DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

PROPOSED

PUBLIC NOTICE

Diamond State Health Plan Plus
Various Related Policies in the Division of Social Services Manual

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) intends to amends policies in the Division of Social Services Manual (DSSM) related to the implementation of Diamond State Health Plan Plus.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Planning & Policy Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 by April 30, 2012.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSAL

The proposal described below amends policies in the Division of Social Services Manual (DSSM) related to the implementation of Diamond State Health Plan Plus.

Statutory Authority

- 42 U.S.C. §1315, *Demonstration projects*
- Social Security Act §1115, *Demonstration projects*

Background

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach has not been demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.

Under a waiver authority of Section 1115(a) of the Social Security Act, the Diamond State Health Plan (DSHP) implemented a mandatory Medicaid managed care demonstration program statewide on January 1, 1996. Using savings achieved under managed care, Delaware expanded Medicaid health coverage to additional low-income adults in the State with incomes less than 100% of the Federal Poverty Level (FPL).

Effective April 1, 2012, the Division of Medicaid and Medical Assistance (DMMA) implements its 1115 Demonstration Waiver to integrate primary, acute and long-term care (LTC) services for the elderly and persons with physical disabilities into the Diamond State Health Plan (DSHP) statewide program under the name “Diamond State Health Plan Plus.”

Summary of Proposal

DMMA is leveraging the existing DSHP 1115 demonstration waiver by expanding it to include full-benefit dual eligibles, individuals receiving institutional LTC (excluding the developmentally disabled population), and individuals enrolled in DMMA’s Elderly and Disabled and AIDS section 1915(c) waivers.

The purpose of this regulatory action is to inform the public of policy revisions and additions to the Division of Social Services Manual (DSSM) to reflect the expansion of the Managed Care program to include full-benefit dual eligibles and Long Term Care Medicaid.

The proposed changes affect the following policy sections:

DSSM 14920 *Enrollment in Managed Care*

DSSM 14920.1, *Retroactive Coverage Limitations*

DSSM 17913, *Premium Requirements*

DSSM 17914, *Managed Care Enrollment Requirements*
DSSM 20100, *Long Term Care Introduction*
ADDED:
DSSM 20110, *Managed Care Enrollment Requirements*
DSSM 25110, *Managed Care Enrollment Requirements*

Fiscal Impact Statement
The proposed regulation imposes no increase in cost on the General Fund.

DMMA PROPOSED REGULATION #12-09
REVISIONS:

14900 Enrollment In Managed Care

On May 17, 1995, Delaware received approval from the Centers for Medicare and Medicaid Services (CMS) for a Section 1115 Demonstration Waiver that is known as the Diamond State Health Plan. The basic idea behind this initiative is to use managed care principles and a strong quality assurance program to revamp the way health care is delivered to Delaware's most vulnerable populations. The Diamond State Health Plan is designed to provide a basic set of health care benefits to current Medicaid beneficiaries as well as uninsured individuals in Delaware who have income at or below 100% of the Federal Poverty Level (FPL). The demonstration waiver will mainstream certain Medicaid recipients into managed care to increase and improve access to medical services while improving cost effectiveness and slowing the rate of growth in health care costs.

Program Expansions

Effective July 1, 2002, a ~~Medicaid only~~ State operated managed care organization, Diamond State Partners, ~~is~~ was implemented. Eligible individuals may enroll in either the Diamond State Health Plan or Diamond State Partners.

Effective April 1, 2012, the Diamond State Health Plan is expanded to include Long Term Care Medicaid and other full-benefit dual eligibles. This Long Term Care Managed Care Program is called Diamond State Health Plan Plus. Long Term Care Medicaid recipients and other full-benefit dual eligibles must enroll in Diamond State Health Plan Plus.

Managed Care Eligibility

The majority of the Medicaid population receiving ~~non institutional~~ Medicaid services will be enrolled into the Diamond State Health Plan, Diamond State Health Plan Plus, or Diamond State Partners. The following individuals cannot enroll in Diamond State Health Plan, Diamond State Health Plan Plus, or Diamond State Partners:

a. Individuals entitled to or eligible ~~to enroll in~~ for a Medicare Savings Program (QMB, SLMB);
b. Individuals residing in an ~~nursing facility or~~ intermediate care facility for the ~~mentally retarded~~ developmentally disabled (ICF/MR);
c. Individuals covered under the ~~home and community based waivers~~ Developmentally Disabled waiver program;
d. Individuals that choose to participate in the Program of All-inclusive Care for the Elderly (PACE);
~~d.~~ e. ~~non~~ Non lawful and non qualified non citizens (aliens);
~~e. individuals who have Military Health Insurance For Active Duty, Retired Military, and their dependents~~
f. Individuals eligible under the Breast and Cervical Cancer Treatment Group;
g. Presumptively eligible pregnant women;
h. Individuals ~~eligible under Medicaid for Workers with Disabilities~~ in need of only the 30-Day Acute Care Hospital program.

(Break in Continuity of Sections)

14920 Retroactive Coverage

The agency must make eligibility for Medicaid effective no later than the third month before the month of application if the individual:

- received Medicaid services, at any time during that period, of a type covered under the plan; and
- would have been eligible for Medicaid at the time he received the services if he had applied (or someone had applied for him, regardless of whether the individual is alive when application for Medicaid is made).

Effective April 1, 2012, those that may be found eligible for retroactive Medicaid coverage include:

a. Individuals entitled to or eligible for a Medicare Savings Program (excluding QMB);
b. Individuals residing in a nursing facility;

c. Individuals residing in an intermediate care facility for the developmentally disabled (ICF/MR);

d. Individuals in need of only the 30-day Acute Care Hospital Program;

e. Women eligible under the Breast and Cervical Cancer Treatment Group;

f. Individuals eligible under the Medicaid for Worker's with Disabilities Group.

14920.1 Retroactive Coverage Limitations

Effective January 1, 1996, retroactive Medicaid coverage is NOT available to any individual who, in the month of application, is eligible for enrollment under the *Diamond State Health Plan* or *Diamond State Partners.*

~~Individuals who are excluded from the *Diamond State Health Plan* or *Diamond State Partners* may be found eligible for retroactive Medicaid coverage. These individuals include:~~

~~a. those entitled to or eligible to enroll in Medicare,~~

~~b. those receiving long term care services (nursing facility and the home and community based waivers),~~

~~c. those living out of state but considered Delaware residents, such as a child placed out of state by DSCYF, and~~

~~d. individuals who have coverage under Military Health Insurance For Active Duty, Retired Military, and their dependents~~

Effective April 1, 2012, retroactive Medicaid coverage is not available to most individuals who, in the month of application, are eligible for enrollment under the Diamond State Health Plan Plus.

See DSSM 14920 for eligibility groups that may be found eligible for retroactive Medicaid coverage.

(Break in Continuity of Sections)

17913 Premium Requirements

Individuals with countable income over 100% FPL are required to pay a monthly premium to receive coverage. Countable income is the same amount that is used to determine eligibility.

When a husband and wife are both MWD eligible, a monthly premium is assessed on each spouse.

The monthly premium will be based on a sliding scale as follows:

Percentage of FPL	Monthly Premium
101-125%	$25
126-150%	$35
151-175%	$45
176-200%	$60
201-225%	$75
226-250%	$90
251-275%	$105

Exception to sliding scale: An individual or couple whose adjusted gross annual income (as determined under the IRS statute) exceeds $90,008 must pay the highest premium amount listed on the sliding scale. This adjusted gross annual income amount will increase each year by the COLA.

A premium is assessed the month an individual is added for coverage including any months of retroactive eligibility. Eligibility for a month is contingent upon the payment of the premium.

Payments that are less than one month's premium will not be accepted.

A monthly premium notice for ongoing coverage will be sent to the individual. The premium is due by the 15th of the month for the next month's coverage. ~~When the premium is not received by the date due, action will be taken to terminate eligibility under MWD. If the premium is received by the last day of the month, eligibility under MWD will be reinstated.~~

Coverage will be cancelled when the individual is in arrears for two premium payments. The coverage will end the last day of the month when the second payment is due. If one premium payment is received by the last day of the cancellation month, coverage will be reinstated.

Coverage continues pending a fair hearing decision if the fair hearing request is filed within the timely notice period, even if the individual is not paying premiums that are due.

17914 Managed Care Enrollment Requirements

Individuals who are found eligible must enroll with a managed care organization. The Health Benefits Manager (enrollment broker) will be responsible for the enrollment process.

(Break in Continuity of Sections)

20100 Long Term Care Introduction

~~There are three major programs~~ Programs under Long Term Care (LTC) Medicaid include:

- ~~Nursing Facility Program~~
- ~~Long Term Acute Care Program~~
- ~~HCBS Wavier~~
- ~~Elderly and Disabled Waiver~~
- ~~AIDS/HIV Waiver~~
- ~~Mental Retardation Waiver~~
- ~~Assisted Living Waiver~~
- Diamond State Health Plan Plus
  - Nursing Facility Program
  - Long Term Care Community Services
- Program of All-inclusive Care for the Elderly (PACE)
- Developmentally Disabled Waiver
- Long Term Acute Care Program

Common to all ~~three~~ long term care programs is the ~~need~~ requirement to be medically and financially eligible. ~~A description of each program and eligibility criteria follows.~~

20110 Managed Care Enrollment Requirements

Individuals who are found eligible must enroll with a managed care organization. The Health Benefits Manager (enrollment broker) will be responsible for the enrollment process.

(Break in Continuity of Sections)

25110 Managed Care Enrollment Requirements

Individuals who are found eligible must enroll with a managed care organization. The Health Benefits Manager (enrollment broker) will be responsible for the enrollment process.

15 DE Reg. 1408 (04/01/12) (Prop.)