STAR+PLUS Medicare-Medicaid Dual Demonstration (STAR+PLUS MMP)

Provider Training

Agenda

- Who is Superior HealthPlan?
- What is the STAR+PLUS Medicare-Medicaid Plan (MMP)?
- Role of the Provider
- Service Coordination
- Transportation
- Verifying Eligibility
- Prior Authorizations
- Appeals
- Pharmacy
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- Cultural Competency and Disability Sensitivity
- Model of Care
- Quality Improvement Program
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- Electronic Visit Verification (EVV)
- Superior HealthPlan Departments
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Who is Superior HealthPlan?

Superior HealthPlan

Superior:

- Is a subsidiary of Centene Corporation providing healthcare for Medicaid and CHIP members across Texas.
- Has been a contracted Managed Care Organization (MCO) for the Medicaid managed care program (STAR program) since December 1999.
- Contracted with the State of Texas to provide all Medicaid lines of business, including:
  - STAR/CHIP
  - STAR Kids
  - STAR+PLUS
  - STAR Health (Foster Care)
  - STAR+PLUS Medicare-Medicaid Plan (MMP)
  - Ambetter Health
  - WellCare By Allwell (HMO and HMO DSNP) Plans
- Among the top-rated Medicaid plans in Texas, earning a score of 3.5 out of 5 in the NCQA Medicaid Health Insurance Plan Ratings.

What is the STAR+PLUS Medicare-Medicaid Plan (MMP)?

STAR+PLUS MMP: Goals

- Ensure the member's Medicare and Medicaid services are provided.
- Utilize Care Management teams for targeted member outreach and care coordination.
- Improve quality and individual experience in accessing care.
- Promote independence in the community.
- Eliminate cost shifting between Medicare and Medicaid.
- Achieve cost savings for the state and federal government through improvements in care and coordination.

STAR+PLUS MMP: Benefits

- Every STAR+PLUS MMP member will be offered the following, but is not limited to:
  - 24-hour emergency care
  - Add-on services
  - Ambulance service
  - Behavioral health services
  - Doctor and clinic visits
  - Family planning services
  - Hearing tests and aids
  - Home health services
  - Hospital care
  - Lab and X-ray services
  - Organ and tissue transplants

Note: All services are subject to benefit coverage, limitations and exclusions. Acute care services fall under the member's Medicare coverage.

Flexible Benefits

- STAR+PLUS MMP members have access to additional services, beyond covered services, depending on their health needs. Flexible benefits may vary for those with HCBS STAR+PLUS waiver coverage.
- Flexible benefits include*:
  - Preventive and Comprehensive dental services
  - Over-the-Counter items
  - Emergency Response Services
  - Routine foot care
  - Routine eye exams and eyewear
  - Home-delivered meals
  - Respite care

*Please note that flexible benefits are subject to change. For a current list, please visit Superior's MMP website.

Enrollment

- Individuals who meet all the following criteria will be eligible for STAR+PLUS MMP:
  - 21 years of age or older at the time of enrollment
  - Are a United States Citizen or are lawfully present in the United States
  - Entitled to benefits under the Medicare Part A and enrolled under Medicare Part B
  - Receive Medicaid benefits through the Superior STAR+PLUS Medicaid program
  - Reside in Bexar, Dallas or Hidalgo Counties
    - (Note: The MMP program is available in 6 counties; these are the 3 which Superior services).
- Not included are individuals who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions (ICF/IID), and individuals with developmental disabilities who get services through one of these waivers:
  - Community Living Assistance and Support Services (CLASS)
  - Deaf Blind with Multiple Disabilities Program (DBMD)
  - Home and Community-based Services (HSC)
  - Texas Home Living (TxHmL)

Enrollment

- Enrollment for eligible individuals into STAR+PLUS MMP may be conducted (when no active choice has otherwise been made) using a seamless, passive enrollment process that provides the opportunity for individuals to make a voluntary choice to enroll or disenroll from STAR+PLUS MMP at any time.
- Under passive enrollment, eligible individuals will be notified of plan selection and of their right to select among other contracted STAR+PLUS MMPs no less than 60 Days prior to the effective date of enrollment and will have the opportunity to opt-out until the last day of the month prior to the effective date of enrollment.
- Disenrollment from STAR+PLUS MMP Managed Care Organizations (MCO) and enrollment from one STAR+PLUS MMP MCO to a different STAR+PLUS MMP MCO will be allowed on a month-to-month basis any time during the year.

Disenrollment

- Required Involuntary Disenrollment
  - Texas and Centers for Medicare and Medicaid Services (CMS) will terminate a member's enrollment in the STAR+PLUS MMP if, for example*:
    - The member loses entitlement to either Medicare Part A or Part B
    - A change in residence makes the individual ineligible
    - MMP's contract with CMS is terminated or reduces its service area to exclude members in those areas
- Involuntary Disenrollment Due to Member Non-Compliance
  - There may be instances when a PCP feels that a member should be removed from their panel. All notifications to remove a patient from a panel must:
    - Be made in writing
    - Contain detailed documentation
    - Be directed to Superior's Compliance department

**Note: This is not an all-inclusive list. For a full list, see the Superior HealthPlan STAR+PLUS Medicare-Medicaid Plan (MMP) Provider Manual (PDF), located on Superior's Training and Manuals webpage.*

Role of the Provider

Primary Care Providers

- The Primary Care Provider (PCP) serves as the “medical home” for the member. The “medical home” concept should assist in establishing a member-provider relationship and ultimately better health outcomes.
- Responsibilities include but are not limited to:
  - Supervision, coordination and provision of care to each assigned member.
  - Initiation of referrals for medically-necessary specialty care.
  - Maintaining continuity of care for each assigned member.
  - Maintaining the member’s medical record, including documentation for all services provided to the member by the PCP, as well as any specialists, behavioral health or other referral services.
  - Screening for behavioral health needs at each visit and when appropriate, initiate a behavioral health referral.

Primary Care Providers

- PCPs should speak to all their members annually about:
  - Reducing the risk of falling
  - Improving bladder control
  - Improving or maintaining mental health
  - Improving or maintaining physical health
  - A review of the member's medication(s)

Specialist as the PCP

- Members with disabilities, special health-care needs, and chronic or complex conditions have the right to designate a specialist as their PCP.
- A specialist may serve as a PCP only under certain circumstances and with approval of Superior's Chief Medical Officer.
- To be eligible to serve as a PCP, the specialist must:
  - Meet Superior's requirements for PCP participation, including credentialing.
  - Contract with Superior as a PCP.
  - All requests for a specialist to serve as a PCP must be submitted to Superior. The request should contain the following information:
    - Certification by the specialist of the medical need for the member to utilize the specialist as a PCP.
    - A statement signed by the specialist that he/she is willing to accept responsibility for the coordination of all the member's health-care needs.
    - Signature of the member on the completed "Specialist as PCP Request" Form.
- Superior will approve or deny the request and provide written notification (including denial reason) of the decision to the member no later than 30 Days after receiving the request. If denied, the member may file a complaint.

Specialty Care Physicians

- Agrees to partner with the member's PCP and Service Coordinator to deliver care.
- Maintain ongoing communication with the member's PCP.
- Most visits to specialist do not require a prior authorization.
- Most specialists will require a written referral from the member's PCP; however, the referral is not required for the claim to be reimbursed by STAR+PLUS MMP.
- Female members can self-refer to an OB/GYN for their annual well-woman checkup or for care related to pregnancy.
- Specialists can elect to limit their practice to established members only upon request to their Account Manager.

Referrals

- All health-care services are coordinated through the PCP.
- PCP is required to refer a member to a specialist when medically-necessary care is needed beyond PCP's scope, such as mental health referrals.
  - There may be times when a referral to an out-of-network may be appropriate. Superior will review the out-of-network request and make a medical necessity decision on the request.
- PCP is not required to issue paper referrals but must obtain a prior authorization to certain specialty physicians and all non-emergent out-of-network providers.
- Specialist may not refer to another specialist.
- Members may self-refer for the following services:
  - Family planning
  - Vision
  - True emergency services
  - Care management for pregnant women
  - Behavioral health
  - Well woman annual examinations
  - OB Care

Referrals for Non-Capitated Services

- Non-capitated services are excluded from covered services; however, MMP members may be eligible to receive from them from Texas Medicaid providers on a Fee-for-Service basis.
- When it is determined that a member may need a non-capitated service, Superior staff will assist the member in requesting these services.
- Services include:
  - ECI Case Management
  - ECI Specialized Skill Training
  - Texas Health Steps environmental lead investigation (ELI)
  - Texas School Health and Related Services (SHARS)
  - HHSC Blind Children's Vocational Discovery and Development Program
  - Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
  - HHSC hospice services
  - Mental Health Targeted Case Management and Mental Health Rehabilitative Services for dual-eligible members
  - Texas Department of Family and Protective Services (DFPS) Nurse-Family Partnership (NFP)
- Claims for non-capitated services should be submitted directly to the HHSC Claims Administrator for reimbursement.

Wrap Services

- STAR+PLUS MMP members are eligible for covered wrap services, which include but are not limited to*:
  - Additional days for Inpatient Hospital Acute and Psychiatric
  - DME for use outside the home
  - Additional hours of home health services
  - Non-Emergency Medical Transportation
  - Occupational therapy services
  - Personal Emergency Response System
  - Rewards and incentives offered by Superior
  - Tobacco cessation counseling for pregnant women
- Medications not covered by Medicare Part D may be covered by Texas Vendor Drug Program (VDP) as a Medicaid benefit via the wrap benefit
  - A 72-hour emergency supply of a prescribed drug must be provided when a medication that is wrapping to the Medicaid benefit is needed without delay and PA is not available.
- Claims for wrap-around services should be submitted directly to the HHSC Claims Administrator for reimbursement.

*A full list of covered wrap services can be found in the STAR+PLUS MMP provider manual.

Behavioral Health Providers

- The behavioral health provider serves certain members participating in the STAR+PLUS MMP program that have mental illness through targeted case management and mental health rehabilitative services.
- Behavioral health providers are required to provide covered health services to members within the scope of their Superior agreement and specialty license.
- For Enrollees with severe and persistent mental illness (SPMI) and severe emotional disturbance (SED), Mental Health Rehabilitative Services and Mental Health Targeted Case Management must be available to eligible enrollees. The STAR+PLUS MMP must maintain a qualified network of entities, such as Local Mental Health Authorities (LMHAs) and multi-specialty groups, that employ providers of these services. Mental Health Rehabilitative services include the following:
  - Adult Day Program
  - Crisis Intervention
  - Medication Training and Support
  - Psychosocial Rehabilitative Services
  - Skills Training and Development

Self-Directed Care

Superior STAR+PLUS MMP providers that offer Primary Home Care (PHC)/Personal Assistance Services (PAS) in-home or out-of-home respite, nursing, physical therapy (PT), occupational therapy (OT) and/or speech therapy (ST), have 3 options available for self-directed care.

1. Consumer-Directed Services - The member or the member's Legally Authorized Representative (LAR) is the employer of record and retains control over the hiring, management and termination of an individual providing the services.
   - The enrollee uses a Financial Management Services Agency (FMSA) to handle the employer-related administrative functions such as payroll, substitutes (back-up) and filing tax-related reports.

Self-Directed Care

2. Service Responsibility Option (SRO) - The member or the member's LAR is actively involved in choosing the member's provider but is not the employer of record.
   - The Home and Community Support Services agency (HCSSA) in the STAR+PLUS MMP provider network is the employer of record for the personal attendant employee and respite provider.
3. Agency Model - STAR+PLUS MMP contracts with a Home and Community Support Services agency (HCSSA) or a certified Home and Community-based Services or Texas Home Living Agency for the delivery of services.
   - The HCSSA is the employer of record and establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up) and filing tax-related reports.

Community First Choice

- Community First Choice (CFC) provides Community-Based Long-Term Services and Supports (LTSS) to eligible enrollees who are elderly and to individuals with physical or cognitive disabilities as an alternative to living in an institution.
- To be eligible for CFC services, an enrollee must meet income and resource requirements for Medicaid under the state plan and receive a determination from HHS that the enrollee meets Level of Care (LOC) requirements for:
  - Nursing Facility care
  - An intermediate care facility
  - An institution for mental diseases

Service Coordination

Service Coordination Team

- Service Coordination teams will:
  - Identify and engage high-risk and non-compliant members.
  - Identify barriers to compliance with treatment plans and goals.
  - Facilitate communication across medical/behavioral health specialties.
  - Coordinate services, including transportation and referrals.
  - Facilitate communication regarding medication adherence.
  - Work closely with the Superior Pharmacy team to provide member education.

Service Coordination

- A special kind of care management used to coordinate all aspects of care for a member.
- Utilizes a multidisciplinary approach to meet the members' needs, including behavioral health referrals and non-clinical social support.
- Members and their respective Nursing Facilities will be assigned the same Service Coordinator.
- Coordinator's names are found on Superior's Secure Provider Portal.

Interdisciplinary Care Team (ICT)

- The purpose of the ICT is to collaborate with the member, their providers/specialists and other health-care professionals to ensure appropriate services are in place and to identify alternative solutions to barriers identified in a member's care plan.
- Superior's program is member-centric with the PCP being the primary ICT point of contact. Superior staff works with all members of the ICT in coordinating the plan of care for the member.
- As part of the ICT process, providers are responsible for:
  - Accepting invitations to attend member's ICT meetings.
  - Maintaining copies of the Individualized Care Plan (ICP), ICT worksheets and transition of care notifications in the member's medical record.
  - Collaborating and actively communicating with care managers the ICT, members and caregivers.
- Superior Coordinators work with the member to encourage self-management of their condition, as well as communicate the member's progress toward these goals to the other members of the ICT.

Interdisciplinary Care Team

- The ICT will be led by a Care Coordinator, and at a minimum is comprised of the following core members:
  - Member and/or authorized representative
  - PCP
  - Family and/or caregiver, if approved by the member
  - Care coordinator(s) (Service Coordinator, Behavioral Health Care Manager)
  - Specialist (if serving as member's PCP)

Responsibility of the ICT

- Analyze and incorporate the results of the initial and annual health risk assessment into the ICP.
- Coordinate the medical, cognitive, psychosocial and functional needs of members.
- The development and implementation of individualized care plan with the member's participation as feasible.
- Conduct ICT meetings according to the member's condition. These meetings may be held face-to-face, via conference call or web-based interface.

Care Coordination

- Superior and its providers partner to identify and manage services for all members, including persons with disabilities, chronic or complex conditions.
- This includes development of a plan of care to meet the needs of the member.
- The plan of care is based on health needs, the member's providers and specialists' recommendations, periodic reassessment of the member's developmental and functional status and service delivery needs.

Behavioral Health and Physical Health Services Coordination

- Superior recognizes that communication is the link that unites all the service components and is a key element in any program's success.
- Providers are required to obtain a consent for disclosure of information from the member permitting exchange of clinical information between the behavioral health provider and the member's physical health provider.
  - If the member refuses to release the information, they should indicate their refusal on the release form. Providers must document the reasons for declination in the medical record.

Behavioral Health and Physical Health Services Coordination

PCPs are required to:

- Send the behavioral health provider initial and quarterly (or more frequently if clinically indicated or court ordered) summary reports of the member's physical and behavioral health status. The report must minimally include:
  - Behavioral health medications prescribed.
  - Behavioral health medication effects reported during PCP visits and information about physical health conditions and treatments that may affect behavioral health conditions and treatments.
- Administer a screening tool at intake, and at least annually thereafter, to identify members who need behavioral health referrals. Behavioral health assessment tools, if available, may be utilized by the PCP.
- Send a copy of the physical health consultation record and the behavioral health screening tool results to the behavioral health provider that referred the member. Make referrals to behavioral health providers when the required Texas Health Steps screen reveals the need for a mental health, substance abuse and/or developmental disability assessment.

Note: Behavioral health providers are required to refer members with known or suspected physical health problems or disorders to the PCP for examination and treatment.

Transportation

STAR+PLUS MMP
Transportation Benefits

- Superior's Medical Ride Program (Non-Emergency Medical Transportation [NEMT] Services) provides transportation to covered health-care services for Medicaid members who have no other means of transportation.
- Transportation includes rides to the doctor, dentist, hospital, pharmacy and other places members receive Medicaid services.
- Transportation services are provided by SafeRide.
- Members must request rides at least two business days in advance and it is the responsibility of the member to coordinate all information needed from both the provider and Superior for SafeRide to consider the request.
- Appointments can be requested Monday through Friday, 8:00 a.m. – 6:00 p.m. CST by calling 1-855-932-2318 (TTY: 7-1-1).

Medical Ride Program Services

- Services offered by Superior's Medical Ride Program include, but are not limited to:
  - Passes or tickets for mass transit within and between cities or states.
  - Commercial airlines transportation.
  - Mileage reimbursement for an Individual Transportation Participant (ITP) using their own vehicle to get a covered health-care service.
    - The enrolled ITP can be the patient, the patient's family member, friend or neighbor.
  - Car, van or private bus services, including wheelchair-accessible vehicles, if necessary.
- Superior's Medical Ride Program will cover the cost of an attendant for patients needing assistance while traveling.
  - Providers may receive a request to provide proof of documentation of medical necessity.

Prior Authorizations

Prior Authorization Process

- Authorizations for these services are requested from the Prior Authorization department. This can be done in one of three ways:

1. Calling the Prior Authorization Hotline at 1-800-218-7508
2. Submitting via Superior's Secure Provider Portal
3. Faxing the *STAR+PLUS MMP Prior Authorization* Form under the *Provider MMP Prior Authorization Forms & Information* section found on Superior's Provider Forms webpage to:
   - Medical Inpatient: 1-877-259-6960
   - Medical Outpatient: 1-877-808-9368
   - Behavioral Health Inpatient: 1-866-900-9618
   - Behavioral Health Outpatient: 1-855-772-7079

Evolent/National Imaging Associates (NIA)

- Evolent, formerly known as National Imaging Associates (NIA), is contracted with Superior to perform utilization review for:
  - High-Tech Imaging Services
  - Interventional Pain Management (IPM)
  - Genetic and Molecular Testing
  - Physical, Occupational and Speech Therapy Treatment Services*
  - Musculoskeletal surgical procedures (Effective 1/1/2024)
- For IPM, a separate prior authorization number is required for each procedure ordered.
- The ordering physician is responsible for obtaining prior authorizations.
- Emergency room and inpatient procedures do not require prior authorization; however, notification of admission is still required through Superior.
  - Observation Imaging Services do not require prior authorization
- To obtain authorization through Evolent, visit the Evolent website or call 1-800-642-7554.
- Claims should still be submitted to Superior for processing.

*Non-STAR+PLUS HCBS Waiver Members

TurningPoint Healthcare Solutions Expansion

- TurningPoint Healthcare Solutions is contracted with Superior to process prior authorization requests for medical necessity and appropriate length of stay for:
  - Certain Cardiac procedures
  - ENT surgeries
- Emergency related procedures do not require prior authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the services should verify that the necessary prior authorization has been obtained. Failure to do so may result in non-payment of claims.
- Prior authorization requirements for facility and radiology may also be applicable.
- TurningPoint's Procedure Coding and Medical Policy Information can be located under *Billing Resources* on Superior's Provider Resources webpage.
- For questions, utilization management or precertification, and to submit PA requests, please contact TurningPoint at:
  - Web Portal Intake: TuriningPoint Provider Login
  - Telephonic Intake: 1-469-310-3104 or 1-855-336-4391
  - Facsimile Intake: 1-214-306-9323

Appeals

Adverse Benefit Determinations

- Adverse Benefit Determination is the denial or limited authorization of a requested service, including determinations based on:
  - Type or level of service, Requirements for medical necessity, Appropriateness setting or effectiveness of a Covered Service.
  - The reduction, suspension or termination of a previously authorized service.
  - The denial, in whole or in part, of payment for a service.
  - The failure to provide services in a timely manner.
  - The failure of the STAR+PLUS MMP to act within the required timeframes for the standard resolution of Grievances and Appeals.
  - The Denial of a members request to obtain out of network services, or the denial of a member's request to dispute a financial liability.
- A peer-to-peer discussion is offered to the requesting provider prior to an adverse determination for a Medicaid covered service.
- Denial letters will be sent to both the member and the provider.
- The notice explains the adverse benefit determination made or intended to make, the reasons for the adverse benefit determination, and the right of the member to request and receive access to and copies of all document's records and other information relevant to the determination.
- Appeal rights will also be fully explained within the notice.

Expedited Appeals

- Expedited Appeals can be requested if the timeframe to complete a standard appeal may jeopardize life, health, or the ability to attain, maintain or regain maximum function.
- May be submitted verbally or in writing.
- Must be requested within 60 Calendar Days from the date of the adverse determination letter.
- Reviewed by a Medical Director who has not been involved in any previous level of review or decision making.
- Expedited appeals for emergency care or continued hospitalization are processed within 1 Business Day of appeal request, but no later than 72 hours of the request.
- All other expedited appeals are completed within 72 hours.

Other Appeals

- State Fair Hearing Process – Members may appeal to the HHSC Appeals Division for Medicaid-based adverse determinations. These appeals must be made in writing via mail, fax or hand-delivery of electronic transmission.
  - Appeals must be filed within 120 Calendar Days of the notice of action.
  - Appeals will be decided within 90 Calendar Days from the date they were filed.
- CMS Independent Review Entity (IRE) – If the internal review is not decided fully in the member's favor, Superior will automatically forward the case for Medicare services to the IRE to be processed as expedited
  - The IRE will notify the member and the provider within 30 Calendar Days of their decision (expedited will be sent within 72 hours of receipt).

Pharmacy

Pharmacy Benefit Management (PBM)

- PBM
  - Responsible for timely and accurate payment of pharmacy claims.
  - Provides pharmacy network for Superior members.
- Centene Pharmacy Services (CPS)
  - Responsible for review of prior authorizations for prescriptions, as applicable.
- CPS Pharmacy and Therapeutics Committee reviews and approves the formulary (list of drugs). Some drugs may not be covered or are excluded, others are not on the list because of clinical and cost reasons.

Part D Transition Fill Policy

For Medicare Part D Drugs

- A transition fill is a temporary supply of medication that allows time for the member and prescriber to either change the drug to a formulary option or submit for coverage determination.
- New plan members can receive a one-time temporary supply of up to 30 days at a retail pharmacy and 31 days at a long-term care pharmacy for a non-formulary drug or a drug requiring coverage determination within the first 90 days of their membership. (Transition refills are not for new prescriptions.)
- This policy also applies to current members if any of their current drugs are taken off the formulary or a coverage restriction is added for the next calendar year for reasons other than safety.

Part D Transition Fill Policy

- When members are transitioning from one care setting to another, they may also be entitled to transition fills – i.e. hospital to Skilled Nursing Facility (SNF), or home.
- Certain additional allowances are made for LTSS members.
- Applies only to Medicare Party D drugs (Tier 1 and Tier 2).
- For additional information, please visit Superior's Drug Transition Policy webpage.

Emergency Supply for Medicaid Covered Drugs

- A pharmacy may dispense a 72-hour (3 day) supply of a Medicaid covered medication (Tier 3 drugs) to any member awaiting a prior authorization or medical necessity determination if the pharmacist determines the member may experience a detrimental change to their health status without the drug.
- If the prescribing provider cannot be reached or is unable to request an authorization, the pharmacy may dispense an emergency 72-hour prescription if the pharmacist determines the member may experience a detrimental change to their health status without the drug.
- A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable (e.g., an albuterol inhaler) as a 72-hour emergency supply.

DME and Medical Supplies – Pharmacy Providers

- If a pharmacy enrolled in Superior's PBM wishes to provide services that are not on the formulary, the pharmacy must enroll as a DME provider and obtain a separate contract with Superior for medical services.
- Includes medically necessary items such as nebulizers, ostomy supplies or bed pans and other supplies and equipment.
- For children (birth through 20 years of age), this includes items typically covered under the Texas Health Steps program including, but not limited to, prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies and some nutritional products.

Pharmacy Resources

- View our formulary at Superior's List of Drugs (Formulary) webpage.
- View our Prior Authorization, Step Therapy and Quantity Limits at Superior's Prior Authorization, Step Therapy and Quantity Limits webpage.
- View our Coverage Determinations and Redeterminations for Drugs at Superior's Coverage Determinations and Redeterminations for Drugs webpage.

Pharmacy Prior Authorization

- For questions or concerns from prescribers and members:
  - Phone: 1-800-218-7453, ext. 22272
  - Fax: 1-866-683-5631
  - E-forms: Visit Superior's Contact Us webpage
- Pharmacy benefit prior authorization requests (Centene Pharmacy Services)
  - Authorization Requests Phone: 1-866-399-0928
  - Authorization Requests Fax: 1-833-423-2523
- Biopharmacy/Clinician Administered Drugs (CAD) Rx administration (Superior Authorizations Department)
  - Authorization Requests Phone: 1-800-218-7453, ext. 22272
  - Authorization Requests Fax: 1-866-683-5631
- Appeal (Superiors Appeals Department)
  - Appeals Requests Fax: 1-866-918-2266
  - Appeals Requests Phone: 1-800-218-7453, ext. 22168

Fraud, Waste and Abuse

Fraud, Waste and Abuse: Definitions

Understanding the terms:

- **Fraud** - Any intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person. The term does not include unintentional technical, clerical, or administrative errors.
- **Waste** – Practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items, or services.
  - Waste also includes incurring unnecessary costs resulting from inefficient or ineffective practices, systems, or controls.
- **Abuse** – A practice by a provider that is inconsistent with sound fiscal, business, or medical practices and that results in an unnecessary cost to the Medicaid program; the reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care; or a practice by a recipient that results in an unnecessary cost to the Medicaid program.

Fraud, Waste and Abuse: Reporting

- Report fraud, waste or abuse:
  - Call the Office of Inspector General (OIG) Hotline at 1-800-436-6184.
  - Visit the HHSC OIG website and select *"Report Fraud"* to complete the online form.
  - Contact Superior's Corporate Special Investigative Unit directly at:

    Centene Corporation
    Superior HealthPlan Fraud and Abuse Unit
    7700 Forsyth Boulevard
    Clayton, MO 63105
    1-866-685-8664
- Examples of fraud, waste and abuse include:
  - Payment for services that were not provided or necessary
  - Upcoding
  - Unbundling
  - Letting someone else use their Medicaid of CHIP ID

Model of Care

Model of Care

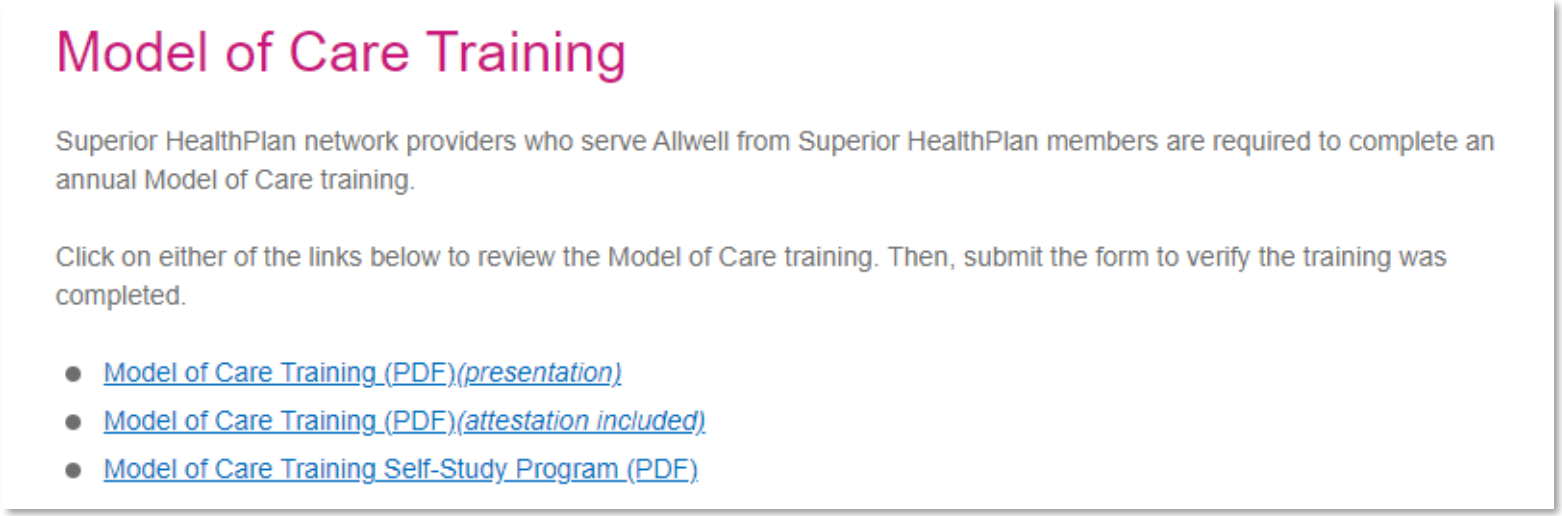
- The Model of Care is Superior's plan for delivering integrated care management programs to members with special needs. The goals of Model of Care are:
  - Improve access to medical, mental health and social services
  - Improve access to affordable care
  - Improve coordination of care through an identified point of contact
  - Improve transitions of care across healthcare settings and providers
  - Improve access to preventive health services
  - Assure appropriate utilization of services
  - Assure cost-effective service delivery
  - Improve beneficiary health outcomes
- Model of Care elements:
  - Description of the STAR+PLUS MMP population
  - Care coordination and care transitions protocol
  - Provider network
  - Quality measurements and performance improvement

Model of Care Process

- Every dual member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 Days of enrollment and, at a minimum, annually, or more frequently with any significant change in condition or transition of care.
- The HRA collects information about the member's medical, psychosocial, cognitive and functional needs, and medical and behavioral health history.
- Members are then triaged to the appropriate Service Coordination Program for follow-up.
- The Model of Care requires that Superior and providers collaborate to benefit members by:
  - Enhancing communication between members, physicians, providers and STAR+PLUS MMP
  - Taking an interdisciplinary approach with regard to the member's special needs
  - Providing comprehensive coordination with all care partners
  - Supporting the member's preferences in the Model of Care
  - Reinforcing the member's connection with their medical home

Model of Care Information

- Model of Care information is available on Superior's Model of Care Training webpage.
- Model of Care training is a CMS requirement for newly-contracted Medicare providers within 30 Days of execution of their contract.
- The Model of Care training must be completed by each participating provider annually, during each Calendar Year.



Model of Care Training

Superior HealthPlan network providers who serve Allwell from Superior HealthPlan members are required to complete an annual Model of Care training.

Click on either of the links below to review the Model of Care training. Then, submit the form to verify the training was completed.

- Model of Care Training (PDF)*(presentation)*
- Model of Care Training (PDF)*(attestation included)*
- Model of Care Training Self-Study Program (PDF)

Quality Improvement Program

Quality Improvement

- Quality Assessment and Performance Improvement (QAPI):
  - Monitors quality of services and care provided to members through:
    - Appointment availability audits
    - After-hours access audits
    - Tracking/trending of complaints
  - Providers participate in QAPI by:
    - Volunteering for Quality Improvement Committees
    - Responding to surveys and requests for information
    - Vocalizing opinions
- Quality Improvement Committee (QIC)
  - Comprised of contracted providers from different regions and specialties
  - Appointed by Superior's Chief Medical Director
  - Serves as Peer Review Committee
  - Advises on proposed quality improvement activities and projects
  - Evaluates, reviews and approves clinical practice and preventative health-care guidelines

Cultural Sensitivity

- Superior encourages providers to provide culturally competent care that aligns with the National Standards on Culturally and Linguistically Appropriate Services (CLAS).
- Sensitivity to differing cultural influences, beliefs and backgrounds can improve a provider's relationship with patients, and the health and wellness of the patients themselves.
- Principles related to cultural competency in the delivery of health-care services to Superior members include:
  - Knowledge
    - Provider's self-understanding of race, ethnicity and influence.
    - Understanding of the historical factors which impact the health of minority populations, such as racism and immigration patterns.
  - Skills
    - Ability to communicate effectively with the use of cross-cultural interpreters.
    - Ability to utilize community resources.
  - Attitudes
    - Respect the importance of cultural forces
    - Respect the importance of spiritual beliefs

Cultural Sensitivity

- Complimentary Interpretation Services
  - Superior offers interpretation services to providers at no cost.
  - To access telephonic interpreters for your members or to schedule an in-person interpreter, please contact Superior's Member Services department.
    - Contact information can be found on Superior's Phone Directory webpage.
- Trainings and Information:
  - The Culture, Language and Health Literacy website provides an exhaustive list of resources regarding cultural competence issues for specific ethnicities, religions and special populations.
    - For more information visit Health Resources & Services Administration Addressing Health Literacy webpage.
  - EthnoMed is a website containing information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants.
    - For more information visit EthnoMed website.
  - Superior's Health Equity webpage offers information about cultural and linguistic competency and available language services.
    - For more information visit Superior's Quality Improvement webpage.

Disability Sensitivity

- The American with Disabilities Act (ADA) defines a person with a disability as “a person who has a physical or mental impairment that substantially limits one or more major life activities.”
  - This includes people who have a record of a disability, even if they do not currently have a disability.
  - It also includes individuals who do not have a disability but are regarded as having a disability.
- Providers have a legal obligation to conform to ADA requirements as noted in their contract with Superior, and to maintain reasonable accommodations for members with disabilities, including seniors and persons with disabilities.
- Reasonable accommodations ensure that:
  - Services are provided in the most integrated setting appropriate for a person’s needs.
  - Members have full and equal access to health-care services and facilities.
  - Reasonable modifications to policies, practices and procedures are made, when necessary, to ensure health-care services are fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of services (i.e., alter the essential nature of services).

Disability Sensitivity

- Examples of reasonable accommodations can include, but are not limited to:
  - Improving the physical environment throughout an office or facility by using universal symbols and signage.
  - Creating adequate space within waiting rooms and exam rooms to comfortably accommodate individuals with physical disabilities (e.g., individuals who use wheelchairs) and non-physical disabilities.
  - Having medical equipment that accommodates individuals with disabilities (e.g., height adjustable exam tables, Hoyer type lifts, wheelchair accessible weight scales, moveable exam chairs).
  - Ensuring the office is accessible with ramps, and adequate parking with proper signage.
  - Providing exam room and waiting room furniture that can accommodate individuals with physical and non-physical disabilities.

Abuse, Neglect and Exploitation

Abuse, Neglect and Exploitation (ANE)

- Abuse:
  - Intentional mental, emotional, physical or sexual injury to people by a caretaker, family member, paid caretaker or other individual who has an ongoing relationship with the victim.
- Neglect:
  - Failure to provide the protection, food, shelter or care necessary to avoid emotional harm or physical injury; or a negligent act or omission that caused or may have caused emotional harm, physical injury or death by a caretaker, family member, paid caretaker or other individual who has an ongoing relationship with the victim.
- Exploitation:
  - The illegal or improper act or process of using, or attempting to use, the resources of the alleged victim, including the alleged victim's social security number or other identifying information, for monetary or personal benefit, profit or gain without the informed consent of the alleged victim by a caretaker, family member, paid caretaker or other individual who has an ongoing relationship with the victim.

How to Report ANE

Providers must report any allegation or suspicion of ANE to the appropriate entity:

- DFPS
  - An adult who is elderly or has a disability, receiving services from:
    - Home and Community Support Services Agencies (HCSSAs)
    - Unlicensed adult foster care provider with 3 or fewer beds
  - An adult with a disability or child residing in, or receiving services from, one of the following providers or their contractors:
    - Local Intellectual and Developmental Disability Authority (LIDDA), Local Mental Health Authority (LMHA), community center or mental health facility operated by DSHS.
    - A person who contracts with a Medicaid managed care organization to provide behavioral health services
    - A managed care organization
    - An officer, employee, agent, contractor or subcontractor of a person or entity listed above
  - An adult with a disability receiving services through the CDS Option
- Call the Abuse Hotline, 24 hours a day, 7 days a week, toll-free at 1-800-252-5400.

How to Report ANE

- HHSC
  - Report an adult or child who resides in or receives services from:
    - Nursing facilities
    - Assisted living facilities
    - HCSSAs – also required to report any HCSSA allegation to DFPS
    - Day care centers
    - Licensed foster care providers
    - Phone: 1-800-647-7418
- Local Law Enforcement:
  - If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and/or DFPS.
- Superior
  - In addition to reporting to HHSC and DFPS, a care provider must report the findings within one business day to Superior.

Claims Submissions

Claims Submission

- Clean Claim – A claim submitted by a provider for healthcare services rendered to a member that contains accurate and compete data in all claim fields required to adjudicate and accurately report and finalize the claim.
- First time claims must be submitted within 95 Calendar Days from the date of service.
- Rejected Claims – An unclean claim that does not contain all elements necessary to process the claim, and/or is not the responsibility of the health plan for adjudication.
  - All rejected claims must be corrected and resubmitted within 95 Calendar Days of the date of service, and therefore a previously rejected claim will not be honored to substantiate timely claim filing
- Superior's Provider Manual provides guidelines on how to submit Clean Claims and highlights the requirements for completing CMS 1450 or CMS 1500 forms.
  - National Provider Identification (NPI) of a referring or ordering physician on a claim
  - Appropriate two-digit location code must be listed
  - Appropriate modifiers must be billed, when applicable
  - Taxonomy codes are required on encounter submissions for the referring or ordering physician
    - ZZ qualifier for CMS 1500 or B3 qualifier for CMS 1450 to indicate taxonomy

Claims Filing

- Claims can be submitted 3 ways:
  - Visit Superior's Secure Provider Portal
  - Through a clearinghouse
    - For a list of our Trading Partners visit Superior's Billing and Coding webpage.
    - Payer ID (Medical and Behavioral Health): 68069
  - By mail on a red and white paper claim form:

    Medical:
    Superior HealthPlan STAR+PLUS MMP
    Attn: Claims
    P. O. Box 3060
    Farmington, MO 63640-3822

    Behavioral Health:
    Superior HealthPlan
    P.O. Box 6300
    Farmington, MO 63640-3806
- .

Corrected Claims Filing

- Must reference original claim number from Explanation of Payment (EOP).
- Must be submitted within 120 Calendar Days of adjudication paid date.
- Resubmission of claims can be done via your clearinghouse, on paper, or through Superior's provider portal.
  - To send both individual and batch claim adjustments via a clearinghouse, you must provide the following information to your billing company: the CLM05-3 must be "7" and in the 2300 loop a REF *F8* must be sent with the original claim number (or the claim will reject).
  - For batch adjustments, upload this file to your clearinghouse or through Superior's Secure Provider Portal.
  - To send individual claim adjustments through the web portal, log in to your account, select **Claim**, then click **Correct Claim**.
  - To file a paper correction, submit to:

    Superior HealthPlan STAR+PLUS MMP

    Attn: Claims Correction

    PO Box 4000

    Farmington, MO 63640-4000

Appealing Denied Claims

- Submit appeal within **120** Calendar Days from the date of adjudication or denial.
- Claims appeals may be submitted one of two ways:
  1. In writing:
     Superior HealthPlan STAR+PLUS MMP
     Attn: Claims Appeals
     P.O. Box 4000
     Farmington, MO 63640-4000

  2. Through Superior's Secure Provider Portal
     - At this time, batch adjustments are not an option via the portal.
- Attach and complete the claim appeal form from the website.
- Include sufficient documentation to support appeal.
- Include copy of UB04 or CMS 1500 (corrected or original) or EOP copy with claim number identified.

Billing the Member

- It is imperative that providers verify benefits, eligibility and cost shares each time a Superior member is scheduled to receive services.
  - Providers may NOT balance bill members for covered services.
  - Superior reimburses only those services that are medically necessary and a covered benefit; an EOP is provided that will detail reimbursement for each claim submitted.
  - Superior STAR+PLUS MMP members do not have copays.
  - Additional details can be found in your provider contract with Superior.

Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV)

- The 21st Century Cures Act Section 12006 is a federal law requiring all states to use EVV for Medicaid personal care services and home health services.
- Service providers or CDS employees providing covered services to an individual or health plan member must use one of the three HHSC approved methods to clock in and out.
- The EVV system electronically documents and verifies service delivery information, such as date, time, service type and location for certain Medicaid service visits.
- Once a provider or Financial Management Services Agency (FMSA) has ensured an EVV visit passes all validation edits they may reference the time recorded in the EVV system to determine billable units/hours.

EVV Claims

- For STAR+PLUS MMP, EVV is required for PAS, In-Home Respite services, CFC PAS and Habilitation and Protective Supervision.
  - For a list of all current programs and services requiring EVV refer to:
    - State-Required Personal Care Services (PDF)
    - Cures Act Home Health Care Services (PDF)
- EVV-relevant claims for programs required to use EVV, must be billed to Texas Medicaid and Healthcare Partnership (TMHP) and are subject to the EVV claims matching process performed by the EVV Aggregator.
- Providers and FSMAs must verify all data elements on EVV claims, including times entered in the EVV system, prior to submitting to EVV Aggregator.
- Providers and FMSAs must ensure the appropriate authorization has been received prior to services being rendered and billed on the claim.
- TMHP submits daily files directly to Superior for all accepted EVV transactions and claims.
- EVV Claims are analyzed by the EVV Aggregator in accordance with EVV data matching requirements before claim adjudication.

EVV Claims

- Bill Units Using the rounded “Pay Hours” calculated in the EVV vendor System.
  - Example: If client was serviced for 48 minutes, .75 units (rounds down to 45 minutes) should be billed. If a client was serviced 52 minutes (round up to 1 hour), 1 full unit should be billed for the respective visit.
- All Unit Increments should be billed in the following format after rounding:

Service Time	Units
60 minutes	1
45 minutes	.75
30 minutes	.50
15 minutes	.25
0 minutes	0

EVV Claims

- The EVV Aggregator conducts validation on data from the EVV visit transaction verifying the data on the billed claim matches the visit data in the EVV portal before forwarding the claim to Superior for adjudication.
- To prevent claim denials, providers and FMSAs should verify the EVV visit transaction is accepted before billing.
- When billing claims, providers and FMSAs must verify the data elements billed match the data listed in the EVV portal.
- Only EVV claims with claim line items displaying a match result code of EVV01, listed in the EVV Portal, may be paid by Superior.
- Providers and FMSAs are required to resubmit claim denials to TMHP.
  - *Note: TMHP refers to the process of resubmitting claims as the appeal process.*

EVV Claims

- The info on EVV claims must match EVV transactions along the following data elements:
  - NPI or Atypical Provider Identifier (API)
  - Date of service
  - Medicaid ID
  - HCPCS codes
  - Modifier(s), if applicable
  - Units (A requirement **only** for program providers, not CDS).
    - All EVV claim line items billed without matching EVV visit transactions will result in denials.
    - Providers or FMSAs will be required to resubmit any denials to TMHP.

Superior HealthPlan Departments

Contact Us

- Account Management:
  - Face-to-face orientations
  - Face-to-face web portal training
  - Office visits to review ongoing trends
  - For any questions, please contact your Account Manager. To access their contact information visit, Find My Account Manager.
- Provider Services: 1-877-391-5921
  - Questions on claim status and payments
  - Assisting with claims appeals and corrections
  - Finding Superior network providers
  - Available Monday through Friday, 8:00 a.m. to 5:00 p.m. local time
- Member Services: 1-866-896-1844
  - Verifying eligibility
  - ID card inquiries
  - Reviewing member benefits
  - Assisting with non-compliant members
  - Helping to find additional local community resources
  - Available Monday – Friday, 8:00 a.m. to 5:00 p.m. local time

Questions and Answers

Let us know what we can do to help.
Thank you for attending!