DELAWARE HEALTH AND SOCIAL SERVICES

DELAWARE MEDICAID RETROACTIVE COVERAGE

PROVIDER FACT SHEET

The Division of Medicaid and Medical Assistance (DMMA) is expanding the groups of individuals who are eligible for retroactive Medicaid coverage. This fact sheet provides what you as a provider need to know!

What is retroactive coverage?

In accordance with 42 CFR 435.915, retroactive coverage means:

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

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

Who may be eligible to receive retroactive coverage?

If an individual (listed below) is determined to qualify for Medicaid during any one or more of the three months prior to the month of application, then the qualified individual will be determined to have "Retroactive Coverage" eligibility during those months. Retroactive coverage is potentially available (if general financial and technical requirements are met) to the following new groups:

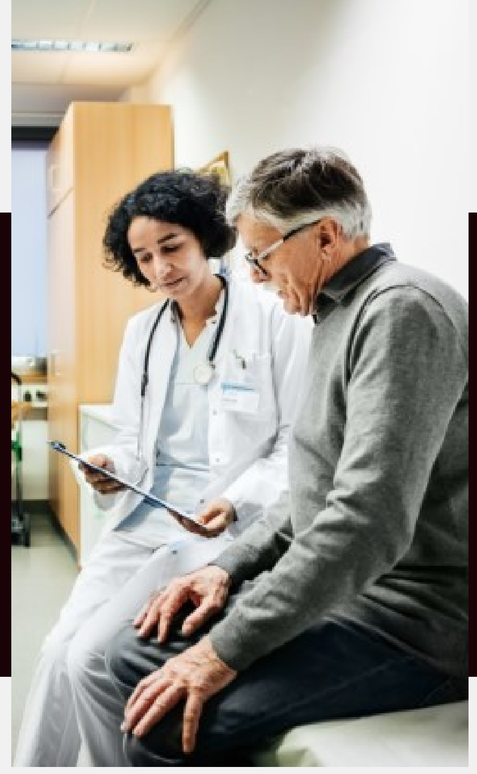
- Pregnant women (including during the 60–day postpartum period beginning on the last day of pregnancy; and
- Individuals under age 19.

When will the retroactive changes go into effect?

Effective July 1, 2020, retroactive coverage is available to qualified pregnant women (including during the 60-day postpartum period) and children under age 19. Additionally, any qualified individual who received a Medicaid-covered service on or after August 1, 2019 could be eligible to receive retroactive coverage for that service.

Who should I contact if I have questions?

Provider Services @ 1-800-999-3371;
Option 0, then Option 2



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How do providers seek reimbursement for unpaid services during the retroactive period?

Members who are determined eligible for retroactive coverage are being instructed to notify their provider(s) when they receive this approval. Providers must be enrolled with DMMA as a fee-for-service provider in order to submit a claim. Fee-for-service providers should submit claims to the Delaware Medical Assistance Program (DMAP) via the provider portal.

- For questions and assistance, providers can contact Provider Services @ 1-800-999-3371; Option 0, then Option 2.

In compliance with Federal Law, 42 CFR 435.915, providers are encouraged to return payment to members that were eligible for Delaware Medicaid Retroactive Eligibility.

If a member paid for a service during their retroactive coverage period, providers should promptly reimburse members if payment was previously made by the member during the three months prior to their eligibility month. Providers may then in turn submit claims to Delaware Medical Assistance Program (DMAP) for payment. FFS providers will submit claims via the DMAP Portal. Special provisions have been made to prevent denial of claims as part of this process.

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