

FREQUENTLY ASKED QUESTIONS

For the Provider Community

Transition and Continuity of Care

Health Options will work collaboratively with providers and members to ensure a smooth and safe transition between managed care organizations, especially for those members with existing care plans. Our goal is to minimize impact and ensure continuity for all necessary care.

How will Health Options manage medical and behavioral health services in progress?

- ✓ For treatment of a condition or diagnosis that is in progress for which prior authorization has been issued, Health Options will cover services from the treating provider for the lesser of 90 calendar days or until the treating provider releases the patient from care. Services requiring prior authorization by Health Options are not considered to be care in progress.
- ✓ If you are providing services to a Health Options member that started prior to 1/1/15 or received a prior authorization from another Medicaid plan for services after 1/1/15, Health Options will honor the existing authorization or episode of care for the lesser of 90 calendar days or completion of treatment.
- ✓ Health Options is relaxing authorization requirements for services required by members for 30 days through the transition period except new services requiring prior authorization. After such time, please contact Health Options' Utilization Management Department at 844-325-6254; for Behavioral Health at 844-325-6257.

Will my claim be paid if services are provided during the transition period?

- ✓ For treatment of a condition or diagnosis that is in progress for which prior authorization for treatment has been issued, Health Options will cover services from the treating provider for the lesser of 90 calendar days or until the treating provider releases the patient from care. New services that are provided on or after 1/1/15 and require prior authorization will require Health Options approval from the UM Department.

Will Health Options accept authorization requests prior to 1/1/15?

- ✓ Providers can fax an authorization request to the Health Option Utilization Management Department at 855-445-4086 using the attached *Authorization Request Fax Form*.
- ✓ Authorizations will be reviewed and issued starting 12/17.
- ✓ If there is an authorization issued by another MCO, providers do not need to get services reauthorized by Health Options.

What if I am not contracted with Health Options and providing services to members?

- ✓ Non-contracted providers providing services to members in an episode of care or previously approved service from another plan on or after 1/1/15 will be reimbursed at the Delaware Medicaid Fee Schedule during the transition period. Services for members in an episode of care should not be disrupted.

Obstetrical Care

- ✓ Health Options will cover prenatal services for a pregnant woman in her second or third trimester from the treating provider through 60 calendar days post-partum.

Who is financially responsible for inpatient admissions prior to 1/1/15?

- ✓ Financial responsibility belongs to the Managed Care Organization (MCO) the member was enrolled with on the date of admission through discharge. For example, an inpatient stay with an admit date of 12/29/14 and discharge date of 1/2/15 is the responsibility of the MCO the member was enrolled with on 12/29/14.

What about prescriptions?

- ✓ New Health Options members will be able to continue treatment of any medications prior authorized by the State through the greater of: (a) the expiration date of active prior authorization by the State's FFS pharmacy program; and (b) the applicable time frame (60 or 90 calendar days) for medication not prior authorized by the State.
- ✓ For non-behavioral health diagnosis, Health Options will provide a transition period of at least 60 days for medications prescribed by a treating provider that were not prior authorized by the State's FFS pharmacy program.
- ✓ For behavioral health diagnoses, Health Options will provide a transition period of 90 days of medication prescribed by the treating provider for the treatment of a specific period of 90 days of medication for the treatment of a specific behavioral health diagnosis that was not prior authorized by the State's FFS pharmacy program.
- ✓ Health Options Pharmacy Department is available 24 hours a day, 7 days a week for Providers at 844-325-6253.
- ✓ Pharmacies will be able to override authorization requirements for 72-hour supply of medications starting 1/1/15.

Are Authorizations Required for Long Term Services and Supports?

- ✓ Health Options will cover services in the DSHP Plus LTSS benefit package authorized by another MCO, in accordance with the approved nursing facility level of service/plan of care, regardless of whether the providers are participating or non-participating providers, for a minimum of 30 calendar days after the member's Enrollment date. Health Options will not reduce these services unless a case manager has conducted a comprehensive needs assessment and developed a plan of care, authorized and initiated services with the member's new plan of care.