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

Supplement to Provider Orientation

Provider Services: 855-878-1785
Medicare-Medicaid (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
Medicare-Medicaid Plan Overview

The Amerigroup STAR+PLUS Medicare-Medicaid Plan (MMP) is a Texas plan contracted with Centers for Medicare & Medicaid Services (CMS) and Texas Health and Human Services Commission (HHSC).

Amerigroup 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 (MMP) for full access to both their Medicaid and Medicare benefits.

Amerigroup 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 health care MMP benefits. See the Amerigroup STAR+PLUS MMP Eligibility and Enrollment section for member eligibility requirements.
## MMP Program Counties

<table>
<thead>
<tr>
<th>County</th>
<th>Health Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexar</td>
<td><strong>Amerigroup</strong>, Molina, Superior</td>
</tr>
<tr>
<td>Dallas</td>
<td>Molina, Superior</td>
</tr>
<tr>
<td>El Paso</td>
<td><strong>Amerigroup</strong>, Molina</td>
</tr>
<tr>
<td>Harris</td>
<td><strong>Amerigroup</strong>, Molina, United</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>Health Spring, Molina, Superior</td>
</tr>
<tr>
<td>Tarrant</td>
<td><strong>Amerigroup</strong>, Health Spring</td>
</tr>
</tbody>
</table>
MMP Member Eligibility

- Reside in one of four counties: Bexar, El Paso, Harris or Tarrant
- Age 21 or older
- Receive Medicare Part A, B and D, and are receiving full Medicaid benefits
- Eligible for or enrolled in the Medicaid 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.
Excluded Population

- Dual eligible children (age 20 and younger) who have chosen to receive their Medicaid services through the STAR+PLUS managed care program
- 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 disenroll, 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 effective March 1, 2015. 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 (continued)

Passive enrollment

Beginning no sooner than April 1, 2015, 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 (continued)

## Passive vs opt-in enrollment eligibility table

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
<th>Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Medicare or Medicare Advantage/DSNP MCO with MMP</td>
<td>STAR+PLUS</td>
<td>Eligible for passive (same MCO) &amp; opt-in</td>
</tr>
<tr>
<td>Medicare Advantage/Dual-Special Needs Plan MCO without MMP</td>
<td>STAR+PLUS</td>
<td>Eligible for opt-in only</td>
</tr>
</tbody>
</table>
# Member Enrollment Notification Timeline

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Intro letter</th>
<th>60-day letter</th>
<th>30-day reminder</th>
<th>Enrollment start date</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>January 2015</td>
<td>N/A</td>
<td>N/A</td>
<td>March 1, 2015 (opt-in)</td>
<td>Any eligible client who opts-in</td>
</tr>
<tr>
<td>1</td>
<td>January 2015</td>
<td>Feb 1, 2015</td>
<td>Mar 2, 2015</td>
<td>April 1, 2015</td>
<td>20% of eligible non-facility clients by zip code in all demo counties</td>
</tr>
<tr>
<td>2</td>
<td>February 2015</td>
<td>Mar 2, 2015</td>
<td>Apr 1, 2015</td>
<td>May 1, 2015</td>
<td>20% of eligible non-facility clients by zip code in all demo counties</td>
</tr>
<tr>
<td>3</td>
<td>March 2015</td>
<td>Apr 1, 2015</td>
<td>May 1, 2015</td>
<td>June 1, 2015</td>
<td>20% of eligible non-facility clients by zip code</td>
</tr>
<tr>
<td>4</td>
<td>April 2015</td>
<td>May 1, 2015</td>
<td>Jun 1, 2015</td>
<td>July 1, 2015</td>
<td>20% of eligible non-facility clients by zip code</td>
</tr>
</tbody>
</table>
| 5      | May 2015     | Jun 1, 2015   | Jul 1, 2015    | August 1, 2015        | 20% of eligible non-facility clients by zip code  
All eligible NF residents in Bexar and El Paso |
| 6      | June 2015    | Jul 1, 2015   | Aug 1, 2015    | Sept 1, 2015          | All eligible NF residents in Harris |
| 7      | July 2015    | Aug 1, 2015   | Sept 1, 2015   | Oct 1, 2015           | All eligible NF residents in Dallas, Hidalgo and Tarrant |
Member Enrollment FAQ’s

Q: Can members opt-out of the demonstration and keep their Medicare & 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 Maximus, the enrollment broker, or Medicare.

Q: Will MMP members have a separate and distinct ID card?
A: Yes. See next slide.
Member ID card

Member Name: <Cardholder Name>
Member ID: <Cardholder ID#>
Health Plan (80840): <Card Issuer Identifier>

PCP Name: <PCP Name>
PCP Effective Date: <PCP Effective Date>
PCP Phone: <PCP Phone>

RxBin: <003858>
RxPCN: <MD>
RxGRP: <WKUA>
RxID: <RxID#1>

[Optional card reader may go here]

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.

En caso de emergencia, llame al 911 o vaya a la sala de emergencia mas cercana. Después de recibir cuidado, llame a su PCP dentro de 24 horas o lo antes posible.

Member Services | Servicios al miembro: <1-855-817-5789 (TTY 1-800-855-2880)>
Behavioral Health | Salud del comportamiento: <1-855-817-5789 (TTY 1-800-855-2880)>
Service Coordination | Coordinador de servicios: <1-855-817-5789 (TTY 1-800-855-2880)>
RX Prior Authorization Fax: <1-800-359-5781>
Website | Sitio web: <www.myamerigroup.com/TXMMMP>
Pharmacy Help Desk: <1-866-805-4598 (TTY 1-800-855-2880)>
Send Claims To: <Claims
PO Box 61010
Virginia Beach, VA 23466-1010>
Claim Inquiry: <1-855-817-5789 (TTY 1-800-855-2880)>
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 transportation, Silver Sneakers fitness program, dental, etc.

• Integrated care and improved coordination with PCP, specialist, behavioral health and LTSS to improve quality of care

See following slides for specific value-added benefits.
STAR+PLUS Medicare-Medicaid Program Services For Your Dual-Eligible Members

If you have Medicaid and Medicare, you’re STAR+PLUS MMP will provide basic health services and medications you’ve been getting through Medicare, plus long term services and supports through Medicaid.

Every STAR+PLUS MMP will offer the same basic health services you’ve been getting through Medicare. These include:

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

In addition to the Medicare services, STAR+PLUS MMP will include Medicaid long term services and supports such as:

- Adult day care
- Adult foster care
- Nursing
- Emergency response services
- Short-term help for caregivers
- Medical supplies
- Assisted living / home care
- Personal assistance (help with dressing, eating, and bathing)
- Adaptive aids (things like walkers and canes)
- Home modifications (things like wheelchair ramps and grab bars)
- Speech therapy (helping you learn to speak again or speak better)
- Occupational therapy (helping you learn to do everyday activities)
- Physical therapy (helping you learn to move around better or become stronger)
- Nursing home services, if you live in a nursing home
# Amerigroup STAR+PLUS MMP Value-Added Benefits

<table>
<thead>
<tr>
<th>Extra services for members</th>
<th>Amerigroup STAR+PLUS MMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-Hour Nurse Line</td>
<td>Yes</td>
</tr>
<tr>
<td>Extra help getting a ride (when state services are not available)</td>
<td>Twenty-four, one-way trips to plan-approved locations every year via taxi, bus/subway or van with prior authorization and referral required</td>
</tr>
<tr>
<td>Extra dental services for adults (age 21 and older)</td>
<td>Comprehensive dental services are limited to $150.00 every three months. Non-routine, diagnostic, restorative, endodontics, periodontics and extractions services with prior authorization and referral required.</td>
</tr>
<tr>
<td>Extra vision services</td>
<td>One pair contact lenses or up to $100 every two years with prior authorization required</td>
</tr>
</tbody>
</table>
| Health and wellness services | • Smoking cessation products and behavioral support once the Medicaid benefit has been exhausted  
  • Twelve visits for cardiac and pulmonary rehabilitation services with prior authorization required (limitations apply)  
  • Six acupuncture and other alternative therapy treatments each year with prior authorization and referral required |
## Amerigroup STAR+PLUS MMP Value-Added Benefits (continued)

<table>
<thead>
<tr>
<th>Extra services for members</th>
<th>Amerigroup STAR+PLUS MMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy play and exercise programs</td>
<td>Membership in Silver Sneakers health club fitness classes (authorization required)</td>
</tr>
<tr>
<td>Extra foot doctor (podiatry) services</td>
<td>One routine foot care visit every three months with prior authorization and referral required (limitations apply)</td>
</tr>
<tr>
<td>Temporary phone help</td>
<td>Free cell phone, up to 250 monthly minutes, extra minutes when enrolled for healthy text messages; unlimited inbound text messages for members in Federal Lifeline program</td>
</tr>
<tr>
<td>Gift programs</td>
<td>• Free first aid kit after completing a personal disaster plan online to all members</td>
</tr>
<tr>
<td></td>
<td>• $5, $10 or $20 debit card for achieving health goals and/or receiving certain health checkups or screenings</td>
</tr>
<tr>
<td></td>
<td>• Member entitled to one gift card annually</td>
</tr>
<tr>
<td></td>
<td>• Call health plan to learn how to qualify for the gift program</td>
</tr>
<tr>
<td>Pest control*</td>
<td>Once every three months to eliminate rodents, roaches and other unsafe pests</td>
</tr>
<tr>
<td>Home visits*</td>
<td>Up to an extra eight hours respite services for non-SPW members age 21 and older</td>
</tr>
</tbody>
</table>

*Services designated with an asterisk (*) are available only to members in the community. All other services are available for both members in the community and members in a nursing facility.*
Provider Value Proposition

- Ease of claim administration
- Dedicated Clinical team to ease practice burden
- Same UM and authorization process
- Dedicated Provider Relations teams:
  - Local help
  - Provider issues/relations
  - Credentialing
  - Provider demographic changes
  - Provider training
Provider Reimbursement

Medicare reimbursement is closely aligned to traditional 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 Medicare-Medicaid Plan (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 1** – 100 percent of Medicaid allowable is less than dual Medicare amount

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

**Example 2** – 100 percent of Medicaid is greater than 100 percent of Medicare

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

$1,000 = payment in full

*(Medicaid will never pay more than Medicare allowed.)*
Claims Submission

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

THE MMP CLAIM SUBMISSION DIFFERENCE:

Providers will only submit claims to Amerigroup for Amerigroup STAR+PLUS MMP members in Texas. 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.

MMP enrollees have no cost-share for any professional or hospital services.

Claims information will be available for Amerigroup STAR+PLUS MMP providers on the secure provider website and Availity.
Claims Submission (continued)

Providers will submit claims electronically to Amerigroup Texas STAR+PLUS Medicare-Medicaid Plan for services provided to MMP members using the same submission processes that exist today.

Paper claims will be mailed to:

P.O. Box 61010 Virginia Beach, VA 23466-101

THE MMP CLAIM SUBMISSION DIFFERENCE:
Providers will only submit claims to Amerigroup TX for Amerigroup Texas STAR+PLUS MMP members. Amerigroup Texas STAR+PLUS Medicare-Medicaid Plan (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 (continued)

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 Medicare-Medicaid Plan (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 secure provider website and Availity for providers.

Service coordinators
The Amerigroup STAR+PLUS MMP will have MMP-specific medical management teams located in all four services counties of Texas. Each member enrolled in the program will have an assigned RN Service Coordinator.
Service Coordination Model

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

**Service Plan**
- Service coordinator makes a minimum of 4 quarterly visits and conducts a comprehensive assessment of all medical, behavioral, social, and long term care needs.
- Service coordinator works with the provider care team of experts to develop a service plan to meet the members needs.
- Member and member’s family reviews the service plan.

**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 service plan.

**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 service plan as needed.
Precertification Requests

Online: providers.amerigroup.com
By phone: 1-866-805-4589
By fax: 1-866-805-4589
• Behavioral health outpatient services: 1-800-505-1193
• Behavioral health inpatient services: 1-877-434-7578
• Therapies, home health, durable medical equipment and discharge planning: 1-888-235-8468
• Concurrent review clinical documentation for inpatient: 1-888-700-2197
Initial admission notification and all other services: 1-800-964-3627

Physical and Occupational Therapy: Fax 1-844-340-6419, Phone 1-844-340-6418
Spine & Back Pain Management procedures Fax 1-844-788-4806, Phone 1-844-788-4805
Radiology (AIM): www.aimspecialtyhealth.com/goweb or call AIM at 1-800-714-0040
Precertification Requests (continued)

Certain services/procedures require precertification from Amerigroup for participating and nonparticipating PCPs and specialists and other providers. Please refer to the list below or the Precertification Lookup tool online, or call Provider Services at MMP Customer Care at 1-855-817-5788 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 health care
- 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 non-emergency service from or referral to a non-contracted Provider
- Durable Medical Equipment (DME)
- Outpatient IV infusion or injectable medications
- Prosthetics
- Certain reconstructive procedures
- Occupational, speech and physical therapy services
- Long Term Services and Supports
Precertification Requests (continued)

Radiology Services
Amerigroup is collaborating with AIM Specialty Health (AIM) to provide certain outpatient imaging utilization management services for STAR+PLUS MMP Members. The ordering provider is responsible for obtaining prior authorization for the following services:

- Computer tomography (CT/CTA) scans
- Nuclear cardiology
- Stress Echocardiography (SE)
- Echocardiogram (Echo)
- Magnetic resonance (MRI/MRA)
- Positron emission tomography (PET) scans
- Resting Transthoracic Echocardiography (TTE)
- Transesophageal Echocardiography (TEE)

Authorization review requests can be initiated by visiting .aimspecialtyhealth.com/goweb or call AIM at 1-800-714-0040 Monday through Friday 8:00 a.m.–5:00 p.m.
Physical and Occupational Therapy
Amerigroup is collaborating with OrthoNet, LLC, to conduct medical necessity reviews for physical therapy, occupational therapy, spine, and back pain management procedures for Amerigroup STAR+PLUS MMP (Medicaid-Medicare Plan) Members. The following procedures must be reviewed by OrthoNet for prior authorization:

- Physical & Occupational therapy
- Spine and back pain management procedures:
  - Epidurals
  - Facet blocks
  - Pain pumps
  - Neurostimulators
  - Spinal fusion
  - Spinal decompression
  - Vertebro/kyphoplast
Precertification Requests (continued)

You may request prior authorization by submitting complete clinical information to OrthoNet Physical Therapy/ Occupational Therapy, Pain Management, and Spinal Surgery by:

Physical and Occupational Therapy
Fax 1-844-340-6419
Phone 1-844-340-6418

Spine and Back Pain Management procedures
Fax 1-844-788-4806
Phone 1-844-788-4805
Provider Quick Facts

• Members will have access to these service partners for MMP, which mirror our partners for Medicaid & Medicare Advantage:
  − DentaQuest
  − OrthoNet
  − Access2Care Transportation
  − Block Vision
  − CPL/LabCorp/Quest

• Dedicated TX MMP 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.  
  https://providers.amerigroup.com
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 (continued)

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her provider and to 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 health care providers.
- Individual preferences affect traditional and nontraditional approaches to health care.
- Patients must overcome their personal biases within health care systems.
- Health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system.
Cultural Competency (continued)

Cultural awareness includes:

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

- Provider Relations Representative
- Medical Management
- Provider Services Call-Line

Provider Services: 1-855-878-1785
Thank You For Partnering With Us