TEXAS
Health and Human
Services Commission

Texas Dual-Eligibles Integrated Care Demonstration Project: Nursing Facility

Program Management

Medicaid and CHIP Division

Health and Human Services Commission

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What is Managed Care?

- Healthcare provided through a network of doctors, hospitals and other healthcare providers responsible for managing and delivering quality, cost-effective care.
- The state pays a managed care organization (MCO) a capitated rate for each member enrolled, rather than paying for each unit of service provided.

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Dual Demonstration

- The Centers for Medicare & Medicaid Services (CMS) and the Texas Health and Human Services Commission (HHSC) established a federal-state partnership to better serve individuals eligible for both Medicare and Medicaid (dual eligibles).
  - HHSC entered into a formal agreement with CMS and the STAR+PLUS Medicare-Medicaid Plans (MMP).
  - Test new payment methodology designed to minimize cost shifting, align incentives and support the best possible health and functional outcomes for enrollees

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Dual Demonstration

- Fully integrated managed care model for adults who are enrolled in Medicare and Medicaid. MMP must provide the full array of Medicare and Medicaid benefits.
  - Amerigroup
  - Cigna-Healthspring
  - Molina
  - Superior
  - United Healthcare
- Members started enrolling March 1, 2015
- Demonstration runs through December 2018

Dual Demonstration Goals

- The goals are to:
  - Integrate the fragmented model of care for dual-eligibles by creating a single point of accountability for the delivery, coordination, and management of Medicare and Medicaid services
  - Require one MMP to be responsible for the full-array of services
  - Streamline process for providers
  - Improve quality of care, reduce health disparities, and meet both health and functional needs of enrollee
  - Reduce avoidable hospitalizations and potentially preventable events
  - Promote independence in the community and improve transition between care settings

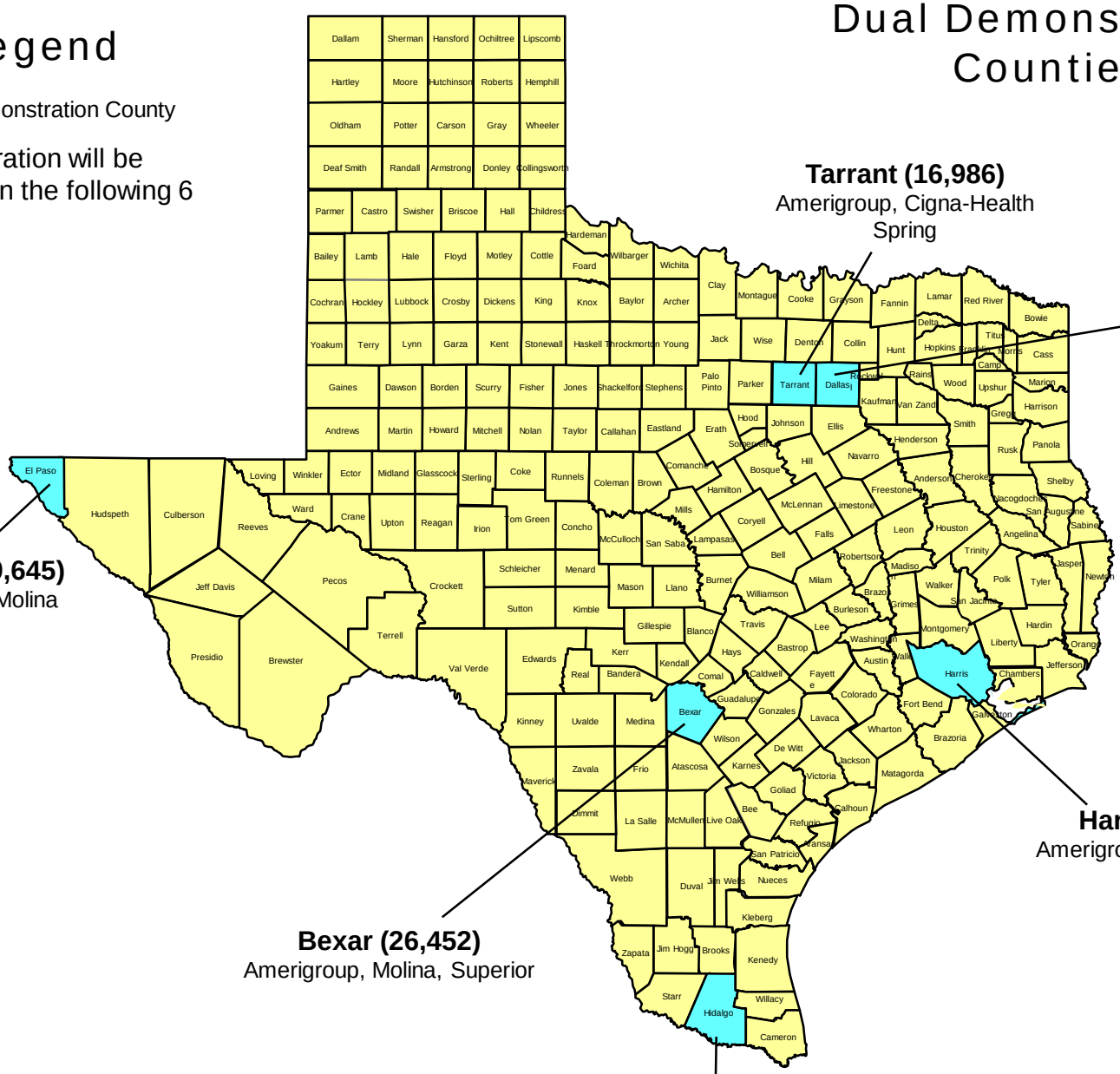
Dual Demonstration Counties

Legend

Dual Demonstration County

The Demonstration will be implemented in the following 6 counties:

- Bexar
- Dallas
- El Paso
- Harris
- Hidalgo
- Tarrant



Tarrant (16,986)
Amerigroup, Cigna-Health Spring

Dallas (27,941)
Molina, Superior

El Paso (19,645)
Amerigroup, Molina

Harris (47,160)
Amerigroup, Molina, United

Bexar (26,452)
Amerigroup, Molina, Superior

Hidalgo (27,090)
Cigna-Health Spring, Molina, Superior

HHSC, Project Management

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Eligible Population

- Clients can participate in the project if they meet all of these criteria:
  - Are age 21 and older and have a physical or mental disability and qualify for SSI
  - Have Medicare Part A, B and D, and are receiving full Medicaid benefits
  - Eligible for or enrolled in the Medicaid STAR+PLUS program, which serves members who have disabilities and those who meet a nursing facility level of care and get STAR+PLUS home and community based waiver services
  - Reside in one of the demonstration counties

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Excluded Population

- Dual eligible children (age 20 and younger) who have chosen to receive their Medicaid services through the STAR+PLUS managed care program.
- Dual eligible individuals not eligible for STAR+PLUS today, including those receiving services in a community based Intermediate Care Facility for Individuals with Intellectual Disabilities or Related Conditions (ICF-IID) or receiving services in the following ICF-IID 1915 (c) waivers:
  - Home and Community-based Services (HCS)
  - Community Living and Support Services (CLASS)
  - Texas Home Living (TxHmL)
  - Deaf-Blind Multiple Disabilities (DBMD)

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Voluntary Populations

- Other eligible individuals may choose to participate, or opt to enroll, but will not be passively enrolled
  - Those in a Medicare Advantage Plan not operated by an MMP participating in the demonstration
  - Those participating in a Medicare Accountable Care Organization with fewer than 9,000 members
  - Those receiving services through the Program of All Inclusive Care for the Elderly (PACE)

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Enrollment

- Enrollment for most eligible individuals will be conducted using a seamless, passive enrollment process and will include:
  - Welcome letter sent 90 days prior to enrollment date
    - Will be sent to address reflected in Texas Integrated Eligibility Redesign System (TIERS)
    - Notify Social Security Administration to update
  - Notification letters to enroll or opt out will be sent at 60 and 30 days prior to enrollment effective date
    - Letters will include the plan the member will be enrolled in if they do not call to disenroll or switch plans.

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Enrollment

- Eligible beneficiaries have the opportunity to make a voluntary choice to enroll (opt-in) or disenroll (opt out), or change plans at any time
- Request to enroll or disenroll can be made through Medicare (1-800-MEDICARE) or MAXIMUS, the State Enrollment Broker, at 1-877-782-6440
- If moving out of a demonstration county, update address and call to disenroll
  - MAXIMUS may accept disenrollment, but cannot re-enroll individuals into previously assigned Medicare Advantage Plan.
- New enrollments will not be accepted within 6 months of the end of the Demonstration.

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Enrollment

- Enrollment requests and plan changes will be accepted through the 12th of each month for effective coverage on the first calendar day of the next month
- Enrollment requests received after the 12th will be effective on the 1st of the second month
- Those opting out after an initial enrollment in an MMP will automatically revert to traditional Medicare. Effective date will always be on the 1st of the next month.

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Passive Enrollment

- Those who do not actively enroll or opt out will be automatically assigned to an MMP
  - Assignment is prioritized based on an algorithm that can be found at http://www.hhsc.state.tx.us/medicaid/managed-care/dual-eligible/enrollment-algorithms.pdf
- Nursing facility passive enrollment schedule
  - August 1, 2015: Bexar and El Paso counties
  - September 1, 2015: Harris county
  - October 1, 2015: Dallas, Hidalgo and Tarrant counties

Primary Care Provider

- Enrollees must choose a Primary Care Provider (PCP), or one will be assigned to them
  - Must be contracted and credentialed with MMP
- May change their PCP at any time with cut-off on the 25th of any month for an effective date on the 1st of the following month
  - Notify MMP to make a change to PCP

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Loss of Eligibility

- CMS will notify the State if resident is no longer entitled to both Medicare A or B benefits.
  - CMS will make disenrollment effective the 1st of the month following the last month of entitlement to either, whichever occurred first
- If resident loses Medicaid eligibility, they will be disenrolled on the 1st of the following month
  - MMP must offer the full continuum of benefits through the end of the calendar month in which the State notified the MMP of the loss of eligibility

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Benefits

- Election of Medicare Hospice Benefit
  - Will remain enrolled in MMP
  - Hospice services billed to Medicare fee for service
  - MMP is required to work with hospice providers to coordinate these services with the rest of residents services including Part D and any flexible benefits offered by MMP
- Behavioral health services for NF residents enrolled in MMP statewide (including the Dallas service area)are billed to MMP

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Benefits

- For pharmacy services, both the STAR+PLUS and the Medicare formularies will be used
- Skilled nursing may be provided without a preceding acute care inpatient qualifying stay
  - Must be prior authorized and clinically appropriate
  - Can avert the need for inpatient stay

Service Coordination

- MMP must:
  - Assign a Service Coordinator (SC) to each resident
  - Notify NF of change in SC within 10 days
  - Ensure SC returns calls to NF within 24 hours
  - Coordinate all aspects of medically necessary acute care and long term services as well as access specialty providers
  - Ensure SC makes initial face to face visit within 30 days of enrollment and quarterly thereafter
    - Must follow up within 14 days upon notification of a significant change in resident condition or of resident request to transition to the community

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Service Coordination

- NF must:
  - Invite SC to care plan, service planning and discharge planning meetings, provided the resident does not object
  - Allow SC access to all medical records, MDS and PASRR records and other information concerning their member while at the facility

Continuity of Care

- Medically necessary covered services must be provided or arranged for during the transition period
- Current acute care services will be authorized for up to 90 days while contracting efforts are underway.
  - Exception made for enrollee who has been diagnosed with and is receiving treatment for a terminal illness, covered services are authorized up to 9 months

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Participating Providers

- Nursing facilities are considered Significant Traditional Providers.
- Medicaid rates protected under provisions of state law
- Separate agreements or contracts must be executed between NF and MMP
  - Credentialing process should take no longer than 90 days after receiving a completed application
  - Recredentialing must occur at least every three years
  - Skilled services rates will be negotiated
  - Providers must not be under sanction from Medicaid or Medicare programs

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Participating Providers

- NF ancillary service providers must meet credentialing requirements and have current Medicare and Medicaid provider numbers. (i.e., physicians, lab, x-ray, pharmacy, DME)
- MMP reserve the right to transition their members to contracted providers after the continuity of care periods conclude.

Prior Authorizations

- For skilled stay admission from hospital or from long term care bed:
- Check your MMP contract for negotiated rate and notification requirements
  - Submit documentation supporting medical necessity via phone, fax or MCO portal
    - Emergency turnaround time -1 business day
    - Standard turnaround time – 3 business days
    - MMP will provide facility notification of # days approved and date for recertification

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Prior Authorizations

- Contact MMP if admission is clinically complex or involves high cost drugs to determine any rate enhancements on a case by case basis.
- Notify MMP immediately upon learning that a resident enrolls in MMP during a traditional Medicare stay to authorize continued services.
- CMS will honor skilled admits without 3 day qualifying stay if member is transitioning to traditional Medicare from MMP, as long as they continue to meet criteria for a skilled stay

Prior Authorizations

- Information generally required to support medical necessity (not all inclusive)
  - Current and historical patient data related to requested services (i.e., therapy notes showing need for continued services, progress, prior level of function)
  - History and Physical (H&P) Assessment
  - Medication list
  - Physician order
  - Nursing and physician progress notes
  - Labs, x-ray information

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Prior Authorizations

- Services and supplies billed to MMP that were historically billed to Medicare Part B require prior authorizations
  - Turnaround time requirements
    - 1 business day-emergent
    - 3 business days-standard
  - Therapies (physical, occupational, speech)
  - Physician ordered supplies traditionally billable to Part B (ostomy, urological, enteral and tracheostomy)
- Ancillary providers are responsible for their own prior authorizations and billing directly to MMP

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Prior Authorizations

- Denials may be sent to both NF provider and resident outlining the reason for denial and information on how to appeal
- Claims without necessary prior authorizations will be denied for payment
- All MCOs will accept the Texas Standard Prior Authorization Request Form for Health Care Services

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Verifying Eligibility

- Can be determined in a number of ways
  - MCP Provider Portal
  - Resident's Plan ID Card
  - IVR Novitas Solutions 1-855-252-8782
  - Texas Benefits provider helpline 1-855-827-3747
  - TexMedConnect at www.tmhp.com
    - Medicaid Eligibility and Service Authorization Verification (MESAV) will show Medicaid Eligibility and the managed care segments for MMP members
  - CMS Common Working File
- Recommend checking each time you bill

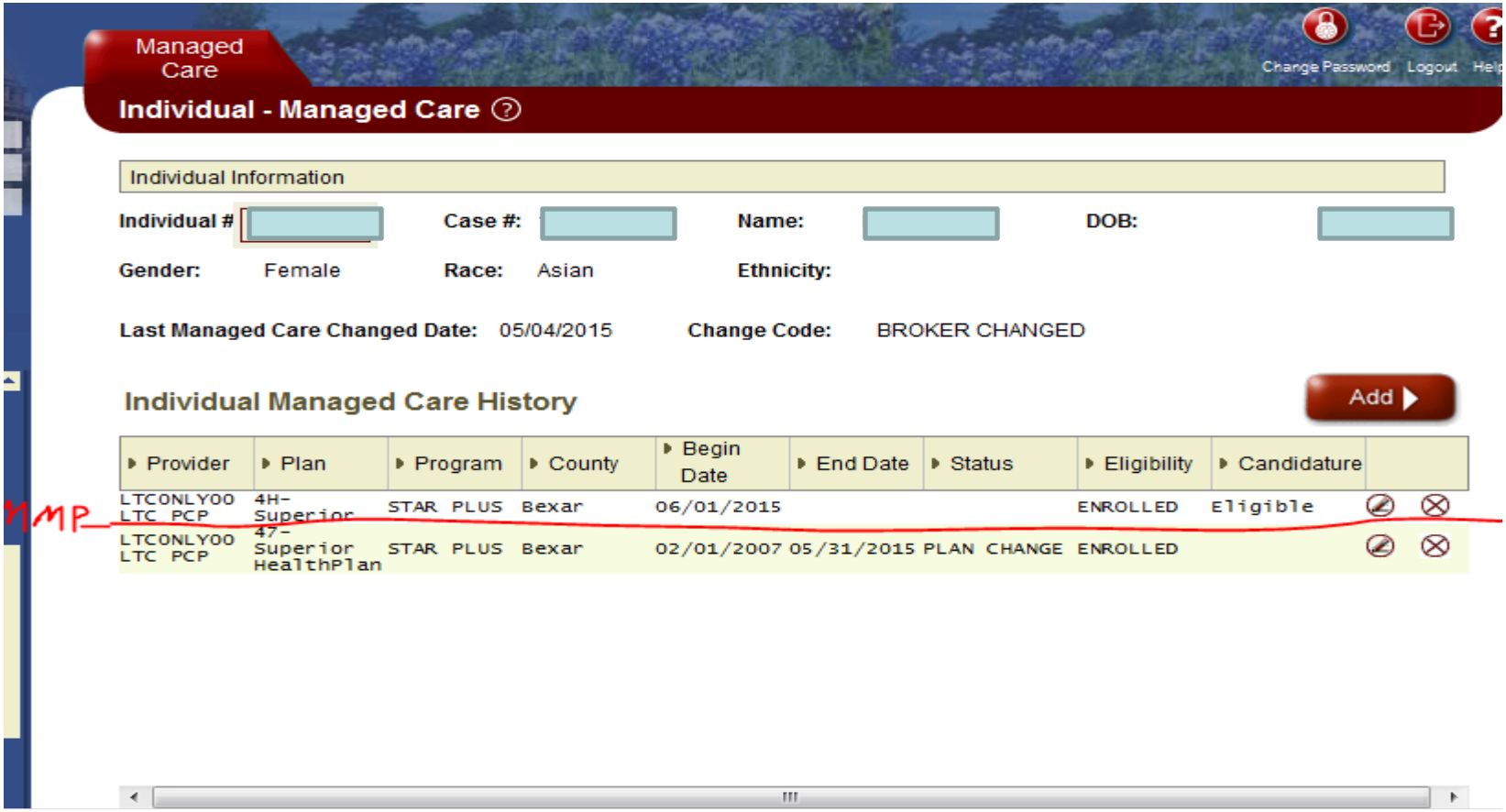
Verifying Eligibility

- MESAV
  - The STARPLUS MMPs have their own plan codes effective March 1, 2015

- Bexar County
  - 4F Amerigroup
  - 4G Molina
  - 4H Superior
- Dallas County
  - 9J Molina
  - 9K Superior
- El Paso County
  - 3G Amerigroup
  - 3H Molina
- Harris County
  - 7Z Amerigroup
  - 7V Molina
  - 7Q United
- Hidalgo County
  - H9 Molina
  - HA Superior
  - H8 Cigna-HealthSpring
- Tarrant County
  - 6F Amerigroup

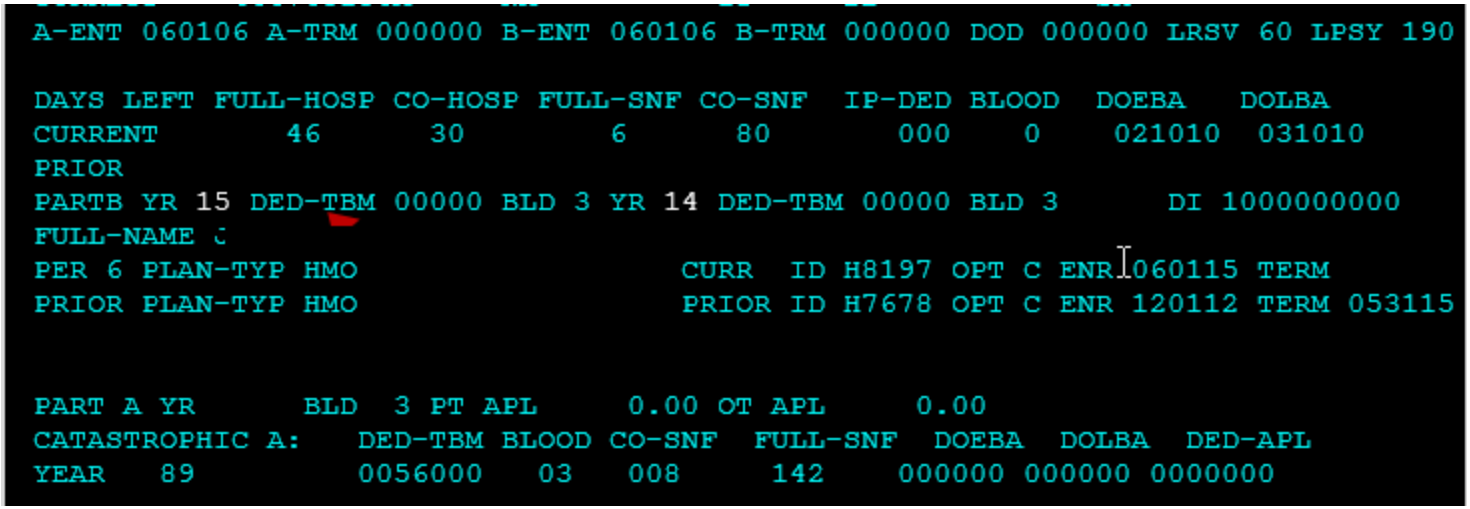
Verifying Eligibility

- MESAV



Verifying Eligibility

- CMS Common Working File (CWF)



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Billing and Reimbursement

- Please refer to contract to identify provider relations representative assigned to each NF
  - Can assist with coordination of MCO portal training
  - Can assist with claims submission, troubleshooting and answer general billing, contracting and credentialing questions

Billing and Reimbursement

- MMP must:
  - Adjudicate NF unit rate clean claims within 10 days
  - Adjudicate therapy clean claims within 30 days
  - Have a mechanism for passing through quality incentive payments from HHSC to NFs.

Billing and Reimbursement

- NF must:
  - Not balance bill the resident covered under MMP for any reason
  - Bill MMP directly for skilled care claims
    - Claims must be submitted within 365 days of beginning of date of service
    - Submit one claim for skilled care stay
      - Check with MMP to schedule NF specific MMP billing training
      - Revenue codes: 0191, 0193 (0192 used for community members entering facility)
      - Revenue code: 01014 for co-insurance portion

Billing and Reimbursement

- NF must:
  - Submit Forms 3619 timely for the State to send accurate co-insurance information to the MMP
  - Bill therapy claims (formerly Part B Therapy) on separate claim, not billed on SNF stay or custodial daily unit rate claims
  - Therapy services HCPCS codes used for prior authorization must also be the same codes used to bill

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Appeals and Fair Hearings

- All Medicare and Medicaid protections remain in place
- 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.
- A beneficiary can also file an appeal through the state fair hearings office within 90 days.

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Appeals and Fair Hearings

- MMPs will be required to use an integrated action notice, informing members of their Medicare and Medicaid rights.
- The Part D appeals process is unchanged.
- For Medicare services, beneficiaries will continue to have appeal rights to an Independent Review Entity (IRE) and to higher levels.

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Provider Complaints

- For Medicaid issues, providers should initially contact the MMP to file a complaint before filing a complaint with HHSC.
  - Providers must exhaust the complaint process with the MMP before filing a complaint with HHSC.
- Appeals, grievances, or dispute resolution is the responsibility of the MMP.
- Providers may file complaints regarding services related to Medicaid with HHSC if they do not receive full due process from the MMP at: HPM_complaints@hhsc.state.tx.us.

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Provider Next Steps

- Become familiar with the MMPs operating in counties where you serve clients.
- Continue the contracting and credentialing process with your MMPs.
- Negotiate with MMPs to become a member of the provider network.
- Become familiar with the MMP billing portals as all claims must be submitted in this way.
- Ensure you understand how to seek authorizations for services from each MMP.

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MMP Provider Helplines

- Amerigroup
  - 1-855-817-5790
- Cigna HealthSpring
  - 1-877-653-0331
- Molina
  - 1-866-449-6849
- Superior
  - 1-877-391-5921
- United
  - 1-888-887-9003

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Questions

Email general managed care questions to:

Managed_Care_Initiatives@hhsc.state.tx.us

Email re: Eligibility, managed care enrollment or technical questions:

ManagedCareExpansion2015@hhsc.state.tx.us

Dual Demonstration Webpage

http://www.hhsc.state.tx.us/medicaid/managed-care/dual-eligible/