Healthy Connections PRIME

MMP and HCBS Provider Introduction and Education Session

February 26, 2016

The objectives of this meeting are to:

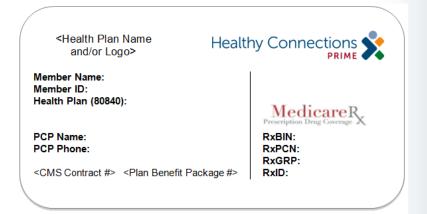
- Increase HCBS Provider understanding of Healthy Connections Prime
- Explain HCBS Provider Contracting
- Outline Claims and Billing processes
- Introduce HCBS Providers to Medicare-Medicaid Plans (MMPs)



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.

Enrollment Phase	Information
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 on going monthly Eligible enrollees are automatically assigned to a Medicare-Medicaid plan

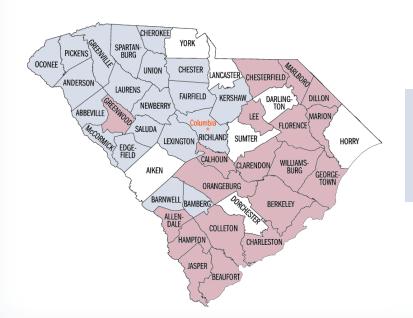
Healthy Connections Prime is voluntary. Members may disenroll at any time, and eligible enrollees may choose not to participate.



Passive Enrollment Timeline*

Wave 1

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



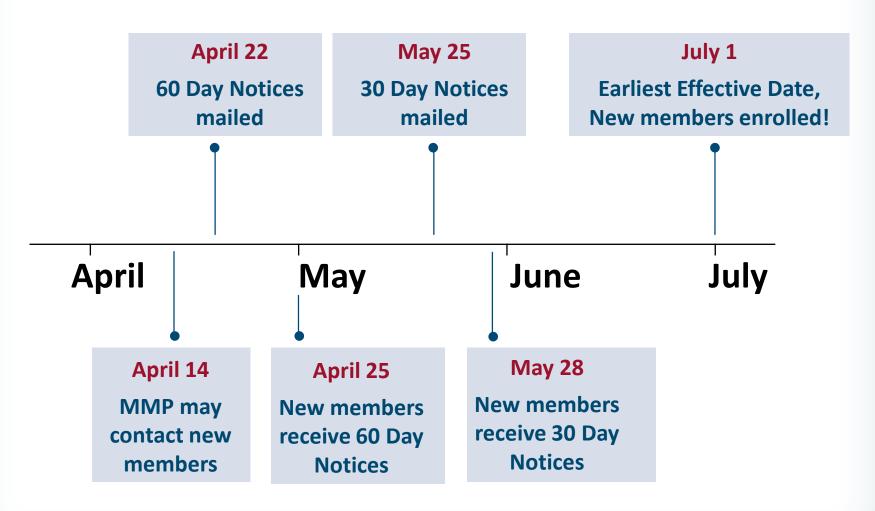
Wave 2

- 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.



Wave 2 Communications to Members (2016)





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?

Does not change

Use of Phoenix

Provider Credentialing

LTC LOC Initial Assessments

Self-Direction

Keep your waiver participants

Changes

PLUS

Provider contracts

Oversight of Waiver CM

LTC LOC Reassessments

Claims processing and payment

Serve non-waiver individuals

Provider Reimbursement

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

New

MMP Care Coordinator

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 inhome visit within 30 days

> Updates service plan as necessary based upon needs not addressed in initial service plan (i.e., environmental modifications, caregiver supports)

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

- Full Contract
 Serve any member
 - Single Case Agreement

 Serve one particular member beyond the six month transition period
 - 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 feefor-service rates



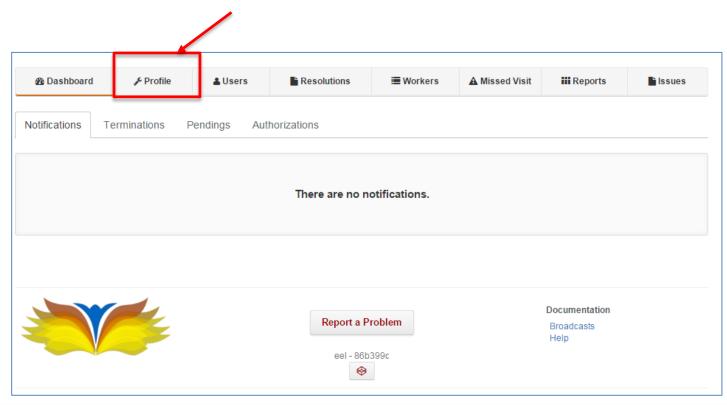
Prime Provider Agreement

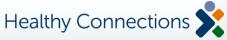
Purpose

- 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 <u>https://providers.phoenix.scdhhs.gov/login</u>
- Click the Profile tab





Click the Agreements tab



 The screen will show the "Healthy Connections Prime agreement waiting to be signed by your company.



- 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

CDHHS Hon



SEARCH

ABOUT PRIME

PROVIDERS

RESOURCES/NEWS

CONTACTS



One plan One card No insurance premiums No drug copays

To Learn More or Enroll

Healthy Connections Prime is a new program that combines all of the benefits of Medicare and South Carolina Healthy Connections Medicaid under a single Medicare-Medicaid plan to make it easier for members to get needed health services.

NAVIGATION





Questions









LATEST NEWS 🖾

Jan 7, 2015 | Press Release

Medicare-Medicaid Plan and Doctor Information

The health plan selection website for South Carolina Healthy Connections Choices now has...

Sep 2, 2014 | Press Release

Stakeholder Engagement: Nursing Facilities

Sep 2, 2014 | Press Release

Notification to Amend Medicald Home and Community-Based Waivers

Sep 2, 2014 | Press Release

South Carolina Hospital Association Agency, Payer, and Provider Summit

Sep 16, 2013 | Press Release

SCDuE Weekly Update | September 16, 2013

SCDuE Weekly Update | September 16, 2013

MORE O

MEMBER STORIES



"I like the personal touches my plan brings. I feel like I joined a family and not an insurance plan. My plan cares about their members." Read More

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

- FAQs
- Educational events
- Member stories
- Program data
- Latest updates
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