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Adoption Assistance and Permanency Care Assistance Provider Information Session

Medicaid and CHIP Services Department

Summer 2017

Overview

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

- What are the Department of Family and Protective Services Adoption Assistance and Permanency Care Assistance programs?
- What is managed care?
- Which managed care programs will serve Adoptions Assistance and Permanency Care Assistance clients?
- What is required of providers?
- How do clients pick a health plan and primary care provider?
- When will clients move to managed care?

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Background

- The 83rd Texas Legislature directed HHSC to move remaining Medicaid fee-for-service clients to Medicaid managed care.
- Currently, Adoption Assistance and Permanency Care Assistance clients receive Medicaid services through Medicaid fee-for-service.
- Most of these clients will move to Medicaid managed care **September 1, 2017**.

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The Programs

- DFPS operates Adoption Assistance and Permanency Care Assistance :
  - The Adoption Assistance program provides help for certain children who are adopted from foster care.
  - The Permanency Care Assistance program gives financial support to family members who provide a permanent home to children who were in foster care but could not be reunited with their parents.

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The Programs (cont.)

- Adoption Assistance and Permanency Care Assistance may provide:
  - Medicaid coverage for the child.
  - Monthly cash assistance from DFPS.
  - A one-time reimbursement from DFPS for some legal expenses that come with adopting or becoming the managing conservator of a child.

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What is Managed Care?

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

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What are the Goals of Managed Care?

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

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Managed Care Programs in Texas

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

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How Many People get Medicaid?

Estimates for April 2017 show:

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

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Data Source: Estimate provided by HHSC Forecasting April 1, 2017

What is a Health Plan?

- Health plans provide a medical home through a main doctor, nurse, or clinic and referrals for specialty services as needed.
  - Exception: Clients who get Medicare and Medicaid (dual eligible) get basic care services through Medicare.
- Health plans may offer extra services, also called "value-added services."
  - Extra vision services
  - Health and wellness services

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What is STAR?

- STAR is a managed care program for most people on Medicaid.
- STAR serves:
  - Children,
  - Low-income families,
  - Former foster care children
  - Pregnant women.
- As of Sept. 1, 2017, most children and youth in Adoption Assistance and Permanency Care Assistance will get services through STAR.

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What are STAR Benefits?

- The same Medicaid benefits you have today.
- Unlimited prescriptions.
- Unlimited necessary days in a hospital.
- A primary care provider (main doctor, nurse or clinic) to serve as medical home.
- Service management for certain members, including Adoption Assistance and Permanency Care Assistance.
- Value-added services.

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What is STAR Service Management?

- A service performed by the health plan to do all of the following:
  - Develop a service plan, which includes a summary of current needs, a list of services required, and a description of who will provide those services.
  - Coordinate services among a member's primary care provider, specialty providers and non-medical providers.
- All Adoption Assistance and Permanency Care Assistance managed care members get service management.

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What is STAR Kids?

- STAR Kids is a managed care program for children and young adults 20 and younger who meet at least one of the following criteria:
  - Get Supplemental Security Income (SSI) or SSI-related Medicaid
  - Are enrolled in Medicare
  - Get services through a 1915(c) waiver program
- As of Sept. 1, 2017, children and youth in Adoption Assistance and Permanency Care Assistance who meet the above criteria will get services through STAR Kids.

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What are STAR Kids Benefits?

- The same Medicaid benefits you have today
- Unlimited prescriptions
- Unlimited necessary days in a hospital
- A primary care provider (main doctor, nurse or clinic) to serve as medical home
- State Plan long-term services and supports, such as private duty nursing and personal care services
- Service coordination
- Extra services

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What is STAR Kids Service Coordination?

- Specialized care service provided by health plan nurses and other professionals with necessary skills to coordinate care, including:
  - Identification of needs, such as, physical health, mental health, long-term services and supports.
  - Development of a person-centered service plan to address identified needs.
  - Making sure clients get the services they need when they need them.
  - Attention to addressing members' unique needs
  - Coordinating with other services when necessary.

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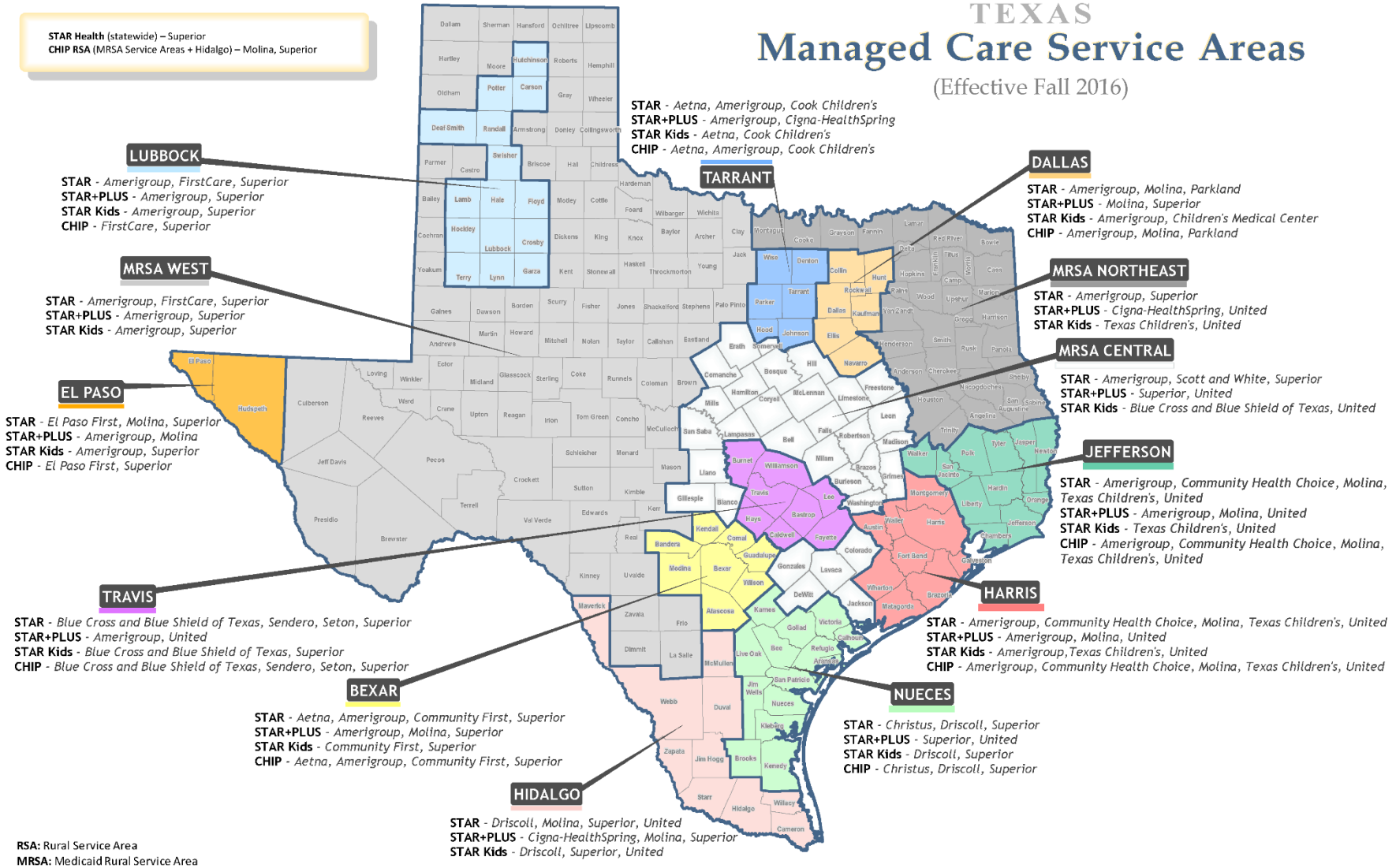
Managed Care Service Areas



RSA: Rural Service Area
MRSA: Medicaid Rural Service Area

Who Will Be in STAR?

- Adoption Assistance and Permanency Care Assistance clients who meet the following criteria will move to STAR on Sept. 1, 2017.
  - Don’t get:
    - Supplemental Security Income (SSI).
    - Medicare.
    - 1915(c) waiver services.
  - Don’t have a disability as determined by the U.S. Social Security Administration or the State of Texas.
  - Don’t live in:
    - A nursing facility.
    - An intermediate care facility for individuals with intellectual or developmental disabilities or related conditions (ICF/IID).

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Who Will Be in STAR Kids?

- Adoption Assistance and Permanency Care Assistance clients who meet the following criteria will move to STAR Kids on Sept. 1, 2017.
  - Get Supplemental Security Income (SSI).
  - Have a disability as determined by the U.S. Social Security Administration or the State of Texas.

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How Will I Know What Plan My Patients Are In?

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

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Continuity of Care

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

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Continuity of Care (cont.)

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

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Will Current Services Be Covered In Managed Care?

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

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Provider Contracting

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

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Significant Traditional Providers

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

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What if the Provider is Out-of-Area?

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

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Out-of-Network Providers

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

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Provider Claims

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

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Appeals and Fair Hearings

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

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Provider Complaints

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

    HPM_complaints@hhsc.state.tx.us

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Complaints and Appeals

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

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Complaint Contacts for Providers

HHSC

HPM Complaints

P.O. Box 85200, MC H-320

Austin, TX 78758

HPM_Complaints@hhsc.state.tx.us

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

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Next Steps

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

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How Clients Choose a Health Plan

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

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Enrollment Activities

- May 2017 – clients get introduction letters.
- June 2017 – clients get enrollment packets.
- July 2017 – clients who haven't picked a health plan get reminder letters.
- Aug. 14, 2017 – clients who don't pick a health plan are assigned to one:
  - Clients may change health plans at any time by contacting the enrollment broker.
- Sept. 1, 2017 – Adoption Assistance and Permanency Care Assistance clients will begin getting their services through a STAR or STAR Kids Health Plan.

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What If I Have Questions?

- Learn more about the transition of Adoption Assistance and Permanency Care Assistance clients to STAR and STAR Kids at:

  hhs.texas.gov/AAPCA

- Learn more about managed care at:

  hhs.texas.gov/services/health/medicaid-and-chip/provider-information/expansion-managed-care

- Send questions to:

  managed_care_initiatives@hhsc.state.tx.us

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