - The Medical Transportation Program is responsible for providing transportation to and from covered Medicaid healthcare services. The toll-free phone number you call to schedule a trip depends on where you live:
 - Live in the Houston / Beaumont area? Call 1-855-687-4786.
 - Live in the Dallas area? Call 1-855-687-3255.
 - Everyone else can call 1-877-633-8747 (1-877-MED-TRIP).
- What is the obligation of the MMP for transportation in the nursing facility (NF)?
 - Nursing facilities are responsible for providing non-emergency transportation (e.g., transportation to doctor appointments, etc.) as occurs currently. This is because non-emergency transportation is included as part of the daily rate. Prior authorizations are not required for emergency services, including emergency transportation.
 - To schedule Medicaid non-emergency ambulance transportation, the NF provider must request authorization from the MMP. MMP prior authorization request forms can be found on the MMP website, or in the MMP provider manual.
 - The MCOs are required to provide authorizations based on medical necessity criteria and respond to authorization requests within 3 business days.

Dental Providers

- Does the Dual Demonstration impact dental providers? What about dental providers who provide care in a nursing facility?
 - Like in the STAR+PLUS program, only members eligible for STAR+PLUS home and community based waiver services are eligible for dental services in the Dual Demonstration. However, some of the MMPs offer dental services as a value added service.
 - Dental providers may continue to provide routine dental services to adult nursing home residents and be reimbursed through an adjustment in their Applied Income in the calculation of Incurred Medical Expense process.

Pharmacy

Will MMP use the STAR+PLUS formulary or the Medicare formulary?

- Both, it is an integrated program and the MMP covers both Part D and Texas Medicaid drugs.

CMS Provider FAQ: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TXProviderFAQ.pdf>

CMS Home Health FAQ: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TXHomeHealthProviderFAQ.pdf>

For more information about the Texas Financial Alignment Demonstration, please visit:

<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Texas.html>