Volunteer State Health Plan - Dual Special Needs Plan (VSHP D-SNP)

Frequently Asked Questions

For Distribution to THA

Why is VSHP adding Medicare Advantage Dual Special Needs Plan?

Over the past few years, the Centers for Medicare & Medicaid Services (CMS) and the State of Tennessee (State) have increased efforts to coordinate the care of people enrolled in both Medicare and Medicaid (dual eligible enrollees). After the implementation of the CHOICES program, it has become more critical that VSHP develop a dual special needs plan to help coordinate the care of members enrolled in the CHOICES program.

What is a Dual Special Needs Plan (D-SNP)?

A Dual Special Needs Plan is a Medicare Advantage HMO that is only for Medicare members who also have Medicaid. These plans are labeled special needs plans because they serve membership that requires a higher level of care coordination.

What is the effective date of the VSHP D-SNP?

The implementation date of VSHP D-SNP is January 1, 2014.

Is this TennCare Plus?

This D-SNP is not part of the of the TennCare Plus program that the Bureau of TennCare has proposed to CMS under the Capitated Financial Alignment Demonstrations Initiave. VSHP has formally expressed its support of the TennCare Plus proposal.

Is this a BlueAdvantage Health Plan?

Although VSHP will use some of the same staff as Blue Advantage to perform certain functions, the VSHP D-SNP is not Blue Advantage. The VSHP D-SNP will most likely be named BlueCare Plus.

When will the D-SNP section of the VSHP Provider Administration Manual be available?

We should complete the D-SNP section of the VSHP PAM by July 1, 2013.

Why is VSHP contracting the network at this time for a plan that will not start until 1/1/2014?

VSHP is currently developing requirements and other pertinent elements needed to implement its D-SNP. We are developing our D-SNP Health Care Professional Network at this time due to the D-SNP application process required by CMS. VSHP will file its application with CMS to become a D-SNP around February 2013. A requirement of the application is the filing of a Health Care Professional Network that meets CMS guidelines for network adequacy. Therefore, VSHP must develop the network for the D-SNP well before the implementation date.

Do other TennCare managed care companies have dual special needs plans?

Yes, two other TennCare MCOs have a dual special needs plan in Tennessee. However, one of the plans does not serve the entire state. The two other D-SNP offered by TennCare MCOs are Amerivantage Specialty+Rx (AmeriGroup) and United Health Care Dual Complete.

Who should providers contact with questions about the implementation of the VSHP D-SNP program?

Providers with questions about the implementation of the VSHP D-SNP may contact their local Provider Network Manager, or visit the Provider page of our company website at VSHPTN.com

Do we have a dual special needs (D-SNP) program now?

VSHP does not have SNP right now.

How many of the duals are eligible for the D-SNP?

Almost all of the Duals are eligible for D-SNP. In Tennessee, there are approximately 135,000 dual members eligible for D-SNPs.

There are 135,000 duals across the state and 40% are enrolled VSHP's TennCare plan. Is the Special Needs Program a sub-set of Duals?

SNP members are a sub-set of dual eligible members. However the 135,000 members are all eligible to be enrolled in a VSHP D-SNP.

Will we be able to market the program to all duals?

Yes, we are eligible to market to all 135,000 duals, but we will focus on the 50,000 with a relationship with VSHP first.

What will the member benefit package look like?

It will have a cost share that is similar to Original Medicare. However, the Bureau of TennCare is responsible for the payment of the cost sharing.

What would the Member Cost Sharing consist of under this plan? Would these patients still have a Medicare deductible and copay? Or would the Cost Sharing be structured completely differently from current Medicare Cost Sharing amounts?

We are still evaluating the member's cost sharing. However, it will be similar to Medicare Fee-For-Service. The Bureau of TennCare will be responsible for reimbursing the hospital for any member cost sharing. Additionally, VSHP has entered into an agreement with TennCare to send them the Medicare D-SNP claims that we process and TennCare will process the cost sharing based on the information that we send them. Therefore, the provider will not be required to bill the Bureau of TennCare directly to receive any TennCare cost sharing reimbursement. This is similar to the process that is used today for Fee-For-Service Medicare. However, our process with TennCare should work better because we have years of experience submitting claims data to the Bureau of TennCare and should have a very high pass rate.

Is the provider required to send a claim to TennCare to receive a payment for the member's cost sharing?

VSHP has entered into an agreement with TennCare called the MIPPA that requires VSHP to coordinate the cost sharing payment with the Bureau of TennCare. Therefore, VSHP will send claim processed by our organization directly to the Bureau of TennCare via 837 format to be processed for cost sharing.

How will the members know which card to give providers?

The provider will need a copy of both cards, but instead of using Medicare, they will have BlueCare Plus.

Will there be education for the providers or members?

Yes, members may give the wrong card and providers will bill to the wrong place. Internally, if a member has BlueCare and a D-SNP, we should be able to coordinate and cross claims for them. If the member does not have VSHP's TennCare plan and does have the VSHP D-SNP, VSHP will coordinate with TennCare and the member's TennCare MCO to the extent allowed/required by the MIPPA agreement.

What are the network requirements?

Requirements differ by county based on the CMS requirements. We may have to request exceptions for some specialties, the same as we do now for the TennCare plan.

The amendment states the payment rate is 100% of Current Year Medicare Per-Diem Rate for rehabilitation facilities. Does this means the per diem rates assigned to various RUG scores derived from MDS assessments?

Yes, we are going to follow the Medicare payment structure to the extent possible. Right now, we do not know of any road blocks to using the Medicare RUG structure and the payment they get from the D-SNP should be the same the payment they get from Medicare for similar services.

Will there be out of network benefits? If the program is currently contracted with Tenncare will they still be able to see these members without signing the amendment?

We will only provide out of network benefits if the member has an emergent or urgent condition that needs to be treated. This is required for all D-SNPs. Therefore, we basically do not have any out of network benefits that are not required by Medicare.

If a provider has opted out of Medicare, does this affect their ability to contract for D-SNP?

Opt-Out Providers *(Medicare Managed Care Manual)*

If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of 2 years. The only exception to that rule is for emergency and urgently needed services where a private contract had not been entered into with a beneficiary who receives such services. See 42 CFR 405.440. An MA organization must pay for emergency or urgently needed services furnished by a physician or practitioner to an enrollee in their MA plan who has not signed a private contract with a beneficiary, but may not otherwise pay opt-out providers. Information on providers who opt-out of Medicare may be obtained from the local Medicare Part B carrier. The MA organization must check this list on a regular basis.

(Source: 42 CFR 422.204(b)(4) and 42 CFR 422.220 and additional instructions.)