TEXAS MEDICAID MANAGED CARE

6 Keys to Success in the New MCO Environment

A GUIDED TOUR THROUGH THE COMPLEX AUTHORIZATION PROCESS

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Presented by: Texas Medicaid Coalition SIMPLELTC™

May 19, 2015

Objectives

1. Understand the differences between MCO requirements for Prior Authorization for therapy
2. Learn to successfully complete a Prior Authorization for Therapy
3. Understand the role of the Primary Care Physician
4. Learn how to change the Primary Care Physician within the MCO system
5. Learn how to assist resident and/or family members in changing MCOs
6. Learn how to read the MESAV to determine the MCO enrollment date and end date

Understanding Managed Care

Managed Care is not an easy concept to wrap our heads around. Let's break it down by pieces…

1. **Medicare Advantage Plans:** this means if a resident has Medicare and chooses to enroll in a Medicare Advantage Plan to take over their Medicare type benefits. This is your Resident who decided to DISENROLL in Medicare and decided to enroll in a Medicare Advantage Plan.
2. **Health Benefit Exchange:** This is the younger population between the ages of 18-64 who were uninsured and enrolled for a Managed Care Plan through the Health Benefit Exchange program.
3. **Affordable Care Act:** This plan moves all the Medicaid Population into a Managed Care Organization. THIS IS US RIGHT NOW – the **Medicaid MCO** we keep referring to in our programs.
4. **Financial Alignment Demonstration**: This is a plan also known as MMP (Medicaid/Medicare Plan) where a Resident with Medicaid and Medicare will be enrolled in a Managed Care Plan for both payor types and the Managed Care Organization will manage both benefits.

Understanding Managed Care (cont.)

- **What is this Medicaid Managed Care that we speak of?** Our Medicaid program is now under the Medicaid Managed Care system
- **What this means to us:** When a resident is enrolled in a Medicaid MCO, the MCO becomes our Payor and we must obtain permission from the MCO to provide Medicaid Only Therapy for a Resident with Medicaid Only as the payor source
- **Meaning:** The resident does not have Medicare Part B to pay for the necessary Therapy Services
- **This is not a resident on Skilled Services with Managed Care covering the Skilled Services.** The Prior Authorization and Continued Authorization is managed quite differently than a resident with Medicaid ONLY and enrolled in a Medicaid MCO (Managed Care Organization).
- **We will only talk about Medicaid Managed Care** from this point forward in the presentation

What changed for us?

OLD WAY:

1. If a resident had a need for therapy and the only payor source was Medicaid, the therapy company would verify benefits, obtain a physician's order, complete the 2464 Rehab Form and submit the form to DADS for therapy approval.
2. The therapy team typically would initiate therapy while waiting for DADS (state) to approve the therapy and would often approve the therapy for the date the 2464 form was submitted.
3. The MESAV would identify the therapy type and amount approved and our billers would bill.

NEW WAY:

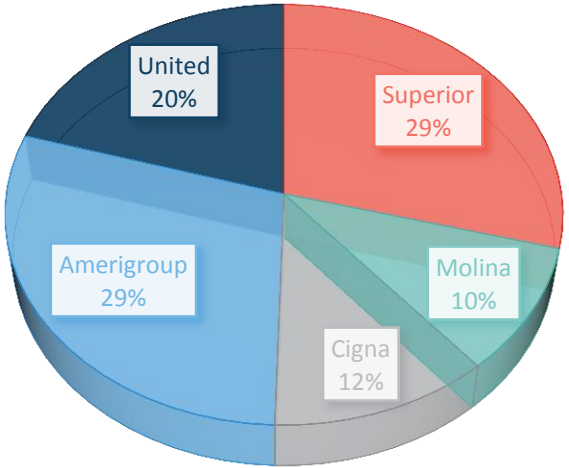
1. If a resident is not enrolled in a MCO and Medicaid is the only payor source, then the 2464 Form and process will be the same as the old way.
2. BUT: If the Resident is enrolled in a Medicaid MCO plan, then the THERAPY must be approved through the Prior Authorization process.
3. This means: The facility is at risk for non-payment if therapy is initiated prior to approval from the assigned MCO.
4. Potential issue: If we start therapy before an approval, therapy will be denied and will create a bigger delay in the delivery of therapy services.

Medicaid MCOs

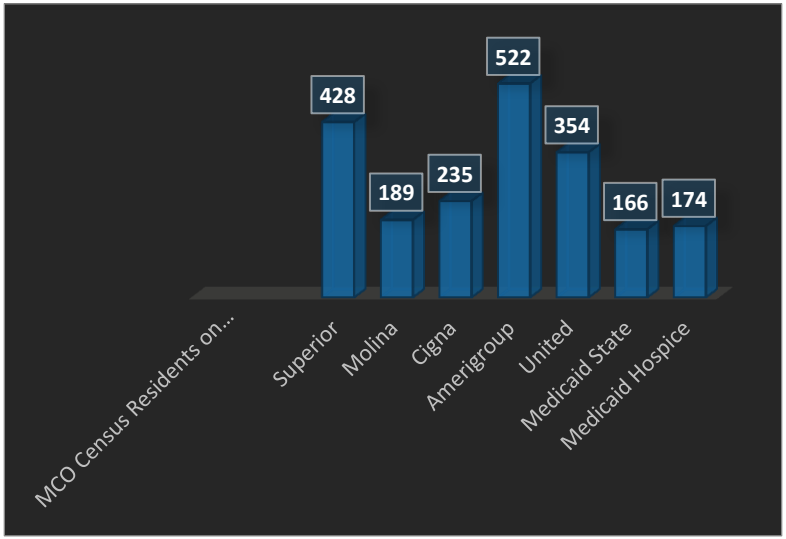
- 5 MCOs are currently assigned to manage Medicaid Residents in nursing facilities:
  1. Superior
  2. United Healthcare Community Plan
  3. Amerigroup
  4. Cigna Healthspring
  5. Molina
- It's critical to understand that every MCO has a different process for Prior Authorizations for Therapy
- How do you know if your Resident is enrolled in a MCO for Medicaid?
  - **CHECK THE MESAV!**

Company caseload example

% of MCOs assigned



# of residents assigned to MCO on April 1



Therapy Prior Auth process

- Note: This may *not* be the process in your facility but provides an example of how to streamline the process in your facility
- Overview:
  1. Therapy requests a Therapy Funding Verification Request be completed by the BOM.
  2. The BOM notifies Therapy of the funding.
  3. If Resident is not enrolled in a MCO yet then the payor is state.
  4. If Resident is enrolled in a MCO- Please utilize the correct Prior Authorization Form for the correct MCO. Therapy has to be told which MCO for Medicaid the resident is enrolled in so please indicate on the Therapy Funding Verification Request.
  5. Therapists is to provide the Prior Auth form to the MDS Case Manager with the appropriate authorization completed.
  6. The MDS Case Manager is to complete the rest of the Form and fax to the MCO the Prior Authorization request along with supporting documentation.
  7. The MCO has 72 hours to respond and we've seen response via Fax in an Authorization Form which includes Dates, approved units/days (depending on MCO) and auth number.
  8. Provide the Prior Authorization approval/denial notice to Therapy, BOM and Administrator.

Therapy Prior Auth process (cont.)

- REMEMBER:
  - The MESAV will no longer show the approved therapy from a MCO so the billers will not know who to bill.
  - We only have 95 days to bill the therapy. The first date of service starts the clock for billing.
- Tight deadline!

Let’s review Prior Authorization Forms

- You may choose to fax your Prior Authorization for therapy
- You may choose to utilize the MCO portal for submission of the Prior Authorization for therapy
- Note: The actual form and the entry items in the MCO portal may differ
- Effective Sept. 1, 2015:
  - Health plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization for a health care service. This includes Medicaid and the Medicaid managed care Plan.
- Keep in mind: the MCO portal will *not* look like the Prior Authorization form

Superior

REMEMBER:

Each MCO is different and has different requirements

Superior Prior Authorization Requirements for Therapy

1. Superior requires a Prior Authorization for therapy EVAL only.
2. Submit the Prior Authorization indicating Evaluation Only for each discipline. Do not complete or submit the evaluation yet! You must have permission first.
3. Submit a signed physician's order for therapy and all the supporting documentation to paint a picture of your resident.
4. Once your therapy evaluation is approved, then you submit your Prior Authorization treatment plan. This will be the completed and signed by the physician therapy evaluation.
5. Superior does not allow RETRO AUTHORIZATION. So on the start date of the Prior Auth Form, it's recommended that you put the date 5 days from the date you submit your evaluation and/or treatment plan. This allows time for the MCO to approve and notify you.

Superior Prior Authorization Requirements for Therapy (cont.)

6. It is extremely important to understand the Start Date and End Date of the Prior Auth form.
7. Superior requires both dates.
8. Do not enter a Start Date for Therapy with a date prior to your submission of the Prior Authorization Form. Superior recommends putting a Start Date 5 days after the date you plan to submit your Authorization Form.
9. Think about how your facility wants to handle initiating therapy prior to an approval.
10. Superior DOES require another Prior Authorization if you determine that you want to extend therapy past the current END date that has been approved to TREAT. You may submit the Prior Auth and enter the START DATE before the current AUTHORIZATION Expires. I recommend a few days prior to the AUTH expiration so the Resident does not have a GAP in their therapy services.

NEW PHRASE: "Plan smart, communicate smart, implement smart, follow up smart."

Molina

REMEMBER:

Each MCO is different and has different requirements

Molina Prior Authorization Requirements for Therapy

1. Molina does NOT require a Prior Authorization for a therapy evaluation.
2. Molina DOES require a Prior Authorization BEFORE therapy can be started.
3. Molina will NOT approve RETRO AUTHS.
4. Prior Authorization form: The START DATE needs to be the date you submit the Prior Authorization. You can choose the END date to be 30, 60, 90 days past the START DATE.
   - The Molina Prior Auth form includes only Date(s) of Service, so add 4/9/15-5/9/15 as an example.
5. Molina DOES require another Prior Authorization if you determine that you want to extend therapy past the current END date that has been approved to TREAT. You may submit the Prior Auth and enter the START DATE before the current AUTHORIZATION expires. I recommend a few days prior to the AUTH expiration so the Resident does not have a GAP in their therapy services.

Molina Prior Authorization Requirements for Therapy (cont.)

6. All relevant clinical documentation needs to be submitted with the Prior Auth.
   - Remember: You are painting a picture of the resident's therapy needs to the reviewer at Molina.
7. Molina does not require a Signed Physician Order for PT, OT or ST to be submitted with the Prior Auth form (although on a continued authorization they may request to see the physician signature if we want to submit a continued authorization to continue treating).
8. Molina does not require a physician-signed Therapy Evaluation to be submitted with a Prior Auth form (although on a continued authorization they may request to see the physician signature if we want to submit a continued authorization to continue treating).

Think about how your facility wants to handle initiating therapy prior to an approval.

Cigna Healthspring

REMEMBER:

Each MCO is different and has different requirements

Cigna Healthspring Prior Authorization Requirements for Therapy

1. Cigna does NOT require a Prior Authorization for a therapy evaluation.
2. Cigna DOES require a Prior Authorization BEFORE therapy can be started.
3. Cigna will NOT approve RETRO AUTHS.
4. At least 5 business days prior to the requested start date of service, we will complete and submit the Prior Auth form. Enter a start date approximately five days in the future to allow time for the Prior Auth to be reviewed and approved before starting therapy.
5. Cigna DOES require another Prior Authorization if you determine that you want to extend therapy past the current END date that has been approved to TREAT. You may submit the Prior Auth and enter the START DATE before the current AUTHORIZATION expires. I recommend a few days prior to the AUTH expiration so the resident does not have a GAP in their therapy services.
6. All relevant clinical documentation needs to be submitted with the Prior Auth.
    - Remember: You are painting a picture of the Residents Therapy needs to the Utilization Management at Cigna.

Cigna Healthspring Prior Authorization Requirements for Therapy (cont.)

7. Per Cigna: You can submit the Therapy Evaluation without a physician signature and it will be at the discretion of the nurse in the Cigna Utilization Management department whether you will need to obtain a physician-signed evaluation.
8. Submit the Therapy Evaluation without a physician's signature to initiate the Prior Authorization process per UM at Cigna.
9. Think about how your facility wants to handle initiating therapy prior to an approval.
10. Cigna hint: The portal will not allow you to submit an authorization to CONTINUE treatment.

NEW PHRASE: "Plan smart, communicate smart, implement smart, follow up smart."

United Healthcare Community Plan

REMEMBER:

Each MCO is different and has different requirements

United Healthcare Community Plan Prior Authorization Requirements for Therapy

1. United does NOT require a Prior Authorization for a therapy evaluation.
2. United DOES require a Prior Authorization BEFORE therapy can be started.
3. At least 5 business days prior to the requested Start date of service, we will complete and submit the Prior Auth form. Enter a start date approximately five days in the future to allow time for the Prior Auth to be reviewed and approved before starting therapy. You can choose the END date to be 30 past the START DATE.
   - United Prior Auth only has a place for date of service. So you can add 4/9/15-5/9/15 as example.
4. United DOES require another Prior Authorization if you determine that you want to extend therapy past the current END date that has been approved to TREAT. You may submit the Prior Auth and enter the START DATE before the current AUTHORIZATION Expires. I recommend a few days prior to the AUTH expiration so the Resident does not have a GAP in their therapy services.

United Healthcare Community Plan Prior Authorization Requirements for Therapy (cont.)

6. All relevant clinical documentation needs to be submitted with the Prior Auth.
   - Remember: You are painting a picture of the resident's therapy needs to Utilization Management at United.
7. At a minimum: Include a physician's clarification order for therapy and the therapist's evaluation. A physician's signature is not required on these forms prior to submission of the Prior Auth.
8. The therapy treatment plan needs to be resident-specific with achievable and measureable objectives that address the resident's needs within a reasonable timeframe.
9. Think about how your facility wants to handle initiating therapy prior to an approval.

Amerigroup

REMEMBER:

Each MCO is different and has different requirements

Amerigroup Prior Authorization Requirements for Therapy

1. Amerigroup does NOT require a Prior Authorization for evaluation.
2. Amerigroup will NOT approve retro authorizations. They will not approve treatments (non-evals) done prior to auth request.
3. Complete the Date of Service section with the following example: 4/9/15-5/9/15 with the first date the same as the Prior auth date. NOT BEFORE.
4. Amerigroup does not require a physician's signature on the therapy evaluation or the clarification therapy physician's order.
5. Amerigroup will automatically set the start date as the date of the Prior Authorization submission. Amerigroup will not approve any visits done in between the eval and the date the request was received.

Amerigroup Prior Authorization Requirements for Therapy (cont.)

- The absolute best process for the fastest turnaround:
  1. Fill out precertification form (Amerigroup calls the Prior Authorization a “Precertification Form”)
  2. Attach therapist evaluation
  3. Attach physician’s clarification therapy order
  4. Fax directly to NF Precert team: 844-206-3445
- Another recommendation:
  - Requests for therapy that exceed 3x week for 4 weeks will automatically go to medical director for review. Your best bet is to ask for therapy at or below this frequency for a quick approval.

What are CPT Codes?

- CPT = Current Procedural Terminology
- Coding system that provides uniform language that accurately describes medical, surgical, and diagnostic services
- CPT codes are solely determined by the Evaluating Therapists

Medicaid 2464 Rehab Form

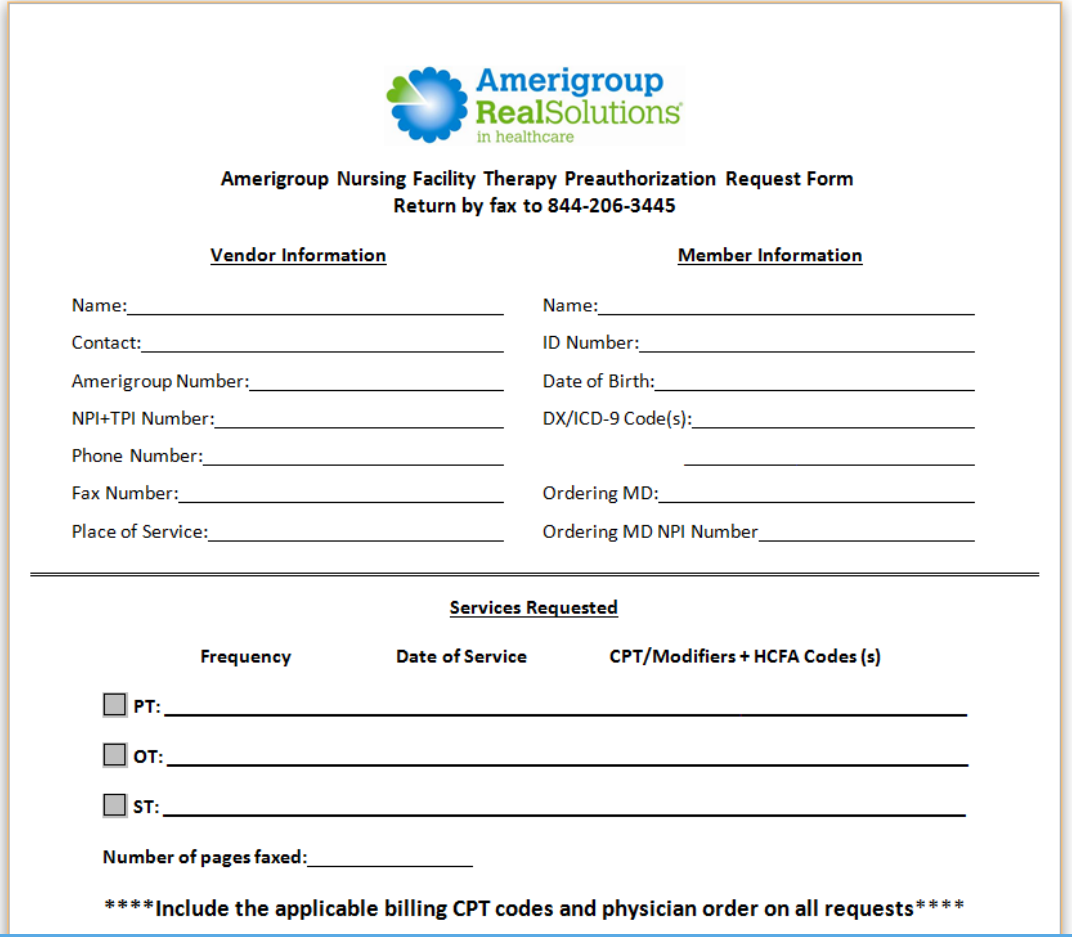
- If a resident is not enrolled in a Medicaid Managed Care plan and requires necessary therapy, the process is the same.
- Therapy will continue to submit the 2464 Form to DADS (state).
- If a resident is approved for Medicaid State Reimbursed Therapy and is enrolled into a MCO during the course of therapy, I recommend notifying your Service Coordinator to make the MCO aware of the current Prior Authorization from state.

Decision timeframe per MCO

- The Medicaid MCO is allowed 72 hours to respond to a therapy request per HHSC.
- It’s imperative that we submit the right form to the right MCO for the right resident AND with all the supporting documentation to prevent delays.

Amerigroup RealSolutions in healthcare

Amerigroup Therapy Preauthorization Request Form



Amerigroup RealSolutions in healthcare

Amerigroup Nursing Facility Therapy Preauthorization Request Form
Return by fax to 844-206-3445

Vendor Information

Name:_____
Contact:_____
Amerigroup Number:_____
NPI+TPI Number:_____
Phone Number:_____
Fax Number:_____
Place of Service:_____

Member Information

Name:_____
ID Number:_____
Date of Birth:_____
DX/ICD-9 Code(s):_____
_____
Ordering MD:_____
Ordering MD NPI Number_____

Services Requested

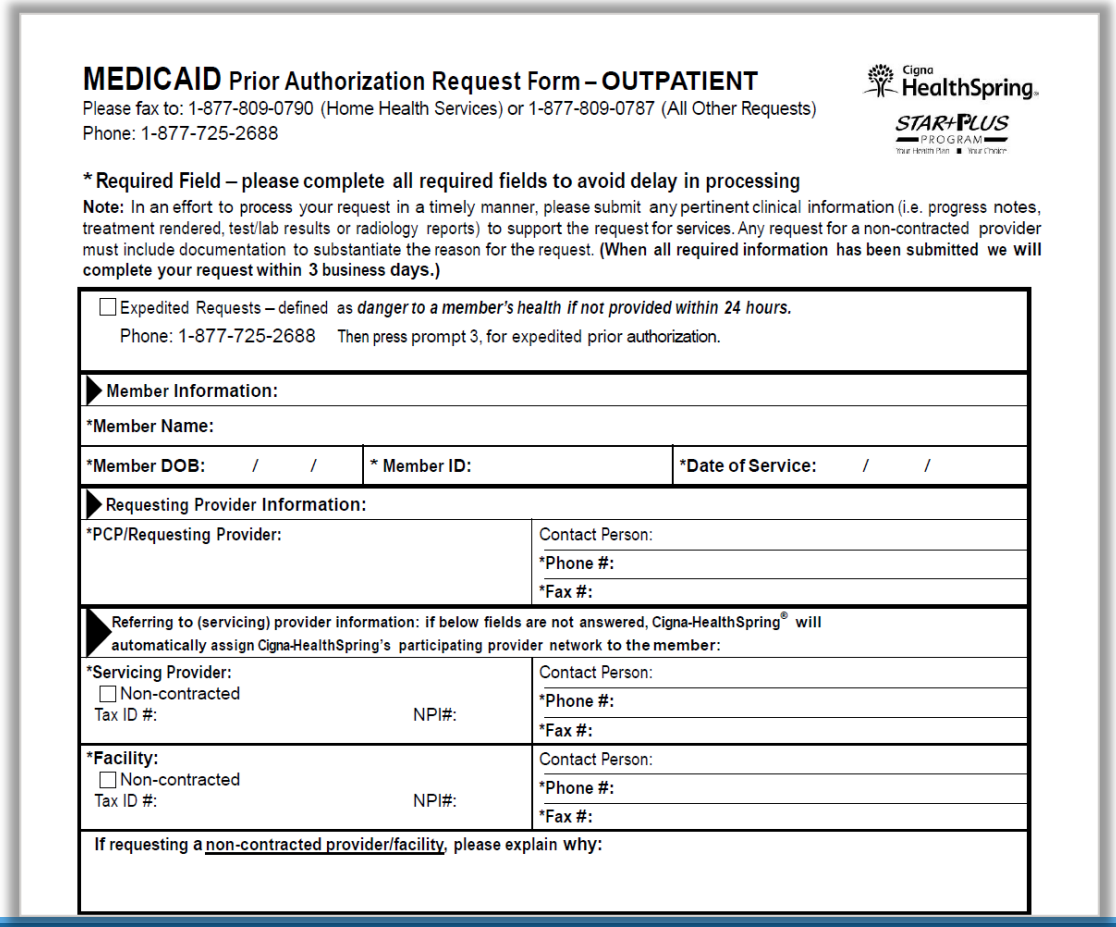
	Frequency	Date of Service	CPT/Modifiers + HCFA Codes (s)
☐ PT:			
☐ OT:			
☐ ST:			

Number of pages faxed:_____

****Include the applicable billing CPT codes and physician order on all requests****

Cigna HealthSpring℠

Cigna Prior Authorization Request Form



MEDICAID Prior Authorization Request Form – OUTPATIENT

Please fax to: 1-877-809-0790 (Home Health Services) or 1-877-809-0787 (All Other Requests)
Phone: 1-877-725-2688

Cigna HealthSpring
STAR+PLUS PROGRAM

*** Required Field – please complete all required fields to avoid delay in processing**

Note: In an effort to process your request in a timely manner, please submit any pertinent clinical information (i.e. progress notes, treatment rendered, test/lab results or radiology reports) to support the request for services. Any request for a non-contracted provider must include documentation to substantiate the reason for the request. **(When all required information has been submitted we will complete your request within 3 business days.)**

☐ Expedited Requests – defined as ***danger to a member's health if not provided within 24 hours.***
Phone: 1-877-725-2688 Then press prompt 3, for expedited prior authorization.

Member Information:

***Member Name:**

***Member DOB:** / /	*** Member ID:**	***Date of Service:** / /

Requesting Provider Information:

***PCP/Requesting Provider:**	Contact Person: ***Phone #:** ***Fax #:**

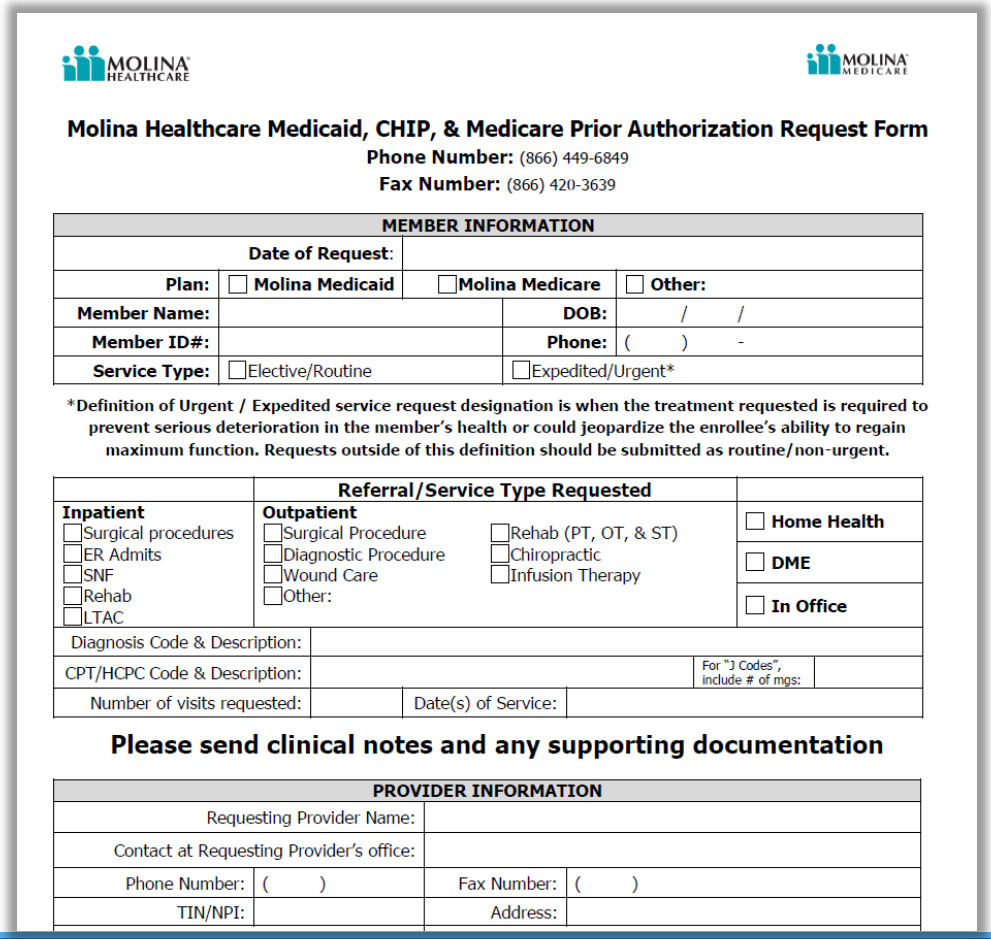
Referring to (servicing) provider information: if below fields are not answered, Cigna-HealthSpring® will automatically assign Cigna-HealthSpring's participating provider network to the member:

***Servicing Provider:** ☐ Non-contracted Tax ID #: NPI#:	Contact Person: ***Phone #:** ***Fax #:**
***Facility:** ☐ Non-contracted Tax ID #: NPI#:	Contact Person: ***Phone #:** ***Fax #:**

If requesting a non-contracted provider/facility, please explain why:

MOLINA HEALTHCARE

Molina Prior Authorization Request Form



MOLINA HEALTHCARE MOLINA MEDICARE

Molina Healthcare Medicaid, CHIP, & Medicare Prior Authorization Request Form

Phone Number: (866) 449-6849

Fax Number: (866) 420-3639

MEMBER INFORMATION				
Date of Request:				
Plan:	☐ **Molina Medicaid**	☐ **Molina Medicare**	☐ **Other:**	
Member Name:		**DOB:**	/ /	
Member ID#:		**Phone:**	( ) -	
Service Type:	☐ Elective/Routine	☐ Expedited/Urgent*		

***Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

	Referral/Service Type Requested	
Inpatient ☐ Surgical procedures ☐ ER Admits ☐ SNF ☐ Rehab ☐ LTAC	**Outpatient** ☐ Surgical Procedure ☐ Diagnostic Procedure ☐ Wound Care ☐ Other: ☐ Rehab (PT, OT, & ST) ☐ Chiropractic ☐ Infusion Therapy	☐ **Home Health** ☐ **DME** ☐ **In Office**

Diagnosis Code & Description:			
CPT/HCPC Code & Description:		For "J Codes", include # of mgs:	
Number of visits requested:		Date(s) of Service:	

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION			
Requesting Provider Name:			
Contact at Requesting Provider's office:			
Phone Number:	( )	Fax Number:	( )
TIN/NPI:		Address:	

superior healthplan

Superior Request for Prior Authorization

REQUEST FOR PRIOR AUTHORIZATION

Date of Request* ___ / ___ / ___

*Required items. Please write only in designated areas.

Member Information

Member ID*

Date of Birth* ___ / ___ / ___

Last Name

First Name

Provider to Perform the Service

NPI*

TPI*

Tax ID*

Fax Number*

Contact Number*

Last Name, First Initial or Facility Name

Contact Name / Requestor

Submitting / Referring / Performing Provider

☐ 'X' in box if same as above.

NPI*

Tax ID*

Fax Number*

Contact Number*

Contact Name / Requestor

Last Name, First Initial or Facility Name

Requested Service

Type of Service

☐ DME Rental* ☐ DME Purchase* ☐ DME Incontinence Supply*

☐ Home Health ☐ SNV ☐ PDN ☐ Therapy

☐ Genetic Testing Type: ________ Pregnant ☐ Yes ☐ No

☐ Outpatient Services ☐ Office Visit

☐ Rehab ☐ Evaluations ☐ Re-Evaluations

☐ Inpatient

☐ Other ________

LTSS Services

☐ PAS

☐ DAHS

☐ ERS

☐ Home Delivered Meals

☐ Med Box Refills

☐ Other ________

Place of Service*

☐ Office

☐ Outpatient Hospital / ASC Gen

☐ Home

☐ Outpatient Clinic

☐ Outpatient Rehab

☐ Inpatient

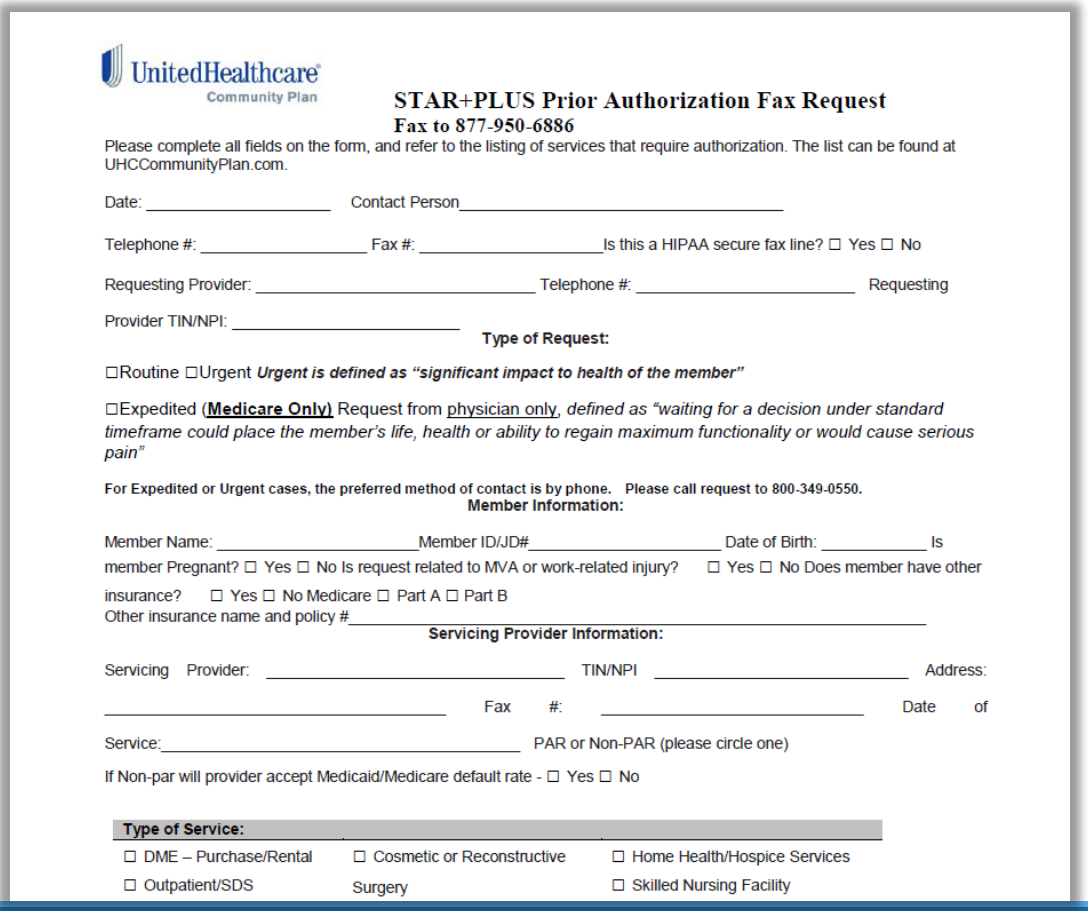
☐ Other ________

*All DME require signed physician orders. All HH and Rehab requests require signed physician's order and plan of care/treatment plan.

Clinical Review

UnitedHealthcare®
Community Plan

United Healthcare Prior Authorization Fax Request



UnitedHealthcare
Community Plan

STAR+PLUS Prior Authorization Fax Request

Fax to 877-950-6886

Please complete all fields on the form, and refer to the listing of services that require authorization. The list can be found at UHCCommunityPlan.com.

Date: _____ Contact Person_____

Telephone #: _____ Fax #: _____Is this a HIPAA secure fax line? ☐ Yes ☐ No

Requesting Provider: _____ Telephone #: _____ Requesting Provider TIN/NPI: _____

Type of Request:

☐Routine ☐Urgent ***Urgent is defined as "significant impact to health of the member"***

☐Expedited (**Medicare Only)** Request from physician only, *defined as "waiting for a decision under standard timeframe could place the member's life, health or ability to regain maximum functionality or would cause serious pain"*

For Expedited or Urgent cases, the preferred method of contact is by phone. Please call request to 800-349-0550.

Member Information:

Member Name: _____Member ID/JD#_____ Date of Birth: _____ Is member Pregnant? ☐ Yes ☐ No Is request related to MVA or work-related injury? ☐ Yes ☐ No Does member have other insurance? ☐ Yes ☐ No Medicare ☐ Part A ☐ Part B
Other insurance name and policy #_____

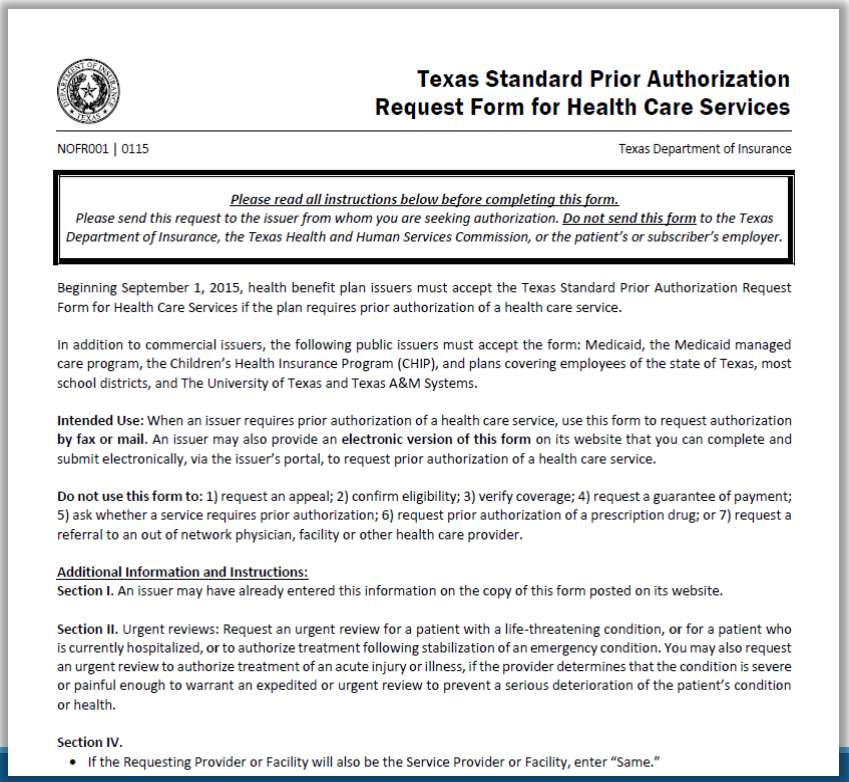
Servicing Provider Information:

Servicing Provider: _____ TIN/NPI _____ Address: _____ Fax #: _____ Date of Service:_____ PAR or Non-PAR (please circle one)

If Non-par will provider accept Medicaid/Medicare default rate - ☐ Yes ☐ No

Type of Service:		
☐ DME – Purchase/Rental	☐ Cosmetic or Reconstructive Surgery	☐ Home Health/Hospice Services
☐ Outpatient/SDS		☐ Skilled Nursing Facility

The new Prior Auth form



Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0115 — Texas Department of Insurance

Please read all instructions below before completing this form.
*Please send this request to the issuer from whom you are seeking authorization. **Do not send this form** to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

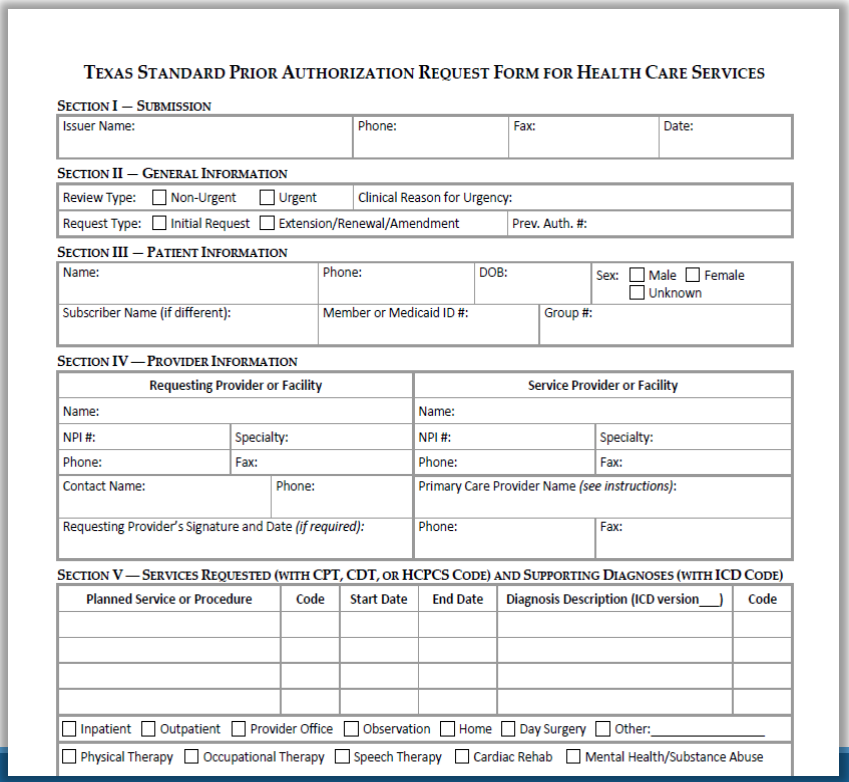
Intended Use: When an issuer requires prior authorization of a health care service, use this form to request authorization **by fax or mail.** An issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, via the issuer's portal, to request prior authorization of a health care service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:
Section I. An issuer may have already entered this information on the copy of this form posted on its website.

Section II. Urgent reviews: Request an urgent review for a patient with a life-threatening condition, **or** for a patient who is currently hospitalized, **or** to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV.
- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."



TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:

SECTION II — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:
Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	Sex: ☐ Male ☐ Female ☐ Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name *(see instructions)*:	
Requesting Provider's Signature and Date *(if required)*:		Phone:	Fax:

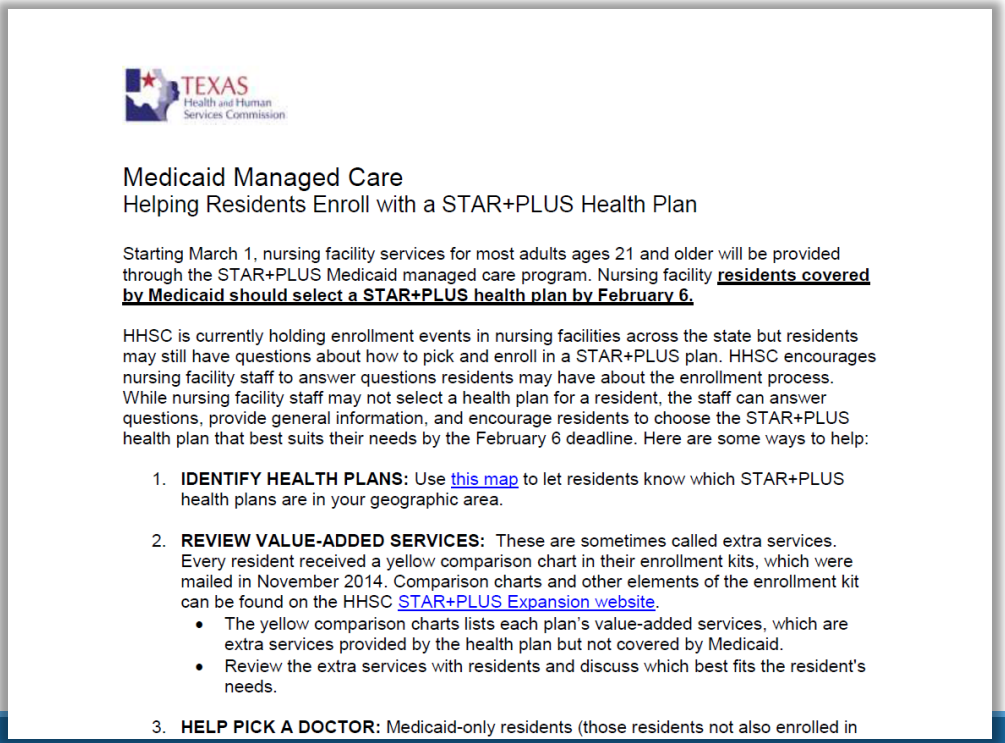
SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version___)	Code

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other:_____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

HHSC enrollment information



TEXAS Health and Human Services Commission

Medicaid Managed Care
Helping Residents Enroll with a STAR+PLUS Health Plan

Starting March 1, nursing facility services for most adults ages 21 and older will be provided through the STAR+PLUS Medicaid managed care program. Nursing facility **residents covered by Medicaid should select a STAR+PLUS health plan by February 6.**

HHSC is currently holding enrollment events in nursing facilities across the state but residents may still have questions about how to pick and enroll in a STAR+PLUS plan. HHSC encourages nursing facility staff to answer questions residents may have about the enrollment process. While nursing facility staff may not select a health plan for a resident, the staff can answer questions, provide general information, and encourage residents to choose the STAR+PLUS health plan that best suits their needs by the February 6 deadline. Here are some ways to help:

1. **IDENTIFY HEALTH PLANS:** Use this map to let residents know which STAR+PLUS health plans are in your geographic area.

2. **REVIEW VALUE-ADDED SERVICES:** These are sometimes called extra services. Every resident received a yellow comparison chart in their enrollment kits, which were mailed in November 2014. Comparison charts and other elements of the enrollment kit can be found on the HHSC STAR+PLUS Expansion website.
   - The yellow comparison charts lists each plan's value-added services, which are extra services provided by the health plan but not covered by Medicaid.
   - Review the extra services with residents and discuss which best fits the resident's needs.

3. **HELP PICK A DOCTOR:** Medicaid-only residents (those residents not also enrolled in

Available at:
http://www.hhsc.state.tx.us/medicaid/managed-care/mmc/docs/nf-new-flyer.pdf

Crosswalk example

Medicaid MCO- updated 4/28/15	Amerigroup	Cigna Healthspring	Molina	Superior	United Healthcare
Prior Auth for Eval Required	NO	NO	NO	YES	NO
Prior Auth to Treat Required	YES	YES	YES	YES	YES
Retro Authorizations approval allowed	NO	NO	NO	NO	NO
Can you bill for therapy provided prior to a Prior Authorization or denial of therapy?	NO	NO	NO	NO	NO
Another Prior Authorization required for a continued authorization to treat	YES- start date needs to be prior to end of current auth. This prevents a GAP in services	YES- start date needs to be 5 days prior to end of current auth	YES- start date needs to be prior to end of current auth. This prevents a GAP in services	YES- start date needs to be 5 days prior to end of current auth	YES- start date needs to be prior to end of current auth. This prevents a GAP in services
Information Required in Prior Auth Forms. Information obtained from Therapy					
Diagnosis Code	YES	YES	YES	YES	YES
Treatment CPT codes	YES	YES	YES	YES	YES
Frequency	YES	YES	NO	YES	YES
Duration	NO	YES	NO	YES	YES
Number of visits requested	NO	YES	YES	NO	YES
Total units/visits/days	NO	NO	NO	YES	NO
*Date(s) of Service	YES	YES	YES	YES	YES
	Start date needs to be the day of prior auth submission.	Start date needs to be 5 days in future to allow time for an approval	Start Date needs to be the date of Prior auth submission. Any dates prior will not be approved	Start date needs to be 5 days in future to allow time for an approval	Start date needs to be 5 days in future to allow time for an approval
*Start and End Date	NO	NO	NO	YES	NO
Number of previous visits for continued auth	NO	YES	NO	NO	YES
Physician Signature Required					
Completed Evaluation signed by physician	NO	NO*	NO**	YES***	NO
Physician Therapy Clarification Order signed by physician	NO	NO*	NO**	YES***	NO
Supporting Documentation	YES	YES	YES	YES***	YES
*Cigna will approve a Prior authorization without a physicians signature but may call and request at Cigna's discretion.					
**Molina will approve a Prior authorization without a physician signature but will require the signature if we plan to submit a continued auth					
***Superior requires a signed physician order for an Evaluation request with supporting documentation for the evaluation auth.					
***Superior requires a Physician signed Therapy Evaluation and additional supporting documentation for the Treatment Auth					
Preferred method of Prior Auth submission					
Portal	NO	YES	YES	YES	YES
Fax	**YES**	NO	NO	NO	NO
	Use the FAX!				
Fax Number	**1-844-206-3445**	1-877-809-0787	1-866-420-3639	1-800-690-7030	1-877-950-6886
Phone number for Utilization Management		1-877-562-4402	1-855-322-4080	1-800-218-7508	1-866-858-3546
Provider Services phone number			1-866-449-6849		

The physician's role in a Medicaid MCO

- Let's review some FAQ:
  - ***APRIL 2015 UPDATED INFORMATION REGARDING PRIMARY CARE PHYSICIANS AND MEDICAID MCO STAR+PLUS.***
  - ***Please review as this will impact our Physicians. You may want to send this information to all your physicians that serve our Residents with Medicaid Only Payor.***

1. **Does the attending physician for a Medicaid Only resident have to be contracted with the MCO?**
   - Ultimately, yes. We canvassed all of the MCO's during the last NF meeting and they all said that they would allow these physicians to follow their patients for up to 180 days (AUGUST 31, 2015) while they are undergoing the contracting and credentialing process and still be able to bill at 100%.

2. **If the attending physician is not contracted with the MCO, can the attending physician treat and receive payment for MCD?**
   - Please see #1 above. If the resident is dual eligible, the physician may still bill Medicare, without having to contract, but if they bill Medicaid for any of their services, they would need to contract.

The physician’s role in a Medicaid MCO (cont.)

3. **If the resident's PCP is on the card and the attending physician in the NH is different than the PCP on the card then what is the potential issue?**
   - PCP may have to make referrals to other doctors. To avoid any complex coordination this may potentially cause, I would suggest that the resident officially choose the doctor that follows them in the nursing facility. Many of the community PCP's were a result of auto assignment or the resident's own doctor not yet being contracted.
4. **If the attending physician does not become contracted and in the directory upon choosing a MCO, will the resident have to choose another physician? Or will MCO/Maximus choose another physician for the resident?**
   - See #3 above. Many were undoubtedly automatically assigned. If the attending physicians will contract with the MCO's they can be chosen as the resident PCP. The resident or responsible party will have to call Maximus to make the change/choice-this is for Medicaid only.

The physician's role in a Medicaid MCO (cont.)

5. **Will there be a grace period for the attending to continue treating and receiving payment for a Medicaid only resident before the physician needs to be contracted with the MCO?**
   - I heard all of the MCO's state that they would honor continued services and reimbursement for 180 days (AUGUST 31, 2015).
6. **Define the difference between an Attending Physician and Primary Care Physician per MCO.**
   - The Primary Care Physician is defined as the "medical home" for the patient, just as it works for us with our insurance. So all paperwork from other procedures gets copied to this physician and they are the central point from which referrals to specialists must come from. So, it is really best if the PCP is the doctor visiting them in the nursing home, so all of the paperwork goes to the medical chart in the NF (which is usually does anyway). So, in reality, I don't believe that much will change as long as the NF doctor starts the contracting process with the MCO. Attending physician is the definition we always used in the NF to denote doctors following residents in the NF that were not contracted with NF (but were credentialed by the NF and had business agreements in place), were other than the Medical Director
7. **Will the resident be able to choose attending physician upon enrollment and the physician only has 90 days before the physician must be contracted with the MCO?**
   - Yes, the resident can if that physician is contracted. The physician can follow the patient technically for 90 days, but I heard all of the MCO's state that they would allow 180 days (August 31, 2015) for contracting activities, while still paying these providers.

Changing the Primary Care Physician

- Steps for nursing facility:
  1. Verify the Medicaid Only residents in the nursing facility.
  2. Determine if the physician is contracted with the Medicaid MCO.
     - If not: provide the information to initiate the contracting/credentialing process to the physician.
  3. Educate the resident and/or family and provide them with the knowledge to make a choice of their physician who is contracted/credentialed and follows the resident at the nursing facility.
  4. Review the admissions process and implement necessary changes from the *beginning* of a resident's stay rather than later.

Changing the Primary Care Physician (cont.)

- The directive from HHSC is to contact Maximus to make the Primary Care Physician update.
- The resident and/or family member may call Maximus Star Plus Program at 877-782-6440 to request the change in PCP to an attending Physician at the nursing facility.

How to make changes

- **Step 1:** If you have a Resident that is enrolled in a MCO outside of your Service Area and plans to stay Long Term.
  - Work with the Resident and/or Family to do the following:
    - Update Address in the Social Security System.
    - How? Here's a few ways:
      - www.ssa.org/myaccount
      - Call 1-800-772-1213
      - Visit your local Social Security Office

How to make changes (cont.)

- **Step 2:** If you have a Resident that is enrolled in a MCO outside of your Service Area and plans to stay Long Term.
  - Work with the Resident and/or Family to do the following:
    - Update the Address Change with HHSC by calling 1-877-541-7905
      - For English: choose 1 > then choose 2 Help with State Benefits > then choose 1 Eligibility.
      - For Spanish: choose 2> then choose 2 Help with State Benefits > then choose 1 Eligibility.
    - Maximus will not complete an ADDRESS CHANGE.

How to make changes (cont.)

- **Step 3:** If you have a Resident that is enrolled in a MCO outside of your Service Area and plans to stay Long Term.
  - Work with the Resident and/or Family to do the following:
    - Final step is to have Resident and/or Family call Star Plus Program “Maximus” at 877-782-6440 to make changes for the Medicaid MCO enrollment.
    - My understanding is the 1-877-782-6440 is a DIRECT LINE to the Star Plus Program and the Resident and/or Family will be able to speak to a Representative from the Star Plus Program within Maximus to better assist.

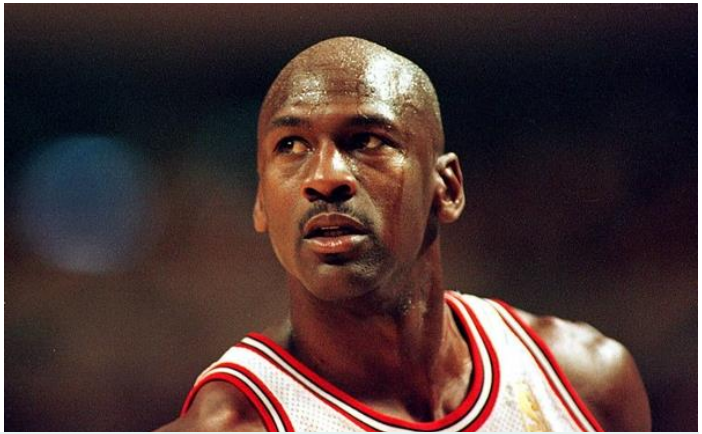
MESAV review

1. The greatest source document to determine which MCO a resident is enrolled in is the **MESAV.**
2. **SimpleLTC** has developed amazing reports within the software.

Thank you!

"I've missed more than 9,000 shots in my career. I've lost almost 300 games. 26 times I've been trusted to take the game-winning shot and missed. I've failed over and over and over again in my life. **And that is why I succeed**."

— Michael Jordan



REMEMBER: You are a CHAMPION!

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