

# **Special Needs BasicCare (SNBC) Expansion Questions and Answers**

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## **GENERAL ENROLLMENT QUESTIONS**

1. What is the advantage of SNBC for the consumer?
  - Through SNBC the consumer can receive additional assistance with access to primary and preventive and dental care. SNBC health plans work on improvements to care and services through disease management and health coaching programs. Some of the SNBC plans may provide some additional benefits such as fitness, dental and podiatry care. The SNBC health plans waive the Medicaid co-pays for their members. There is a nurse available to answer health questions 24 hours a day, seven days a week.
2. Put together a list of pluses – health coaching, gym membership, rides to gym, medication/disease management, podiatry, dentist/(network access)
  - Thank you for the suggestion. DHS has prepared a side-by-side [comparison of key SNBC plan features \(PDF\)](#). This document is being used by the Disability Linkage Line and advocacy organizations to assist interested people in understanding the choices that are available under SNBC.
3. Negatives to opting in /enrollment – medication not on formulary, doctors/providers not in network, MCO not accepting more providers into network, # of authorization requirements, timelines of service needed.
  - These are all issues to watch for when deciding whether or not to enroll in a health plan. These issues are pointed out in the SNBC Enrollment Guide handbook which can be obtained from the SNBC web site [www.dhs.state.mn.us/SNBC](http://www.dhs.state.mn.us/SNBC) or e-docs form DHS- 5567.
4. Is there any problem with people enrolling in a SNBC health plan now versus waiting for the roll out? Can they contact the health plan directly?
  - Eligible potential SNBC enrollees may enroll in SNBC now or at any time by contacting the Disability Linkage Line at 1-866-333-2466 or contacting the health plan directly and filling out an enrollment form.
5. How often can individuals change health plan providers?
  - Individuals can change health plans monthly, though for continuity of care purposes this is not advisable. There has not been a pattern of frequent plan switching under SNBC, though enrollees certainly can and do change plans.
6. When someone asks why this change (mandatory enrollment) was made & what the perceived benefits were, what is DHS' answer?

- Enrollment in SNBC is not mandatory. Enrollment remains voluntary due to the opt-out process. The change in the enrollment process came from the Minnesota Legislature in 2011, not from DHS.
  - DHS has now had four years of experience with SNBC, and SNBC provides an opportunity for improved access to primary and preventive care for its enrollees.
7. If a person has Health Partners, can they also sign up for SNBC and keep Health Partners?
    - If the person has a private health insurance plan with Health Partners they cannot sign up for SNBC because state law does not allow people to be enrolled in more than one health maintenance organization (HMO) for their Medical Assistance benefits.
  8. Will the expansion of SNBC affect people currently enrolled in a health plan?
    - The expansion of SNBC is only targeted to people in Medical Assistance (MA) fee-for-service (FFS). A person who is currently in a health plan might voluntarily choose to go into SNBC if they qualify, but the person would not be receiving the initial letter informing them of their ability to enroll in SNBC.
  9. Can you tell me what the enrollment process will be for consumers who are the financial responsibility of our county but live in another county?
    - Eligibility for enrollment into managed care is done according to the county the person is living in, and the county of financial responsibility does not come into play with enrollment. The person is eligible to enroll in the SNBC plan(s) that serve the county where the person lives. The person cannot enroll in an SNBC plan based on county of financial responsibility.
  10. If a person has multiple choices of health plans how will they decide which health plan to enroll in and where do they get the enrollment form?
    - If person has more than one health plan to choose from, DHS will send them a letter telling them they have the option to opt out of enrollment or select one of the plans that is available in that county. The letter also states which health plan they will be enrolled in if they do not make a choice. People are encouraged to call the Disability Linkage Line at 1-866-333-2466 or contact the health plan directly to gain a better understanding of the health plan.
    - Five managed care organizations in Minnesota currently offer a SNBC health plan: Medica, Metropolitan Health Plan (MHP), PrimeWest Health, South Country Health Alliance (SCHA), and UCare.
  11. How many health plans are available in each county?
    - Please see the attached map, which can also be found on the SNBC web site [www.dhs.state.mn.us/SNBC](http://www.dhs.state.mn.us/SNBC) or in e-docs form # DHS- 5218.
  12. Will DHS be mailing the opt-out/choice letters or are the counties responsible to mail them to potentially eligible people?
    - DHS will be mailing the opt-out/choice letter to people since counties are currently not responsible for SNBC enrollment.
  13. Why are current HMOs such as Health Partners and Blue Plus excluded from SNBC?
    - DHS has not excluded Health Partners or Blue Plus from participating in the SNBC program. Health Partners has never responded to a Request for Proposal (RFP) expressing interest in participating in the

SNBC program. Blue Plus did participate in SNBC from January 1, 2008 to December 31, 2010, but has terminated their contract with DHS for the SNBC program.

14. What is meant by the statement “DHS will be enrolling people into SNBC on the Medicaid side only”? What does this mean to me as a case manager and to providers?
- With the SNBC expansion, DHS will be enrolling the eligible population into the Medicaid (MA) coverage side of the SNBC health plan. If the enrollee has dual coverage, meaning they have MA and both Parts Medicare A and B, the Medicare covered services will still be paid by Medicare Fee-for-Service (or Original Medicare).
  - The health plan will coordinate the Medical Assistance and Medicare covered services, which means that the provider must submit any Medicare service claims to Medicare before submitting them to the health plan.
  - The enrollee with Medicare coverage also needs a Medicare Part D drug plan for their Medicare drug coverage. The SNBC plan will pay for the drugs covered by Medical Assistance.
  - Starting January 2012, MHP, PrimeWest and South County Health Alliance (SCHA) will have an integrated SNBC product available. An integrated SNBC product includes both the Medicare and the MA covered benefits. The enrollee will have to request the integrated coverage and sign an enrollment form. Medica and UCare will not have an integrated SNBC product available.
  - Case managers / providers need to know when a dual eligible person is enrolled in SNBC, and if they are enrolled in the integrated or non-integrated SNBC product.
  - When checking MN-ITs case managers/providers will need to understand that:
    - MA37- Special Needs BasicCare (SNBC) is the non-integrated product so providers/case managers will need to determine the appropriate entity to bill first for Medicare services.
    - MA17 is the integrated product; dual eligible people enrolled in this SNBC product will receive both the Medicare and Medicaid services through the SNBC health plan.
    - An integrated SNBC plan means the health plan controls the administration of the Medicaid and Medicare services and a provider would submit any Medicare /Medicaid claims directly to the health plans. Please note the Medicaid services that continue to be paid Fee-for-Service so they are billed through MMIS: PCA, Private Duty Nursing (PDN), and waiver services.
15. If a person chooses to enroll in an SNBC plan, do they need to select a primary hospital and primary pharmacy as a part of their network?
- A person who chooses to enroll in SNBC must choose a primary care clinic and receive pharmacy and hospital services through the SNBC health plan network.
16. If a person enrolls in SNBC and is on the waiver are they enrolled in Medical Assistance through Fee for Service (FFS) as well as SNBC?
- Eligible individuals will be enrolled in SNBC for their health care services (unless they opt out). Some services (waiver service, PCA, PDN) will remain in MA Fee-for-Service (FFS) and outside the “benefit set” that the SNBC health plan manages. The individual is enrolled in SNBC and continues to receive those services not in the SNBC benefit set through FFS.
17. A stay in an IMD is usually time limited to 3 months. What happens when a person leaves the IMD?

- When people leave the IMD and they have a disability basis of Medicaid eligibility they will be asked to enroll in SNBC and given an opportunity to opt out.
18. Are the Medical Assistant recipients recently enrolled related to financial qualification affected at all by the SNBC shift January 1, 2012?
- People new to Medical Assistance would be affected if they are MA-eligible as a person with a disability.
19. How soon will new-to-Medical Assistance recipients with disabilities be enrolled in SNBC?
- System changes will have to be made to automate this process. Until system changes are complete, once a quarter, the newly eligible Medical Assistance recipients will be sent a notice to enroll in SNBC or to opt out of SNBC.
20. Who will send marketing and enrollment information to the prospective enrollees?
- DHS will send an initial mailing to individuals informing the SNBC- eligible population of the new legislation and their coverage options.
  - Once a person has enrolled in a health plan, they will receive additional information from that health plan.
21. What will the information mailings contain regarding health plan choices? Will it give full details on the benefit set or just the names of the plans available?
- The initial SNBC mailing will be a letter stating only the health plans available in their county, their rights, the opt-out process, and how to contact the Disability Linkage Line for assistance in making a decision.
22. What are the "cut off" dates for each enrollment phase to opt out or select a health plan?
- Group one: December 20, 2011
  - Group two: January 20, 2012
  - Group three: February 17, 2012
  - Group four: April 19, 2012
  - Group five: May 21, 2012
  - Group six: June 20, 2012
  - Group seven: not yet determined
23. Will MCOs need to be prepared to field calls about enrollment of the 7/1/12 effectives (primarily children) between 10/15/11 and 12/15/11 as part of this initial expansion communication?
- DHS will not be able to predict which enrollees will call the MCOs, so while children are not being enrolled at that time, MCOs may still receive calls.

## ASSIGNMENT PROCESS

1. If a person does not choose a health plan, how will they be assigned to a health plan?
  - If a person does not choose a health plan, they will be assigned to a health plan on a random basis, depending on the plan(s) available in the county where they live.
2. If a person will be randomly assigned to a health plan how will this random assignment be done?
  - At this time this decision has not been made. When this information becomes available it will be posted.
3. Will the person be told in their letter from DHS which plan they will be randomly assigned to if they do not choose a health plan?
  - In the informational letter the person is told that if they do not pick a plan, they will be assigned to the first plan listed in that letter.
4. If a person is dual eligible (Medicare and Medicaid)but they don't choose a health plan and don't opt out of SNBC, could they conceivably be in one health plan for Medical Assistance (MA) and one health plan for Medicare?
  - Yes. A person could be enrolled in Medicare FFS for Part A and Part B, be enrolled in another health plan for Part D coverage, and be enrolled in a third health plan for SNBC at the same time.
5. If a person has two different health plans, how will this be coordinated?
  - Health plans currently do coordination of benefits and they will continue to coordinate benefits.
6. What will happen to persons with disabilities in counties where SNBC is not an option?
  - DHS will procure (contract) for participation in SNBC in those counties for an effective date of July 1, 2012.

## OPT-OUT PROCESS and DISENROLLMENT

1. How does a person opt-out of managed care?
  - A person may send the opt-out form back to DHS or they may call the Disability Linkage Line at 1-866333-2466 for assistance in opting out. The opt-out form is included in the initial mailing to prospective enrollees. The same opt-out process is used for the SNBC expansion and when offering SNBC to persons newly eligible for Medicaid.
  - Subsequently, individuals will be able to disenroll at any time by sending a written request to their health plan or to DHS stating they want to disenroll from the health plan. The disenrollment request must include their name, Medical Assistance ID Number (PMI), and their signature.
  - If a person is already enrolled in a health plan, they can send their disenrollment request to DHS or to their health plan.
  
2. Do opt-out requests have to be made in writing, or will individuals be able to opt out verbally? For written requests, will only the specified opt-out form be accepted?
  - Recipients can call the Disability Linkage Line (DLL) at 1-866-333-2466. DLL staff has the authority to take opt-out requests verbally, over the phone, because all calls with DLL staff are recorded. DLL staff can take the person's opt out request 1) prior to the person's enrollment in a health plan, and 2) only during the month following the person's auto enrollment into SNBC.
  - A person may submit any document to DHS to opt out of SNBC, however the document must contain all the elements that are included in the opt-out document.
  
3. Is the guardian able help the person to opt out of SNBC?
  - Yes, guardians may assist a person to opt out of SNBC. However special rules apply if the guardian is also the case manager.
  - MN statutes and rules regarding the roles of guardians and case managers require that best interest decisions made on behalf of state wards is the role of the guardian (as decision maker). The role of administrative responsibility (case manager) must be separate. Additionally, when health care decisions such as plan enrollment are made, the advantages as well as potential disadvantages to the ward should be well documented for the purpose of transparency should their decisions come under public scrutiny.
  
4. Is the Case Manager able to help the person to opt out of SNBC?
  - Case managers **cannot** opt a person out of managed care unless they are the legal guardian. If when acting as the legal guardian they decide to opt a person out of SNBC, the advantages as well as potential disadvantages to the ward should be well documented for the purpose of transparency should their decisions come under public scrutiny.
  
5. Is the provider able to help the person to opt out of SNBC? • Providers cannot opt a person out of managed care unless they are the legal guardian. Providers should refer member and guardian questions to the Disability Linkage Line at 1-866-333-2466 to assist the person in making an informed decisions regarding SNBC enrollment.
  
6. Can DHS identify people on FFS who are receiving MH targeted case management and then send enrollment information to MH targeted case managers so they can support their clients to make informed choices? •

If the Mental Health Targeted Case Manager (MH-TCM) is also the person's legal guardian and is listed in MAXIS as the AREP, they will be sent a copy of the letter regarding enrolling in SNBC. See response to question 3 in this section. If the MH-TCM is not the guardian the MH-TCM should refer the person to the Disability Linkage Line at 1-866-333-2466 to assist the person in making an informed decision regarding SNBC enrollment. If a person wants their MH-TCM included in the conversation with DLL regarding their enrollment in SNBC, the DLL has the ability to conduct a 3-way call if the person requests that.

7. How will people get information about making an informed choice as to whether to opt out or not and who can discuss the options with them?
  - The Disability Linkage Line (DLL) staff has been trained by DHS and the health plan staff on SNBC. DLL staff is qualified to assist people in making an informed decision about enrollment in SNBC as they have been trained and are a neutral organization. Information on how to contact DLL staff is provided in the DHS mailings.
8. What role will MCOs have in the opt-out process?
  - If an MCO receives an opt-out form for a non-member, the MCO can fax the opt-out form to DHS.
9. If an MCO receives an opt-out request, will the MCO be required to accept the opt-out request and then provide the request (be it verbal or written) to DHS?
  - If the MCO receives an opt-out form they can fax the form to DHS. If they receive a verbal request from a non-health plan member they should direct the person to Disability Linkage Line (DLL) staff at 1-866333-2466. All health plan staff should direct SNBC expansion opt-out questions to DLL. The opt-out process is used for the expansion and when offering SNBC to new Medicaid eligibles.
10. Will the health plan need to instruct the member to direct their opt-out request directly to DHS?
  - If a current member of a health plan wants to disenroll from the health plan, nothing has changed from the current process: the health plan takes the disenrollment information and forwards it to DHS. The opt-out process is used by DHS for the expansion and when offering SNBC to new Medicaid eligibles.
11. Will health plans only be involved in the current disenrollment process for current SNBC members?
  - MCOs can continue to take disenrollment information from their SNBC members and then forward the request to DHS. Nothing has changed in regards to member disenrollment processes.
12. Are the individuals able to opt out prior to January 1<sup>st</sup>, 2012? If so, what is the timing?
  - DHS has developed an implementation schedule and will be sending out notices over the next several months to individuals informing them of the legislation regarding enrollment in SNBC. After people receive this initial notice, which includes the opt-out form, it is recommended they contact DLL staff to review their options and /or enroll in SNBC or send their opt-out form to DHS. Opt-out forms should not be sent in to DHS until people receive the notice that they are eligible to enroll.
13. How will the opt-in/opt-out process be monitored and/or regulated to avoid "churning" and to promote effective delivery of services?

- SNBC remains a voluntary option for members, under state and federal authorities. DHS will track those who have opted out, but there is nothing to prohibit them from deciding to enroll later, and there is nothing to prohibit enrollees from opting out of their choice once they have enrolled.

14. Once a person opts out, will they face auto enrollment again in later years?

- People who have opted out will not be subject to assignment to an SNBC plan unless they change their mind and decide to enroll. People who have opted out will receive a future mailing about their SNBC enrollment options, but once someone has opted out, they will not be assigned to a health plan.

15. If a person opts out of SNBC now, can they choose to enroll later?

- A person may choose to enroll in SNBC at any time they are eligible for SNBC. The effective date of enrollment is usually the first day of the month after they submit their application. A person may choose to disenroll in SNBC at any time. The effective date of disenrollment is usually the last day of the month they notify DLL or DHS or their health plan of their choice to disenroll.



## **RE-ENROLLMENT INTO SNBC**

1. If a person enrolls into SNBC, on September 30<sup>th</sup> their Medical Assistance closes due to failure to complete a renewal and they are disenrolled from SNBC. The person provides the renewal and all necessary verifications on October 20<sup>th</sup> and Medical Assistance is reinstated back to October 1<sup>st</sup>. Would the person be re-enrolled into SNBC back to October 1<sup>st</sup>, or the next available month November?
  - The person would be retroactively enrolled in SNBC as long as their case is reinstated within 90 days. This works the same way as it does for MSHO and MSC+. DHS will go back up to three months to maintain continuity of care. This is only for enrollees whose span closes with an EE (eligibility ended) which is the disenrollment code used when a case closes for review. If the case is not reopened within 90 days or if there is a gap in eligibility, the enrollment will not be reinstated.
  
2. Will the re-enrollment take place automatically or will the eligibility worker have to do something to reenroll that individual?
  - It will happen automatically as long as the worker hits PF9 from RELG after reopening.

## PEOPLE EXCLUDED FROM SNBC ENROLLMENT

I hear people at DHS speak about people on State-certified HMOs who cannot enroll in SNBC and these people will remain Fee-for-Service (FFS). Which are the State certified HMOs?

- The state-certified HMOs in Minnesota are Blue Plus, Health Partners, Medica, Preferred One, Sanford Health Plan, Group Health, UCare, and Metropolitan Health Plan. If someone is already enrolled in a HMO, they will remain FFS unless they choose to change to a SNBC plan.

2. Anyone with a spenddown is excluded from SNBC, correct?

- Only people in community living arrangements with a medical spenddown will be excluded from SNBC. DHS is applying the same criteria to these exclusions as we do to other managed care groups. DHS will be enrolling people with institutional spenddowns.

3. If you are not enrolling people with a medical spenddown into SNBC as of January 1, 2012 what happens to people on SNBC who currently have a spenddown? Will they be disenrolled effective January 1, 2012?

- People currently on SNBC with a spenddown (either medical or institutional) can remain enrolled in SNBC in 2012 as long as the person continues to pay their spenddown either to the state or an assigned designated provider.

4. If you are excluding people with spenddowns are you also excluding people on MA-EDP?

- People who access Medical Assistance through MA-EDP (Medical Assistance for Employed Persons with Disabilities) are eligible to enroll as long as they continue to pay their MA-EPD premium.

5. One of the reasons for exclusion from enrollment is that the recipient has "cost effective employersponsored private health care coverage.." What is "cost effective coverage"?

- Cost effective coverage is other health care coverage for which the amount paid for premiums, coinsurance, deductibles, and other costs is likely to be less than the amount paid by MA for an equivalent set of services. Cost effective coverage could include, but is not limited to, coverage through: group health care coverage, COBRA, individual health care coverage, long-term care insurance, coverage available through a parent or spouse, TRICARE, CHAMPVA, and Medicare.
- The local agency will pay the cost-effective premiums for the applicant.

6. Who is excluded from enrolling in SNBC?

- (1) Recipients eligible for the Refugee Assistance Program pursuant to 8 USC 15 § 1522(e).
- (2) Persons up to eighteen (18) years of age or over sixty-five (65) years of age. Enrollees who turn 65 years of age while already enrolled may choose to remain in SNBC.
- (3) Residents of State institutions, unless the MCO approves placement. For purposes of this Contract, approval by the MCO would include a placement that is court-ordered within the terms described in section 6.1.25(E)
- (4) Medical Assistance Recipients who are eligible while receiving care and services from a non-profit center established to serve victims of torture.
- (5) Recipients eligible for the emergency Medical Assistance program.
- (6) Undocumented, and non-immigrant non-citizen Recipients as defined under Minnesota Statutes, § 256B.06, subd. 4.

- (7) Women receiving Medical Assistance through the Breast and Cervical Cancer Control Program.
- (8) Recipients, who at the time of notification of mandatory enrollment in managed care, have a communicable disease whose prognosis is terminal and whose primary physician is not a Participating Provider in the MCO, and that physician certifies that disruption of the existing physician-patient relationship is likely to result in the patient becoming noncompliant with medication or other health services.
- (9) Recipients who are terminally ill as defined in Minnesota Rules, Part 9505.0297, subpart 2, item N (hospice) and who, at the time enrollment in SNBC would occur, have an established relationship with a primary physician who is not part of the SNBC MCO.
- (10) Medical Assistance Recipients with private health care coverage through a HMO certified under Minnesota Statutes, Chapter 62D. Such Recipients may enroll in managed care on a voluntary basis if the private HMO is the same as the MCO the person will select under SNBC.
- (11) Recipients with cost effective employer-sponsored private health care coverage, or who are enrolled in a non-Medicare individual health plan determined to be cost-effective according to Minnesota Statutes, § 256B.69, subd. 4(b)(9).
- (12) Recipients who are on the Consumer Support Grant (CSG).
- (13) Individuals who are Qualified Medicare Beneficiaries (QMB), as defined in § 1905(p) of the Social Security Act, 42 USC § 1396d(p), and who are not otherwise eligible for Medical Assistance.
- (14) Individuals who are Specified Low-Income Medicare Beneficiaries (SLMB), as defined in § 1905(p) of the Social Security Act, 42 USC § 1396a(a)(10)(E)(iii) and § 1396d(p), and who are not otherwise eligible for Medical Assistance.
- (15) Persons who are eligible for Medicare Part A only or Medicare Part B only.
- (16) Recipients who live in the community and have a medical spenddown.

## CARE COORDINATION / NAVIGATION

How can the counties and individuals find the name and phone number of the care coordinator / navigator from the SNBC health plan, once a person is enrolled?

- Call member services at the health plan.
2. Will certain requirements be changed or loosened? For example, the requirement for an assessment within 30 days? Will the health plans be required to perform a health risk assessment on each enrollee?
    - DHS will work with the health plans on the health risk assessments (HRA) requirements in order to allow time for this transition. During this January to July expansion, the requirement to complete the HRA has been extended to 90 days. After the last group is enrolled in July, the time requirement will return to 30 days for HRA completion.
  3. Prior to referring a client for a waiver assessment, will this HRA be done and shared with the county at the time the referral is made?
    - County and tribal staff currently have access to the HRA assessment results via MMIS; however DHS and the health plans are open to improving this process as needed. DHS has established a county /tribe/ health plan workgroup to recommend improvements to the process, and that question is being discussed.
  4. What kind of information is included in a health risk assessment?
    - The health risk assessment will include questions designed to identify health risks and chronic conditions, including but not limited to:
      - activities of daily living,
      - risk of hospitalizations,
      - need for primary and preventive care,
      - mental health needs,
      - rehabilitative services needs, and
      - protocols for follow up to assure that physician visits, additional assessments or Case Management interventions are provided when indicated.
  5. What requirement might be put in place to prevent duplication of services between current SNBC coordination services and care coordination provided under Healthcare Home (HCH) benefit?
    - Care coordination provided through the HCH addresses specific member medical needs that do not necessarily overlap with the SNBC Care Coordinator role. Health plans continue to coordinate and explore ways to improve collaboration with HCH teams.
  6. Intersection with health care/medical homes and care coordinators within primary care clinics' service coordinators (as well as other case managers) for children 0-3 in early childhood special education. Is this different than in PMAP?
    - There is an added benefit for children if they enroll in SNBC. Members in PMAP currently do not have a care coordination benefit. The child may have a county waiver worker or mental health targeted care

manager (MH-TCM); the SNBC CC will collaborate with the various case management systems, including the HCH team, to help meet all needs of the individual.

7. For people on LTC waivers, what can/should be done to eliminate duplication of services by case managers/care coordinators? What is the role of the SNBC health plan care coordinator?
  - The SNBC care coordinator/ case management system:
    - Works in partnership with the enrollee, primary care physicians in consultation with any specialists, and with the waiver case manager to develop and provide medical treatments or services.
    - Conducts a health risk assessment of members upon enrollment and annually thereafter to identify health risks and chronic conditions.
    - Will provide a range of services from telephone consultation to face-to face visits depending on the needs of the member. Services range from assisting members to access services, to management of disability related medical conditions, distribution of self-management/educational materials, communication and coordination with counties/tribes and providers.
8. Please include AXIS/MNDHO experienced staff & leaders in these discussions to look at the “bridge” that AXIS care coordinators were between “medical” & “community”.
  - We welcome their participation in these workgroups.
9. Have you looked at the transition from MnDHO to SNBC last year to see what worked and what did not to inform this process?
  - Yes, we are looking at this, thank you for the suggestion.

## DHS / COUNTY / TRIBE / HEALTH PLAN COMMUNICATIONS

If a person is currently receiving CAC, CADI, or BI waiver funding through a tribe (i.e. White Earth), how does enrolling in a SNBC place effect their funding? At this time, the White Earth Tribe does not contract for waiver services, i.e. case management/care coordination, with any SNBC plans. Please consider including the Tribal language, not just “county” in the process of incorporating the Tribal waiver for clients that choose to enroll in a SNBC, but want to keep their Tribal waiver case manager.

- DHS will incorporate the county/tribe language in our messaging, thank you for this input. The SNBC health plans will collaborate with the tribes in the same manner they do with county CAC, CADI, BI and DD case managers.
2. Please remember to invite the Tribes to the regional meetings as the Tribes also provide Waiver Case Management. These clients do not go to the counties for questions.
    - DHS posts the Stakeholder meetings and various workgroup meetings on the DHS website at [www.dhs.state.mn.us/SNBC](http://www.dhs.state.mn.us/SNBC) and works with other DHS liaison staff to keep the Tribes informed of the various meetings and issues regarding SNBC expansion. Please let us know how we could improve communications.
  3. Who will provide mental health case management for population when they chose SNBC?
    - The SNBC health plan is responsible to provide mental health case management service for SNBC members. SNBC health plans may contract with behavioral health agencies, mental health professionals and counties / tribes to provide this service. People providing mental health case management services must meet DHS qualifications that are outlined in the SNBC contract.
  4. If the health plan chooses to provide the SNBC care coordination service, what happens with the waived services case management?
    - The county or tribe remains responsible for waived services including waiver case management. These services are not provided through the SNBC health plan. The SNBC health plan care coordinator works in coordination with the waiver case manager.
  5. Will plans receive funding for care coordination in the same way they do for MSHO? By that I mean the reimbursement is fairly equal from the plans for MSHO but in SNBC the reimbursement varies significantly.
    - The SNBC health plans are not given any Medicaid dollars for care coordination for SNBC enrollees as the SNBC health plan is not responsible for waiver services. Care coordination dollars are obtained through Medicare cost savings. With the SNBC expansion DHS is enrolling people on the Medicaid side only so there will be limited funding available for SNBC care coordination.
  6. As DHS & MCOs proceed to develop forms and web based care planning and transition tools, how will you ensure that you are not at odds with the MN Department of Health (MDH) software? For example: Electronic Health Records (EHR) workflows are under development or already developed for major electronic medical record software systems. How are you planning to integrate (DHS/MCO care planning tools) this ware with e health?
    - These communications processes and tools would be directed at communications that are more external to clinics’ normal use of EHR, such as communications with counties. So we are looking for

communication strategies that are not tied to any particular software or record systems, but that could be easily incorporated into clinic and county systems. We expect to work closely with MDH.

7. How will counties know who opts out?
  - Counties can find out who is enrolled through InfoPak reports. Changes are needed to the reports; **however this has not been deemed a high priority since counties are not involved in enrollment of SNBC members.**
8. What type of communication implementation (enrollment & disenrollment) lists will you send to the counties and tribes? Will these lists be provided monthly like MSHO/MSC+ reports?
  - Counties and tribes can find out who is enrolled through InfoPak reports or MN-ITS. PWMW0507 – PPHP NEW ENROLLEE REPORT (SORT BY COUNTY), which has been used for several years for counties/tribes to identify new MSHO/MSC+ enrollees, has been expanded to include new enrollees into all SNBC products, MA 17, MA 19 and MA 37. PWMW0504 – PPHP CURRENT ENROLLMENT REPORT – FOR COUNTY, identifies all recipients enrolled in all managed care plan but financial worker. Disenrollment would be identified by checking MMIS or MN-Its.
9. How are you working with Economic Assistance so they understand how this auto enrollment will occur?
  - We have invited Financial Worker Supervisors to all of the 6 webinars thus far and we have sent information to this group as well.
10. Does Economic Assistance know which managed care provider the individuals will be enrolled in?
  - This information is available in MN-ITS.
11. With the change coming January 1, 2012 where all Medical Assistance eligible people with disabilities can be eligible for SNBC services, are there plans for DHS to get reports or lists by name, address, disability type, etc., to counties with all potential enrollees?
  - Counties and tribes can find out who is enrolled through InfoPak reports or MN-ITS. Changes are needed to the reports, however this has not been deemed a high priority since counties and tribes are not involved in enrollment of SNBC members.
12. Communication with Health Plans – the universal transfer form (UTF) has not been formally posted in a bulletin since DHS acquired it from metro county work group. Please post with instructions to include centralization of how forms are given and received. Consider DHS electronic transmission of UTF from DHS web site.
  - Thank you for this suggestion, we are still working on this internally with DSD.
  - DHS is sharing data on new members with the health plans after the enrollment effective date (within the first week of enrollment).
13. Another thing that we've been trying to find a source for is regarding potential mental health Targeted Case Management folks. Health plans notify those MA enrollees / potential MH-TCM enrollees that they might be eligible. Does DHS get specific names to the plans, or do the plans pull those names from a report? What triggers are used to get those specific names?
  - DHS does not have information to provide to MCOs on who might be eligible for MH-TCM unless people are already eligible.

- For those who are already eligible, DHS shares this information with SNBC MCOs once people are enrolled. We cannot share this information prior to enrollment due to HIPAA requirements. MCOs are required to conduct screening of people who may be eligible for MHTCM services according to protocols established by the DHS Chemical and Mental Health Services Administration. MCOs must then refer people who qualify to appropriate MH services.



## **SNBC BENEFITS**

If a person enrolls in a SNBC health plan will this change which doctors they can get services from?

- Potential enrollees should utilize the Disability Linkage Line (DLL) staff or the health plan customer services as a resource to inquire whether specific doctors are in the health plan network.
2. How does enrollment in managed care affect the individual's ability to change doctors?
    - Although a person can change primary care doctors at any time, they must follow the health plan rules regarding accessing services. Members are generally required to see an in-network doctor unless they have been approved to go to an out-of-network doctor or specialist. This approval is not needed for emergencies, urgent care and open access family planning services.
  3. How does enrollment in managed care affect the individual's ability to see a specialist?
    - The person must follow the health plan rules regarding accessing specialty care. Potential enrollees should ask health plan customer service staff or DLL staff to inquire if the health plan they are thinking of enrolling in requires a referral to see a specialist within their network, and if their specialist is in that network.
  4. Will enrollment in managed care change the pharmacies the individuals can go to?
    - Health plans have almost all Minnesota pharmacies within their network. It is possible that they may have to change pharmacies.
    - Check with the health plan to see if a pharmacy is covered or have DLL staff check with the health plan for you.
  5. Will the health plan cover all the prescriptions a person needs? If not, what are the individual's options?
    - Health plans must cover the same drugs that are on the Medical Assistance drug formulary or the therapeutic equivalents. Exceptions to the health plan formulary are available for situations where the prescribing provider indicates a need for a specific drug not on the plan formulary. Prescriptions must be written by a provider within the health plan network.
  6. Will the individuals have a co-pay/share charge for doctor's visits? Is there a max charge for per year?
    - SNBC health plans waive cost-sharing (copays and the family deductible) for SNBC enrollees.
  7. Will enrollment in managed care affect an individual's ability to use the after-hours services, hospital emergency rooms, etc.?
    - Check with the health plan to find out about the rules for accessing these services. Health plans are required to cover emergency care outside the health plan network but may require that they be notified after that care is received. Urgent care is covered out-of-network if the enrollee is outside the service area.
    - There are several added benefits to being enrolled with a health plan such as the 24 hour /day nurse line, etc.
  8. With the Dual Demo, will health plans be responsible for nursing home costs beyond 100 days?
    - No, the current SNBC benefits are not changed by the Dual Demo.

9. Why are the SNBC health plans off the hook for paying for services for people who go to a nursing home after 100 days?
  - The SNBC health plans continue to pay for all medical services and supplies that are not the responsibility of the nursing home after the health plan pays for the 100 days of nursing home room and board. Fee for service picks up only the cost of the nursing home room after the health plan has met the 100 day obligation. This payment methodology is accounted for in the rates paid to the health plans.
  
10. How will the mental health benefits package for children in SNBC differ between what they have access to if they are in a PMAP now and what will be available through their SNBC plan? Will all plans need to include same services?
  - DHS has a workgroup discussing child issues.
  
11. In our county, we have clients receiving Rule 79 & case management through PMAP Health Partners. HP does not have a SNBC program. Will those clients need to leave HP for one of the plans that has an SNBC?
  - SNBC enrollment is only for people with disabilities. People with disabilities are currently excluded from enrollment in PMAP, unless they have more than one basis of eligibility and have chosen to enroll in PMAP. If they have chosen to enroll in PMAP, they may remain enrolled in PMAP.
  
12. Is SNBC structured like PMAP with Medicare as a benefit of the insurance plan or is it that Medicare is primary with the plan secondary?
  - For people with dual eligibility for Medicare and Medicaid, Medicare is always primary for Medicare covered services.
  - PMAP family and children plans do not provide Medicare.
  - All MSHO plans do include both Medicare and Medicaid.
  - Some SNBC plans do have a corresponding Medicare Special Needs Plan for SNBC members, but others do not.
  - Keep in mind that with the SNBC expansion, DHS will be enrolling the eligible population into the Medicaid coverage side of the SNBC health plan. Please refer back to the answer in question 10 under general enrollment questions.
  
13. Will SNBC enrollment issues be take care of like PMAP/MSc+? When DHS is contacted (i.e.: continuity of care, gap months, DX access issues, etc.).
  - Yes.
  
14. What are the plans/actions to assure continuity of care for those who are auto enrolled and do not know anything about the change (did not get notice, could not understand, do not open mail, etc.)? Can DHS assure a transition time to allow continued access to meds and providers while the person learns about their new health plan and the option to disenroll? Do we have continuity provisions that apply to this situation?
  - Per the SNBC contract the SNBC health plans will continue to provide for continuity of care.
  - The health plan is responsible for transition services in the following situations:
    - Services previously authorized. Medically necessary covered services, including State Plan home care services, that an out of plan provider, another MCO or the State has service authorized before enrollment in the health plan, until a comprehensive care plan is in place. → Orthodontia Care

- At Risk Pregnancy
- Chemical Dependency (CD) Treatment Services
- Mental Health Services
- Pharmacy

15. Over the years (at least the past 15) there's been an emphasis on addressing the individual's particular needs, breaking down the silos that confuse people and prevent their getting the services they need that would optimize health and quality of life. How will the SNBC health plans work with me?
  - The SNBC health plans are committed to working with the member to get their medical needs met and believe in person centered care.
  
16. People with disabilities have a huge need for safe and affordable housing. The ability to actually coordinate an individual's care depends a lot on, do they have stable housing? It would be really nice to start thinking about folding in housing help, support, access and expedited access to section 8 programs with SNBC.
  - Thank you for this comment; perhaps this idea can be incorporated into future reform efforts.
  
17. If a client who is eligible for Mental Health -Targeted Case Management (MH- TCM) as an individual who has a serious and persistent mental illness (SPMI), chooses to enroll in SNBC, how is their TCM covered? Is it covered by the health plan or fee for service? For example, if we have a client who chooses health plan XYZ SNBC (or is defaulted to health plan XYZ SNBC because they do not opt out), does this automatically enroll them in the rest of health plan XYZ and therefore, we need to request health plan XYZ authorization for TCM services?
  - MH-TCM services are covered by the health plan if someone enrolls in SNBC. The MH-TCM would need to request authorization from the health plan to provide MH-TCM services. Remember there are transitional services that allow for continuity of care.
  
18. If folks choose health plan XYZ for SNBC does that mean their waived services will go to health plan XYZ?
  - SNBC does **NOT** include waiver services. Waiver services will continue to be billed to FFS, and administered by the county or tribe.
  - The only home care services included in SNBC are home health aide (HHA), skilled nurse visit (SNV), and therapies. The health plan would be responsible to pay for HHA, SNV and therapies for people on the waiver.
  
19. A misunderstanding about when to use the X5609 code for SNBC enrollees has "mushroomed". Could you explain the use of the X5609 code on MMIS service agreements when people are enrolled in SNBC and receiving services on the CAC/CADI/Brain Injury and Developmental Disability (CCB-DD) waivers? Also please explain how providers get paid when FFS uses the X5609 code on a MMIS service agreement.
  - Recipients age 65 and younger or 65 and older who are currently receiving waiver services from the Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), Brain Injury (BI), or Developmental Disability (DD) waiver programs and who are enrolled in Special Needs BasicCare (SNBC) will continue to have a MMIS service agreement through the FFS waiver programs. Waiver services, personal care assistance (PCA), private duty nursing (PDN), and extended state plan MA home care services will be paid through MMIS from the service agreement.

- State plan MA home care services for HHA, SNV and therapies will be paid through the health plan billing process. State plan MA home care services (S9129, S9131, S5181, S9128, T1021, or T1030) are not billed off the MMIS CAC/CADI/Brain Injury and Developmental Disability (CCB-DD) MMIS service agreement. Providers should contact the appropriate health plan for billing instructions for the state plan Medical Assistance (MA) home care services. The total cost of the SNV, HHA, and therapy home care services provided within the waiver service agreement period are shown in MMIS as one line item under pseudo code X5609. The health plan or lead agency's provider number can be added to the line item on MMIS for the pseudo code x5609. Provider Claims are not submitted against the pseudo code line item but the total cost of the services plus CAC/CADI/Brain Injury and Developmental Disability (CCB-DD) waiver services must be kept under the recipient's waiver allocation amount.

## CHILDREN IN MANAGED CARE

1. As children grow, their needs change. The health plan needs to be able to accommodate and enhance their lives. The health plan needs to accommodate and enhance developmental needs. The efforts and perspectives of the parents have to be considered. Parent education is very important.
  - Thank you for this comment. DHS has developed a Children with Disabilities in Managed Care: Issues and Readiness workgroup to address these and other issues.
  
2. For dual eligible children – Can they opt to be coded as a “child” and have access to all health plans or do they have to be in a SNBC where there are only a few plans?
  - There are only about 100 children under age 18 with disabilities in the State who are dually eligible. But children with disabilities who qualify for Medical Assistance with more than one eligibility category may choose which basis of Medical Assistance eligibility they want to use and therefore plan choices for this group may be different.
  - If the basis for Medical Assistance eligibility chosen is “disability” then the person can access only the SNBC health plans in the county in which they live.
  
3. Do you have a team that represents home medical equipment for all your demo projects especially going forward with SNBC in children?
  - DHS, along with health plan and home medical equipment staff, met December 16, 2011 to discuss SNBC expansion and durable medical equipment and supplies issues.
  - Health plans have now been attending the DHS DME provider trainings and meetings.
  
4. Why were children initially excluded from enrollment in SNBC and why are they now a part of the expansion?
  - This was a decision made by the legislature, not a proposal that came from DHS.
  - DHS had excluded children under age 18 from SNBC enrollment in the past because the SNBC program was new. However, the program is now four years old and participating health plans have had more experience dealing with the needs of people with disabilities including children between the ages of 18-21 years.
  
5. What special issues need to be considered for enrolling children with disabilities in SNBC?
  - DHS has developed a Children’s with Disabilities in Managed Care: Issues and Readiness workgroup to explore any issues that need to be addressed when enrolling children with disabilities in SNBC.
  
6. Children in Foster Care are eligible for Medical Assistance (MA) as a family of one. When a child ages out at 18, 19 or 20 - they are automatically eligible for MinnesotaCare (upon application) and continuously eligible until 21. If the child is disabled, how will SNBC work for those young people?
  - Children with disabilities who have more than one basis of eligibility may choose which program they want to be enrolled in. If these 18-21 year olds choose MinnesotaCare eligibility, they must enroll in a health plan under MinnesotaCare, and they will not be eligible for enrollment in SNBC. If the decision is made for the child to access Medical Assistance through the disabled basis of eligibility, they may enroll in SNBC or opt-out and remain in FFS.

## PROVIDER QUESTIONS

1. If a provider is not a Medicare provider will they not be able to accept SNBC clients? Does a program need to be a Medicare provider to qualify to be part of the (in network) network?
  - For Medicare covered services and some services where Medical Assistance also requires Medicare certification, providers must be Medicare certified. However, there are some services that are only provided through Medical Assistance and no applicable Medicare certification exists.
  - Please note that the legislature recently required that home medical equipment suppliers participating in Medical Assistance must now be Medicare certified (256B.0625 subd. 31(b)(c).)
2. How will DHS ensure that Medicaid approved providers can be allowed to join these plan networks that may be closed to ensure continuity of care for clients?
  - Health plans are required to provide adequate access to services for their members. DHS has monitoring procedures to assure network adequacy and access to care. However, health plans are allowed to limit the number of providers they contract with as long as access to care is maintained.
3. How will prior authorization for home medical equipment be handled with the opt-out option? (i.e.: start with MA & go to plan or vice versa).
  - DHS has transition procedures for people who are moving to managed care but already have approved authorizations under FFS.
  - If the person is already enrolled in SNBC the authorization process must start with the health plan.
  - Providers must check MN-ITS each month to determine whether recipients have joined a managed care plan. Providers can contact the health plan to check on the authorization.
4. How will your goal of primary and preventive care be attainable when Medicare only has a goal of medical necessity “in the home” especially for home medical equipment?
  - Medicare and Medicaid both cover some home medical equipment but there are different coverage criteria for Medicare covered items and Medical Assistance covered items. This policy is not changing. SNBC plans are still required to use Medical Assistance criteria for Medical Assistance covered services.
5. Accreditation of home medical equipment providers; as part of any program be required to accept CMS approved accreditation programs for home medical equipment companies?
  - Health plans are required to credential and/or monitor the quality of their providers. They may determine which accreditation programs they accept.
6. From a practical standpoint – the health plans available vary greatly in how often & effectively they reimburse for services provided. Is there an agency or a person an agency can contact when health plans do not reimburse for services provided?
  - You may contact the health plan’s provider help desk or the DHS provider help desk who will work with the DHS health plan contract manager to resolve the issues.
7. Will rehab services be offered, same set of benefits across all health plans similar to MA FFS?
  - The SNBC health plans must offer all of the Medical Assistance benefits and services offered under Medical Assistance Fee for Service.

8. Will rates be standardized to Medical Assistance (MA) rates? What about rates to providers, will they also be same as MA?
  - Not necessarily. Health plans are allowed to negotiate with providers and to pay different rates than Fee for Service (FFS). For some services health plans do pay the DHS FFS Medical Assistance service rates.
  
9. Where is CMS on fixing the disconnect for dual eligible in terms of rates?
  - DHS and health plans continue to have discussions with CMS about risk adjustment and payment issues that Medicare Advantage Special Needs Plans serving people with disabilities are encountering. With current Medicare budget pressures we are not expecting a quick fix to this problem.
  
10. Why can't DHS post the ADA Accessibility survey online like the State of Indiana? Seems a pretty basic thing to do.
  - Thank you for this idea. We will look into this suggestion with our web staff.

## DATA

1. What is the volume of population to be enrolled per county?
  - The number of SNBC potential adult eligible population by county is available on the SNBC web site [www.dhs.state.mn.us/SNBC](http://www.dhs.state.mn.us/SNBC).
  - The breakout information regarding potential eligible children will be posted at a later date.
  
2. Exactly what is the number of people eligible for enrollment by each phase-in group?
  - Group 1: Approximately 8700 adults
  - Group 2: Approximately 6300 adults
  - Group 3: Approximately 20,600 adults
  - Group 4: Approximately 13,900 adults
  - Group 5: Approximately 13,200 adults
  - Group 6: Approximately 11,900 adults
  - Group 7: Approximately 11,000 children
  
3. Could DHS provide potential membership data in the following breakout categories – eligible children by county, eligible adults by county, eligible adults by county and waiver type, if any? Lists by county of how many potential new members in MCO's adult vs. children
  - Please see the SNBC web site for eligible population breakout information for the adult population.
  - The breakout information regarding potential eligible children will be posted at a later date.
  
4. Since all SNBC enrollees are certified disabled it would be extremely helpful to have access to the Basis of Disability information that Social Security has on file. Could we have this along with the enrollment information that we receive from DHS? This would allow us to provide focused care coordination right from enrollment and save lots of time.
  - DHS does not have access to Social Security disability files. We do not have this information to share with health plans.
  
5. Give us data in the diagnosis/disability of kids in TEFRA.
  - Many TEFRA children will be excluded from enrollment due to other health insurance exclusions.
  - DHS is not be able to share diagnoses and disability types on anyone not enrolled in that health plan due to HIPAA requirements.



## **PIN (PREFERRED INTEGRATED NETWORK IN DAKOTA COUNTY)**

1. It would be good to have a presentation on the PIN.
  - DHS can arrange a presentation on PIN for one of the workgroups or stakeholder meetings. Contact DHS to request a presentation.
2. Was the data from Dakota/Medica PIN collected to learn from experience? Example: communication to public, advocate, clients about the changes to come to assist with enrollment & opt out process.
  - The legislature wrote the language regarding having people opt-out of SNBC. DHS was not involved in writing this legislation. Dakota County has shared information with DHS and at public meetings.
3. How does this enrollment differ from the “Passive” enrollment that PIN had?
  - With the PIN enrollment, DHS assigned people to the plan and gave them a period to opt out. For the SNBC expansion, DHS will allow a period for opting out before assignment to a plan is made.
4. How will people in the Dakota County PIN be treated?
  - People with disabilities enrolled in the PIN are not subject to this process since they are already enrolled in SNBC.

## **DHS CONTRACTS WITH HEALTH PLANS (PROCUREMENT)**

1. Legislation requires that SNBC plans have a Medicare advantage SNP plan. Does legislation need to be changed to allow the Medicaid only SNBC option?
  - DHS proposed language last session to clarify that DHS does not contract directly with a Medicare SNP because a Medicare SNP is not a legal entity. Medicare SNPs are Medicare Advantage products that may be sponsored by a County Based Purchasing entity or HMO approved to operate in Minnesota. All Minnesota CBPs and MCHP HMOs do operate SNPs. However, since DHS cannot control whether or not a specific product such as SNBC is approved or viable under Medicare, DHS must contract with the CBP or HMO as the legal entity for Medicaid services, not the SNP.
  
2. For the 2013 Re-procurement: Will all health plans be required to respond to the RFP?
  - This decision has not been made.
  
3. Will DHS automatically include the children/children's services into the SNBC contract with the health plan, or will health plans choose to respond/or not to the procurement?
  - DHS will not automatically include children under 18 in the current SNBC contracts. Because serving children younger than age 18 was not included in the original scope of the SNBC procurement, an additional procurement will be needed.
  
4. Will health plans like Blue Plus be required to participate again in SNBC?
  - This decision has not been made.

## EDUCATION AND TRAINING

1. SNBC – Are there going to be information sessions available to those affected by the policy change and those who support them? When and where will information sessions be held so that info on the choice is available to all?
  - Please see the SNBC website for a list of presentations and meetings with consumers, advocates, counties, providers and others interested in the expansion. For most presentations and meetings, you may request phone-in opportunities in advance.
  - Contact DHS to request a presentation.
  
2. Will health plans be required to provide information to consumers about how to access services and utilize insurance?
  - Yes, health plans are required to provide an Evidence of Coverage to each member that outlines all available benefits and information on how to access them. This is sent shortly after enrollment. Generally, health plans have these posted on their website.
  
3. Could there be a commitment to training county case managers?
  - There was a work group session with counties, tribes, and health plans on December 19<sup>th</sup>, 2011. We need to understand what counties' and tribes' training needs are. SNBC has been in operation since 2008 so it is not new to counties, but there may be new issues that people need information about.
  - Let DHS know what your training needs are. DHS is available to do presentations and trainings.
  
4. Lots of health plans already work (or contract) with CAC, CADI, BI, DD waiver workers in Health Plan programs which will be helpful with the transition. This would be a great piece to include in the MCO 101 training.
  - This information was included in the MCO 101 training held November 4<sup>th</sup>, 2011.
  
5. What education efforts will be implemented/available/used around SNBC expansion effort?
  - Please see the SNBC website for a list of presentations and meetings with consumers, advocates, counties, providers and others interested in the expansion.