

Model of Care and Dual-Eligible Member Cost-Protections Provider FAQs	
Question	Answer
What is the Model of Care Program?	Pursuant to MIPPA legislation, WellCare has enhanced our Model of Care Program for all WellCare Dual Special Needs Plans (D-SNPs) Members. The Model of Care is designed to improve Members' access to medical, social and mental health services while improving transitions of care across health care settings and Providers.
What is MIPPA?	Passed by Congress, the Medicare Improvements for Patients and Providers Act (MIPPA) extends the Special Needs Plans (SNP) program until December 31, 2010. MIPPA includes new policies requiring Medicare Advantage plans to institute accountability measures to reduce health disparities through increased access to preventive and mental health services.
What are Special Needs Plans (SNPs)?	<p>A type of Medicare Advantage Coordinated Care Plan focused on certain vulnerable groups of Medicare beneficiaries including:</p> <ul style="list-style-type: none"> • Institutionalized (I-SNP) • Dual-eligibles (D-SNP) • Beneficiaries with severe or disabling chronic conditions (C-SNP) <p>SNPs are designed to improve care for Medicare beneficiaries with special needs through improved coordination and continuity of care. WellCare currently only offers D-SNP products.</p>
What are Dual Special Needs Plans (D-SNPs)?	A type of Medicare Advantage Coordinated Care Plan focused on dual-eligible Medicare beneficiaries. D-SNPs offer basic Medicare benefits, often provide supplemental benefits, and help to coordinate services offered under the Medicaid program.
Can dual-eligible beneficiaries enroll in any Medicare Advantage plan?	Yes. Dual-eligible beneficiaries may enroll in any Medicare Advantage plan, including D-SNP plans. <i>Dual-eligible beneficiaries for whom the state holds harmless for Medicare Parts A and B cost sharing (copayments, coinsurance and deductibles), regardless of their type of plan, are protected from balance-billing. Providers may not balance bill a dual eligible Member for whom the state holds harmless in any MA plan beginning 1/1/2010 and must either bill the appropriate state source or accept the MA Plan payment in full.</i>
What Dual Special Needs Plans (D-SNPs) does WellCare offer?	Access and/or Select Dual Special Needs Plans (D-SNPs) are available in all markets, with the exception of Hawaii. <i>Advocate Complete and Liberty</i> are Dual Special Needs Plans (D-SNPs) available only in certain counties in New York.

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Will all WellCare D-SNP Members receive a Health Risk Assessment (HRA)?	Yes. All existing WellCare Members (as of October 1, 2009) will begin receiving a telephonic Health Risk Assessment completed between October 1, 2009, and June 30, 2010. All newly enrolled D-SNP Members will have a Health Risk Assessment completed within ninety (90) days of enrollment.
How often are Health Risk Assessments (HRAs) completed?	Re-assessments are completed annually for existing Members.
What services do all D-SNP Members receive in the Model of Care Program?	<p>All D-SNP Members receive:</p> <ul style="list-style-type: none"> • A Health Risk Assessment (HRA) • An individualized Care Plan providing coordination of care and assisting with any transition services • Regular telephonic contact with their Nurse Case Manager • Interdisciplinary Care Team meetings to re-evaluate the Member's needs • Periodic mailings for preventive health care or reminders
What is the Health Risk Assessment (HRA) used for?	The Health Risk Assessment is used to determine the Member's level of health and functioning. From this, WellCare, with the help of the Member's Providers, develop an individualized Care Plan for each WellCare D-SNP Member.
What is the individualized Care Plan used for?	The individualized Care Plan is based on feedback from the Member's Health Risk Assessment. The Care Plan is used to provide coordination of care and to assist the Member with any transition of care across health care settings and Providers. By increasing coordination and transition of care, WellCare can improve Members' access to medical, social and mental health services.
What are the health risk levels as identified by the Health Risk Assessment (HRA)?	The Health Risk Assessment is used to determine the Member's level of health and functioning. Members with Acuity Levels 1 or 2 have a higher level of functioning. Members with Acuity Levels 3 or 4 have a higher health risk and require additional Provider attention.
Why are Members with an Acuity Level of 4 provided a Home Health Assessment (HHA)?	The Home Health Assessment (HHA) is an added service for Members with an Acuity Level of 4 due to the higher level of risk based on their condition(s).
Can a Member's level of health and function improve or worsen?	Yes. Providers can expect Members to move up or down the continuum of care based on their changing health needs. If the Member's health improves or worsens, the Acuity Level may change to appropriately reflect their needs.

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<p>What are WellCare's expectations of the Provider(s)?</p>	<p>Ongoing participation from Providers and Members is essential to the success of the Model of Care program. Providers are requested to:</p> <ul style="list-style-type: none"> • Review the faxed Care Plan for <u>each</u> WellCare D-SNP Member to whom the Provider provides care • Update <u>each</u> Care Plan with any changes and fax back to WellCare if changes are necessary • Discuss the Care Plan with <u>each</u> WellCare D-SNP Member to whom the Provider provides care • Communicate with the Interdisciplinary Care Team (ICT) as requested to ensure optimal coordination of care and transition of care for the Member • Supply a copy (or copies) of the Care Plan to the Member upon request
<p>What is an Interdisciplinary Care Team (ICT)?</p>	<p>The Interdisciplinary Care Team comprises the Member's Case Manager, Caregiver (if applicable), Primary Care Physician, and any other health care professional providing care to the Member. Examples of health care professionals may be the Member's pharmacist, any specialist Providers, nurses, etc.</p>
<p>How can I contact the Case Management department?</p>	<p>Providers can reach WellCare's Case Management department at 1-866-635-7045 or may call the Nurse Case Manager directly by calling the number included on the fax cover sheet of the Member's Care Plan.</p>
<p>Are Pharmacy services impacted by the Model of Care Program?</p>	<p>Yes. The Member's Case Manager will work directly with a WellCare Medical Director and the Pharmacy department in instances in which the Member requires Pharmacy services.</p>
<p>What does "Dual-Eligible Member Cost Protections" mean?</p>	<p>Pursuant to Chapter 11 of the <i>Medicare Managed Care Manual</i> and WellCare's <i>2009-2010 Medicare Advantage Program Requirements Addendum</i>, Providers acknowledge and agree to not "balance bill" any Dual-Eligible Member for whom the State Medicaid agency holds harmless, for Medicare Part A and B Member Expenses;</p> <p>The Provider agrees that regardless of whether the amount the Provider receives is less than the allowed Medicare amount or Provider charges due to limitations on additional reimbursement provided in the State Medicaid Plan, the Provider will not "balance bill" the Dual Eligible Member;</p> <p>Additionally, the Provider agrees it will accept WellCare's payment as payment in full or will bill the appropriate State source if WellCare has not assumed the State's financial responsibility under an agreement between WellCare and the State.</p>

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<p>How do I correctly determine Dual-Eligible Member cost-share?</p>	<p>To correctly determine Member cost-share, ALWAYS check Member Eligibility by these three steps:</p> <ol style="list-style-type: none"> 1. Request <i>both</i> the WellCare ID card <i>and</i> the Medicaid ID card 2. Verify eligibility with both WellCare <i>and</i> the State's Medicaid program 3. Verify the Member's Medicaid eligibility level by using the state's Medicaid resource(s), such as Integrated Voice Response (IVR) or Medicaid Management Information System (MMIS)
<p>If I do not accept Medicaid, may I bill the Member directly?</p>	<p>No. Even if you do not accept Medicaid, you are prohibited from balance-billing a Dual-Eligible Member for whom the state holds harmless.</p>
<p>How do I correctly submit claims for reimbursement for a Dual-Eligible Member?</p>	<p>Submit for reimbursement based on one of the following scenarios:</p> <ol style="list-style-type: none"> 1. Non-Coordination of Benefits Agreement: <ul style="list-style-type: none"> ▪ Submit the claim to WellCare electronically or via paper ▪ WellCare will remit Medicare payment with an Explanation of Payment (EOP) ▪ Follow state Medicaid filing requirements for any applicable secondary payment 2. Coordination of Benefits Agreement <ul style="list-style-type: none"> ▪ Member cost-share is generally determined by WellCare and its contract with the state ▪ Submit the claim to WellCare electronically or via paper ▪ WellCare will remit two EOPs and two payments: <ul style="list-style-type: none"> ○ WellCare Medicare payment as primary ○ WellCare Medicaid cost-share payment (if applicable) ▪ You must accept WellCare's reimbursement as payment in full