08/19/2024

Request for Managed Care Organization Feedback about Rider 32 Implementation

Background:

As required by the 2024-2025 General Appropriations Act, House Bill 1, 88th Texas Legislature, Regular Session, 2023 (Art. II, HHSC, Rider 32), the Texas Health and Human Services Commission (HHSC) must transition to Medicaid-only services for dually eligible people enrolled in Medicaid managed care from a fee-for-service (FFS) to a managed care service delivery system.

Currently, for dually eligible individuals enrolled in Medicaid managed care:

- Medicaid managed care organizations (MCOs) cover long-term services and supports;
- Medicare covers most acute care services; and
- HHSC's FFS Medicaid claims administrator covers Medicaid-only (i.e., not covered by Medicare) acute care services.

To implement Rider 32, HHSC must transfer the responsibility for covering Medicaid-only acute care services for dually eligible managed care members from HHSC's FFS Medicaid claims administrator to Medicaid MCOs. These Medicaid-only acute care services are limited to the managed care services that MCOs already cover for their members who do not have Medicare. Services provided via FFS for all Medicaid beneficiaries, such as pediatric nursing facility services, are not impacted by this transition. Providers will bill an MCO directly for the Medicaid-only acute care services provided to dually eligible members.[1]

In the September 2024 contract amendment cycle, HHSC modified the STAR+PLUS, STAR Kids, and STAR Health contracts to specify that, on the effective date established by HHSC, Medicaid wrap-around services for which MCOs are responsible must include all Medicaid managed care covered services not already covered by Medicare.[2] MCOs must also:

· not require a provider to submit a Medicare denial or explanation of benefits with a prior authorization request or claim for a Medicaid wrap-around service that is a covered service but is not covered by Medicare; and

· ensure continuity of care as part of this transition.

MCOs are contractually required to ensure their providers and dually eligible members are informed about the upcoming changes to the covered managed care services. MCOs must:

· notify providers about changes impacting the prior authorization[3] and claims submissions processes in advance.[4]

· educate members about changes to covered services, notifying all applicable existing dually eligible members through a written notice, such as a mailed letter or electronic mail, within a timeframe approved by HHSC.

· revise and gain approval of the member handbook or provide an insert informing members of changes to covered services, upon HHSC notification and at least 30 days prior to the effective date of such change in covered services.[5]

Summary of Request:

From this point forward in this notice, "MCOs" refers to STAR+PLUS, STAR Kids, and STAR Health Medicaid MCOs.

MCOs are not responsible for implementing Rider 32 by September 1, 2024. HHSC plans to implement these changes in March 2025 or September 2025.

HHSC is requesting feedback from MCOs about the implementation of Rider 32 as described in the "Action" section of this MCO notice. Information requested includes the operational changes, system changes, and the time MCOs need to implement these and other requirements. Below are potential impacts for MCOs to consider while responding to the questions.

To implement Rider 32, MCOs must cover, as Medicaid wrap-around services for their dually eligible members, all covered Medicaid services that are not covered by Medicare. These services are limited to the managed care services that MCOs already cover for their members who do not have Medicare.[6]

HHSC anticipates the following impacts to MCOs.

- By the date established by HHSC, MCO systems must:
    - have the functionality and business rules to identify the Medicaid services not covered by Medicare as of the date on the prior authorization or the claim's date of service.
    - maintain an up-to-date list of Medicare services to compare to the Medicaid services on prior authorization requests and claims.
    - have automated processes that protect against requiring a Medicare denial or explanation of benefits to process prior authorizations and claims.
- MCO networks may be impacted if dually eligible members are using Medicaid acute care providers that are not in the MCOs' networks.
- MCOs may need to modify their contracts with providers because of Rider 32 implementation.
- MCOs may need to update member and provider materials to clarify that the MCO will cover all Medicaid covered services not covered by Medicare for its dually eligible members.
    - MCOs must also send the required advanced written notice to members and providers.

HHSC's FFS Medicaid claims administrator will forward to MCOs the Medicaid-only acute care claims submitted by FFS providers in error. HHSC will conduct trader partner testing on this functionality with MCOs. Also, 180 days in advance of the implementation date, HHSC will conduct a readiness review on items such as the MCOs':

- prior authorization and claims processes;
- Systems; and
- the revised member and provider materials.

Action:

HHSC requests that MCOs provide written responses using the attached Rider 32 Implementation Survey template by close of business, **Friday, August 30, 2024.**

Email your responses to Managed_Care_Initiatives@hhs.texas.gov, copying your MCCO monitoring team, with the subject line: Rider 32 Implementation.

Resources:

Managed Care Organization Feedback about Rider 32 Implementation Survey Template FINAL (attached)

Footnotes for Aug. 19 MCO Notice “Request for Managed Care Organization Feedback about Rider 32 Implementation” (attached)

Contact:

Managed_Care_Initiatives@hhs.texas.gov

Attachment:

Managed Care Organization Feedback about Rider 32 Implementation Survey Template FINAL. docx Footnotes for Aug. 19 MCO Notice “Request for Managed Care Organization Feedback about Rider 32 Implementation”.docx

Type: Action Required

To: STAR+PLUS; STARHEALTH; STAR_KIDS

From: Policy