Texas Dual Eligibles Integrated Care Demonstration Project – FAQs about Home Health Services

Under the Texas Dual Eligible Integrated Care Demonstration Project (the Demonstration), individuals will have access to all home health services covered by Medicare and Medicaid. Medicare home health services include intermittent skilled nursing care, physical therapy, continuing occupational therapy, speech–language pathology, home health aide services, and medical social services. Medicaid home health services include nursing services, home health aide services, medical supplies, equipment, and appliances, and physical therapy, occupational therapy, or speech pathology and audiology services.

How will coverage of home health services change in the Texas Demonstration?

Outside the Demonstration, home health services can be covered by either Medicare or Medicaid, depending on the circumstances, and the onus is on the providers to determine when a bill should be sent to Medicare or Medicaid. In the Demonstration, Enrollees will continue to have access to all Medicare and Medicaid benefits to which they are entitled today, including home health services, but these will be covered and reimbursed by a Medicare-Medicaid Plan (MMP). Providers should bill the MMP for all home health services. The MMPs in the Texas Demonstration are called "STAR+PLUS MMPs."

What does the Demonstration mean for home health providers?

For enrollees in the Demonstration, home health providers should consider the following changes:

- Home health providers should bill the STAR+PLUS MMP for all services, rather than bill Medicare or Texas Medicaid separately.
- Except for certain circumstances, a home health agency must be contracted with an enrollee's STAR+PLUS MMP to receive payment.
- Unless a contract between a provider and health plan specifies otherwise, there is no need for provider payment rates to differentiate whether the services are covered through Medicare or Medicaid.
- Home health agencies and STAR+PLUS MMPs may execute contracts with payment terms that are different from Medicare fee-for-service. It presents an opportunity to establish payment models that support best practices in clinical care.

Will the STAR+PLUS MMPs have pre-authorization requirements for home health?

In the Demonstration, as in STAR+PLUS (Medicaid) and Medicare Advantage, STAR+PLUS MMPs may apply prior authorization and other utilization management requirements for home health services, as long as they operate within the contractual definition of medical necessity, which is approved by both Medicare and Texas Medicaid. For 2015, all STAR+PLUS MMPs have received approval to apply prior authorization for home health. Emergency services never require prior authorization.

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Are there any requirements for the STAR+PLUS MMPs to respond to authorization requests in a timely manner?

The STAR+PLUS MMPs are required to make coverage determinations as expeditiously as the enrollee's condition requires but within three (3) business days for standard requests and one (1) business day for expedited requests. Plans must respond to service authorization requests for post-stabilization or life-threatening conditions within one (1) hour.

When an enrollee moves from Medicare FFS to a STAR+PLUS MMP, which entity pays for home health services?

If a beneficiary under Medicare FFS receiving home care enrolls in a STAR+PLUS MMP during an episode, the episode will end and be proportionally paid according to its shortened length (a partial episode payment (PEP) adjustment). The STAR+PLUS MMP becomes the primary payer upon the MMP enrollment date. Other changes in eligibility affecting FFS status should be handled in a similar manner (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf).

When an individual enrolls in a STAR+PLUS MMP, there is a continuity of care period for 90 days for most services and up to 6 months for long-term services and supports (LTSS) where the individual may maintain current home health service authorizations and providers may bill the new plan. After the continuity of care period ends and the enrollee has completed a comprehensive health risk assessment, the STAR+PLUS MMP may update the individualized service plan, issue new home health service authorizations, and help the enrollee transition to an in-network provider as applicable.

If the MMP denies an authorization request for home health services, can the beneficiary or provider appeal the plan's decision?

An enrollee, or a provider acting on behalf of an enrollee and with the enrollee's written consent, may file an appeal. All appeals, including for home health services, should first be directed to the STAR+PLUS MMP. An enrollee may also file a request for a Medicaid fair hearing with the HHSC Appeals Division at any time. Decisions made by the STAR+PLUS MMP that are not fully in favor of the enrollee will be auto-forwarded to the Medicare independent review entity (IRE). If an Appeal is both auto-forwarded to the IRE and the enrollee files for a hearing with the HHSC Appeals Division, any favorable decision from either review entity will be binding, and the STAR+PLUS MMP must pay the home health provider for the service or item that was appealed.

Will home health still be required to complete OASIS documents, obtain face-to-face documentation, and follow Medicare coverage requirements?

Nothing in the Demonstration changes the requirements for Medicare certification for home health agencies. Any HHA seeking Medicare certification is required to meet the Medicare Conditions of

Participation (CoP) prior to certification. This includes compliance with the OASIS (the Outcome and Assessment Information Set) data set collection and transmission requirements.

As in Medicare Advantage, an MMP's authorization for home health services may substitute for the Original Medicare face-to-face certification requirement for the authorization of home health care services. In certain circumstances, MMPs are not required to follow Original Medicare documentation requirements for the provision of Medicare covered services, but may substitute methods they deem appropriate for ensuring that the services provided are medically necessary, so long as they are not more restrictive than the coverage standards that apply in Original Medicare.

Under the Demonstration, home health providers will bill all home health services directly to the STAR+PLUS MMP. If a determination of medical necessity is made for home health services, then Medicare homebound requirements are not relevant for purposes of enrollee access to services.

Will providers still be required to deliver advance beneficiary notices when home health services are reduced?

Providers serving MMP enrollees should follow the Medicare Advantage procedures for advance beneficiary notices, not the fee-for-service rules. Under Medicare Advantage, providers do not issue advance beneficiary notices to beneficiaries. The same rules apply to MMPs. Reductions in services require the plan, not the provider, to issue an Integrated Denial Notice. Providers should consult with their plan if they have questions.

Note, however, rules governing the issuance of the Notice of Medicare Non-Coverage (NOMNC) remain in place. When Medicare services are terminating, a Medicare provider (or health plan, but usually the provider) must give beneficiaries a completed copy of the NOMNC. The NOMNC informs individuals of their right to an immediate, independent review of the proposed discontinuation of covered services.

In accordance with Medicare rules, the NOMNC should only be issued when services are terminating due to lack of medical necessity. In an integrated STAR+PLUS MMP, if a beneficiary continues to receive home health services because he/she meets the Medicaid standard for home health services, issuing the NOMNC would be unnecessary and confusing to the beneficiary.