Nursing Facility Services Transition into Medicaid Managed Care

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Managed Care

• Managed care is 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 (fee-for-service)
Managed Care Client Enrollment

• As of May 2015, an estimated:
  • 3.9 million clients are enrolled in Texas Medicaid
  • 3.4 million members are enrolled in:
    • STAR – 2.8 million
    • STAR Health – 30,000
    • STAR+PLUS – 577,000

Data Source: Medicaid/CHIP Data Analytics May 2015
STAR+PLUS

- Integrates the delivery of acute care and long-term services and supports (LTSS) through a managed care system
- About 577,000 members currently served
- Main feature - service coordination
  - Specialized care management service that is available to all members and performed by an MCO service coordinator
- Available statewide as of September 1, 2014

Data Source: Medicaid/CHIP Data Analytics April 2015
STAR+PLUS Benefits

• **Medicaid Only**
  • Traditional Medicaid benefits
  • Primary Care Provider (PCP)
  • Community-based LTSS: personal attendant services (PAS) and day activity and health services (DAHS)
  • Nursing facility benefits: daily care services, applicable enhancements, Medicare Part A coinsurance, and add-on services
  • Service coordination
  • Unlimited prescriptions

• **Dual Eligibles**
  • Individuals eligible for both Medicaid and Medicare receive their LTSS through the STAR+PLUS program and their acute care though Medicare
Recent Initiatives

• Ongoing efforts to improve how Medicaid services are delivered to the elderly and individuals with disabilities continued with the implementation of two new initiatives:
  • Transitioning nursing facility services into managed care on March 1, 2015
  • Implementing the Texas Dual Integrated Care Project (called the Dual Demonstration)
    • Passive enrollment for NF residents begins August 2015
Recent Initiatives

• The goal of both initiatives is to improve quality of care and health outcomes for Medicaid clients through:
  • Coordinating healthcare and access to services
  • Ensuring needs are addressed in the least restrictive, most appropriate settings
  • Reducing unnecessary hospitalizations and potentially preventable events
  • Dual Demonstration, eliminating cost shifting between Medicare and Medicaid
Nursing Facility Implementation

- On March 1, 2015, most people living in a nursing facility (NF) began receiving Medicaid services through a STAR+PLUS MCO

- The MCOs are responsible for:
  - Reimbursing providers for services rendered to STAR+PLUS managed care members
  - Ensuring appropriate utilization of NF add-on and acute care services
  - Providing access to service coordination to ensure care coordination
  - Helping to reduce preventable hospital admissions, readmissions, and emergency room visits
Nursing Facility Implementation: STAR+PLUS Populations

• Mandatory:
  • Adults age 21 and older enrolled in Medicaid
  • Meet STAR+PLUS eligibility requirements

• Excluded:
  • Individuals age 20 and younger
  • Individuals living in the Truman W. Smith Children’s Care Center
  • Individuals living in a state veteran’s home

• Approximately 50,000 nursing facility residents transitioned to STAR+PLUS, with 50 percent of residents actively choosing their managed care plan
Nursing Facility Implementation: Outreach and Education

• Outreach and education activities included:
  • YouTube informational video (October 2014)
  • 54,994 introduction letters (November 2014)
  • 64,012 enrollment packets (November 2014)
  • 50,071 reminder letters (January 2015)
  • 1,026 enrollment events at nursing facilities statewide (November 2014 – February 2015)
  • 14 provider trainings (including two webinars) and two HHSC In Touch articles (January – February 2015)
  • 25 Department of Aging and Disability Services (DADS) Long Term Care news articles; eight DADS Information Letters; and four DADS Long Term Care provider bulletins (April 2014 – May 2015)
  • Creation of Provider Inquiries chart for use by nursing facility staff
Nursing Facility Implementation: Monitoring

• HHSC is monitoring implementation closely and addressing items as needed
  • Daily calls with TMHP and DADS on claims, claims forwarding, and claims processing, through the end of March
  • Bi-weekly check-in calls with TMHP, DADS, and the MCOs on call center volume and trends through the end of March
  • Twice weekly individual calls with the MCOs on claims processing, authorizations, and service coordination scheduled through the end of May
  • Command Center to resolve eligibility and enrollment inquiries related to implementation
  • Health Plan Management Complaint email box operational ongoing
  • Monthly stakeholder meetings
  • Weekly Claims and Authorization reports submitted by each MCO
Nursing Facility Implementation: Claims Data

• From March 1 through May 14, 2015:
  • More than 342,000 NF claims were submitted through the TMHP portal or directly to the MCOs
    • 110,000 or 32 percent of claims submitted to MCOs
    • 232,000 or 68 percent of claims submitted through TMHP
  • More than 274,000, or 80 percent, of NF claims totaling over $229 million were paid
  • Overall, 16 percent of claims are being denied by the MCOs
    • January 2015 FFS data show 294,458 claims submitted with a 20 percent rejection/denial rate
    • February 2015 data show 251,916 claims submitted with an 18 percent rejection denial rate
Nursing Facility Implementation: Claims Denial Data

• Top five NF claims denial reasons
  • Duplicate claims
  • Provider rates not found
  • Invalid diagnosis codes
  • Service authorizations not found
  • Incorrect number of units billed on claims
Nursing Facility Implementation: Claims Rejection Data

- Top five NF claims rejection reasons
  - Diagnosis codes
  - Tax identification (TaxID)
  - Attending provider national provider identification (NPI)
  - Claims with other insurance (OI)
  - External cause of injury diagnosis codes
Nursing Facility Services: Service Coordination

- MCOs will assign a service coordinator for each NF
  - Licensed RN, NP, or LVN
- Service coordination includes:
  - Identifying and addressing residents’ physical, mental or long term needs
  - Assisting residents and families to understand benefits
  - Ensuring access to and coordination of needed services
  - Transition to community in adherence with the Texas Promoting Independence Initiative, including Money Follows the Person, as appropriate
- MCO service coordinators will visit residents at least quarterly
  - Exception for NF residents receiving hospice or outside the MCOs service areas
Nursing Facility Services: MCO Service Coordinator Responsibilities

- MCO service coordinators will assist with:
  - Finding providers to address specific needs
  - Coordination and notification of add-on services not included in the daily rate
  - Collection of applied income:
    - Business office manager (BOM) is responsible for collecting applied income
    - BOM can notify MCO service coordinator if they have made two unsuccessful collection attempts
Nursing Facility Services: MCO Service Coordinator Notifications

- NFs should notify the MCO service coordinators within one business day for:
  - NF admission/readmission and discharge
  - Change in payer source (Medicaid/Medicare) or bed type (skilled/non-skilled)
  - Transition to hospice
  - Use of emergency room or emergency transportation
    - Prior authorization not required for emergency services
  - Significant change in resident condition potentially requiring hospitalization
Nursing Facility Services: MCO Service Coordinator Notifications

- MCO service coordinators should work closely with NFs to coordinate efforts related to:
  - Allegations of resident abuse, neglect and/or exploitation – MCO service coordinators must inform NF administration immediately upon hearing of allegation
  - Access to resident medical information
  - Transition to a less restrictive environment
Nursing Facility Services: Authorizations Process

• DADS will continue to authorize services for:
  • NF unit rate (daily care and room and board)
  • Medicare coinsurance
  • Child tracheostomy care
  • Ventilator care

• MCOs will authorize add-on services for:
  • Physical therapy
  • Speech therapy
  • Occupational therapy
  • Durable medical equipment (such as customized power wheel chairs)
Nursing Facility Services: Authorizations for Add-ons and Acute Care

• For add-on and acute care services, providers must:
  • Request authorizations from MCO using the MCO portal
  • Use the MCO-specific prior authorization request form:
    • MCO website
    • Provider manual

• MCOs:
  • Provide authorizations based on medical necessity criteria
  • Respond to authorization requests within three business days
  • May issue authorizations for more than 30 days
Nursing Facility Services: Authorizations in Progress

• **Therapy services:**
  - MCOs will receive open service authorizations as of March 1 for managed care members
  - NFs should submit claims to TMHP for dates of service prior to March 1 for managed care members
  - NFs or therapists should submit claims incurred on or after March 1 to MCOs for managed care members

• **Durable Medical Equipment (DME):**
  - Service authorizations requested prior to March 1 to DADS or TMHP will continue to be processed and paid by TMHP
  - NFs should not submit a fee for service DME claim to TMHP for payment if the resident is a managed care member
  - Details of payment for these DME will be forthcoming from DADS
Nursing Facility Services: Billing and Reimbursement

- MCOs pay providers:
  - Daily rate - based on resident’s minimum data set (MDS) resource utilization group (RUG) level
  - Negotiated rates for other medically necessary services including add on and acute care services
    - Rates for goal directed therapy are set by the State
  - For services under the NF unit rate, MCOs must pay NFs no less than the Medicaid fee-for-service (FFS) rate
    - Unit rate includes staff rate enhancement and liability insurance
Nursing Facility Services: Services Excluded from Managed Care

- Although NF residents may be in managed care, providers must bill traditional FFS Medicaid for:
  - Hospice services
  - Preadmission Screening and Resident Review (PASRR) services
  - For new admits that have not yet enrolled in managed care
- MCOs will pay for all other services for NF residents
• MCOs may pend claims if more information is needed to adjudicate
  • For example: explanation of payment (EOP) for other insurance, payment reconsideration
  • Providers must follow-up directly with the MCO
• MCOs may require providers to bill unit rate and add-on services separately
• Submitting claims directly to the MCO and through the state portal will require input in fields that include:
  • Primary diagnosis
  • Admit date
  • Other insurance (if applicable)
  • Taxonomy
• HHSC encourages NFs to bill MCO portals directly
  • MCO portals allow enhanced functionality, tracking, submission of attachments, and additional timeliness
  • NFs can submit claims for unit rate services through the state portal to forward to the appropriate MCO
  • NFs must use MCO portal to make corrections/adjustments or request an appeal of their claims
  • NFs must use MCO portal to obtain status of submitted claims
Nursing Facility Services: Client Enrollment Activities

• Ongoing, managed care candidates will have 15 days to choose an MCO

• Managed care members may switch MCOs at any time

• To request a change, NF residents or their authorized representatives should contact MAXIMUS, the state’s enrollment broker
  • Phone: 1-877-782-6440
  • Fax: 1-855-671-6038
  • Online: http://www.yourtexasbenefits.com
Nursing Facility Services: Client Complaints

- NF residents may need assistance in determining the appropriate avenue to file a complaint
  - If the complaint is about managed care services or service coordination, contact the MCO directly
  - If complaint is about the NF, contact DADS:
    - Allegations of Abuse, Neglect or Exploitation involving NF staff
    - Long-Term Care Ombudsman involving perceived violations of resident rights
  - Other allegations
    - Adult Protective Services Abuse Hotline 1-800-252-5400
    - Local Law Enforcement
Nursing Facility Services: Provider Complaints

- Contact the MCO first and exhaust the MCO resolution process before filing a complaint with HHSC
- Contact the MCO directly:
  - Questions about claim adjudication
  - Appeals, grievances or dispute resolution
- Contact DADS:
  - Issues with RUG (daily rate) or permanent medical necessity
  - Self Reports of abuse/neglect/exploitation
- Contact TMHP:
  - LTCMI issues
  - Medical Necessity denials
- Contact HHSC:
  - Email HPM complaints, if you feel you do not receive resolution from the MCO at HPM_Complaints@hhsc.state.tx.us
Nursing Facility Services: Appeals and Fair Hearings

• If services are denied, reduced or terminated, clients may:
  • Appeal to the MCO
  • File a fair hearing request with the State.

• Services may continue during the review of the appeal or fair hearing if:
  • The request was submitted within the adverse action period
  • The member requests continued services pending the appeal.

• Medicaid appeal process will not change with managed care
  • Members have 30 days to file an appeal with the MCO
  • Members can also file an appeal through the Fair Hearings Office within 90 days
  • No changes have occurred with medical necessity determination outcome appeals process
Dual Demonstration Implementation

• The Centers for Medicare and Medicaid Services (CMS) and HHSC established a federal-state partnership to better serve individuals eligible for both Medicare and Medicaid.

• The initiative will test an innovative payment and service delivery model to improve coordination of services for dual eligibles with the goal of enhancing quality of care and reducing cost.
  • Require one health plan to be responsible for the full array of services.
  • Create a single point of accountability for the delivery, coordination and management of Medicare and Medicaid services.
  • Integrate the fragmented model of care for dual eligibles.
Dual Demonstration Implementation: Participating Counties

- The following six counties are in the Dual Demonstration:
  - Bexar
  - Dallas
  - El Paso
  - Harris
  - Hidalgo
  - Tarrant

- Fully integrated managed care model for individuals who are enrolled in Medicare and Medicaid (dual eligibles)
- Each member is enrolled in a Medicare-Medicaid Plan (MMP)
- Enrollment for most eligible residents will be conducted using a passive enrollment process, with the opportunity to opt out
- Demonstration started March 1, 2015, and will run through December 2018
Dual Demonstration Implementation: Eligible Population

• Clients can participate in the project if they meet all of these criteria:
  • Are age 21 and older
  • Get 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
Dual Demonstration Implementation: Enrollment

• Enrollment for most eligible individuals will be conducted using a seamless, passive enrollment process.

• Passive enrollment is a process through which an eligible beneficiary is enrolled into a MMP following a notification process that identifies the MMP selected for them if the beneficiary takes no action.

• The beneficiary has the opportunity to select a different plan, make another enrollment decision, or decline enrollment and opt out of the demonstration prior to the effective date of coverage.

• To enroll or disenroll, members can call the Medicaid Enrollment Broker or Medicare.
Dual Demonstration Implementation: Enrollment

- The enrollment process will include:
  - Welcome letter 90 days prior to the start date
  - Notification of enrollment and the choice to opt out of the demonstration (60 and 30 days prior to the start date)
  - The option to opt in or out on a monthly basis

- Other eligible individuals may choose to participate, or opt to enroll. Those include but are not limited to:
  - Individuals in a Medicare Advantage plan not operated by a MMP participating in the demonstration
  - In an ACO with fewer than 9,000 members
Dual Demonstration Implementation: Passive Enrollment

- This chart outlines the population eligible for passive or opt-in enrollment:
  - **Passive enrollment**: enrollment for eligible beneficiaries into the demonstration that provides the opportunity for beneficiaries to make a voluntary choice to enroll or disenroll at any time.
  - **Opt-in enrollment**: beneficiary-initiated elections to enroll in the demonstration.

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
<th>Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Medicare</td>
<td>STAR+PLUS Medicaid</td>
<td>Eligible for Passive</td>
</tr>
<tr>
<td>Medicare Advantage (non-MMP plan)</td>
<td>STAR+PLUS Medicaid</td>
<td>Eligible for Opt-in</td>
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</tbody>
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# Dual Demonstration Implementation: Passive Enrollment Notification

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Intro letter</th>
<th>60 day letter</th>
<th>30 day reminder</th>
<th>Enrollment Start Date</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>January 2015</td>
<td>N/A</td>
<td>N/A</td>
<td>March 1, 2015 (opt-in)</td>
<td>Any eligible client who opts-in</td>
</tr>
<tr>
<td>1</td>
<td>January 2015</td>
<td>Feb 1, 2015</td>
<td>March 2, 2015</td>
<td>April 1, 2015</td>
<td>20% of eligible non-facility clients by zip code in all demo counties</td>
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<tr>
<td>2</td>
<td>February 2015</td>
<td>March 2, 2015</td>
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<td>May 1, 2015</td>
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</tr>
<tr>
<td>3</td>
<td>March 2015</td>
<td>April 1, 2015</td>
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<td>4</td>
<td>April 2015</td>
<td>May 1, 2015</td>
<td>June 1, 2015</td>
<td>July 1, 2015</td>
<td>20% of eligible non-facility clients by zip code</td>
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<tr>
<td>5</td>
<td>May 2015</td>
<td>June 1, 2015</td>
<td>July 1, 2015</td>
<td>August 1, 2015</td>
<td>20% of eligible non-facility clients by zip code, All eligible NF residents in Bexar and El Paso</td>
</tr>
<tr>
<td>6</td>
<td>June 2015</td>
<td>July 1, 2015</td>
<td>Aug 1, 2015</td>
<td>Sept 1, 2015</td>
<td>All eligible NF residents in Harris</td>
</tr>
<tr>
<td>7</td>
<td>July 2015</td>
<td>August 1, 2015</td>
<td>Sept 1, 2015</td>
<td>Oct 1, 2015</td>
<td>All eligible NF residents in Dallas, Hidalgo and Tarrant</td>
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Dual Demonstration Implementation: Billing

- Providers will only be required to submit one bill to MCO for most acute and long term care services covered under Medicare and Medicaid
- Payment for Medicare and Medicaid services will be sent from MCO
- MCO will authorize services
- Prior authorizations are not required for emergency services
- Hospice, non-emergency medical transportation & PASRR specialized services will remain in FFS
- Residents can be admitted under skilled criteria without having required 3 day hospital stay
  - May also be able to stay within facility without hospitalization by obtaining authorization from MCO
Questions and Resources

- **Email provider and member complaints/inquiries:**
  HPM_Complaints@hhsc.state.tx.us

- **Email eligibility and enrollment questions:**
  ManagedCareExpansion2015@hhsc.state.tx.us

- **Email general managed care questions to:**
  Managed_Care_Initiatives@hhsc.state.tx.us

- **NF Provider page:**

- **Dual demonstration webpage:**
  http://www.hhsc.state.tx.us/medicaid/managed-care/dual-eligible/