Diamond State Health Plan Plus Program
Managed Long Term Care

QUESTION & ANSWERS

OCTOBER 2011

QUESTION BY CATEGORY	ANSWERS
General Provider Questions	
1. If we are a current Waiver provider, do we have to apply with the Managed Care Organizations (MCOs)?	Yes.
2. Will the contract shift from the state to the MCOs?	Yes.
3. Can we have more details about the contract transition?	The MCOs will be approaching current Waiver providers to initiate contract negotiations.
4. Will the MCO take over as intermediary for billing?	The providers will be billing the MCOs and the MCOs will be paying the providers.
5. What will the reimbursement schedule be with the MCO?	The MCOs will be negotiating rates with community-based providers. DMMA will continue to set the rates for nursing homes and the MCOs will pay the nursing homes the rates established by DMMA. This will be revisited as the program progresses.
6. Who are the MCOs?	The State plans to contract with Delaware Physicians Care, Inc. (DPCI) and UnitedHealthcare Community Plan (previously known as Unison Health Plan of Delaware).
7. Will there be a transition period for agencies who are not Medicare certified?	The Waiver providers should connect with the MCOs to discuss this question.
8. Do you foresee a change in the current reimbursement for providers?	The MCOs will be negotiating rates with community-based providers. Waiver providers should connect with the MCOs.
9. After the transition to the MCOs, will the prior authorization process change?	The MCOs will have their own prior authorization process. Waiver providers should connect with the MCOs.
10. What will be the procedure for assigning new cases?	Each current Long Term Care Medicaid and Dual eligible (Medicare and Medicaid) client will need to choose between the two MCOs. Current clients' community based services will remain unchanged until the MCO has assessed the client. All clients have the right to choose their direct service provider from the list of MCO-enrolled providers.

11. Will the MCOs provide the electronic billing system and will it be the same billing system?	The MCOs have their own electronic billing system. Waiver providers should connect with the MCOs.
12. When will the providers hear from the MCOs?	The MCOs are very anxious to connect with the providers as soon as possible. Providers may also reach out directly to the MCOs.
13. Who will be the case managers?	The MCOs will be responsible for case management. They may hire case managers or contract the service.
14. Will all the Diamond State Health Plan clients automatically be a part of the Plus program?	No. The Diamond State Health Plan Plus Plan requires clients meet certain level of care and financial tests in order to be eligible for long-term care services and supports.
15. Are home visits expected to continue?	Yes. The MCOs will be required to make home visits.
16. Will the services remain the same for 90 days?	Yes, care plans will remain the same for at least 90 days or until the MCOs make a home visit to evaluate the client.
17. Will the MCOs require Medicare certification?	Providers of services that are eligible for Medicare reimbursement will continue to be required to be Medicare certified. Providers should contact the MCOs to discuss their requirements.
18. Will the MCOs negotiate rates with the provider?	Yes, the MCOs will negotiate rates with community-based providers.
19. If a client needs services in their home, does Long Term Care Medicaid look at caregiver availability before approving hours?	Currently the client's formal and informal supports are taken into consideration in determining the services needed. This will continue to be the case.
20. When DSHP Plus is implemented and we screen a client on the DMAP website, will the site make the distinction between DSHP and DSHP Plus.	Yes.
21. Will individuals who need behavioral health or substance abuse services be enrolled in Diamond State Health Plan Plus?	The majority of Medicaid recipients are already enrolled in managed care organizations (MCOs) through the existing Diamond State Health Program (DSHP). The MCOs are responsible for covering 20 outpatient and 30 inpatient visits for behavioral health and substance abuse. Services in excess of these limits are provided as a fee-for-service wraparound. Individuals who are determined to have a Severe and

	Persistent Mental Illness (SPMI) also receive services on a fee-for-service basis, with care management provided by the Division of Substance Abuse and Mental Health. Individuals who are enrolled in Diamond State Health Plan Plus (full dual Medicare/Medicaid eligibles, HCBS recipients, and Nursing Facility Residents) will receive the same behavioral health and substance abuse coverage as that described above.
22. Will individuals who transition out of facilities through the MFP program be enrolled in Diamond State Health Plan Plus?	Individuals who transition to the community from nursing facilities, Stockley Center, or Delaware Psychiatric Center will be enrolled in Diamond State Health Plan Plus.
23. Please clarify the exclusion related to individuals with developmental or cognitive disabilities.	Individuals who are enrolled in the Developmental Disabilities Home and Community-Based Services waiver are not currently included in the waiver to implement Diamond State Health Plan Plus. Services for these individuals will continue to be paid on a fee-for-service basis. Medicaid individuals with developmental disabilities who are not served under the DDDS HCBS Waiver program are already being served by our MCOs under DSHP if they do not also have Medicare. Those individuals who have both Medicaid and Medicare will be enrolled in a MCO under DSHP Plus effective 4/1/12. However, DMMA will continue to cover any DDDS Day Habilitation service they receive under the State Plan and fee-for-service.
Hospice Questions	
24. When billing the MCO's are they paying for room and board?	MCOs and the Hospice providers will need to negotiate through contract negotiations.
25. What are the revenue codes?	The MCOs will provide the Hospice providers with the revenue codes.
26. Will there be a pass through billing?	The hospice providers will be paid by the MCOs.
27. What will be the reimbursement rate?	The reimbursement rates are part of the contract negotiations with the MCOs.
Nursing Facility Questions	
28. For a dual eligible patient when a patient is covered under Part A Medicare, will the Medicare rate be	The Plus Program (Managed Long Term Care) will not impact Medicare rates or payment. Medicare will continue to be primary.

paid at the same rate in place prior to the inception of managed care; or will the integration of Medicare and Medicaid benefits somehow impact the Medicare rate for full-eligible dual eligibles?	
29. How will the current Medicaid rates with all the levels and "add-ons" on many of these rates be handled under a managed care model?	We are exploring the elimination of the "add ons" but are just in the preliminary planning stages. We will involve the nursing homes in this process. Should the ultimate decision be made to eliminate the "add-ons", it would collapse the virtual 32 levels into 9. The money that would normally be paid out via add ons could then be folded into the nursing homes' base rates.
30. Will there be a hold harmless built-in for some period of time for providers so their Medicaid payments with managed care are not lower than the Medicaid rates in place prior to the implementation of managed care?	As a matter of policy, DMMA will require the MCOs to pay nursing facilities rates equivalent to what fee-for-service would have paid for the first three years of the DSHP Plus program and the capitation rates will reflect this policy.
31. How will rate changes occur under a managed care level?	The Medicaid Reimbursement Team will continue to set the reimbursement level for nursing home residents. DMMA will continue to establish the rates using the nursing homes' cost reports following the normal process.
32. Will January still be the effective date for rate changes?	Yes, the reimbursement schedule will remain the same.
33. When is it anticipated that the payments for the nursing homes under a managed care model will be lower than payments that would be made to nursing homes under the current payment system?	DMMA will continue to set the nursing homes' payment rates for at least three years. We will revisit this as we approach the three-year mark.
34. One of the exclusions mentioned is "Dual eligibles other than full-benefit duals". Can you please provide a definition of this type of Dual Eligible versus what providers may typically think of as a Dual Eligible?	A partial dual eligible is a typical QMB (Qualified Medicare Beneficiary). Under this program, Medicaid pays the patient's Medicare Premium, co insurance and deductibles only. The patient is not eligible for full Medicaid benefits. A full dual is someone who has full Medicaid and full Medicare coverage.

35. What does it mean, "patients whose needs can no longer be safely handled in the community can be granted an exception"? That note is a footnote to the table listed above.	This is in reference to a possible change in the Assisted Daily Living (ADL) requirement for nursing home placement. This has not been approved by CMS. This is still under exploration.
36. Will ADLs of 3 or more automatically qualify an individual for nursing home admission?	We are still exploring changing the ADL requirement from the individual having to need assistance with one ADL to qualify medically for Medicaid nursing home coverage to having to need assistance with two or more ADLs. Should that change occur, we would expect that individuals needing assistance with 3 or more ADLs who prefer to receive their care in a nursing home would qualify medically for Medicaid nursing home coverage.
37. Will the reimbursement rates for nursing homes as of the inception of managed care be impacted in any way?	No, the nursing home rates will pass through the MCO but be set by the state.
38. Has statutory language been drafted addressing Medicaid Managed Care Long Term Care Policy Considerations? If so, can it the language please be provided.	Not at this time. The DMMA policy unit is working on amending DMMA's policy as needed. Every policy change will be published for comment.
39. Can you provide a more detailed implementation timeline?	This timeline was provided at our meeting and a copy can be found on the web site.
40. Will the Plans be allowed to exclude any provider from their network at any time? If so, for what reasons?	The Plans will be required to contract with all current Delaware Medicaid enrolled nursing facilities. It is possible that a nursing home would refuse to contract with a MCO. If this should occur and the nursing facility has Medicaid patients, the MCO would pay the facility as a non-participating provider at a reduced rate.
41. Will there be two types of plans for recipients or only one?	We are not certain if you are asking about Health Plans or Plan Benefits. If you are asking about Health Plans, then there will be two Health Plans for recipients to choose from. If you are asking about Health Benefits, then full duals in the

	community that do not qualify medically and financially for Long Term Care Medicaid services will receive the same benefit package that current Diamond State Health Plan programs recipients receive and will not receive the enhanced long term care services that those that qualify medically and financially for Long Term Care Medicaid services. Those that qualify for Long Term Care Medicaid services will receive all of the services that current Diamond State Health Plan members receive plus the enhanced long-term care services.
42. What incentives will be established with individual health plans as part of the procurement/contracting process to maximize appropriate safe community placement?	The details are being worked out now. The State will retain a strict quality oversight for this program.
43. What performance measures will there be in place to ensure quality care is being provided to clients (outside of skilled nursing facility settings) and what checks and balances will there be in place to ensure that the client is placed in the most appropriate setting and not the least costly setting.	The MCO contract and quality strategy is currently being developed. Delaware is committed to finding the most appropriate and safe setting for clients.
44. How many levels of care are envisioned for the program? Who will determine these levels of care?	We need clarification regarding what you are asking. DMMA will determine if DSHP Plus applicants meet the medical eligibility requirement for the program. If you are asking about nursing home reimbursement rates, please see the response to question #2.
45. Who will provide the counseling to clients who have to make a decision regarding placement?	This will be the responsibility of the MCOs with oversight by the State. In addition, the Aging & Disability Resource Center (ADRC) staff within the Division of Services for Aging & Adults with Physical Disabilities provide options counseling for individuals facing these types of decisions. Ultimately, placement is the client's decision.
46. How will assignment to the MCO work? If the recipient fails to choose a	There will be a 50/50 auto assignment to the plans if the

plan, how will this work?	client fails to choose a plan within 30 days. The client will have a 90-day period to change plans for any reason. In addition, a client can change Plans for "good cause" at any time. Finally, all clients can change Plans for any reason during the annual Open Enrollment process.
47. How will this work if the client is enrolled in a Medicare Advantage Plan or Special Needs Plan?	Medicare and the Advantage or Special Needs Plan will be primary and the Medicaid MCO will pay co-pays, deductibles and for services not covered by Medicare. We will be exploring how to better coordinate care between Special Needs Plans and Medicaid MCOs in the future.
48. Has language been drafted to establish an independent appeal process for denial of claims and/or coverage?	The MCOs are already required to have an internal appeal process for members and for providers. DMMA has staff on the MCOs member appeal board. In addition, members may also petition separately through the State's appeal process.
49. Who will set the rates?	Delaware Medicaid will set the nursing home rates.
50. Will the Plans be allowed to pay higher rates for patients requiring medically complex services such as ventilator care?	Delaware Medicaid will set the nursing home rates.
51. How will the establishment of a Delaware Quality Improvement Fund (provider tax) be incorporated into the program?	Funds from the tax would be taken into account by the Medicaid when it establishes the nursing home rates. These rates would be passed on to the MCOs, which would be contractually required to pass the rates on to the nursing homes.
52. How will this be designed and protected? Prompt payment contract must be part of the contract with the MCOs and be set at 14 days for clean claims.	There are prompt pay requirements in the MCO contracts.
53. What contractual obligations will be imposed on the MCOs with regard to billing systems and claims processing?	There are contractual requirements regarding billing systems and prompt pay requirements.

54. What is the plan or process to ensure that Medicare crossover claims are processed properly and that documentation is sufficient to support federal requirements for Medicare bad debt?	This will be a part of the discussion with the MCOs.
55. What are the proposed retroactive Medicaid eligibility standards?	Eligibility rules will remain the same and should Medicaid approve a nursing home resident for retroactive Medicaid eligibility, the MCO will be required to pay the nursing home for the care provided retroactively.
56. What are the plans for including quality outcomes data reporting by the MCOs?	This will be addressed in the Quality Strategy and is being developed now.
57. MCOs must be held accountable alongside providers for outcomes.	We agree.
Consumer Questions	
58. Who are the MCOs?	The State plans to contract with Delaware Physicians Care, Inc. (DPCI) and UnitedHealthcare Community Plan (previously known as Unison Health Plan of Delaware).
59. Will the eligibility requirements (medical and financial) remain the same?	For community-based services, yes. DMMA is evaluating whether it will change medical eligibility for nursing home care from the current criteria of assistance with 1 Activities of Daily Living (ADL) to needing assistance for 2 or more ADLS. Financial eligibility requirements for community-based and nursing home services will remain unchanged.
60. Will clients who are currently open in Long term Care Medicaid have to reapply or recertify?	No. They will automatically be approved for Diamond State Health Plan Plus. They will however, need to enroll in a managed care plan.
61. Currently there is a $2500/lifetime transition services benefit for the Money Follow the Person (MFP) program. Will this be available after 2016 when the MFP grant period ends?	Should CMS not renew MFP after 2016, we will determine whether to add Transition Services as a permanent DSHP Plus enhanced service.
62. The 1115 Waiver Amendment states,	Yes, after the initial 90 days if the MCO case manager

"If, at the time of implementation, an individual is currently receiving HCBS under the E/D or Aids section 1915(c) waiver and continues to meet a nursing facility level of care, the member will continue to receive HCBS from their current provider(s) for at least 90 days and until a care assessment has been completed by and MCO case manager." Does this mean the type and amount of services can change depending on the new care plan developed by the MCO case manager?	determines that the services should change they can implement the change. If the services decrease, they will have to request permission from the state.
63. Will both MCOs be required to have identical services and policies in determination and delivery of services?	Yes, but the MCOs will have the option of providing more services.