MMP and HCBS Provider Introduction and Education Session

February 26, 2016
Objectives

The objectives of this meeting are to:

- Increase HCBS Provider understanding of Healthy Connections Prime
- Explain HCBS Provider Contracting
- Outline Claims and Billing processes
- Introduce HCBS Providers to Medicare-Medicaid Plans (MMPs)
Background and Timeline
Background

• **New program** for seniors age 65 and older with Medicare and Medicaid

• **Healthy Connections Prime** is part of a national initiative jointly administered by CMS and SCDHHS, designed to integrate all the services of Medicare, Medicare Part D, and Medicaid under a **single Medicare-Medicaid plan (MMP)**

• In South Carolina, Medicare-Medicaid plans are called **Coordinated and Integrated Care Organizations (CICOs)**.
Individuals may be eligible to enroll if they are:

- Age 65 or older;
- Have Medicare benefits;
- Have full Healthy Connections Medicaid benefits; and
- Are living in the community.

<table>
<thead>
<tr>
<th>Enrollment Phase</th>
<th>Information</th>
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| Open Enrollment (~51,000 eligible enrollees) | • Ongoing  
• Medicare-Medicaid enrollees choose to participate with Healthy Connections Prime |
| Passive Enrollment (~12,800 eligible enrollees) | • Will occur in two initial phases, and is ongoing monthly  
• Eligible enrollees are automatically assigned to a Medicare-Medicaid plan |

*Healthy Connections Prime is voluntary. Members may disenroll at any time, and eligible enrollees may choose not to participate.*
Passive Enrollment Timeline*

Wave 1
- Effective April 1, 2016
- Upstate Region
- Projected Eligibles = 5,300

Wave 2
- Effective July 1, 2016
- Coastal Region and CLTC Waiver Population
- Projected Eligibles = 7,500
  - Waiver participants ~ 2,263

*Members with comprehensive insurance or who have previously been passively enrolled into a standalone prescription drug plan are excluded from passive enrollment.

Note: Aiken and Dorchester counties are eligible for “choice only” enrollment. In addition, the following counties are not participating in Healthy Connections Prime: Lancaster, Horry, Darlington, Sumter and York.
Wave 2 Communications to Members (2016)

April 22
60 Day Notices mailed

May 25
30 Day Notices mailed

July 1
Earliest Effective Date, New members enrolled!

April
- April 14: MMP may contact new members
- April 25: New members receive 60 Day Notices

May
- April 25: New members receive 60 Day Notices
- May 28: New members receive 30 Day Notices

June

July
Passive Enrollment Intelligent Assignment Criteria

**Rule 1 – Enrollment History**
- Uses previous 6 months of enrollment history
- Considers how member disenrolled from previous plan:
  - Voluntarily, or
  - Involuntarily

**Rule 2 – Most Frequently Utilized Provider**
- Identifies most frequently utilized provider (MFUP) through historical claims data
- Uses MFUP to assign plan
- Uses Rule 3 if the MFUPs are contracted with multiple plans

**Rule 3 – Family Health Plans**
- Assigns member to the same plan as the other family member
- Assigns member to the plan with the majority of the family members
- Use Rule 4 to assign member to health plan, if a tie.

**Rule 4 – Health Risk Score**
- Balance the assignment to the available plans in the county based on health risk score.
HCBS Transition
## How does this impact CLTC waiver service providers?

<table>
<thead>
<tr>
<th>Does not change</th>
<th>Changes</th>
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<tr>
<td>Use of Phoenix</td>
<td>Provider contracts</td>
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<td>Provider Credentialing</td>
<td>Oversight of Waiver CM</td>
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<tr>
<td>LTC LOC Initial Assessments</td>
<td>LTC LOC Reassessments</td>
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<td>Self-Direction</td>
<td>Claims processing and payment</td>
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<tr>
<td>Keep your waiver participants</td>
<td>Serve non-waiver individuals</td>
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<td>Provider Reimbursement</td>
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<td>Part of a care team</td>
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**PLUS**

Keep your waiver participants serve non-waiver individuals and are part of a care team.
2016 Changes

- SCDHHS will transition the following responsibilities to the MMPs.
  - Service Plan
    - Approval
    - Monitoring
  - LTC Annual Reassessment
  - Provider reimbursement
  - Provider contracts
HCBS Service Plan

Referral made to CLTC
- Member must meet both financial and medical necessity criteria
- Any entity (i.e. beneficiary, family, physician, etc.) may make a referral

Nurse Consultant
- Performs level of care determination

CLTC Case Manager II
- Develops initial service plan
- Sends provider choice list to participant and/or primary contact
- Participant selects waiver case manager from MMP network

Waiver Case Manager
- Conducts in-home visit within 30 days
- Updates service plan as necessary based upon needs not addressed in initial service plan (i.e., environmental modifications, caregiver supports)

MMP Care Coordinator
- Reviews Service Plan
- Approves and/or modifies updated service plan
- Conducts ongoing monitoring of service plan
- Approves or disapproves subsequent modifications and service plan changes

Healthy Connections
Claims and Billing

• Providers will continue to use Phoenix for billing
  • Billing agreement required (to be discussed later)

• Claims generated based on authorized services

• Providers are currently paid by the state and payment recouped from each MMP

• May 1, 2016 - anticipated implementation of claims processing and payment by MMPs

• Reimbursement based upon Fee-For-Service rate floor

• Reimbursement schedule does not change
Why Contract with MMPs?

HCBS providers are encouraged to join one or more MMP networks.

• To be a part of the health plan provider network
• To continue serving members beyond 6 month Continuity of Care period
• To receive future referrals for waiver and waiver-like services
Continuity of Care

- 6-month continuity of care period
- Participants maintain providers and services
- Maintains service authorization levels for waiver services, unless change in service needs

CONTINUITY OF CARE OPTIONS

1. Full Contract
   Serve any member

2. Single Case Agreement
   Serve one particular member beyond the six month transition period

3. Transition Process
   Serve for up to six months while member transitions to a Healthy Connections Prime provider

Out-of-network providers reimbursed at current Medicare and Medicaid fee-for-service rates
Prime Provider Agreement
Purpose

• In order for SCDHHS to submit claims to the MMP for waiver participants, providers need to complete a Healthy Connections Provider Agreement.

• The agreement must be signed and completed electronically.

• The agreement is located in Phoenix Provider Portal under the “Profile” tab.
• Log into the Phoenix Provider Portal at https://providers.phoenix.scdhhs.gov/login
• Click the Profile tab
• Click the Agreements tab

<table>
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<tr>
<th>Agreement</th>
<th>Signed?</th>
<th>Signed By</th>
<th>Signed At</th>
</tr>
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<tbody>
<tr>
<td>Healthy Connections Prime Agreement</td>
<td>No</td>
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</table>
Clicking “Healthy Connections Prime Agreement” displays the document on the screen to be reviewed.

After reading the agreement, check the box stating I agree to the Terms and Conditions.

Type the name and title of the person accepting the terms and conditions on behalf of the provider agency.
• Click the Sign Agreement button
• To print the signed agreement, click the Download Signed Copy button.
• The user will be asked to enter a password. The password is the user’s login ID.
• Click your web browser’s print button or right mouse click on the document to print.
Additional Resources
Contact us by email: primeproviders@scdhhs.gov

Or visit our website at: www.scdhhs.gov/prime

- FAQs
- Educational events
- Member stories
- Program data
- Latest updates
- Provider toolkit
- Additional materials
- Contacts
Questions?