Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) dual demonstration

Supplement to provider orientation

Provider Services: **855-878-1785**

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.

Amerigroup STAR+PLUS MMP goals

- Integrate the fragmented model of care for dual-eligible members
- Create a single point of accountability for the delivery, coordination, and management of Medicare and Medicaid services
- Streamline process for providers
- Improve quality and individual experience in accessing care
- Promote independence in the community

Amerigroup STAR+PLUS MMP overview

Amerigroup STAR+PLUS MMP is a Texas plan contracted with CMS and Texas Health and Human Services Commission (HHSC).

Amerigroup STAR+PLUS MMP integrates care and reimbursement for Texas members who have Medicare Part A, Medicare Part B, Medicare Part D, and Medicaid benefits (dual-eligible members), and consolidates their care through one Medicare-Medicaid plan for full access to both their Medicaid and Medicare benefits.

Amerigroup STAR+PLUS MMP will offer this plan for dual-eligible members who reside in one of four counties: Bexar, El Paso, Harris, and Tarrant.

Members will have one ID card, one health plan, and one member service team for their healthcare MMP benefits. See the *Amerigroup STAR+PLUS MMP Eligibility and Enrollment* section for member eligibility requirements.

Amerigroup STAR+PLUS MMP member eligibility

- Reside in one of four counties: Bexar, El Paso, Harris, and Tarrant.
- Age 21 or older
- Receive Medicare Part A, B, and D, and are receiving full Medicaid benefits
- Eligible for or enrolled in the 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
- Do not have third-party insurance (other than Medicare and Medicaid)

Note: Eligibility is based on member location. Providers located outside the four demonstration counties will have access to MMP members and will be compensated according to their contract for covered services provided.

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Excluded population

- Dual-eligible children (age 20 and younger)
- Dual-eligible individuals receiving services in a community-based intermediate care facility for individuals with intellectual disabilities or related conditions (ICF-IID)
- Dual-eligible individuals not eligible for STAR+PLUS today, including those receiving services in the following *ICF-IID 1915*© waivers:
  - Home- and community-based services (HCS)
  - Community living and support services (CLASS)
  - Texas home living (TxHmL)
  - Deaf-blind multiple disabilities (DBMD)

Member 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 dis-enroll, members can call the Medicaid enrollment broker or Medicare.

Member enrollment process

Voluntary enrollment

Eligible members may choose to enroll into a particular STAR+PLUS MMP. Eligible members who do not select a STAR+PLUS MMP or who do not opt out of the demonstration will be assigned to a STAR+PLUS MMP during passive enrollment.

Requests to enroll, which includes enrollment or change from one STAR+PLUS MMP into a different STAR+PLUS MMP, will be accepted through the 12th of the month for an effective date of coverage on the first calendar day of the next month. Enrollment requests received after the 12th of the month will be effective the first calendar day of the second month following initial receipt of the request.

Member enrollment process (cont.)

Passive enrollment

Passive enrollment will be used to assign eligible members who do not select a STAR+PLUS MMP, opt out, or disenroll from the demonstration.

Passive enrollment is effective no sooner than 60 calendar days after beneficiary notification of plan selection, the right to select a different STAR+PLUS MMP, or the option to opt out until the last day of the month prior to the enrollment effective date.

Member enrollment process (cont.)

Passive versus opt-in enrollment eligibility table

Medicare	Medicaid	Demonstration
Original Medicare or Medicare Advantage/DSNP MCO with MMP	STAR+PLUS	Eligible for passive (same MCO) and opt-in
Medicare Advantage/Dual-Special Needs Plan MCO without MMP	STAR+PLUS	Eligible for opt-in only

Member enrollment FAQ

Q: Can members opt out of the demonstration and keep their Medicare and Medicaid benefits?
A: Yes.

Q: What is the timing for members to change plans or opt out of the demonstration altogether?
A: Enrollment requests, choosing a different MMP managed care organization (MCO), and/or requests to opt out of the demonstration received on or before the 12th of the month will be effective the first calendar day of the next month. Requests received ***after*** the 12th of the month will be effective the first calendar day of the second month following initial receipt of the request.

Q: Who do members contact to make changes to their enrollment?
A: To select an MMP MCO or to opt-out of the demonstration, the member can contact the state enrollment broker or Medicare.

Q: Will MMP members have a separate and distinct ID card?

A: Yes, see the next slide.

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Member ID card

Benefits to participating in MMP

- Less administrative work for providers; easier for members to have one plan, one ID card, and having a service coordinator to help coordinate care and navigate the system
- Improved member experience in accessing and receiving person-centered care
- Improved care coordination and access to enhanced benefits, such as SilverSneakers* fitness program, dental, pest control, etc.
- Integrated care and improved coordination with PCP, specialist, behavioral health, and long-term services and supports (LTSS) to improve quality of care.

See following slides for specific supplemental benefits.

Amerigroup STAR+PLUS MMP program services for your dual-eligible members

If your patient has Medicaid and Medicare, their Amerigroup STAR+PLUS MMP plan will provide basic health services and medications they've been getting through Medicare, plus LTSS through Medicaid.

Amerigroup STAR+PLUS MMP will offer the same basic health services they've been getting through Medicare. These include:

- Doctor and clinic visits.
- 24-hour emergency care.
- Hospital care.
- Surgery.
- Ambulance services.
- Lab and X-ray services.
- Major organ transplants.
- Family planning services.
- Hearing tests and aids.
- Home health services.
- Chiropractors.
- Podiatrists.
- Dialysis for kidney problems.
- Eye checkups, glasses, and contact lenses.
- Mental health services (such as counseling).
- Yearly adult checkup.
- Short-term rehab in a skilled nursing facility.

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Amerigroup STAR+PLUS MMP

Extra services for members	Amerigroup STAR+PLUS MMP
24-Hour Nurse Line	Yes
Extra dental services for adults (age 21 and older)	Comprehensive dental services (nonroutine services, diagnostic services, restorative services, and endodontics/periodontics/ extractions) are limited to $1,600 each calendar year or $400 every quarter. Any unused balance from the $400 quarterly benefit carries over to the next quarter, but not the next calendar year. The benefit renews January 1 each year. STAR+PLUS waiver members must exhaust their benefits under the waiver before using these supplemental benefits.
Extra vision services	One pair of frames, eyeglass lenses, and/or contact lenses every year, not to exceed a combined maximum of $300.
Health and wellness services	• Counseling to stop smoking or tobacco use • Twelve visits for cardiac and pulmonary rehabilitation services with prior authorization required (limitations apply) • Six acupuncture treatments per year

Provider value proposition

- Ease of claim administration
- Dedicated Clinical team to ease practice burden
- Same utilization management (UM) and authorization process
- Dedicated Health Care Networks teams:
  - Local help
  - Provider issues/relations
  - Credentialing
  - Provider demographic changes
  - Provider training

Provider reimbursement

Medicare reimbursement is closely aligned to traditional Fee-for-Service (FFS) Medicare. Medicaid reimbursement is aligned to your current reimbursements. For specific reimbursement terms, please refer to the reimbursement section of the *Amerigroup STAR+PLUS MMP Participation Agreement.*

As dual members do not have a cost-share for physician and hospital services, the reimbursement amount received from Amerigroup STAR+PLUS MMP for applicable services should be viewed as payment in full.

See reimbursement scenarios on the following slides.

Reimbursement scenarios

Example one: 100% of Medicaid allowable is less than dual Medicare amount:

- $1,000 = 100% Medicare allowable
- Medicare FFS = 20% member's responsibility = $200
- $500 = 100% of Medicaid allowable
- $1,000 to $200 = $800 dual Medicare amount
- $800 > $500
- $800 = payment in full

Reimbursement scenarios (cont.)

Example two: 100% of Medicaid is greater than 100% of Medicare:

- $1,000 = 100% Medicare allowable
- Medicare FFS = 20% member's responsibility = $200
- $1,200 = 100% of Medicaid allowable
- $1,000 to $200 = $800 dual Medicare amount
- $800 < $1,200
- +200

Claims submission

Providers will submit claims to Amerigroup STAR+PLUS MMP for services provided to members using the same submission processes that exist for Amerigroup Amerivantage (Medicare Advantage) and STAR+PLUS plans.

The Amerigroup STAR+PLUS MMP claim submission:
Providers will only submit claims to Amerigroup STAR+PLUS MMP for Amerigroup STAR+PLUS MMP members in Texas. Amerigroup STAR+PLUS MMP will administer the member's Medicare and Medicare benefits and will process one claim for both benefits. **Providers will no longer coordinate care between two payers.**

Amerigroup STAR+PLUS MMP enrollees have no cost-share for any professional or hospital services.

Claims information will be available for Amerigroup STAR+PLUS MMP providers.

Claims submission (cont.)

Providers will submit claims via Avality.com* to Amerigroup STAR+PLUS MMP for services provided to Amerigroup STAR+PLUS MMP members using the same submission processes that exist today.

Paper claims will be mailed to:

P.O. Box 61010 Virginia Beach, VA 23466-1010

The Amerigroup STAR+PLUS MMP claim submission difference
Providers will only submit claims to Amerigroup STAR+PLUS MMP for Amerigroup STAR+PLUS MMP members. Amerigroup STAR+PLUS MMP will administer the member's Medicare and Medicaid benefits and will process one claim for both benefits. *Providers will no longer coordinate care between two payers.*

Claims submission (cont.)

Claims filing deadlines:

- For all providers **except** nursing facilities daily-rate charges, the claims filing deadline is **95 days**.
- Nursing facilities have **365 days** to file daily-rate claims.

Claims processing turnaround times:

- Clean claims adjudicated within 30 calendar days from the date of submission.
- Cleans claims for some nursing facilities daily-rate will be processed within 10 days of submission.

Medical management

PCP selection
Amerigroup STAR+PLUS MMP is a health maintenance organization (HMO) product; members will select a PCP, or one will be assigned to them. Members are encouraged to see their PCP for care; however, the plan is an open-access product as long as members receive care from participating providers. Nonparticipating providers must obtain precertification for all services.

Authorization tools
Authorization tools will be available on the provider website and Availity Essentials for providers.

Service coordinators
Amerigroup STAR+PLUS MMP will have MMP-specific medical management teams located in all four service counties of Texas. Each member enrolled in the program will have an assigned RN or social worker service coordinator.

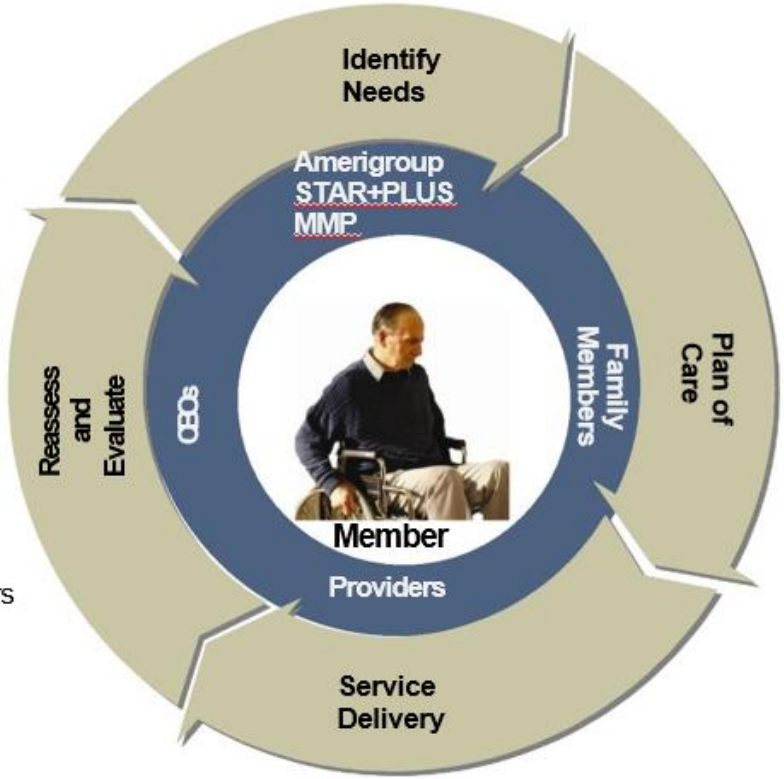
Service coordinator model

Reassess and Evaluate

- Service coordinator contacts member and reassess the member's needs and functional capabilities.
- Service coordinator in collaboration with the provider care team and member/member family evaluate and revise the plan of care as needed.

Service Delivery

- Member selects providers from the network.
- Service coordinator works with care team to authorize and deliver services as necessary.
- Service coordinator ensures all appropriate services are authorized and delivered according to the plan of care.



Identify Needs

- Members contacted and screened for complex needs and high risk conditions
- Identify complex and high risk members

Plan of Care

- Service coordinator conducts 2 – 4 visits per year and conducts a comprehensive assessment of all medical, behavioral, social, and long term care needs annually.
- Service coordinator works with the provider care team of experts to develop a plan of care to meet the members needs.
- Member and member's family reviews the plan of care.

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Service Coordination Team (SCT)

Each member has an SCT assigned to assist with developing plans of care, collaborating with other team members, and providing recommendations for the management of the member's care. The SCT is person-centered and built on the member's specific preferences and needs, ensuring transparency, individualism, accessibility, respect, linguistic and cultural competency, and dignity.

Typically, the team can be made up of the member and/or their designee, assigned service coordinator, primary care physician, specialists, behavioral health professional, the member's home care attendant, or LTSS provider and other providers, as applicable.

The member is an important part of the team and is involved in the planning process. Healthcare practitioners and providers of care in the home or community are also very important members of the team and help to establish and execute the plan of care.

Discharge planning

We will promptly assess the needs of a member discharged from a hospital, nursing facility, or other care or treatment facility.

A service coordinator will work with the member's PCP, the hospital, or nursing facility discharge planner, the attending physician, the member, and the member's family to assess and plan for the member's discharge.

When LTSS are needed, we will ensure the member's discharge plan includes arrangements for receiving community-based care whenever possible.

The service coordinator will provide information to the member, the member's family, and the member's PCP regarding all service options available to meet the member's needs in the community.

Behavioral health

PCPs providing behavioral health services must have screening and evaluation procedures for detection and treatment of, or referral for, any known, or suspected behavioral health problems and disorders. Screening and assessment tools to assist with the detection, treatment, and referral of behavioral healthcare services are found on our website.

PCPs should:

- Educate members with behavioral health conditions about the nature of the condition and its treatment.
- Educate members about the relationship between physical and behavioral health conditions.
- Contact a behavioral health clinician when behavioral health needs go beyond their scope of practice.

Behavioral health (cont.)

PCPs can offer behavioral health services when:

- Clinically appropriate and within the scope of their practice.
- The member's current condition is not so severe, confounding, or complex as to warrant a referral to a behavioral health provider.
- The member is willing to be treated by the PCP.
- The services rendered are within the scope of the benefit plan.

Cultural competency

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies, and procedures into a system or agency or among professionals. Cultural competency helps providers and members:

- Acknowledge the importance of culture and language.
- Assess cross-cultural relations.
- Embrace cultural strengths with people and communities.
- Expand their cultural knowledge.
- Understand cultural and linguistic differences.

Cultural competency (cont.)

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to their provider and adhere to recommended treatment. Some of the reasons that justify a provider's need for cultural competency include:

- The perception of illness and disease and their causes vary by culture.
- The belief systems related to health, healing, and wellness are very diverse.
- Culture influences help-seeking behaviors and attitudes toward healthcare providers.
- Individual preferences affect traditional and nontraditional approaches to healthcare.
- Providers must overcome their personal biases within healthcare systems.
- Healthcare providers from culturally and linguistically diverse groups are underrepresented in the current service delivery system.

Cultural competency (cont.)

Cultural awareness includes:

- The ability to modify one's own behavior to respond to the needs of others while maintaining one's objectivity and identity.
- The ability to recognize the cultural factors (norms, values, communication patterns, and world views) that shape personal and professional behavior.

Providers must adhere to *Americans with Disabilities Act (ADA)* requirements, meet Texas Accessibility Standards, and meet applicable state and local building codes.

Precertification requests

- Online: Availity.com
- By phone: **855-878-1785**
- By fax: **866-959-1537**:
  - Behavioral health outpatient services: **844-430-6804**
  - Behavioral health inpatient services: **844-451-2825**
  - Concurrent review clinical documentation for inpatient: **888-700-2197**
  - Initial admission notification and all other services: **866-959-1537**

- Physical and occupational therapy: phone **800-714-0040**
- Spine and back pain management procedures: phone **800-714-0040**
- Radiology: Carelon Medical Benefits Management, Inc.:*
  - Online via the ***Provider****Portal*: providerportal.com
  - Phone: **833-305-1809**

Precertification requests (cont.)

Certain services/procedures require precertification from Amerigroup STAR+PLUS MMP for participating and nonparticipating PCPs, specialists, and other providers. Please refer to the list below, the Precertification Lookup tool online, or call Provider Services at **855-878-1785** for more information. The following are examples of services requiring precertification before providing the following non-emergent or urgent care services:

- Inpatient mental health services
- Behavioral health partial hospitalization
- Skilled nursing facility (SNF)
- Home healthcare
- Diagnostic tests, including but not limited to MRI, MRA, PET scans, etc.
- Hospital or ambulatory care center-based outpatient surgeries for certain procedures
- Elective inpatient admissions
- Transplant evaluation and services
- Any nonemergency service from or referral to a noncontracted provider
- Durable medical equipment
- Outpatient IV infusion or injectable medications
- Prosthetics
- Certain reconstructive procedures
- Occupational, speech, and physical therapy services
- LTSS

Precertification requests (cont.)

Radiology services

- Amerigroup STAR+PLUS MMP is collaborating with Carelon Medical Benefits Management to provide certain outpatient imaging utilization management services for Amerigroup STAR+PLUS MMP members. The ordering provider is responsible for obtaining prior authorization for the following services:
  - Computer tomography (CT/CTA) scans
  - Resting transthoracic echocardiography (TTE)
  - Nuclear cardiology magnetic resonance (MRI/MRA)
  - Stress echocardiography (SE)
  - Positron emission tomography (PET) scans
  - Echocardiogram (Echo)
  - Transesophageal Echocardiography (TEE)

Authorization review requests can be initiated by visiting the ***Provider****Portal* at providerportal.com or call Carelon Medical Benefits Management at **833-305-1809** Monday through Friday 8 a.m. to 5 p.m.

Precertification requests (cont.)

Physical and occupational therapy

Amerigroup STAR+PLUS MMP is collaborating with Carelon Medical Benefits Management to conduct medical necessity reviews for physical therapy, occupational therapy, and spine and back pain management procedures for our members. The following procedures must be reviewed by Carelon Medical Benefits Management for prior authorization:

- Physical and occupational therapy
- Spine and back pain management procedures:
  - Epidurals
  - Facet blocks
  - Pain pumps
  - Neurostimulators
  - Spinal fusion
  - Spinal decompression
  - Vertebro/kyphoplast

Precertification requests (cont.)

Authorization review requests for physical therapy/occupational therapy, pain management, and spinal surgery can be initiated by visiting providerportal.com or call Carelon Medical Benefits Management at **833-305-1809** Monday through Friday 8 a.m. to 5 p.m.

Critical events

Providers are obligated to identify and report to the state a critical event or incident, such as abuse, neglect, or exploitation.

See provider manual, section: *Reporting Abuse, Neglect, or Exploitation (ANE)* for further information.

Provider quick facts

- Members will have access to these service partners for Amerigroup STAR+PLUS MMP, which mirror our partners for Medicaid and Medicare Advantage:
  - Liberty Dental Plan*
  - Carelon Medical Benefits Management
  - Superior Vision*
  - LabCorp/Quest*
- Dedicated provider manual
- Providers will have access to all existing tools, including Patient360.
- Providers can access the website for detailed information on multiple topics, including vendor partners, provider tools, and program details.

Your support system

- Provider Relationship Management representative
- Medical Management
- Provider Services call-line **855-878-1785**
- Provider website: https://provider.amerigroup.com/TX
- Provider manual: https://provider.amerigroup.com/TX > Resources > Provider Manuals and Guides
- Availity Essentials: Availity.com
- Carelon Medical Benefits Management: providerportal.com

* Tivity Health, Inc. is an independent company providing the SilverSneakers fitness program on behalf of the health plan. Availity, LLC is an independent company providing administrative support services on behalf of the health plan. Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan. Liberty Dental is an independent company providing dental benefit management services on behalf of the health plan. Superior Vision, offered by Versant Health, is an independent company providing routine and medical optometry services on behalf of the health plan. LabCorp and Quest are independent companies providing laboratory services on behalf of the health plan.

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