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Medicaid for Breast and Cervical Cancer Program Client 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 is Medicaid for Breast and Cervical Cancer (MBCC)?
- What is managed care?
- What is STAR+PLUS?
- What about my providers?
- How do clients pick a health plan?
- When will MBCC 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, women in the Medicaid Breast and Cervical Cancer (MBCC) program get Medicaid services through Medicaid fee-for-service.
- Most MBCC clients will move to STAR+PLUS managed care Sept. 1, 2017

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What is MBCC?

- MBCC provides Medicaid services to women diagnosed with breast or cervical cancer, or certain pre-cancer conditions.
- A woman can get MBCC services if she is:
  - Uninsured
  - Between age 18 until the month she turns 65.
  - A US citizen or qualified immigrant
  - A Texas resident
  - Meets income guidelines

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What is MBCC? (cont.)

- Women in MBCC will continue to receive full Medicaid benefits as long as they are eligible and every six months:
  - Submit of proof of active treatment for breast or cervical cancer from the treating doctor (Form H1551, Treatment Verification) and
  - Complete and submit MBCC Renewal (Form H2340).

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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 get 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?

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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.

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

What Is A Health Plan?

- Health plans provide a medical home through a primary care provider and referrals for specialty services as needed.
  - Exception: Clients who get Medicare and Medicaid (dual eligible) get acute care services through Medicare.
- Health plans may offer extra services, also called “value-added services”
  - Respite
  - Extra vision services
  - Health and wellness services

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What is STAR+PLUS?

- STAR+PLUS is a Texas Medicaid managed care program for certain populations.
- STAR+PLUS delivers basic care and long-term services and supports.
- As of Sept. 1, 2017, most women in MBCC will get Medicaid services through STAR+PLUS.

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Who is in STAR+PLUS?

- Adults who:
  - Are in a waiver program
  - Qualify for Supplemental Security Income (SSI) or SSI-related Medicaid
  - Live in a facility
    - Most adults who live in nursing facility
    - Most adults who live in an intermediate care facility
  - Qualify for Medicaid because they meet a nursing facility level of care and need STAR+PLUS Home and Community Based Services.
  - Are in the MBCC program.

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What are STAR+PLUS Benefits?

- Traditional Medicaid benefits
- Unlimited prescriptions
- A primary care provider
- Service coordination
  - Includes development of a service plan and coordination of services
- Value-added services
  - Extra services offered by the health plan like respite and extra vision care

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STAR+PLUS Long-Term Services and Supports

- Nursing facility services
- Day activity and health services
- Personal assistance services
- Community First Choice
- STAR+PLUS Home Community Based Services program

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What is STAR+PLUS Service Coordination?

- A specialized care management service performed by a health plan service coordinator who is a nurse, social worker, or other professional with the necessary skills to coordinate care.
  - Identify and address a member's physical, mental or long term care needs through a person-centered service plan
  - Assist members and families to understand benefits and services
  - Ensure access to and coordination of needed specialty services

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What is STAR+PLUS Service Coordination? (cont.)

- Arrange for other Medicaid services (e.g. medical transportation)
- Assist with coordination of community supports including those that may be non-medical, or not covered by Medicaid

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What is STAR+PLUS Service Coordination? (cont.)

- Individuals can get more or less Service Coordination based on their needs
  - At a minimum, women in MBCC receive:
    - A single, identified person as their assigned service coordinator
    - At least one face-to-face visit and one phone call every year
    - Help with MBCC Medicaid eligibility renewal
    - Help getting any long term services and supports they might need
    - Help transitioning to another program, if needed

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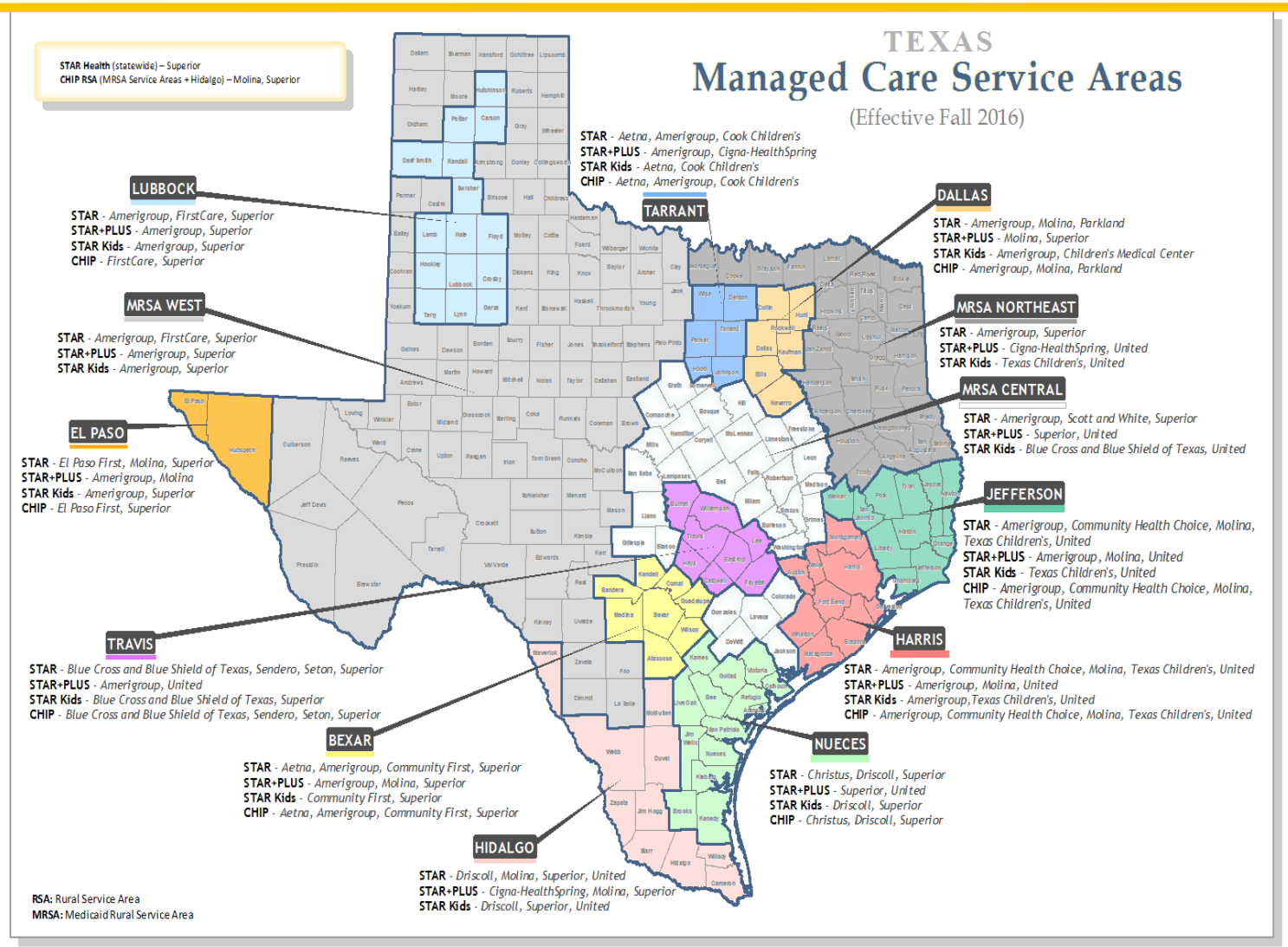
Managed Care Service Areas



How Will My Doctor Know What Health Plan I'm In?

- All STAR+PLUS 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 (STAR+PLUS)
  - Health plan name
  - PCP 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, PCP address)

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Continuity of Care

- The state requires STAR+PLUS health plans provide continuity of care”
  - Authorizations for basic care, like 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, until the authorization expires, or until the health plan issues a new one.
  - During the transition period, you can continue to see your current providers, even if they are out of the health plan’s network.

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Will My Current Services Be Covered In Managed Care?

- Approved and active authorizations for covered services will be given to the STAR+PLUS health plan you pick before Sept. 1, 2017.
- These authorizations are subject to the continuity of 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 Networks

- Providers must contract and be credentialed with a health plan to be “in network” and provide Medicaid managed care services.
- You can talk to your health plan or your service coordinator if you think you need to see a provider who is not in network.
- Referral, authorization and claims payment requirements might be different between health plans.
- Rates are negotiated between the provider and the health plan.

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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 plan networks must have enough doctors and providers to meet clients' needs.
- Health plans can also pay providers outside their service area in certain situations
  - Emergency services
  - To maintain ongoing care with an existing provider
  - A particular specialist isn't available in your area

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What If My Provider Doesn't Join The Health Plan?

- If providers choose not to contract with health plans in there service area, the providers won't be part of the health plans' network.
- 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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Appeals and Fair Hearings

- You have the right to appeal to the health plans and file a fair hearing request with the state if services are denied, reduced, or terminated.
- Services may continue during the review of the appeal or fair hearing when requested on time and the member asks for continued services pending the appeal.

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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
- Common complaints:
  - Quality of care or services
  - Accessibility or availability of services
  - Claims processing

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What if I Have a Question About Medicaid Services?

- As of Sept. 1, 2017, members should:
  - Call the number on the health plan ID card
  - If the problem isn't resolved, call the HHS Office of the Ombudsman managed care assistance team:

    1-866-566-8989

- If you have any questions before Sept. 1, call the Ombudsman's main hotline:

  1-877-787-8999

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How Do I Choose a Health Plan?

- You will get a packet in the mail with facts about the health plans in your area. The enrollment packet will have:
  - Provider directories listing the doctors and other providers for each health plan in your area.
  - Instructions about how to pick a health plan and other helpful information.
  - A phone number to call to get help or ask questions about picking a health plan.
  - Everyone will be able to pick from at least two health plans.

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How Do I Choose a Health Plan? (cont.)

- 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.
- HHSC's enrollment broker, Maximus, can help you with this process. Call 877-782-6440 for help.
- Members can change their health plan at any time. Changes take 15-45 days to take effect.

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What Should I Do Next?

- Get to know the health plans operating in counties where you get services
- Make a list of the providers you see including specialists
  - Find out if your doctors and specialists are in each health plan's network.
- Look over the value-added services offered by the plans in your area
- Talk to the health plans today. Tell the health plans about the doctors and providers you see.
- Make sure your address is up to date with the state.

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How Do I Enroll?

- You can enroll during an information session .
- Find out about enrollment events in your area at www.txmedicaidevents.com.
- If you don't pick a health plan you will get a reminder letter in July.
- If you haven't picked a health plan by August 14, 2017, HHSC will pick a health plan and primary care provider for you.
- You can change health plans at any time by calling MAXIMUS. It might take between 15 and 45 days to process your request.

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How Do I Enroll? (cont.)

- Call MAXIMUS, the state's enrollment broker, to ask questions.
- The MAXIMUS toll-free number is 1-877-782-6440,
- They are available 8 a.m. to 6 p.m. Central Time.
- This number will be in your enrollment packet
- You can call MAXIMUS to pick a plan over the phone, or you can mail your enrollment information using the postage-paid envelope.

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What Dates Do I Need To Know?

- 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 do not pick a health plan are assigned to one:
  - Clients may change health plans at any time by contacting the enrollment broker.
- Sept. 1, 2017 – MBCC clients will begin getting their services through a STAR+PLUS health plan.

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What If I Have Questions?

- Learn more about the transition of MBCC clients to STAR+PLUS at: **https://hhs.texas.gov/mbcc**
- Learn more about managed care at: **http://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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