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Managed Medical Assistance Frequently Asked Questions

1. General Medicaid and SMMC Questions

Question:

What is managed care?

Answer:

Managed care is a term for the process of how health care organizations manage the way their enrollees receive health care services. Managed care organizations work with different health care providers to offer quality health care services to ensure enrollees have access to the health care providers they need.

Question:

Why are changes being made to the Florida Medicaid Program?

Answer:

The Florida Legislature created a new program called “Statewide Medicaid Managed Care” (SMMC), which will change how some individuals receive health care from the Florida Medicaid program.

Question:

What is the intent of creating the Statewide Medicaid Managed Care program?

Answer:

The Statewide Medicaid Managed Care program is designed to: Emphasize patient centered care, personal responsibility and active patient participation; Provide for fully integrated care through alternative delivery models with access to providers and services through a uniform statewide program; and implement innovations in reimbursement methodologies, plan quality and plan accountability.

Question:

Does the SMMC program cut the Medicaid Budget?

Answer:

No, however, it is expected that with additional care coordination, the program may result in a reduction in growth of Medicaid expenditures and provide increased budget predictability.

Question:

How will changes be made to Florida Medicaid?
Managed Medical Assistance Frequently Asked Questions

Answer:

The Statewide Medicaid Managed Care program will be implemented statewide. The State has been divided into 11 regions that will coincide with the existing Medicaid areas. Each region must have a certain number of managed care plans. AHCA has invited qualified managed care plans to participate in the Statewide Medicaid Managed Care program, then choose the plans that may participate in the program through a competitive contracting process. AHCA must choose a certain number of managed care plans for each region to ensure that enrollees have a choice between plans. After plans are chosen, AHCA will begin to notify and transition eligible Medicaid recipients into the program. There will be two different components that make up the SMMC program: The Florida Long-term Care program and The Florida Managed Medical Assistance program. It is anticipated that the Florida Long-Term Care Managed program will be available in all areas of the state by March 1, 2014. It is anticipated that the Florida Managed Medical Assistance program will be available in all areas by October 1, 2014.

Question:

Is the Statewide Medicaid Managed Care program an expansion of the Medicaid Reform Pilot and will the current Medicaid Reform Pilot program, if it receives the federal extension, run in tandem with the Statewide Medicaid Managed Care program?

Answer:

No, legislation created the Statewide Medicaid Managed Care program independent of the Medicaid Reform Pilot. That said, Florida has received an amendment to the Agency’s current authority to operate the Reform Pilot to implement certain aspects of the Managed Medical Assistance program. It is also important to note the SMMC program will improve upon the current reform program and upon full implementation, the Reform Pilot will sunset.

Question:

How does a recipient find a list of providers accepting Medicaid?

Answer:

For a list of Medicaid enrolled physicians, please contact the Medicaid office in your area of the state. For a list of the Medicaid offices around the state, you can access the following link on the Agency for Health Care Administration’s website: http://ahca.myflorida.com/Medicaid/index.shtml#areas

Question:

What is the MMA program?

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Managed Medical Assistance Frequently Asked Questions

Answer:
MMA stands for the Managed Medical Assistance program. This is the program authorized in Part IV, Chapter 409, Florida Statutes, which includes the medical component of the Statewide Medicaid Managed Care Program, such as physician services, hospital, prescribed drugs, etc. It will be implemented in 2014. For more information on the MMA program, please go to the Agency for Health Care Administration’s Statewide Medicaid Managed Care Program website at:
http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#MMA

Question:
How does MMA affect the Program of All-inclusive Care for Children (PACC)?

Answer:
The Program of All-inclusive Care for Children (PACC) provides pediatric palliative care support services to children enrolled in the CMS Network who have been diagnosed with potentially life-limiting conditions and are referred by their primary care provider. Participation in PACC is voluntary. PACC services are currently available in 48 counties of the state. CMS Network care coordinators refer appropriate children to participating hospices for an assessment and development of a comprehensive care plan.

PACC services will only be provided under the CMS Specialty Plan. Services must continue to be provided by a participating hospice and are limited to the current services: Support Counseling, Expressive Therapies, Respite Support, Hospice Nursing Services, Personal Care, Pain and Symptom Management, and Bereavement and volunteer services.

Question:
Does this new statewide Medicaid managed plan take the place of the managed care system that we have in region 9-for instance we have United Health Care for Medicaid clients but they are not listed on your slide?

Answer:
Yes, the Statewide Managed Medical Care program takes the place of the existing Medicaid managed care programs in Florida.

Question:
How will the program changes affect pregnancy Medicaid?

Answer:
The MMA plans will offer pregnancy services for enrollees. Upon identification of an enrollee’s pregnancy through medical history, examination, testing, claims, or otherwise, the MMA plan shall immediately notify DCF of the pregnancy and any relevant information known (for example, due date and gender).
Managed Medical Assistance Frequently Asked Questions

Question:
Can you give some examples of what type of complaints should be directed to the centralized complaint unit?

Answer:
Complaints can relate to any problem a provider or recipient is having with a managed care plan including but not limited to a disruption in services, dissatisfaction with access to care, problems with claims, authorizations, network adequacy.

Question:
Regarding the specialty plans, are these for the PCP to enroll in or are these for specialists to enroll in?

Answer:
Each MMA specialty plan must provide a full array of services, including primary care and physician specialist services. Providers that wish to participate in a plan’s network must work directly with the plan to meet its credentialing requirements.

Question:
Does “patient responsibility” and “share of cost” mean the same thing?

Answer:
While these terms are often used interchangeably, ‘patient responsibility’ and ‘share of cost’ are not the same. Patient responsibility can be referred to as the recipient’s share in the cost of nursing facility care or the recipient’s ‘patient liability’.

‘Share of cost’ is a term used to refer to the Medically Needy program.

A recipient must submit the appropriate medical bills to the Department of Children and Families (DCF) before DCF can determine the individual has met their ‘share of cost’ and can be determined eligible for Medicaid as ‘Medically Needy.’

DCF calculates the amount of the recipient’s patient responsibility when DCF determines an individual eligible for the Institutional Care Program (ICP). DCF calculates the amount of a recipient’s patient responsibility using financial and technical criteria, based on the information submitted by the applicant.

Please note that a recipient cannot be eligible for ICP Medicaid if they are Medically Needy.

Question:
Why would a region not have a plan for HIV/AIDS? Where would those clients go?
Managed Medical Assistance Frequently Asked Questions

Answer:
Managed care plans were not required to submit proposals in response to the competitive bid in every AHCA region. Plans were able to choose the areas of the state they wished to bid on for a contract.

Question:
The implementation plan lists pre-welcome letter going out 120 days prior to region go-live. Today we heard 90 days. Which one is it?

Answer:
The pre-welcome letter for Managed Medical Assistance will be mailed to recipients 120 days prior to region go-live.

Question:
What will happen to the medically needy patients?

Answer:
There will be no changes in the way that Medically Needy recipients receive their services at this time. Once they meet their share of cost, they will continue to receive their services on a fee-for-service basis.

Question:
After the complete roll out what role will eQHealth and Sandata play in the authorization process and billing process?

Answer:
eQHealth is one of the Agency’s prior authorization vendors, and Sandata is an AHCA contractor, providing electronic visit verification (EVV) services for home health services. Once the SMMC program is fully implemented in all regions, eQHealth and Sandata will continue to provide utilization management or quality assurance services (as specified in their contract) for those recipients who remain in fee-for-service.

Question:
For recipients that have "other creditable health care coverage" and that will not be required to enroll in MMA, will Medicaid continue paying providers directly for the services rendered?

Answer:
Yes. Medicaid will continue to reimburse providers directly for services rendered to recipients in fee-for-service. However, if the recipient has TPL (private insurance) the provider must bill the TPL source prior to billing Medicaid.

Question:
How does Assisted Living fit with the MMA program?
Managed Medical Assistance Frequently Asked Questions

Answer:
Assisted Living Facilities (ALFs) are eligible to provide assistive care services under the MMA program. The ALF provider must contract with the managed care plan in order to bill the plan for assistive care services provided to MMA recipients. For more information about ACS services in the SMMC program, please visit this link: http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Assistive_Care_Services_Flyer.pdf. You can also review the Agency’s webinar on Mixed Services, located at http://ahca.myflorida.com/SMMC. Select News and Events, then Event and Training Materials.

Question:
What is the date for the roll out of the Child Welfare specialty plan? Will this plan be available at the same time as the standard plans?

Answer:
The Child Welfare Specialty Plan will roll out at the same time as the standard MMA plans, according to the MMA roll-out schedule. To view the roll-out schedule, please visit: http://ahca.myflorida.com/MEDICAID/statewide_mc/#MMA

Question:
Will there be a mechanism for MMA plans to assess the patients for long term care needs to be enrolled into a LTC managed care program?

Answer:
No. Comprehensive Assessment and Review for Long-Term Care Services (CARES) staff will continue to be responsible for determining medical eligibility for Medicaid long-term care services. Recipients who are interested in accessing home and community-based services through the Statewide Medicaid Managed Care Long-term Care program must submit an application through their area Aging and Disability Resource Center (ADRC). Individuals will be enrolled onto the LTC program, as funding becomes available to serve additional participants. MMA enrollees wishing to enroll in the LTC program can continue to receive state plan services through their MMA plan until they are able to enroll in an LTC plan.

Question:
Will the MCO transition have any impact to the processing of pharmacy claims for other programs covered by the State of FL like the Division of Blind Services, Brain & Spinal Injury, or FL Vocational Rehab?
Managed Medical Assistance Frequently Asked Questions

Answer:

No, there will be no impact on the processing of these claims due to the transition to Medicaid managed care.

Question:

Will providers continue treating and billing CMS kids the same way we do now?

Answer:

No. The Children’s Medical Services Network (CMSN) Plan will receive and process claims through their third party administrator. Children currently enrolled in the Children’s Medical Services (CMS) program will have the option to transition to the Children’s Medical Services Network (CMSN) Plan, when it becomes operational on August 1, 2014. Providers must be contracted with the CMSN Plan in order to continue providing services to these recipients.

Question:

If there are claims with date of service prior to June 30th, 2014 but are submitted to Medicaid after June 30th, 2014 will Medicaid still be responsible for paying the provider?

Answer:

The provider should submit claims to the source in which the recipient was enrolled in at the time the service was provided (e.g., current Medicaid health plan, MMA plan or LTC plan, or fee-for-service Medicaid).

Question:

Is there a list of the Comprehensive MMA plans?
Answer:

Comprehensive plans are managed care plans that offer both Long-term Care and Managed Medical Assistance coverage in a region. The following reflects the comprehensive plans and the type of plan coverage they are providing in each region.

<table>
<thead>
<tr>
<th>SMMC Region</th>
<th>Amerigroup</th>
<th>Coventry</th>
<th>Humana</th>
<th>Molina</th>
<th>Sunshine</th>
<th>United</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>MMA</td>
<td>LTC</td>
<td>LTC</td>
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<td>LTC</td>
<td>COMP</td>
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<tr>
<td>5</td>
<td>MMA</td>
<td>LTC</td>
<td>LTC</td>
<td>COMP</td>
<td>LTC</td>
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<tr>
<td>6</td>
<td>MMA</td>
<td>LTC</td>
<td>MMA</td>
<td>LTC</td>
<td>COMP</td>
<td>LTC</td>
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<tr>
<td>7</td>
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<tr>
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<td></td>
<td>LTC</td>
<td>MMA</td>
<td>MMA</td>
<td>COMP</td>
<td>LTC</td>
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<td>COMP</td>
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<tr>
<td>11</td>
<td>COMP</td>
<td>COMP</td>
<td>COMP</td>
<td>COMP</td>
<td>COMP</td>
<td>COMP</td>
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</tbody>
</table>

Question:
Can you please clarify if managed care plans are now the only plans available under Florida Medicaid?

Answer:

Upon implementation of the Managed Medical Assistance component of the Statewide Medicaid Managed Care program, MMA and Long-term Care (LTC) plans will be responsible for providing services to most Medicaid recipients. Recipients who are not required to participate or who are excluded from participation in the SMMC program will continue to receive their services through fee-for-service Medicaid.

Question:
Will existing health plans be going away?

Answer:

Once the MMA program is implemented in a region, current health plans that were not awarded contracts under the Managed Medical Assistance program will no longer cover services. To view a list of all MMA plans and their regions of operation, please review the MMA Snapshot, located at http://ahca.myflorida.com/SMMC. Select the Managed Medical Assistance tab, and then the Managed Medical Assistance program Snapshot.

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Managed Medical Assistance Frequently Asked Questions

Question:
The 60 day period that providers can continue to provide services is after the effective date of the MMA plan? and if so, do providers get paid by continuing to bill Medicaid (ex-MediPass) after the cutoff date?

Answer:
Service providers should continue providing services to MMA enrollees during the continuity of care period for any services that were previously authorized or prescheduled prior to the MMA implementation, regardless of whether the provider is participating in the plan’s network. Providers should notify the enrollee’s MMA plan as soon as possible of any prior authorized ongoing course of treatment or prescheduled appointments. Non-participating providers will continue to be paid at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning to the MMA plan for a minimum of 30 days, unless the provider agrees to an alternative rate. Providers will need to follow the process established by the managed care plans for getting these claims paid appropriately.

Question:
For pediatric patients who have straight Medicaid secondary to private insurance and do not choose to enroll in a MMA plan, how will this affect eQHealth authorization requirements for pediatric inpatient and recurring therapies?

Answer:
eQHealth will continue to provide authorization for Medicaid fee-for-service inpatient and therapy services for those recipients who are not enrolled in an MMA plan. MMA plans will only process authorization requests for their enrollees.

Question:
As a provider, is there a way to access recipient address information so we can notify and assist our clients in updating incorrect addresses?

Answer:
No. the Agency cannot share recipient information unless the proper authorization is obtained from the recipient. As such, it is important to encourage recipients to visit or contact their local Department of Children and Families (DCF) Service Center. A list of the service centers is available on the DCF website at: http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/locate-service-center-your-area. Recipients may also use DCF’s online ACCESS system to complete and submit a Change Report Form (CF-ES 3052A) electronically.

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Managed Medical Assistance Frequently Asked Questions

Question:
Where can we get more information on what exactly is going on with the CMS Network in regards to Title 21 shifting over Title 19 and such?

Answer:
Children currently enrolled in Title XXI CMS will be eligible for participation in the MMA program if their family income is under 133% of the federal poverty level. Eligible recipients receiving Title XIX or Title XXI benefits may choose from among any of the available MMA plans in their region or transition to the CMSN plan on August 1, 2014.

Question:
Does Medicaid waiver MWA still exist with SMMC?

Answer:
MWA is an aid category designation for recipients who have met income requirements and been approved for participation in a Medicaid home and community-based waiver. Some recipients enrolled in the Long-term Care program or one of the other Medicaid waivers will continue to have the MWA aid category under the Statewide Medicaid Managed Care program.

Question:
If a Medicaid patient received personal care services only, that were approved already by eQ health, what happens with that client?

Answer:
eQ Health will continue to provide prior authorization for personal care home health services to recipients not participation in the MMA program. eQ is contracted with the Agency to provide utilization management for the Home Health program.

Question:
How does SMMC impact concurrent care for children receiving hospice care? Which program will cover this care—LTC, MMA, Comprehensive, or Specialty plan?

Answer:
Concurrent care for children is a mandatory provision for all states. In September 2010, a letter was sent from the Centers for Medicare and Medicaid to all State Medicaid Directors instructing them to submit a State Plan Amendment (SPA) to implement this provision of the ACA. Florida’s SPA was approved in March 2012. Under the policy for concurrent care for children, curative services are paid for separately from those provided under the child’s hospice benefit. For a child who is receiving hospice services and is enrolled in a Managed Medical Assistance plan, the Managed Medical Assistance Plan, hospice, and treating providers must work closely together to ensure care plans and services are coordinated.
Managed Medical Assistance Frequently Asked Questions

Question:
For physicians caring for nursing home residents, how would they be involved in the MMA program?

Answer:
Physicians will need to contract with the recipient’s MMA plan in order to continue providing physician services to nursing facility residents who are enrolled in an MMA plan. Regardless of the enrollee’s LTC plan enrollment, physician services are billed to the recipient’s MMA plan, separate from the nursing facility per diem. If the enrollee has Medicare, physician services must first be billed to Medicare, and the MMA plan will cover any crossover (co-payment, coinsurance, or deductibles) payments.

Question:
Are you going to be posting a MMA Provider Manual and Medicaid Summary of MMA Services Manual?

Answer:
Yes, the Agency intends to post, on its Web site, a document that can be used by providers as a resource for information on the MMA program.

Question:
What is the difference between an MMA plan and a comprehensive plan?

Answer:
A Managed Medical Assistance (MMA) plan provides medical, dental, and behavioral health services for its enrollees. A comprehensive plan, also called a comprehensive long-term care plan, is a managed care plan that holds a contract with the Agency to cover both Long-term Care (LTC) and Managed Medical Assistance services.

Question:
Are there comprehensive plans in ALL areas of the state?

Answer:
Here is a chart of the regions in which a comprehensive plan is available.

<table>
<thead>
<tr>
<th>Region</th>
<th>Comprehensive Plans Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None available</td>
</tr>
<tr>
<td>2</td>
<td>None available</td>
</tr>
<tr>
<td>3</td>
<td>Sunshine, United</td>
</tr>
<tr>
<td>4</td>
<td>Sunshine, United</td>
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<td>5</td>
<td>Sunshine</td>
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<tr>
<td>6</td>
<td>Sunshine</td>
</tr>
<tr>
<td>7</td>
<td>Molina, Sunshine, United</td>
</tr>
<tr>
<td>8</td>
<td>Sunshine</td>
</tr>
<tr>
<td>9</td>
<td>Sunshine</td>
</tr>
<tr>
<td>10</td>
<td>Humana, Sunshine</td>
</tr>
<tr>
<td>11</td>
<td>United, Amerigroup, Sunshine, Molina, Humana, Coventry</td>
</tr>
</tbody>
</table>

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Managed Medical Assistance Frequently Asked Questions

Question:
What is the advantage of joining a Comprehensive Plan?

Answer:
The advantage of joining a comprehensive plan is the increased ability of the managed care plan to coordinate care. The comprehensive plan will assign enrollees to a single care coordinator, who will conduct an assessment and assist the recipient in accessing needed medical and long-term care services. The care coordinator will be responsible for coordinating with the recipient’s medical and long-term care providers.

2. Agency Payment to Plans

No Questions at this time

3. Health Plan Contracts

Question:
Will the HMOs be required to serve the rural areas of the state? How will AHCA ensure that plans enter rural areas and remain in those areas?

Answer:
In order to ensure managed care plan participation in rural areas of the state, the Agency was directed to award an additional contract to each plan with a contract award in Region 1 or Region 2, which is mostly in the Panhandle area. The additional contract shall be in any other region in which the plan submitted a responsive bid and negotiates a rate acceptable to the Agency. There are several provisions in place to provide stability to recipients. First, there are penalties for plans that reduce enrollment levels or leave a region before the end of the contract term. Specifically, if a plan reduces enrollment or leaves a region before the end of their contract, they must reimburse the Agency for the cost of enrollment changes and other transition activities associated with the plan action. In addition to the payment of these costs, substantial financial penalties are imposed on the plans. If a plan is going to withdraw from a region, the plan is required to provide at least 180 days’ notice to the Agency. Finally, if a plan leaves a region before the end of the contract term, the Agency is required to terminate all contracts with that plan in other regions.

Question:
Are all of the MMA plans that participate going to follow Medicaid guidelines or will they each have their own set of standards for say authorizations required, etc. or will there be one set of authorization standards?

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Managed Medical Assistance Frequently Asked Questions

Answer:

Yes, all managed care plans are required to comply with any Medicaid Coverage and Limitations handbooks. However, the plans are permitted to establish their own processes for utilization management determinations.

Question:

Are the fee for service plan provider names available?

Answer:

There is one fee for service plan in Long-term Care—American Eldercare. There are no fee for service plans in MMA.

Question:

The health plans that were not chosen, once their members are transition, would those health plans have any obligations to continue with any contract requirements?

Answer:

Some contract provisions, such as certain reports, will continue for a period of time, but they will not be providing services once their members transition to an MMA plan.

Question:

For the new Managed Medical Assistance programs being implemented this Spring and Summer, how long are the contracts for the managed care plans?

Answer:

The MMA plan contracts are for five years.

Question:

Will FQHC (federally qualified health centers) be part of the MMA program?

Answer:

Yes, MMA plans can include FQHC’s in their provider network.

Question:

In AHCA’s contract with a Medicaid HMO/PSN, were there any requirements established related to a Health Plan’s utilization management (UM) program, policies and procedures? For instance, timeframes to respond to a provider’s request for preauthorization on a diagnostic procedure (e.g. MRI)
Managed Medical Assistance Frequently Asked Questions

Answer:

Yes. The model contract describes general provisions for a UM program. However, the Managed Care Plan plans can establish their own program specific UM requirements. Managed Care Plans must provide notice within seven days of their decision for a standard authorization, and within 48 hours for an expedited authorization. If the enrollee or provider request an extension and the extension is in the enrollee’s best interest, the Managed Care Plan may extend the timeframe by up to an additional seven days for a standard authorization and by up to an additional two days for an expedited authorization.

Question:

I notice that United Healthcare HMO is not X'd in District 6. Does this mean that UHC will no longer be participating in this area and the patients we have not will have to change to another plan? Will they be getting a letter as well that their plan is changing?

Answer:

United Health Care will not have an MMA plan available in Region 6. Recipients will need to choose an MMA plan that best meets their needs. Current health plans that did not receive a contract in a region will send providers in their network a notice 30 days prior to the implementation of MMA in that region notifying them of the change. Providers should seek to enroll with MMA plans that will be providing services in their region if they wish to continue to serve Medicaid recipients.

Recipients will receive a series of letters in the months prior to the MMA implementation in their region to inform them about the program and how to select an MMA plan.

The MMA plan must continue to pay for ongoing treatment for up to 60 days after the effective date of a recipient’s enrollment or until the enrollee's PCP or behavioral health provider reviews the enrollee's treatment plan, whichever comes first. However, after the continuity of care period, if the provider is still not a part of the plan’s network, the enrollee may have to change providers in order for the plan to continue to pay for services. If the enrollee must change to a new provider, the plan must ensure that any needed medical records information is transferred and that services continue uninterrupted until treatment resumes with the new provider.

Question:

Will current HMO plans stay in effect?

Answer:

Many of the current health plans will continue to provide services in the MMA program. Information about the MMA plans available in your region can be found on the SMMC website at the following link:

http://ahca.myflorida.com/SMMC.
Managed Medical Assistance Frequently Asked Questions

4. MMA Recipient Eligibility

Question:
Does the SMMC program change eligibility for Medicaid in Florida?

Answer:
No, the Statewide Medicaid Managed Care program does not change Medicaid eligibility requirements.

Question:
Are individuals who are receiving home health services under the State Plan required to enroll in LTC plans? Will they be required to enroll in SMMC?

Answer:
Individuals not residing in a nursing facility and not receiving services through one of the identified home and community-based waiver programs will not be required to select a LTC plan to manage their Medicaid home health services. Once the Managed Medical Assistance (MMA) program is implemented, individuals who are receiving home health services under the State Plan will be required to enroll in an MMA plan.

Question:
Will the MediPass program continue in any form after the Statewide Medicaid Managed Care program is implemented?

Answer:
No, all recipients currently enrolled in MediPass are mandatory for plan enrollment under the Statewide Medicaid Managed Care program. Unlike the current system, the definition of “plan” under the SMMC program does not include MediPass. HB 7109 creates an interim program in which the Agency is required to contract with a single Provider Service Network to function as a managing entity for the MediPass program in all counties with fewer than two prepaid plans. The authority to maintain this contract expires October 1, 2014, or upon full implementation of the Managed Medical Assistance program, whichever is sooner.

Question:
Will dual eligibles be handled under the statewide expansion by a special program, or will they be directed to specialty plans such as United Evercare, or will they be absorbed with the rest of the Medicaid population?
Managed Medical Assistance Frequently Asked Questions

Answer:
There is not a separate program for dual eligibles. Duals eligible for the Long-term Care (LTC) program must choose a LTC plan. Those not eligible for LTC will choose a Managed Medical Assistance (MMA) plan when one becomes available in their area. In both the LTC and MMA programs, if a dual eligible does not make a choice of plan, he or she will be assigned to a plan.

Question:
Could you please clarify if people with Developmental Disabilities that live in private ICF/DD settings are required to apply for Managed Care?

Answer:
Recipients residing in an ICF/DD are excluded from enrollment in the LTC program; they cannot enroll in a Long-term Care plan. Recipients residing in an ICF/DD are voluntary for the MMA program; they are not required to enroll in an MMA plan but can choose to do so. ICF/DD services will be reimbursed by the MMA plan for recipients in those settings who choose to enroll in an MMA plan.

Question:
Are children residing in nursing home part of the LTC program or MMA program? Are they required to enroll?

Answer:
Recipients under the age of 18 are not eligible for the Long term Care (LTC) program. Recipients under the age of 18 residing in a nursing facility are required to enroll in the Managed Medical Assistance (MMA) program. Nursing facilities that serve a recipient under the age of 18 enrolled in a MMA plan will bill Medicaid fee-for-service for the recipient’s nursing facility care.

Question:
Can you confirm that recipients currently receiving Medicaid private duty nursing services in the home will be part of this program, unless they have an intellectual disability?

Answer:
For Long-term care, individuals not residing in a nursing facility and not receiving services through one of the identified home and community-based waiver programs will not be required to select a LTC plan to manage their Medicaid home health services. Once the Managed Medical Assistance (MMA) program is implemented, most individuals who are receiving home health services under the State Plan will be required to enroll in an MMA plan. Exceptions to this are excluded populations such as children receiving services in a Prescribed Pediatric Extended Care center or populations that can choose whether or not to enroll in an MMA plan, such as individuals with intellectual disabilities.

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Question:

Who will be allowed to stay in the Medicaid fee-for-service (FFS) program not covered under the Managed Medical Assistance (MMA) Program?

Answer:

The following individuals are NOT required to enroll, although they may enroll if they choose to:

- Medicaid recipients who have other creditable health care coverage, excluding Medicare
- Persons eligible for refugee assistance
- Medicaid recipients who are residents of a developmental disability center
- Medicaid recipients enrolled in the developmental disabilities home and community based services waiver or Medicaid recipients waiting for waiver services
- Children receiving services in a prescribed pediatric extended care center

The following individuals are NOT eligible to enroll:

- Women who are eligible only for family planning services
- Women who are eligible through the breast and cervical cancer services program
- Persons who are eligible for emergency Medicaid for aliens

Question:

What will happen if a child loses their Medicaid eligibility? Will they still be eligible to enroll in SMMC?

Answer:

No. With the exception of two special eligibility categories under the Long-term Care program (Medicaid pending and SIXT), individuals must have fully Medicaid eligibility in order to enrol in the SMMC program. Please see the FAQs for more information about these special eligibility categories.

Question:

Will FLMMIS still be available to check eligibility once MMA is rolled out?

Answer:

Yes. The Agency is in the process of schedule a webinar on verifying eligibility and enrollment in April. To receive an update when the webinar is available, go to http://ahca.myflorida.com/SMMC and click the Program Updates button on the right-hand side to sign up. You can also check periodically for new informational materials on the same website by going to the News and Events tab and selecting Event & Training Material.
Managed Medical Assistance Frequently Asked Questions

Question:
There will be two different components that make up Statewide Medicaid Managed Care, the Long-Term Care Managed Care Program and the Managed Medical Assistance Program.

As a provider will we know which of our patients are enrolled in a Long-term care plan, a Managed Medical Assistance plan or both? Is there something that would tell us beyond patient notification?

Answer:
Providers will be able to check a plan enrollee’s eligibility in the FMMIS web portal. After the Managed Medical Assistance program is implemented, all MMA enrollees will have a SMMC-MMAC span. Long-term Care plan enrollees will have either a SMMC-LTCC or a SMMC-LTCF span. Recipients in LTC will also have a SMMC-MMAC span, once their enrollment in an MMA plan begins. Each span will identify the plan or plans a recipient is enrolled in.

Question:
Do children that have been adopted from foster care that now have straight Medicaid have to enroll in a plan?

Answer:
Yes, recipients who have adoption subsidy Medicaid are mandatory for enrolling in an MMA plan, unless they are otherwise excluded from participation in the program.

Question:
Will kids who have commercial insurance and Medicaid as a secondary be required to enroll in MMA or will they remain fee for service?

Answer:
Medicaid recipients who have other creditable health care coverage, excluding Medicare may voluntarily choose to participate in the managed medical assistance program.

Question:
If the client has primary commercial coverage and Medicaid secondary, do they continue to have Medicaid through the state as straight Medicaid?

Answer:
Recipients with other creditable coverage (other than Medicare) are voluntary for enrollment into an MMA plan under the Statewide Medicaid Managed Care program. They can choose to enroll in a managed care plan, but are not required to do so. If the recipient does not enroll in an MMA plan, he or she will continue to receive their Medicaid services through fee-for-service Medicaid.

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Managed Medical Assistance Frequently Asked Questions

Question:
If a recipient with a third party insurance loses their primary insurance, will they be enrolled in an MMA plan?

Answer:
If a Medicaid recipient loses their primary coverage and Medicaid becomes the recipient’s primary coverage, the recipient will likely have to enroll in an MMA plan, unless he or she is excluded from or voluntary for participation under some other category specified in the law. If the recipient becomes mandatory for an MMA plan, the recipient will receive a welcome letter to instruct them to select an MMA plan. For information on which recipients are eligible for MMA please visit: http://ahca.myflorida.com/SMMC.

5. Network Provider Contracts

Question:
What does a potential network provider need to know about the difference between a PSN and an HMO? Are there different requirements with regard to contracting?

Answer:
The main difference for network providers is how they are paid. HMOs (capitated) directly pay their network providers. PSNs may be either capitated or fee-for-service (FFS). If FFS, providers will be paid by the Agency’s fiscal agent after the claims are submitted to the PSN for authorization. The PSN awarded a Long-term Care contract is a FFS PSN. The contracting requirements are generally the same for HMOs and PSNs. Because of the way providers get paid, providers contracted with the FFS PSN must be enrolled as Florida Medicaid providers. HMOs and capitated PSNs need only ensure that all contracted providers are eligible for participation in the Medicaid program and that all providers are registered with Medicaid.

Question:
Will health plans in the SMMC program be required to have a certain number of primary care doctors and specialists?
Managed Medical Assistance Frequently Asked Questions

Answer:

Yes, the Agency has established specific standards for the number, type, and regional distribution of providers in plan networks. In addition, plans are required to establish and maintain online an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, and specific performance indicators. The provider database must allow comparison of the availability of providers to network adequacy standards and accept and display feedback from each provider’s patients. Finally, certain providers are classified as essential providers and must be included in plan networks for at least the first contact year. Other providers are considered statewide essential providers and must be included in all plan networks.

Question:

Will ancillary providers be able to contract with MMA Standard Plans?

Answer:

MMA plans are required to provide most services covered under the Medicaid State Plan and to maintain a network of providers that can address the needs of their enrollees.

Question:

Will Specialty pharmacies be required to contract with each MMA HMO and PSN separately to be able to provide for their recipients?

Answer:

Yes. In order to receive reimbursement for services rendered to Medicaid recipients enrolled in an MMA plan, providers will need to contract directly with the plans (HMOs and PSNs) available in their region. MMA plans must ensure that all contracted providers are eligible for participation in the Medicaid program and that all providers are registered with Medicaid. Information about contracting with the MMA plans available in your region can be found on the SMMC website at the following link: [http://ahca.myflorida.com/SMMC](http://ahca.myflorida.com/SMMC).

Question:

We are a Optometry network for Medicaid plans in the state. Can you kindly advise on what the standards will be for us to provide utilization data to the plans for submission to the state for Routine Optometry?

Answer:

The MMA plans are responsible for submission of utilization data to the State through encounter claims. Each MMA plan will include requirements for submission of claims data in its provider contracts, as well as provide training to its provider network on submission requirements.

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Managed Medical Assistance Frequently Asked Questions

Question:
What happens if you provide service to an MMA enrollee and you are not a participating provider?

Answer:
The MMA plan must reimburse for any previously authorized services for up to 60 days or until the recipient’s primary care physician or behavioral health provider has reviewed the recipient’s treatment plan, whichever comes first regardless of whether the provider is participating in the plan’s network or not. After that time period, in order to receive reimbursement, the provider must contract or develop an agreement with the MMA plan in order to get paid for services provided to the enrollee.

Question:
We have been asked to contract with Magellan and they are not listed in area 6 as a provider. Are they going to be added?

Answer:
Magellan Complete Care was awarded a contract as a specialty plan serving recipients with serious mental illness in Region 6. Please view our Web site for plan contact information if you wish to join their networks.
6. Plan Payment to Providers

Question:
The requirement to increase physician fees - will this apply to dental providers too? If not how will you prevent dental fees from being reduced? My concern is that if there is not a requirement to keep or increase dental provider pay levels and there is an incentive for health plans to share in savings, what prevents the health plans from cutting dental?

Answer:
Dental providers are not included in the requirement for Managed Medical Assistance (MMA) plans to increase physician compensation Medicaid rates to be equal to or exceed Medicare rates. The MMA plans are required to cover full dental services to recipients under the age of 21. Also, some plans have elected to offer dental services to recipients age 21 and older as an expanded benefit. The MMA plans must report certain requirements to the Agency to ensure that quality services are being rendered. MMA plans that meet or exceed certain benchmarks will be eligible for an achieved savings rebate. If they fall below the required benchmark they are subject to sanctions or liquidated damages. The MMA plans are also required to conduct at least one performance improvement project with a focus on preventative dental care for children. MMA plans are required to report their performance on the following dental services measures: annual dental visits, complete oral evaluation and sealants.

Question:
Will providers still be able to send claims to FL for DME items or will they need to be sent directly to the managed care companies?

Answer:
Medical Equipment and Supplies, which includes durable medical equipment (DME), is a covered service under the managed long-term care program. All enrollees in the program will access necessary DME services through their managed long-term care plan’s network of service providers and the providers will bill the LTC plan for reimbursement. If the individual is not in an LTC plan, but is in an MMA plan, the provider will bill the MMA plan for medical equipment and supplies.

Question:
How will services for a child placed in SIPP facilities be funded? Currently we have to go thru a staffing to get the funding but I don't know what will happen after this change.

Answer:
The MMA Plans will pay Statewide Inpatient Psychiatric Programs (SIPPs) the payment rates established by the Agency.
Question:
Will each managed care program have their own fee schedules or will they all follow one straight Medicaid fee schedule?

Answer:
The MMA plans may set their own fee schedules, with some limited exceptions.

Question:
What form do we use to bill services under the Statewide Medicaid Managed Care Program?

Answer:
The Agency has not directed the managed care plans to utilize a specific billing format. The plans must be able to accept electronically transmitted claims from providers in HIPAA compliant formats. The plans must additionally ensure that claims are processed and comply with the federal and state requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., whichever is more stringent.

Question:
Will all hospice care performed at home or in a nursing home be billed to the MCO’s? Meaning the routine, respite continuous care, and GIP (general inpatient) levels of care.

Answer:
Yes, hospice claims for enrollees in the Long-term Care program or the Managed Medical Assistance program should be submitted to the managed care plan for processing.

Question:
What Benefit Plan codes on the AHCA eligibility screen would hospice providers see if the patient is all set up correctly to bill hospice service to the MCO’s?

Answer:
There is no one specific benefit plan that a provider might see if a recipient is eligible for hospice services. Providers will be able to check a plan member’s eligibility in the FLMMIS web portal. Long-term Care plan members will have either a SMMC-LTCC or a SMMC-LTCF span. Managed Medical Assistance plan members will have a SMMC-MMAC span. Prior to rendering services, hospice providers should check with the recipient’s managed care plan to ensure that all service authorization requirements have been met.
Managed Medical Assistance Frequently Asked Questions

Question:
If a patient is in both the LTC and MMA, which program pays for the DME?

Answer:
If a recipient is in both the Long-term Care program and the Managed Medical Assistance Program, the Long-term Care plan would pay for the recipient’s Durable Medical Equipment.

Question:
Will there be universal authorization request forms or will we have to fill out and submit authorization request differently for each HMO?

Answer:
Authorization forms may vary depending on the managed care plan(s) with which you have contracted. This should be addressed in your contract or provider handbook from the managed care plan.

Question:
Does the requirement that the physicians be paid at or above Medicare apply to all specialties?

Answer:
The Affordable Care Act physician fee increase applies to primary care physicians. The MMA plans must ensure the physician payment applies to such primary care services provided by physicians with a specialty designation of family medicine, general internal medicine, or pediatric medicine or related subspecialists. [Source: Required MMA Benefits: Attachment II-A, Section V.A.1.(24)(d)(ii)]

In addition, Florida law requires that after two (2) years of continuous operation under the SMMC program, the MMA plan’s physician payment rates must equal or exceed Medicare rates for similar services. The Agency may impose fines or other sanctions if the plan fails to meet this performance standard. [Source: Other Sanctions: Attachment II, Section XI.D.3.]

Question:
With regard to the MMA roll out, if a participant’s home address is from one region that has already rolled out this change and the participant moves to a region that has not rolled out this plan, how does the provider handle whom to bill for those services.

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Managed Medical Assistance Frequently Asked Questions

Answer:

A Medicaid recipient must update their address with the Department of Children and Families or Social Security Administration after moving. This address change will trigger a change of Managed Care Plans in the Medicaid enrollment system. Providers must verify eligibility prior to providing services to a recipient and contact the recipient’s managed care plan to determine whether authorization is needed. All services provided to an enrollee out of area must be prior authorized by the Managed Care Plan. Prior to the full implementation of the MMA program in August 2014, an MMA enrollee will be put in fee-for-service if he or she moves to an area where the MMA program has not been implemented.

Question:

Will the Medicaid Managed Care program pay the providers their usual bill rates?

Answer:

Except where specified in the law, providers and the Managed Care Plan will negotiate mutually agreed-upon rates as part of their contract.

To ensure continuity of care during the implementation, MMA plans must pay non-participating providers at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of 30 days, unless the provider agrees to an alternative rate. The only exception to the requirement is for pharmacy services:

- For the first 60 days after implementation in a region, MMA plans or Pharmacy Benefit Managers (PBMs) are required to operate open pharmacy networks so that enrollees may continue to receive their prescriptions through their current pharmacy providers until their prescriptions are transferred to in-network providers. MMA plans and/or PBMs must reimburse non-participating providers at established open network reimbursement rates.

- For new plan enrollees (i.e., enrolled after the implementation), MMA plans must meet continuity of care requirements for prescription drug benefits, but are not required to do so through an open pharmacy network.

Question:

Will claims for MMA participants enrolled in the Children’s Medical Services Network continue to be submitted as fee for service or will CMS handle claims similar to the commercial MMA plans?
Managed Medical Assistance Frequently Asked Questions

Answer:

Except for pharmacy claims, the CMSN Plan under MMA will authorize and pay claims through its third party administrator.

Question:

What are the payment rules governing Pre Medicaid Expansion and Post Medicaid Expansion in regard to non-contracted providers with the plans, Emergent and non-Emergent?

Answer:

MMA plans are responsible for the costs of continuing any ongoing course of treatment without regard to whether such services are being provided by participating or non-participating providers. Once SMMC has been implemented in a region, the non-contracted provider should continue to serve their existing client for up to 60 days, or until the enrollee’s primary care practitioner or behavioral health provider reviews the enrollee’s treatment plan. The MMA plan must pay non-participating providers at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of 30 days, unless the provider agrees to an alternative rate. The MMA plan must cover any medically necessary stay in a non-contracted facility, which results from a medical emergency, until such time as the MMA plan can safely transport the enrollee to a participating facility. The MMA plan is not liable for the cost of non-emergency services if the plan did not refer the enrollee to the non-participating provider or authorizes the out-of-network services.

Question:

Will LTC or MMA provider rate/reimbursement information be posted on the agency’s web site?

Answer:

Unless specified in law, LTC and MMA plans and their providers will develop mutually acceptable rates which will be specified in the provider’s contract.

Question:

Will MMA provider rates be static through all SMMC providers?

Answer:

Unless specified in law, LTC and MMA plans and their providers will develop mutually acceptable rates which will be specified in the provider’s contract.

Question:

If we have issues with the MMA plans on the way they process our claims, how involved is the state going to be in resolving these issues?

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Answer:
The Agency will monitor timely payment of claims by MMA plans monthly and will issue monetary fines to plans determined not to meet requirements for timely claims processing. For help with billing issues, providers can contact the LTC or MMA Plan or use the Agency’s complaint process by submitting an issue online at: http://ahca.myflorida.com/SMMC. Select the blue “Report a Complaint” button and complete the online form. If you need assistance completing this form or wish to verbally report your issue, please contact your local Medicaid area office. Find contact information for the Medicaid area offices at: http://ahca.myflorida.com/AreaOffices

Question:
Under straight Medicaid, 340B pharmacies were required to pass on acquisition cost plus a dispensing fee. What is the requirement with the managed care plans under MMA?

Answer:
It will be the MMA plan’s responsibility to decide whether it will also pass on acquisition costs or dispensing fees.

Question:
Once the consumer has enrolled in an MMA plan, is it the consumer’s responsibility to provide information to the provider on whether to bill Medipass or the MMA plan?

Answer:
No. If you are a network service provider for the MMA program, you should contact the plans in your area for any necessary training on billing, if they have not already reached out to you. If you are an out-of-network provider, please contact the MMA plan in your region for more information on how to become a network provider. Please review the link below to the MMA plan contact in your region: http://ahca.myflorida.com/SMMC. Select the Managed Medical Assistance tab, then MMA Providers, and then Plan Contacts for Providers.

Question:
What billing codes will providers be using when requesting reimbursements for the Healthy Start Prenatal Risk Screens from the MMA plans and will the reimbursements be matched to current Medicaid Reimbursements?

Answer:
The current procedure codes for the Healthy Start Prenatal Screenings will continue to be used. The MMA plans will be responsible for negotiating rates for these screenings with their providers.
Managed Medical Assistance Frequently Asked Questions

Question:
What happens with patients who are receiving hospice services at a NH that expire prior to enrolling with an MCO? Who does the hospice provider bill for R&B?

Answer:
If a recipient not enrolled in the MMA or LTC programs expires while receiving hospice services in a nursing facility, the hospice provider should submit their claims to the Medicaid fiscal agent.

Question:
If a manual wheelchair rental is not a Long-term Care Service benefit and our DME company does not participate with the assigned HMO or PSN plans, are we eligible for reimbursement under the Full Medicaid benefit?

Answer:
Durable medical equipment and supplies is considered a “mixed service”, in that it is covered by both the LTC and MMA plans. As such, the LTC plan must cover any medically necessary DME and supplies. If the recipient’s DME provider is not a part of the plan’s network, the recipient may need to change to a participating provider in order to receive the service. The only exception would be during the continuity of care period for new enrollees.

Please view the Agency’s webinar on “Long-term Care and Managed Medical Assistance: Putting the Pieces Together” for more information on the circumstances in which a LTC plan or MMA plan would reimburse for the service as well as other materials (FAQs, webinar presentations, etc.) on our site that address continuity of care requirements.

Question:
What if providers are not paying within the guidelines? What is our recourse as a SNF?

Answer:
While LTC plans are required to reimburse nursing facilities according to the Agency’s established rates, MMA plans may negotiate mutually acceptable rates with nursing facility providers. You may submit complaints for further investigation and resolution to the Agency at http://apps.ahca.myflorida.com/smmc_cirts/.

Question:
Under the Statewide Medicaid Managed Care program, can you please advise if there is a reimbursement limitation on the technical component for facilities?
Answer:

No. MMA plans may negotiate mutually agreeable rates with their network practitioners and facilities with respect to the fees paid for the technical and professional components for diagnostic imaging services.

Question:

Will we be able to bill MMA claims through the Webportal or will the claims/encounters have to be sent to each HMO Insurance directly?

Answer:

Claims should be submitted to the MMA plan directly for reimbursement.

Question:

Who is going to be the overseer/gatekeeper for these new HMOs to ensure claims are being paid appropriately?

Answer:

The Agency will monitor the plans to ensure providers are promptly paid and comply with all contractual requirements. Providers may report any complaints related to timely payment via the Agency’s online complaint form at http://apps.ahca.myflorida.com/smmc_cirts/.

Question:

Have there been any changes to SIPP being provided by all the HMO’s at no lower than the Mercer certified rate of $408?

Answer:

No, plans are required to reimburse SIPP providers at the Agency approved rate, which is $408 per day. SIPP rates were factored into the capitation rate for plans.

Question:

Will inpatient hospital claims for MMA enrollees be paid based on DRG?

Answer:

MMA plans are not required to reimburse based on the DRG payment methodology. Providers should work with their MMA plan to determine how reimbursement will be made.

Question:

Will the reimbursement for PT, OT, ST, and ST be at the Medicaid handbook rate of 16.78 per unit for everyone one of the plans?
Managed Medical Assistance Frequently Asked Questions

Answer:
Except where stated in the law, MMA plans will negotiate mutually acceptable rates with providers.

Question:
The rates could be less than what we are already currently getting through Medipass?

Answer:
MMA plans have the flexibility to negotiate rates that are different than the Agency established Medicaid rate, unless the minimum rate of payment was specified in the law.

Question:
Will physicians continue to receive the EHR incentive payment once MMA is implemented?

Answer:
While the EHR incentive program will be offered until 2021, Florida’s Medicaid incentive program is dependent upon legislative authority. If you are in the MMA plan network, you must be fully enrolled in Medicaid either as a fee-for-service provider or member of a fee-for-service group to participate in the Florida Medicaid EHR Incentive Program. The last year for a provider to enroll for the initial payment is 2016. For more information about the EHR incentive payments, please send your questions to MedicaidHIT@ahca.myflorida.com.

Question:
Are the provider reimbursement rates in the MMA plans less than the Medicare allowable rates?

Answer:
Except where specified in the law, providers and the managed care plans must negotiate mutually agreed-upon rates as part of their contract/agreement. However, MMA plans must ensure that physician payment rates are equal to or exceed Medicare rates for primary care services provided by certain physicians until December 31, 2014, in accordance with the Affordable Care Act. In addition, Florida law requires that after two (2) years of continuous operation under the SMMC program, the MMA plan’s physician payment rates must equal or exceed Medicare rates for similar services.

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Question:

A recipient was recently approved by eQHealth for a power wheelchair and it has been delivered. Currently this is being billed to MediPass. At what rate will claims be paid for the remaining months once the recipient changes to an MMA plan?

Answer:

Providers should notify the enrollee’s MMA plan as soon as possible of any prior authorized ongoing course of treatment or prescheduled appointments, including rent-to-own equipment. The MMA plan must reimburse for durable medical equipment (DME) during the continuity of care period. The MMA plan must reimburse for any previously authorized services and equipment for up to 60 days or until the recipient’s primary care physician or behavioral health provider has reviewed the recipient’s treatment plan, whichever comes first regardless of whether the provider is participating in the plan’s network or not. The MMA plan must reimburse non-participating providers at the rate they received for services or equipment rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of thirty (30) days, unless the provider has agreed to an alternative rate.

If the recipient’s DME provider is not a part of the plan’s network, the recipient may need to change to a participating provider in order to continue to receive the service or DME item. After the continuity of care period, the MMA plan must ensure that services and access to DME items continue uninterrupted. If the enrollee’s DME provider is still not in the plan’s network, the plan must:

1. Transfer the enrollee to a participating DME provider, ensuring that access to medically-necessary equipment is not interrupted and any needed medical records information is transferred to the new provider; or;

   • Continue to authorize and reimburse for the DME item with the non-participating DME provider until the DME service can continue with a participating provider or until the conclusion of care.
7. Provider and Recipient Appeals

Question:

When an enrollee has requested services be reduced should the plan send notice of the action with rights to a fair hearing?

Answer:

Yes, notice to the enrollee should be sent by the Managed Care Plan any time services are being reduced whether by the Managed Care Plan or at the request of the enrollee. The contract requires an advance notice of 10 days prior to the reduction or service. One exception to that is given in 42 CFR 431.213, which allows for the notice to be sent no later than the date of the service reduction when “The agency receives a clear written statement signed by a beneficiary that— (1) He no longer wishes services; or (2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information.”

Question:

Will denials from MMA plans go through the same denial process and appeal process that is currently in place?

Answer:

No. The MMA Plans can establish their own program specific utilization management process as described in their contract with the Agency. However, enrollees or providers have the right to file an appeal with the MMA plan, and enrollees may request a Medicaid Fair Hearing if they would like to contest a denial or reduction in services.

8. Provider Enrollment

Question:

Will all providers be required to be credentialed individually or will a Medicaid provider number be sufficient to be a participating provider?

Answer:

The managed care plans are responsible for the credentialing and re-credentialing of their provider network. The plans must establish credentialing and re-credentialing criteria for all providers that, at a minimum, meet the Agency's Medicaid participation standards. Each provider that wishes to participate in a plan's network must work directly with the plan to meet their credentialing requirements.
Managed Medical Assistance Frequently Asked Questions

Question:
Are the companies that are awarded the MMA contracts in region six required to contract with existing Medicaid providers?

Answer:
No, MMA plans are not required to contract with all existing Medicaid providers. Plans are required to contract with a sufficient number of providers to ensure access to all covered services. The MMA plans are not required to contract with a specific provider other than those designated as statewide essential providers. Statewide essential providers are:

- Faculty plans of Florida medical schools;
- Regional Perinatal Intensive Care Centers (RPICCs);
- Specialty children's hospitals as defined in s. 395.002(28), F.S.; and
- Accredited and integrated systems serving medically complex children that are comprised of separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

Question:
Providers have been encouraged to contact the plans awarded in their region to initiate the contracting process. Is there a directory of plans with contact information?

Answer:
Information about the MMA plans available in your region can be found on the SMMC website at the following link: http://ahca.myflorida.com/SMMC.

Question:
In regards to the Florida Managed Medical Assistance Program will providers who are in network with straight Medicaid have to enroll with these plans to be in network or will Medicaid’s enrollment roll over into these plans?

Answer:
Once a Medicaid recipient is enrolled in a Statewide Medicaid Managed Care Managed Medical Assistance plan, providers will be reimbursed through the Managed Medical Assistance plan and will no longer reimbursed through Medicaid fee-for-service claims. In order to continue to receive reimbursement for services provider to Medicaid recipients enrolled in an MMA plan, a provider must enter into a contract with the MMA plan.

Question:
Are there specific contact numbers to reach the HMO/PSN's that won the MMA bids in the State? We need to contract with them.

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Managed Medical Assistance Frequently Asked Questions

Answer:

Yes, please see the Agency’s website for Statewide Medicaid Managed Care site ([http://ahca.myflorida.com/SMMC](http://ahca.myflorida.com/SMMC)). Select the MMA tab, then the MMA Providers tab.

Question:

We have approached every HMO that won contracts to serve Medicaid recipients in Florida about admission to their networks as a provider. All refused us or referred us to Univita. Can AHCA help us receive provider numbers with these HMO’S?

Answer:

The Agency is not able to require the plans to admit a provider into their network unless they are deemed an essential provider or Florida Statute specifically required that a contract be offered. Without knowing what type of provider you are I am not able to answer your question specifically. You may report this as a complaint to the Agency at [http://apps.ahca.myflorida.com/smmc_cirts/](http://apps.ahca.myflorida.com/smmc_cirts/) for further investigation and resolution.

Question:

We are having trouble with return communication from the managed care programs while trying to become a therapy provider in advance of the implementation for Area 9. What is the best way to get return calls or info from them?

Answer:

You may report this as a complaint to the Agency at [http://apps.ahca.myflorida.com/smmc_cirts/](http://apps.ahca.myflorida.com/smmc_cirts/) for further investigation and resolution.

Question:

Do we still need to enroll individual practitioners as Medicaid providers after this takes place?

Answer:

To submit fee-for-service claims under a fee-for-service provider service network (PSN), a provider must be fully enrolled in Medicaid. To submit encounter data under a capitated managed care organization, a provider must be a registered Medicaid provider. All providers must meet Medicaid provider requirements at the time the service is rendered.

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Question:
Since I am in the corner of the county, I have patients from surrounding counties Orange, Osceola and Lake. They will be receiving care in one county, but residing in another county. Do I credential for their areas or do they get covered by a plan in my area. I would imagine that I would credential in the other areas?

Answer:
Recipients choose from among the managed care plans that serve the region in which the recipient resides. Managed care plans must have networks that are sufficient to serve their region; this often means contracting with providers on the borders of the region. Providers should contact the contracted plans in the regions in which they serve for specific credentialing requirements. Credentialing requirements will also be addressed in the provider’s contract with the managed care plan.

Question:
Many managed care plans that have been selected for the program are informing the provider community that they have closed provider networks and will not allow new providers into their networks. This can cause significant continuity of care issues. If a provider meets all credentialing, quality and pricing requirements are there any requirements under the Any Willing Provider protections that would require these plans to accept a provider into their network?

Answer:
Florida law requires the Managed Medicaid Assistance (MMA) plans to allow participation of certain essential providers and statewide essential providers in plan networks. (See section 409.975(1)(a)(b), Florida Statutes.) At this time, the Agency has not designated additional essential providers in a specific region. In the future, if the Agency identifies essential providers in a specific region, the Managed Medical Assistance (MMA) plans will have to comply with the requirements outlined in the law. The Agency does not require the plans to admit a provider into their network unless they are deemed an essential provider.

If an MMA plan does not respond to inquiries about network participation due to discrimination, please submit your complaints to the Agency at http://ahca.myflorida.com/smmc for assistance.

Question:
I am wondering if we’ll need to contract with the MMA plans in addition to the LTC plans to have access to FL Medicaid patients for hospice care? We already have contracts with the LTC plans.
Managed Medical Assistance Frequently Asked Questions

Answer:

You will need to contract with the Managed Medical Assistance plans if you would like to provide hospice services to Medicaid recipients who are not enrolled in the Long-term Care program.

Question:

I am a mobile therapist do you need to have a physical space to be a provider for the HMOs?

Answer:

The MMA and LTC plans are responsible for credentialing their network providers to ensure that at a minimum, providers meet the Agency’s Medicaid participation standards. All network providers will be required to register with Medicaid to ensure that the provider is eligible for participation in the Medicaid program.

Question:

I am a behavioural Health provider who is trying to contract with the Managed care to continue providing services to our clients, however, they claim that their panel is close and currently are not accepting new providers. How do you handle that area?

Answer:

Plans are required to maintain a network of providers that is sufficient to provide all of the covered services and ensure that services are provided promptly and are readily available to recipients. The plans must submit reports to the Agency on a regular basis to demonstrate that their network meet the standards. If you believe that recipients do not have adequate availability to covered services, you may submit a complaint to the Agency, and we will investigate. Complaints can be submitted at the following link: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml

Question:

If a provider already has a contract with one of the managed Medicaid contract in place with these plans is there a need to gain a new contract?

Answer:

Yes, you will need a new contract with the managed care plans for the Managed Medical Assistance Program.

Question:

When will the providers get to contract with the MMA plans?
Managed Medical Assistance Frequently Asked Questions

Answer:
The Managed Medical Assistance plans are currently working on building their networks. If you would like to contract with one of the Managed Medical Assistance plans you should contact the winning plans in your Region.

Question:
There are little to no HMO providers in Monroe County. Most of our Medicaid recipients are enrolled in Medipass. How clients be assigned if providers in this area choose not to enroll in HMO’s. Will they be sent to Miami for PCP which may be more than 100 miles away depending on where in the Keys the clients live?

Answer:
The Managed Medical Assistance (MMA) plans are required to meet certain network adequacy standards, which include ensuring access to a primary care provider within a 30 minute (or 20 mile) travel distance from the enrollee’s residence. If the plan is able to demonstrate to the Agency’s satisfaction that a region as a whole is unable to meet network requirements, the Agency may waive the requirement at its discretion in writing. As soon as additional service providers become available the plan must augment its network to include such providers in order to meet the network adequacy requirements. Unless the network adequacy requirements are waived by the Agency, the MMA plan may be subject to performance penalties for failure to meet the minimum standards outlined in the contract.

Question:
Do you anticipate significant hospice volume from MMA plans or mostly from the LTC plans? Trying to decide if we need to contract with MMA plans for hospice care or not.

Answer:
Medicaid will provide hospice services under both the Long-term Care program and the Managed Medical Assistance program. If you would like to serve those hospice recipients enrolled in the Managed Medical Assistance program who are not also enrolled in the LTC program, you will need to contract with the winning MMA plans in your region.

Question:
Our understanding of the Florida Statutes is that only direct service providers that volunteer more than 20 hours a month are required to complete the Level 2 background screening. We had to attest to our providers in Area 10 that we provide level 2 screen for volunteers that are direct service providers. Should all our volunteers complete the Level 2 background screening or just the ones that volunteer 20 hours+?

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Answer:

All individuals providing a direct service to an enrollee require a Level 2 background screening. (See Chapter 435 and section 408.809, F.S.)

Question:

Can MMA plans limit the network of providers?

Answer:

Plans must have a sufficient provider network to serve the needs of their plan enrollees, as determined by the State, and MMA plans may limit the providers in their networks based on credentials, quality indicators, and price. However, MMA plans must include statewide essential providers which are defined in Florida law, including: Faculty plans of Florida Medical Schools; Regional Perinatal Intensive Care Centers (RPICCs); Specialty Children’s Hospitals; and health care providers serving medically complex children, as determined by the State.

Question:

Will assistive care providers be under MMA or remain under Fee for Service Medicaid?

Answer:

The Agency has developed an info graphic to help providers understand how assistive care services are available to MMA, LTC and fee-for-service recipients: [http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Assistive_Care_Services_Flyer.pdf](http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Assistive_Care_Services_Flyer.pdf). Assistive care providers may contract with an LTC plan, MMA plan, or both. The only situation in which fee-for-service Medicaid would be reimbursed is if the recipient is not enrolled in an LTC or MMA plan. To be reimbursed for fee-for-service claims, ACS providers must be fully enrolled as Florida Medicaid providers.

Question:

Do physicians have to enroll in all of the MMA plans?

Answer:

No. Physicians may choose whether or not to participate in any managed care plan. In order to continue to receive payment for services provided to Medicaid recipients enrolled in an MMA plan, a provider must enter into a contract with the MMA plan.

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Managed Medical Assistance Frequently Asked Questions

Question:
As a DME company currently in network with CMS, are we going to automatically continue to be a DME provider for the new CMS network after MMA is implemented? Not only for the 60 days after but continually after that?

Answer:
Providers will need to contract with the new Children's Medical Services Network (CMSN) Plan in order to provide services to CMSN Plan enrollees. Please contact the CMSN Plan directly for information on contracting with this plan.

Question:
I wanted to clarify if the long term care facility will need to enroll in each MMA program in that region?

Answer:
If the long-term care facility wishes to provide services to MMA enrollees, the facility will need to pursue contracts with the MMA plans. However, in the event that an LTC recipient needs MMA services outside of the facility, the enrollee’s MMA plan is responsible for coordinating and paying for the services.

Question:
When will panels be open for provider enrollment at this time all networks appear to be closed?

Answer:
You will need to contact the MMA plan directly for enrollment procedures and timeframes with the particular plan. For a list of MMA provider contacts, please visit: http://www.ahca.myflorida.com/SMMC. Select the Managed Medical Assistance tab, then MMA providers, then Plan Contacts for Providers. You may also visit plan websites to complete provider applications for enrollment. To locate the plan websites, visit http://flmedicaidmanagedcare.com. Select Welcome, enter the zip code or county to find your area. Next, select Managed Medical Assistance. In the ribbon under the AHCA logo, select Plan Information. You will then see a list of all MMA plans in your area, which includes each plan’s website information. You can also select Specialty Plan Information in the ribbon for information on the specialty plans.

Question:
If we are now a pharmacy provider of Medicaid, will we be automatically enrolled in the standard plans or will each pharmacy have to enroll with each plan for the area?

Answer:
No. Pharmacies will not automatically be enrolled in a plan’s network if they are directly enrolled with Medicaid. Each pharmacy will need to have a contract or agreement with each plan in their region in order to serve MMA enrollees.

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Managed Medical Assistance Frequently Asked Questions

Question:
If the provider falls under the category of essential provider and a plan does not contract with that provider-- will the plan get penalized by AHCA for not contracting with that essential provider?

Answer:
The MMA plans are required to contract with essential providers per the contract between the plans and the agency. Please report complaints with plans to the agency by using the Agency’s complaint process by submitting an issue online at: http://ahca.myflorida.com/SMMC. Select the blue “Report a Complaint” button and complete the online form. If you need assistance completing this form or wish to verbally report your issue, please contact your local Medicaid area office. Find contact information for the Medicaid area offices at: http://ahca.myflorida.com/AreaOffices. Where necessary, the Agency will take action to enforce contract provisions with the MMA plans.

Question:
When Medicaid goes to Managed Care will physicians dispensing still have to get a dispensing number even though they have a Medicaid Provider Number?

Answer:
Yes. The dispensing physician must be enrolled or registered in Medicaid for physician services, then the physician must apply as a pharmacy and is assigned a second ID to use when billing for the drugs they dispense. Please reference the excerpt below from the Florida Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook:

“The Medicaid prescribed drug program may reimburse physicians and other practitioners for dispensing drugs to Medicaid recipients if the practitioner meets all of the following conditions:

1. Is registered with his or her professional licensing board as a dispensing practitioner.
2. Enrolls in the Medicaid program as a pharmacy provider and complies with all other requirements of the prescribed drug services program.
3. Maintains a current Florida Medicaid Medical Provider agreement.”


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Managed Medical Assistance Frequently Asked Questions

9. Recipient Enrollment and Transition

Question:
Is there still going to be a Prepaid Mental Health program and will it still be tied to MediPass?

Answer:
No, the Prepaid Mental Health program (PMHP) is ending. Under the Statewide Medicaid Managed Care program, those currently enrolled in MediPass and PMHP's will be required to enroll in a Managed Medical Assistance plan. Recipients will receive behavioral health services from their MMA plan. Behavioral health services are included as part of the minimum benefit packages that plans must cover under the Statewide Medicaid Managed Care program.

Question:
Will recipients that have other third party insurance have the option to be in a managed care plan?

Answer:
Yes, recipients with other creditable coverage (other than Medicare) are voluntary for enrollment into a health plan under the Statewide Medicaid Managed Care program. They can choose to enroll in a health plan, but are not required to do so. In addition, the SMMC program contains a provision that allows recipients with access to employer sponsored insurance programs to opt out of all managed care plans and to use Medicaid financial assistance to pay for the recipient's share of the cost in their employer-sponsored coverage.

Question:
How will the Statewide Medicaid Managed Care program affect recipients in Kidcare or the Healthy Kids programs?

Answer:
Children enrolled in the Title XXI Kidcare programs will generally not be impacted. Once the SMMC program is implemented and plans are selected, all children ages 1-4 in MediKids will have a choice of two or more plans.

Question:
Patients are required to sign up for a new health plan within 30 days of becoming eligible for the Medicaid program. If a patient has not signed up for a health plan within the time frame, how will the state confirm they have not made a choice? Will the patients confirm in writing to AHCA that they have not chosen?

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Answer:

All Medicaid recipients will be enrolled in a managed care plan unless specifically exempted. (See 409.969(1), F.S.) Each recipient has a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient. Medicaid recipients will have at least 30 days in which to make a plan choice. The Agency will automatically enroll into a Managed Medical assistance plan those Medicaid recipients who do not voluntarily choose a plan. (See 409.984(1), F.S.) Further, after a Medicaid recipient has enrolled in a managed care plan, the recipient will have 90 days to voluntarily disenroll and select another plan. (See 409.969(2), F.S.) After 90 days, no further changes may be made except for an Agency approved good cause reason. The agency's systems are able to track which recipients have made a choice and which plan they would like.

Question:

What will happen to the Prepaid Dental plans under the Statewide Medicaid Managed Care Plans?

Answer:

Dental services are a required minimum benefit under the Statewide Medicaid Managed Care program; therefore all recipients enrolled in a health plan under the Statewide Medicaid Managed Care program will receive their dental services through their health plan. Upon full implementation of the SMMC program, the prepaid dental plans will not continue.

Question:

Are Agency for Persons with Disabilities (APD) waiver clients (iBudget waiver enrollees) required to enroll in a Statewide Medicaid Managed Care Managed Medical Assistance (MMA) plan?

Answer:

No, Medicaid recipients enrolled in the Developmental Disabilities (iBudget) Waiver programs are not required to enroll in an MMA plan. iBudget waiver recipients are a voluntary population under MMA and can choose to enroll in a plan if they want to. Choosing to enroll in a MMA plan will not affect the recipient’s iBudget waiver services. MMA will begin to roll out statewide in 2014.

Question:

If someone enrolled in the Development Disabilities (iBudget) Waiver program chooses to enroll in the MMA program, must they disenroll from the iBudget waiver program?

Answer:

No, DD waiver enrollees do not have to disenroll from the iBudget waiver program in order to enroll in an MMA plan.

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Managed Medical Assistance Frequently Asked Questions

Question:
If someone is on the waitlist for the iBudget waiver program, and is otherwise eligible for Medicaid, can they enroll in the MMA program?

Answer:
Yes, if someone is on the iBudget waitlist and is otherwise eligible for Medicaid, they can choose to enroll in the MMA program.

Question:
If someone is on the waitlist for the iBudget program, and they are not otherwise eligible for Medicaid, can they enroll in the MMA program?

Answer:
No, individuals must be eligible for Medicaid to enroll in an MMA plan.

Question:
How is the Managed Medical Assistance (MMA) program going to be implemented and how can members continue with their PCP.

Answer:
Details regarding providers enrolled in each MMA plan's network, including primary care providers, will be available to recipients required to enroll in the MMA program through choice counseling materials and the choice counseling website. Recipients can choose a plan based on the participation of their existing PCP if they so choose. We encourage you to continue discussion with all MMA plans in your region. Please note that exclusive contracts are not a requirement of the Medicaid Medical Assistance (MMA) program.

Question:
Will clients be assigned to out of county primary care providers (PCP) if there aren't enough PCPs enrolled in their county?

Answer:
Managed Medical Assistance (MMA) plans are required to maintain a region wide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. If the MMA plan is unable to provide medically necessary services to an enrollee through its network, the plan must cover these services in an adequate and timely manner by using providers and services that are not in their network for as long as the plan is unable to provide the medically necessary services within its network.

If it is determined that the plan is only able to provide the primary care services needed through an out-of-county provider, that would be permissible if the provider were within 30 minutes (or 20 miles) travel distance from the enrollee’s residence. Otherwise, the plan must receive a written waiver of the requirement from the Agency.

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Managed Medical Assistance Frequently Asked Questions

Question:
Do clients who only have MEDIPASS that are living with AIDS and are enrolled with us in the Project AIDS Care Medicaid Waiver have to enroll in a Managed Care Plan? Your informational material states that Medipass will be discontinued, however when I have called the Medicaid HOT LINE we have been told: “If Client is happy with Medipass, they DO NOT have to switch to an HMO”. Is this true?

Answer:
Recipients enrolled in the Project AIDS Care (including MediPass recipients) must enroll in a Managed Medical Assistance (MMA) plan. Prior to implementing the MMA program in a region, recipients will receive a letter with enrollment information, including information on how to enroll. The recipient will have 30 days to choose a managed care plan from the plans available in their region. Recipients will have 90 days after enrollment to choose a different plan. The Medipass program will be discontinued in a region when the Managed Medical Assistance Program is implemented in that region.

Question:
Will recipients be allowed to change plans if they have an existing relationship with a provider?

Answer:
Once a recipient is enrolled with a managed care plan, the recipient will have 90 days to voluntarily disenroll and select another plan. After 90 days, no further changes may be made except for an Agency approved good cause reason.

Prior to enrollment, recipients can review the providers in a managed care plan’s network so they can choose a plan that has providers in their network that are important to them.

Question:
How will MMA affect nursing home residents and their current relationships with their primary care physicians (PCPs) who provide care IN the facility? Will these practitioners need to be credentialed by the plan the resident selects?

Answer:
Each recipient who does not choose an MMA plan will be assigned to a plan based on a number of factors, including their primary care physician (PCP), if known. When choosing an MMA plan, recipients will have an opportunity to review the providers in each plan’s network and to select the plan that has the providers that are important to them, including PCPs. In addition, the choice counselors will assist enrollees in choosing a plan that has most of the enrollee’s providers in their network.

The MMA plans are responsible for credentialing all providers with whom they contract, including primary care physicians.
Managed Medical Assistance Frequently Asked Questions

Question:
What happens to the current Medipass enrollees? Will they stay with existing primary care physician they have or will they be reassigned?

Answer:
Each recipient who does not choose a plan will be assigned to a plan based on a number of factors, including their primary care physician, if known. When choosing a managed care plan, current MediPass enrollees will have an opportunity to review the providers in each plan’s network and to select the plan that has the providers that are important to them, this includes primary care physicians. In addition, the choice counselors will assist enrollees in choosing a plan that has most of the enrollee’s providers in their network.

To ensure continuity of care during the implementation, MMA plans are required to authorize and pay for existing services for up to 60 days (whether or not the provider is in the plan’s network) or until the enrollee’s primary care practitioner or behavioral health provider reviews the enrollee’s treatment plan.

Question:
We have seen different ways to designate the number the recipient can call. In communication to recipients will it be called Choice Counseling Phone number, Medicaid Enrollment Options or Medicaid Options?

Answer:
Recipients will contact Choice Counseling to make managed care choices 1-877-711-3662.

Question:
For a recipient who lives in a skilled nursing facility, could they have different plans for their LTC and their MMA?

Answer:
Yes, recipients are able to choose a different plan for their LTC plan and their MMA plan.

Question:
If a person has a condition covered by a specialty plan, will they automatically be enrolled in that plan - cardiovascular disease for example?

Answer:
Yes, recipients identified as eligible for a specialty plan will be assigned to those plans automatically by the Agency. However, recipients may choose any other available health plan during their choice period, if they do not wish to be enrolled in a specialty plan.

Question:
When will recipients in each Region receive notice that it is time to enroll in an MMA plan?

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Managed Medical Assistance Frequently Asked Questions

Answer:
The full schedule of enrollment correspondence is online at http://ahca.myflorida.com/smmc. Select the MMA tab, then the Recipient tab, then select “When will I be notified and required to enroll?”

Question:
Can a person sign up for an MMA plan and still stay in their home and community based services waiver program?

Answer:
Yes. Individuals enrolled in the following home and community based services waivers can continue to receive those waiver services once enrolled in an MMA plan:

- Adult Cystic Fibrosis
- Familial Dysautonomia
- Individual Budgeting (iBudget)
- Long-term Care
- Model
- Project AIDS Care
- Traumatic Brain Injury/Spinal Cord Injury

Question:
Regarding the Child welfare plan, will all foster care children be enrolled in the specialty plan or will other plans in the regions also be serving this population?

Answer:
Children in foster care can choose to enroll in the Child Welfare specialty plan or in any standard non-specialty Managed Medical Assistance plan operating in their region. All standard plans are required to provide the full array of services, including special services that are only available to children in the child welfare system.

Question:
For comprehensive plans are both LTC and MMA membership going to come on the same 834 file?

Answer:
Plans will get a separate 834 file for each provider ID unless they choose to link their provider IDs using a function available to them for one large 834 file.

Question:
During the 60 day continuity of care period, who will notify providers when there is a change of service provision, PCP or plan or who?

Answer:
The Managed Care Plan will notify both the recipient and their primary care provider if there is any change in services.

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Question:
Are Nursing home recipients that are approved for ICP Medicaid and that have selected a LTC plan still required to select a MMA plan?

Answer:
Yes, LTC enrollees must select an MMA plan in order to receive their medical services, unless they are an excluded or voluntary population, per Florida Statutes.

Question:
If MMA is optional for APD clients who are eligible, what happens if they choose not to participate?

Answer:
If a recipient is voluntarily for the Managed Medical Assistance program and chooses not to participate, the recipient will receive their medical/acute care services on a fee-for-service basis.

Question:
According to the MMA web page "Medicaid recipients, who have other creditable health care, excluding Medicare, will not be required to enroll in the MMA" What is considered other creditable health care?

Answer:
TPL (Third Party Liability) or private insurance is considered as "other creditable health care coverage."

Question:
My question is specific to those children/families who currently have Children’s Medical Services (CMS) as their Managed Care provider. Will this type of Medicaid also no longer exist?

Answer:
The Children’s Medical Services Network (CMSN) will be available under the SMMC program as an MMA Specialty Plan, serving children with special health care needs. The CMSN plan will be implemented statewide on August 1, 2014.

Question:
Will kids who are assigned to Medicaid through Temporary Assistance for Needy Families (TANF) be required to go to a Managed Care plan?
Answer: Children with full Medicaid coverage (through TANF) will be required to enroll in a Managed Medical Assistance plan, unless they are in an excluded or voluntary population.

Question: How will an MMA plan know if a person is in the DD waiver?

Answer: The Agency will provide an indicator on each plan’s enrollment files to identify recipients who are enrolled in the iBudget waiver.

Question: Is the voluntary enrollment into LTC or MMA for DD waiver recipients scheduled to change and become required in the future?

Answer: This population will continue to be voluntary for enrollment in both programs unless the law is changed by the Florida Legislature.

Question: For MMA in AHCA areas 5 & 6 United Health Care (UHC) is no longer participating. What happens to UHC M*plus and MediKids children who are on these plans?

Answer: Children on MediKids will have the opportunity to enroll in one of the MMA plans participating in their region. Eligible recipients will receive a series of letters to inform them about the new program and invite them to choose an MMA plan. For information about enrolling in the program and the enrollment schedule, please visit http://ahca.myflorida.com/SMMC. Select Managed Medical Assistance, then MMA recipients.

Question: Will children in Foster Care be exempt from having to enroll in an MMA plan? Can they remain on Fee-for-Service Medicaid?

Answer: Unless they are in a population that is voluntary or excluded from participation in the MMA program, children with an open child welfare case will be required to enroll in an MMA plan.
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Question:

Does the patient have the choice to enroll in an MMA specialty plan for behavioral health or choose a regular plan that has a behavioral health plan within the plan?

Answer:

All MMA plans provide a full range of medically necessary behavioral health services to enrollees in accordance with the behavioral health related Medicaid Coverage and Limitations Handbooks. Specialty Plans are MMA plans that serve Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis. The agency has contracted with a specialty plan, Magellan Complete Care, in certain regions of the state to serve Medicaid recipients diagnosed with a serious mental illness. Individuals with SMI can choose to enroll with the specialty plan or choose among the other standard MMA plans.

Question:

Will Nursing Home Residents that are enrolled in LTC plans and under ICP Medicaid need to select an MMA plan as well?

Answer:

Yes. Nursing facility residents who are enrolled in an LTC plan must also enroll in a Managed Medical Assistance (MMA) plan as they become available in their region.

Question:

Will clients enrolled in a FACT program be required to choose an MMA plan?

Answer:

Yes, unless they are in a population that is voluntary or exempt from participation in MMA, Medicaid recipients participating in the Florida Assertive Community Treatment Team (FACT Team) are required to enroll in a Managed Care Plan. FACT clients will receive medical care and any behavioral health services not provided by FACT through their MMA plan.

Question:

If individuals on DD waiver choose to not enroll in an MMA plan, then they remain under fee for service but not in MediPass?

Answer:

Once the MMA program is implemented, some programs that were previously part of the Medicaid program will be discontinued, including the MediPass program. Recipients enrolled in the iBudget waiver who choose not to enroll in an MMA plan will receive their state plan services through a fee-for-service arrangement.

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Question:

The roll-out dates are close for someone that has already enrolled in an LTC plan that may want to have a comprehensive plan for MMA. Will this be considered a good cause reason in order to be able to change from an LTC plan that is not comprehensive to one that is?

Answer:

Yes. During the initial choice period for MMA, recipients can switch LTC plans to enroll in a comprehensive plan. However, after the MMA 90-day change period, mandatory recipients are locked-in and can only change plans during their open enrollment period or with a State-approved good cause reason.

Question:

Who determines which diagnosis is appropriate for an MMA specialty plan or is a client with any diagnosis allowed to choose an MMA specialty plan?

Answer:

Each specialty plan has defined clinical eligibility criteria for enrollment into that plan. The Agency or its agent will be responsible for identifying the defined specialty population and enrollment of such recipients in an MMA specialty plan. Clinical assessment and/or referral may be required to determine eligibility for MMA specialty plan enrollment. For more information, please review the webinar on Specialty Plans, located at http://ahca.myflorida.com/SMMC. Select News and Events, and then Event and Training Materials.

Question:

Will children with CMS Medicaid continue with their current coverage through the MMA program?

Answer:

Children’s Medical Services will cover services under the MMA program as the Children’s Medical Services Network (CMSN) plan. Recipients currently enrolled in the Children’s Medical Services Reform Plan or Children’s Medical Services Network will have an option to enroll in the CMSN MMA plan on August 1, 2014 or choose a standard MMA plan. The only exception would be recipients who are specifically excluded from participation in the MMA program in Florida law. Recipients must meet the clinical eligibility criteria for enrollment into the CMSN plan (i.e., children with special health care needs or chronic conditions); this includes siblings.

Question:

New Medicaid recipients will have 30 days to choose an MMA plan. During that time will they be covered by straight/regular Medicaid? Billable as it is now?
Managed Medical Assistance Frequently Asked Questions

Answer:

Individuals who are newly eligible for Medicaid and are required to participate in the MMA program will be given 30 days to select an MMA plan. Prior to that recipient’s enrollment in their MMA plan, the recipient’s services will be reimbursed through a fee-for-service arrangement.

Question:

How many times within the first 90 days can the recipient change MMA plans?

Answer:

After joining a plan, recipients will have 90 days to choose a different plan in their region. After 90 days, recipients will be locked in and cannot change plans without a state-approved good cause reason or until their annual open enrollment. However, each time a recipient changes plans during their 90 day period, they receive a new 90 day period to change plans beginning with the effective date of their new plan choice.

Question:

Since a client can change providers within an MMA plan frequently what are the timeframes to be assigned to the new provider?

Answer:

The MMA plans are responsible for the management and continuity of services to their enrollees. The MMA plans must provide timely access to services essential to medical and behavioral health care for all enrollees. The MMA plan will provide enrollees with a handbook that describes the plan’s process and timeframes when changing providers.

Question:

Will pregnancy be a qualifying condition to change MMA plans once the 90 days is over?

Answer:

No. Pregnancy is not included as an Agency good cause reason. Good cause reasons include poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. After a Medicaid recipient has enrolled in a managed care plan, the recipient will have 90 days to voluntarily dis-enroll and select another plan. After 90 days, no further changes may be made except for good cause. After 90 days, no further changes may be made except for cause.

Question:

Part of the challenge we have had moving people to managed care organizations is that their primary care physicians or other important doctors do not take the particular plan chosen. As case managers, we are concerned about jeopardizing long term relationships in a hurry to change the plan. Once they choose, can they return back to straight Medicaid?

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**Answer:**

If the recipient is not identified as being "voluntary" or "excluded" from participation, then the recipient must enroll in an MMA plan.

**Question:**

Is there an advantage to enrolling in an MMA plan if the (DD waiver) participant’s current plan is adequately meeting their needs?

**Answer:**

The advantage of a recipient enrolling in an MMA plan is that it emphasizes patient-centered care, personal responsibility and active patient participation. It provides fully integrated care through alternative delivery models with access to providers and services through a uniform statewide program; and implements innovations in reimbursement methodologies, plan quality and plan accountability. In addition, recipients in an MMA plan have access to an array of expanded benefit that are not available under the fee-for-service Medicaid program.

**Question:**

Hemophilia patients previously had to be enrolled in the disease management program and they choose between a few Specialty Pharmacy providers. Will this change under the MMA program?

**Answer:**

No. A letter will continue to be sent monthly to each new recipient who meets the eligibility requirements and asking them to choose between Coram and Caremark. The recipient is instructed to call the area office to make their election. The area office shall notify the contract manager of such elections in a timely manner. While the recipients may be mandatory for the MMA program, the Comprehensive Statewide Hemophilia Disease Management Program will remain a fee-for-service program.

**Question:**

Will children receiving MFC be auto-enrolled in the CMS Network?

**Answer:**

Children with an open case in the Florida Safe Families Network (FSFN) will have an option to choose among all MMA standard plans in their region, the child welfare Specialty plan, and the Children’s Medical Services Network plan. If a choice is not made within with the required timeframe, the child will be enrolled in the child welfare specialty plan. However, the child’s legal representative will have 90 days to change plans, if desired.
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Question:
Will a recipient be enrolled with the same plan for both LTC and MMA?

Answer:
Six of the seven LTC plans were also awarded contracts as an MMA plan in certain regions of the state. If a comprehensive plan is available in a region, LTC plan enrollees will have the option of selecting that plan during the choice counseling period.

Question:
We are in Region 5 with roll out of 6/1/14, however, can our patients enroll NOW in an MMA plan?

Answer:
The Agency has posted the following schedule on its Web site:
- The beginning date that enrollment information will be mailed to recipient’s in each region;
- The last date to choose a plan in each region; and
- The effective date of enrollment into an MMA plan.

Please visit: http://www.ahca.myflorida.com/SMMC. Select the “Managed Medical Assistance” tab, then “MMA Recipients”, and then “When will I be notified and required to enroll?”

Question:
What happens if a patient doesn't make an election to choose an MMA plan? Will they be put on one automatically? How will it be decided?

Answer:
For recipients who are required to enroll in an MMA plan, the Agency will automatically assign recipients to an MMA plan if the recipient does not make a plan selection by a certain date. The Agency will determine MMA assignment based on whether the recipient:
- Is identified as eligible for a specialty plan;
- Has a prior Medicaid managed care plan that is also an MMA plan;
- Is already enrolled (or has asked to be enrolled) in a long term care plan with a sister MMA plan; or
- Has a family member(s) already enrolled in, or with a pending enrollment, in an MMA plan

Once a recipient is enrolled in a plan, they will have 90 days to change plans. After 90 days, if they want to change plans, they can do so once a year during a special time called Open Enrollment. Before Open Enrollment period begins, recipients will receive a reminder letter and information about their plan choices.

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Question:
Where can I find more information about the specialty programs for services for children with disabilities?

Answer:
See the Agency’s presentation materials on specialty plans at: http://ahca.myflorida.com/SMMC. Select News and Events, and then Events and Training Materials. Select the webinar presentation on Specialty Plans.

Question:
It was mentioned that a recipient can go to any PCP or specialist within that plan each month - is that correct? If so, would that not be difficult for the provider to coordinate that patient's care if they can "hop" around and go to another PCP within that month?

Answer:
The managed care plan must assign a PCP to those enrollees who did not choose a PCP at the time of managed care plan selection. The PCP must provide, or arrange for coverage of services, consultation or approval for referrals twenty-four hours per day, seven days per week (24/7) by Medicaid-enrolled providers who will accept Medicaid reimbursement. The managed care plan must permit enrollees to request to change PCPs at any time.

Question:
Will a PCP change within the same plan be granted on the same day or will there be lag time?

Answer:
An enrollee’s request to change PCPs will become effective on the first day of the next month. If the enrollee request is not received by the Managed Care Plan’s established monthly cut-off date for system processing, the PCP change will be effective the first day of the following month.

Question:
So when children are transferred from CMS to MMA plan will the CMS dept. cease to exist?

Answer:
No, CMS will become a specialty plan under MMA, the Children’s Medical Services Network plan. Children currently enrolled in CMS will have the option to transition to CMSN plan effective August 1, 2014.

Question:
How can we find out ahead of time what Program the recipient has been enrolled in? The recipient may not be able to tell us this info.
Managed Medical Assistance Frequently Asked Questions

Answer:

Prior the recipient’s enrollment providers will not be able to access information from the Agency regarding a recipient’s choice.

Question:

Will current Medicaid members have the same plan as of June 1st or will they start as straight Medicaid and then choose one of the managed care plans?

Answer:

Current Medicaid recipients will remain in their current payment arrangement (current health plan or fee-for-service) until their region transitions into the MMA program. Current Medicaid recipients who are mandatory and voluntary for participation will select an MMA in the months prior to implementation, and the recipient will transition directly into their new MMA plan at the time their region is implemented.

Question:

How does TPL work? Will they be enrolled as straight Medicaid or one of the MMAs?

Answer:

Recipients with other creditable coverage (other than Medicare) are voluntary for enrollment into a health plan under the Statewide Medicaid Managed Care program. They can choose to enroll in a health plan, but are not required to do so. In addition, the SMMC program contains a provision that allows recipients with access to employer sponsored insurance programs to opt out of all managed care plans and to use Medicaid financial assistance to pay for the recipient's share of the cost in their employer-sponsored coverage.

Question:

When do the serious mentally illness programs open in other regions than the one listed on the slide?

Answer:

At this time, the Serious Mental Illness specialty plan will become operational in July 2014.

Question:

In region 7, may members begin to select Children's Medical Services Network as a plan with an August 1, 2014 effective date?

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Managed Medical Assistance Frequently Asked Questions

Answer:
Medicaid recipients who are enrolled in the Children’s Medical Service (CMS) program and who are clinically eligible for the program can continue to participate in CMS until the statewide implementation of the Children’s Medical Services Network (CMSN) plan on August 1, 2014. At that time, they will be automatically enrolled in the CMSN plan, but can choose a different MMA plan if they desire. All recipients must meet the clinical eligibility criteria for enrollment into the CMSN plan (i.e., children with special health care needs or chronic conditions); this includes siblings. Siblings who are not clinically eligible for the CMSN plan will need to choose a different MMA plan.

Question:
Upon enrollment, managed care plans are required to send to DCF a 2515 form on each new member within five business days. What information are we required to indicate on the 2515?

Answer:
The Agency, in coordination with DOEA, will be providing additional information to the managed care plans on the use of the 2515 form in the near future.

Question:
When exactly does the MMA responsibility for payment end for those enrollees admitted to a nursing facility and an ICP application has to be filed? We have had ICP applications take longer than 90+ days to receive an approval and your answer states approximately 30-60 days. Do you have a more definitive answer other than approximately 30-60 days?

Answer:
No. The 30-60 days is the approximate length of time DCF requires to complete processing of an individual's ICP eligibility for nursing facility services.

Question:
How can recipients select a comprehensive plan?

Answer:
Recipients (including nursing home residents) will receive a letter from the Agency that will include information about the MMA program, which plans are available in their region (including comprehensive LTC plans), and how to enroll.

- Recipients can choose to enroll in a comprehensive plan if they qualify for both LTC and MMA plan benefits.
- Recipients can also be in one plan for their long-term care services and a different plan for their medical services.
- If a recipient's LTC plan is also an MMA in their region (making it a comprehensive plan), the recipient will be assigned to the comprehensive plan.

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Question:

Is it true that family members of those that qualify for specialty plans can be added to the specialty plan as well?

Answer:

No. Medicaid recipients must meet certain clinical eligibility criteria prior to being determined eligible to enroll in an MMA specialty plan. Family members who do not meet the eligibility criteria for enrollment in an MMA specialty plan may not enroll in the specialty plan. For example, a mother may be diagnosed with HIV and enrolled in the HIV/AIDS specialty plan based on that diagnosis. However her child, who has not been diagnosed with HIV or AIDS, is not eligible for enrollment in the HIV/AIDS specialty plan, but the child may be eligible for enrollment in a standard MMA plan.

Question:

Will there be a 30 day waiting period once the patient becomes eligible for Medicaid prior to being enrolled in a HMO or will it be instant?

Answer:

The Agency for Health Care Administration (Agency) is notified by the Florida Department of Children and Families when an individual is determined eligible for Medicaid. If the individual meets all other enrollment criteria for the Statewide Medicaid Managed Care (SMMC) program, the individual is sent a letter by the Agency’s enrollment broker at least thirty days prior to his or her effective date of enrollment notifying the individual of his or her options and the managed care plan that the recipient will be assigned if a choice is not made within a certain timeframe. Enrollments in the SMMC program (both the Managed Medical Assistance and Long-term Care programs) are based in whole months, so enrollments always begin on the first of each month. An individual’s enrollment in the SMMC program will likely never begin on the same day as his Medicaid eligibility determination.

Question:

If a recipient is already in an MMA plan will they be pulled out and assigned to a specialty plan?

Answer:

MMA enrollees who become eligible for a specialty plan will receive a letter from the Agency’s enrollment broker to notify them that they are eligible for a specialty plan and to provide them with an opportunity to enroll in the specialty plan.
Managed Medical Assistance Frequently Asked Questions

Question:
Where can I find information on the different timeline for Duals apart from the MMA region timeline (5/1-8/1)?

Answer:
The Agency has created a document to address dual eligible enrollment which can be found on our website at: www.ahca.myflorida.com/SMMC. Select Managed Medical Assistance and scroll down to select the link for Coordinating Dual Eligibles’ Medicare and Medicaid Managed Medical Assistance Benefits Snapshot.

Question:
Many of the recipients authorized through EQ Health to receive Personal Care services, are also authorized under the iBudget program to receive Respite services. In this situation, can you please confirm if they would be in a mandatory or voluntary status to change to the MMA program for the Personal Care services?

We do understand that recipients solely enrolled under the iBudget program are in a voluntary status to change to the MMA program, although we have received conflicting information when they are enrolled in both programs for different services.

Answer:
Because the recipient is enrolled in the iBudget waiver, he or she would be voluntary for enrollment in the MMA program. If they choose to enroll in an MMA plan, it will not affect their waiver services; they will be in the MMA plan and the waiver simultaneously. If the recipient chooses an MMA plan, services previously authorized by eQHealth would be authorized by the MMA plan (if required). Waiver services will continue to be authorized through the Agency for Persons with Disabilities. If the recipient does not choose an MMA plan, their medical care will be covered through fee-for-service Medicaid and will continue to be authorized by eQHealth. Please refer to the iBudget snapshot on the SMMC website at http://ahca.myflorida.com/SMMC.

Question:
We are trying to find out how a newborn would be added to an MMA plan. Does that still go through the state first and then the state notifies the HMO’s of the newborn’s enrollment and ID, etc?
Managed Medical Assistance Frequently Asked Questions

Answer:
The newborns are presumptively eligible for Medicaid and will be automatically enrolled in the same plan as the mother (unless the mother is enrolled in a MMA specialty plan). Plans are required to notify DCF of enrollees who are pregnant and DCF will generate a Medicaid ID number for the unborn child.

Question:
In what plan will children with special needs be enrolled?

Answer:
For the most part, the Agency will identify recipients who are eligible to enrol in a specialty plan and notify them of their plan options. Children with special health care needs can choose to enroll in one of the standard MMA plans that are available in their region, the Children’s Medical Services Network plan, or another specialty plan if they meet the criteria for that plan. If a parent or legal guardian believes that their child is eligible for one of the specialty plans available in their region, they can call the Agency’s enrollment broker at: 877-711-3662. A choice counselor can explain the options available for the child.

Question:
Is a newborn that is Medicaid eligible covered under Medicaid fee for service for the first thirty days, and then required to enroll in a MMA plan? Or are they required to enroll in a plan at birth before leaving the hospital?

Answer:
Newborns are presumptively eligible for Medicaid and will be automatically enrolled in the same plan as the mother (unless the mother is enrolled in an MMA specialty plan) or in the plan of the mother’s choice. Plans are required to notify DCF of enrollees who are pregnant, and DCF will generate a Medicaid ID number for the unborn child. The plan is also required to notify DCF of the birth so that the ID can be activated, and the child can be enrolled in Medicaid and enrolled in a standard MMA plan. The newborn will be enrolled in the plan retroactively to birth.

Question:
Will the Newborn Activation forms still be accepted to activate the baby's MDCD ID once the child is born? Will the submission fax number change?

Answer:
The MMA plans are responsible for submitting the Newborn Activation forms for enrollees in the plan. Providers are responsible for notifying the recipients MMA plan when the recipient presents to give birth to the child. Providers will still submit the Newborn Activation form to the Department of Children and Families for Medicaid recipients who are not enrolled in a managed care plan.
10. Services

Question:
How are services covered for a voluntary recipient who chooses not to participate or wants to disenroll from their MMA plan?

Answer:
A voluntary recipient may choose to disenroll from an MMA plan at any time. If a voluntary recipient chooses not to participate in the MMA program, the recipient will continue to receive their medical/acute care services on a fee-for-service basis.

Question:
Does the SMMC program reduce services available through Florida Medicaid?

Answer:
No, health plans will be required to provide services at a level equivalent to the state plan. The Agency has requested authority for plans to customize their benefit packages to non-pregnant adults, vary cost sharing provisions, and provide coverage for additional services. To view a table of expanded benefits offered by each MMA plan, go to the SMMC website, click on the Managed Medical Assistance tab, and then click on Expanded Benefits Offered by the Plans. [http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#MMA](http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#MMA).

Question:
Could you provide us with a definite time as to when Medicaid non-emergency transportation in District 2 would be passed over to HMO's?

Answer:
Under the Managed Medical Assistance (MMA) component of the Statewide Medicaid Managed Care Program, the managed care plans will be responsible for providing transportation services to their enrollees. The implementation schedule for the MMA program is included below. The MMA program will be implemented in Region 2 in May 2014.

<table>
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<td>July 1, 2014</td>
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<tr>
<td>1, 7 and 9</td>
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Managed Medical Assistance Frequently Asked Questions

Question:
What will happen to those clients that are receiving services from Medicaid state plan and the Long-term Care (LTC) program at the same time? Medicaid state plan is providing personal care services and the LTC program is providing homemaker or companion services. Will the new Medicaid Medical Assistance (MMA) program or the LTC program provide all the services or will the Medicaid state plan continue to pay for such services.

Answer:
Enrollees who are in both the MMA and the LTC program will have their services for the two program components coordinated by their LTC care manager to ensure medically necessary services are provided and no duplication of services occurs.

Question:
Will clients have to be referred from the primary care provider in order to receive behavioral health services?

Answer:
No, recipients do not need to have a primary care physician’s referral in order to receive behavioral health services.

Question:
Do Managed Medical Assistance plans cover substance abuse services?

Answer:
Yes. The Managed Medical Assistance plans will be responsible for covering community behavioral health services for substance abuse disorders and inpatient detoxification services.

Question:
The managed care plans all have different authorization request processes. One plan’s is online, another’s is by email and a third plan’s is by fax.

Answer:
While each Managed Medical Assistance (MMA) plan may have specific service authorization requirements for their network providers, all plans must minimally comply with the following:

• Maintain automated prior authorization systems; plans may not require paper authorization in addition as a condition for providing treatment; and
• Maintain a 24-hour-a-day, seven-day-a-week provider help line to respond to prior authorization requests.

Question:
Will each HMO decide what services will require authorization? Does AHCA have a list of authorizations that should require authorization?

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Managed Medical Assistance Frequently Asked Questions

Answer:
The Agency does not have a list of services that require authorization under the Managed Medical Assistance (MMA) program. Each MMA plan will determine which services require prior authorization. However, the plan may not require prior authorization of emergency services or care.

Question:
Will each Managed Medical Assistance plan be required to continue to cover all Medicaid services as they presently do?

Answer:
The Managed Medical Assistance (MMA) plans will be required to cover most Medicaid State Plan services. MMA plans are responsible for the following covered services:

- Advanced Registered Nurse Practitioner
- Ambulatory surgical center services
- Assistive care services
- Behavioral health services
- Birth center and licensed midwife services
- Clinic services
- Chiropractic services
- Dental services
- Child health check up
- Immunizations
- Emergency services
- Emergency behavioral health services
- Family planning services and supplies
- Healthy Start services
- Hearing services
- Home health services and nursing care
- Hospice services
- Hospital services
- Laboratory and imaging services
- Medical supplies, equipment, prostheses and orthoses
- Optometric and vision services
- Physician assistant services
- Podiatric services
- Practitioner Services
- Prescribed drug services
- Renal dialysis services
- Therapy services
- Transportation services

During the competitive procurement process, the State negotiated additional expanded benefits with the selected MMA plans such as additional primary care provider visits, adult dental, waived co-payments and several other benefits that are not currently state plan covered services.

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Managed Medical Assistance Frequently Asked Questions

Question:
So once the rollout takes place MCNA & DentaQuest will no longer be the only ones administering Medicaid dental services for children?

Answer:
All Managed Medical Assistance (MMA) plans will be responsible for providing Medicaid-covered dental services for children and adults. MMA plans may elect to subcontract with entities such as MCNA and DentaQuest to manage the dental benefits for their plan members.

Question:
Do each of the plans have to implement Florida's current Medicaid formulary and implement the drug's PA criteria?

Answer:
Managed Medical Assistance (MMA) plans must follow Florida Medicaid’s current formulary for one year, at a minimum. MMA plans may adopt the Medicaid prior authorization criteria or develop their own criteria. Prior authorization and step therapy protocols for preferred drug list drugs, however, may not be more restrictive than those posted on the Agency website.

Question:
What happens when a recipient from outside of our Medicaid Region wants services and they have an SMMC plan that is not active in our Medicaid Region?

Answer:
Where an enrollee uses services available under the MMA or LTC plan from a non-participating provider, the MMA or LTC plan is not liable for the cost of such services unless the plan referred the enrollee to the non-participating provider or authorized the out-of-network service. The enrollee is liable for the cost of such unauthorized use of covered services from non-participating providers, with some exceptions, which are described as follows:

- MMA plans are required to pay for emergency services, regardless of whether the enrollee obtains the service within or outside of the plan’s network.
- MMA plans must also pay for post-stabilization services, regardless of whether the enrollee obtains the service within or outside of the plan’s network, in certain circumstances, including:
  - The post-stabilization services were pre-approved by the plan;
  - The post-stabilization services were not pre-approved by the plan, but the plan did not respond within one hour to the treating provider’s request for pre-approval;
  - The treating provider could not contact the plan for pre-approval;
  - Those post-stabilization care services that a treating physician viewed as medically necessary after stabilizing an emergency medical condition are non-emergency services.
- MMA plans must pay for family planning services from any participating Medicaid provider without prior authorization.
Managed Medical Assistance Frequently Asked Questions

Each enrollee will receive a handbook from their MMA plan that describes emergency services and procedures for obtaining services both in and out of the MMA plans’ region. The handbook will including the explanation that prior authorization is not required for emergency or post-stabilization services, as well as other post-stabilization services requirements.

Question:
Will the MMA plans cover ABA therapy for children with autism?

Answer:
At this time, the Managed Medical Assistance (MMA) plans are not responsible for covering Applied Behavioral Analysis (ABA) services for children under 21 with autism spectrum disorders. ABA services will continue to be reimbursed on a fee-for-service basis (as they are now) for all eligible Medicaid recipients after the MMA program is implemented.

For more information on Florida Medicaid’s coverage of ABA services, please refer to the Provider Alerts at our Web site: http://ahca.myflorida.com/Medicaid/childhealthservices/chc-up/index.shtml.

Question:
Will managed care plans be allowed to reimburse providers for vision services provided in/by a mobile unit?

Answer:
Yes. The Agency has determined it appropriate, for the Managed Medical Assistance (MMA) plans to contract with mobile vision providers directly and not through the county health departments. The MMA plans must otherwise comply with provisions of the Florida Medicaid Services Coverage and Limitations Handbooks.

Question:
Will Medicaid case managers for home and community based programs be contacted by the new MMA Plan?

Answer:
If a Medicaid recipient is enrolled in a home and community based waiver and a MMA plan, the care manager for the home and community based program and the care manager with MMA plan should coordinate with each other to ensure medically necessary services are provided and no duplication of services occurs.
Managed Medical Assistance Frequently Asked Questions

Question:
What coverage is provided for Diabetes Self-Management Education?

Answer:
Freedom Health Plan has a specialty plan for diabetes in most areas of the state that will focus on coordination of care and specific medical needs of recipients with diabetes. Education will be a component of the plan. All standard MMA plans must have a disease management program for enrollees with diabetes who live in regions where the specialty plan is not available or who do not choose to enroll in a specialty plan.

Question:
For children who are on Medipass and have an auth from EQ Health, will that auth still cover him/her after implementation? 60 days even though we are not current providers with that managed care plan as of right now?

Answer:
When a recipient is enrolled in a managed care plan the authorization from eQ Health Solutions will not be valid any longer. However, the new managed care plan must continue to cover the same services in the same amount by the same provider for up to 60 days or until they have completed a new assessment and issued a new authorization.

Question:
What, if any will be the impact on children/adolescents in residential care....authorization process/referral process etc?

Answer:
Some residential services will be covered by the MMA plans, such as statewide inpatient psychiatric inpatient (SIPP) services and therapeutic group care services. The plans will establish their own processes for utilization management of the services. The referral process for SIPP will not change as it is established by Chapter 65E-9, Florida Administrative Code, which gives Department of Children and Families oversight of the admission process.

Question:
For the Statewide Medicaid Managed Care Program (Long-term Care program and Managed Medical Assistance Program), is Telephonic/Electronic Visit Verification required? If so, is it required for the entire State of Florida or just certain areas? Do LTC health plans have the option to require or not require electronic verification of services delivered in homes?

Answer:
Long-term Care (LTC) and Medicaid Managed Assistance (MMA) plans are not required to utilize telephonic/electronic visit verification technology. LTC and MMA plans may use telephony or electronic visit verification (as a part of their anti-fraud plan), but plans may also use other methods to verify whether the services billed were actually provided.
Question:
We are a Community Behavioural Health Center in Area 11 providing a variety of different services. Will there be universal authorization request forms?

Answer:
No, the MMA plans are permitted to develop their own utilization management process. The plans are required to have automated authorizations systems and may not require paper authorizations in addition as a condition for providing treatment.

Question:
Will AHCA inform hospice plans if members are enrolled in hospice?

Answer:
The hospice is responsible for verifying Medicaid eligibility. Each local DCF office has one or more hospice coordinators who are responsible for processing Medicaid hospice eligibility. Each hospice is responsible for contacting and working with a local DCF hospice coordinator on issues related to Medicaid hospice eligibility. Questions regarding hospice eligibility should be addressed with the local DCF office. In addition, hospice providers should notify the recipient's plan if the recipient elects hospice.

Question:
Will clients have to be referred by the Primary Care Physician in order to receive Behavioral Health or Substance Abuse services?

Answer:
No, behavior health services and substance abuse services will not require a referral from their primary care physician.

Question:
Since we have 60 days from a child entering foster care to enroll a foster child in ANY Managed Care Plan offered in my District, does that mean that all Managed Care Plans are prepared to provide child welfare specific services, such as Comprehensive Behavioral Health Assessments, Specialized Therapeutic Foster Care, Behavioral Health Overlay Services and/or State Inpatient Psychiatric Program? Or is Sunshine Health, the Child Welfare Specialty Plan the only Managed Care plan that can deliver the aforementioned services?

Answer:
Yes, all of the MMA plans must be able to provide access to behavioral health services for child welfare populations. The Child Welfare Specialty Plan is not the only MMA plan that can provide the above services.
Question: How are Applied Behavior Analysis (ABA) services for children with autism spectrum disorders going to be managed once the SMMC is implemented?

Answer: At this time, reimbursement for ABA services for children with autism spectrum disorder will remain the same after the implementation of the MMA program; it will continue to be reimbursed on a fee-for-service basis regardless of whether the recipient is enrolled in an MMA plan or not.

Question: Will there be funding to include home delivered meals in LTC or MMA?

Answer: Home-delivered meals are a covered service under the Long-term Care Program. Home-delivered meals are not a state plan service and are not required in the Managed Medical Assistance (MMA) program; however, some MMA plans are offering post-discharge meals (a time-limited home-delivered meals service for enrollees who have been discharged from certain types of inpatient/institutional care) as part of their expanded benefits package.

Question: Once enrolled in MMA what will the process be for current beneficiaries that are renting DME?

Answer: During the continuity of care period, the MMA plan must continue to pay for any prior approved services, regardless of whether the provider is in the plan’s network. During this timeframe, the plan should be working with the enrollee and their treating practitioner to obtain any information needed to continue authorization after the continuity of care period (if the service is still medically necessary). After the continuity of care period, if the provider is not a part of the plan’s network, the enrollee may be required to switch to a participating provider.

Question: Through MMA how are comorbidities handled in specialty plans versus the regular plans?

Answer: All MMA plans, including specialty plans, are responsible for identifying enrollees with co-morbid medical conditions and addressing those disorders and identifying appropriate medical treatment.

Question: Will patients with communicable diseases be able to go to any provider whether the provider is in the MMA health plans network or not?

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Answer:
If a recipient with a communicable disease is part of an MMA mandatory enrollment group, the recipient will have a choice of providers enrolled in their plan’s provider network. However, all plans are required to include infectious disease specialists in its provider networks.

Question:
Once enrolled in an MMA health plan, can a recipient see any provider in that health plan’s network? Are they assigned a PCP, and can they change their PCP?

Answer:
When enrolled in an MMA health plan, an enrollee may choose from among participating providers in their MMA plan’s network for that region. The MMA plans will assign a Primary Care Physician (PCP) to those enrollees who did not choose a PCP at the time of managed care plan selection. The MMA plan takes into consideration the enrollee’s last PCP (if the PCP is known and available in the Managed care plan’s network), the closest PCP to the enrollee's ZIP code location, recipient’s current PCP, enrollee’s language, and enrollee age. MMA plans must permit enrollees to request a change of PCPs at any time.

Question:
Will all services, including the mental health services, be provided by the MMA plan or will the mental health services be provided by the DCF contracts?

Answer:
The MMA Plans will cover a full range of medically-necessary medical and behavioral health services to enrollees as authorized under the State Plan, covered in the Florida Medicaid Coverage and Limitations Handbooks, and included in the plans’ contracts with the Agency. For basic information about covered services, please see the Managed Medical Assistance Snapshot located at: http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_MMA_Snapshot.pdf.

Question:
Will products that are currently covered by FL under a medical benefit, such as diabetic supplies, be covered similarly through MMA, or will they move to a pharmacy benefit?

Answer:
Yes, MMA plans will cover durable medical equipment and supplies as a medical service. The MMA plan must comply with provisions of the Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

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Managed Medical Assistance Frequently Asked Questions

Question:
Will home health agencies be providing any MMA services?

Answer:
MMA plans may contract with home health agencies to provide services as specified in the Medicaid Home Health Coverage and Limitations Handbook, and in accordance with licensure requirements.

Question:
Will SIPP services be covered under the MMA program beginning with the Regional implementation dates or will this service be rolled into the program at a later date?

Answer:
Managed Medical Assistance plans will be required to cover Statewide Inpatient Psychiatric Program (SIPP) services upon implementation of the MMA program in a region.

Question:
Under MMA does the influenza vaccine benefit include retail pharmacy outlets?

Answer:
Medicaid Fee-for-Service reimburses pharmacies for dispensing flu vaccines for institutionalized patients. Therefore, if an MMA plan decides to pay for all recipient vaccines it would be considered less restrictive than Medicaid and would be allowable.

If a retail pharmacy contracts with an institutionalized setting, the pharmacy can bill for the recipient. If the plans are covering vaccines for any recipient, any retail pharmacy in the plan’s network may bill.

Question:
Can you clarify how certain items currently covered under FL Medicaid’s formulary (for example, diabetic supplies) will be covered under the MMA program?

Answer:
MMA plans are required to cover all drugs under Florida Medicaid’s formulary. Please work with your plan for specific information on processes and procedures for coverage. Diabetic supplies are covered under Florida Medicaid’s durable medical equipment (DME) and supplies policy. DME and supplies are one of the required services that plans must cover.
Managed Medical Assistance Frequently Asked Questions

Question:
Will MMA cover outpatient rehab including physical, occupational & speech therapies as well as neuropsychology?

Answer:
MMA plans will cover physical, occupational, speech language pathology, and respiratory therapy services complying with provisions of the corresponding Medicaid coverage and limitations handbooks and the Medicaid State Plan. Neuropsychology is currently not a covered service under Florida Medicaid and will not be covered under contracted MMA plans.

Question:
Flu vaccines are not currently covered for 21+ through Medicaid. Some MMA plans include it in their expanded service. Does that mean they will be covered this year?

Answer:
Most MMA plans elected to cover influenza vaccinations as an expanded benefit. For MMA plans covering this vaccine, the coverage will be offered upon the recipient’s enrollment in the plan.

Question:
Will specialty injectables be required to be purchased through buy and bill specialty distribution or specialty pharmacy under the MMA program?

Answer:
Under MMA, pharmacy purchases for enrollees are handled through the MMA plans. However, all contract provisions related to coverage, access, and continuity of care must be met.

Question:
Will patients be able to receive services through the MMA program while receiving home health skilled services through Medicare?

Answer:
Most individuals who have Medicare coverage will need to enroll in a Medicaid Managed Medical Assistance plan to receive Medicaid services. MMA enrollees will continue to receive home health services through Medicare, as the primary payor before Medicaid.

Question:
Will the waiver support coordinators be a part of iBudget under MMA?

Answer:
The MMA program does not change the way the iBudget waiver services are provided. iBudget Waiver support coordinators will continue to support individuals enrolled in the iBudget waiver.

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Managed Medical Assistance Frequently Asked Questions

Question:
Will all plans require patients to have a primary care provider with a referral in order to see a specialist?

Answer:
Each plan will provide its enrollees with a member handbook that tells the enrollee how to access services.

Question:
How will pediatric audiology services be provided by the MMA plans?

Answer:
Newborn and infant hearing screenings are covered through Medicaid fee-for-service (FFS). All other pediatric audiology services will be covered by MMA plans in accordance with the Florida Medicaid Hearing Services Coverage and Limitations Handbook. Services must be provided in the same amounts of frequency, intensity and duration as determined medically necessary coverage through the handbook. Providers must contract with MMA plans in order to provide hearing services to MMA enrollees.

Question:
Will existing Medicaid or Medipass authorizations continued to be honored by the MMA plans?

Answer:
Yes. The new MMA plan is required to honor any existing authorizations for up to 60 days, or until the enrollee’s primary care practitioner or behavioral health provider reviews the enrollee’s treatment plan, whichever comes first.

Question:
How will MMA effect funding of therapy in the schools by Medicaid?

Answer:
Therapy services that are provided by the school districts or county health department as a part of the Medicaid Certified School Match program will continue to be reimbursed through a fee-for-service arrangement.

Question:
If a provider is not contracted with an MMA plan and the Medicaid recipient wishes to see the provider for services anyway, may the provider have the recipient sign a waiver for services?

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Managed Medical Assistance Frequently Asked Questions

Answer:
Yes. However, the enrollee’s plan is not required to pay for unauthorized services provided by a non-network provider, unless it is for emergency services. To be reimbursed for services, providers must have a contract or agreement with the enrollee’s MMA plan.

Question:
Will MMA cover for Adult Day Care services?

Answer:
No, adult day care services are not covered under the Managed Medical Assistance program.

Question:
Will the MMA plans cover out-of-state emergency services?

Answer:
Yes. MMA plans are required to cover emergency services when the enrollee is out of state.

Question:
Is medical foster care a service plans are required to cover? Is it in their rates?

Answer:
No. Medical foster care (MFC) is not one of the minimum required services that the MMA plans must provide; as such, it will be covered under fee-for-service Medicaid for eligible children. The MFC service is not included in plan capitation rates.

Question:
Can a child receive medical foster care services from any MMA plan, or do only some plans provide it?

Answer:
Medical foster care (MFC) is not one of the minimum required services that the MMA plans must provide; as such, it will be covered under fee-for-service Medicaid for eligible children. The Department of Health, Children’s Medical Services is responsible for authorizing and managing medical foster care services.
Question:

Alternatively, is the medical foster care service paid for fee-for-service (a carve-out)? If yes, are there any limits on which plan a child can be in and still receive the service?

Answer:

Any eligible recipient under the age of 21 may access medical foster care through fee-for-service Medicaid, regardless of MMA plan enrollment.

Question:

Will ground non-emergency ambulance transports in FL, between hospital to hospital, hospital to nursing home, nursing home to dialysis, home to doctor’s appointment for care, etc, continue to be carved out from the MMAs and process directly with the State for claim payment?

Answer:

No, MMA plans are responsible for covering all emergency and non-emergency transportation for MMA services to their enrollees.

Question:

Are there HEDIS measures for MMA for Routine Eye Exams? If so, what are they?

Answer:

The only HEDIS measures related to eye exams/screenings are: Glaucoma Screening in Older Adults, and Eye Exam (retinal) Performed, which is a component of the Comprehensive Diabetes Care measure (and only includes those with Diabetes). There are no HEDIS measures related to routine eye exams for a general population. MMA plans are required to report on all components of the Comprehensive Diabetes Care measure.

Question:

Can you please define the taxonomy code for non-emergency transportation that is being required to transfer to MMAs?

Answer:

For information on taxonomy and the taxonomy codes, see www.wpc-edi.com/codes/taxonomy.

Question:

With Medicaid Managed Care plans, like Prestige, WellCare, United Healthcare, and Sunshine, when we run FMMIS to check eligibility for dental services, will the Managed Care medical insurance plan show under dental or will the dental plan show?
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Answer:
Dental services are included in the MMA benefit package. Only the enrollee’s MMA and/or LTC plans will appear in FMMIS. Providers will need to work with each plan directly in order to determine if they are using a Dental Benefits Administrator and how to obtain authorization and payment for dental services.

Question:
If an authorization is obtained for services prior to the change to an MMA plan (e.g., MedSolutions for current MediPass patients), will that authorization be honored for services?

Answer:
The MMA plan will honor any previous prior authorization of ongoing covered services for a period of 60 days after the effective date of enrollment, or until the enrollee’s PCP or behavioral health provider reviews the enrollee’s treatment plan, whichever comes first.

Question:
Which pharmacy benefit manager (PBM) is going to be the prescription processor for each of the MMA plans? Is there a place on the website where this information can be found?

Answer:
The MMA plan may contract with the Agency’s current PBM vendor or they may contract with a different PBM vendor. Providers should work with each enrollee’s MMA plan to determine which PBM the plan is contracted with.

Question:
Are MMA plans required to assist with ramp installation or portable ramps for home bound patients?

Answer:
Home modification is not one of the minimum required services that MMA plans must provide. However, this is a covered service under the Long-term Care component of the SMMC program.

Question:
Will transportation (both emergency and non-emergency) be covered by the MMA plans?

Answer:
MMA plans are required to cover emergency and non-emergency transportation services for any covered service (including expanded benefits) for enrollees who have no other means of transportation available. The MMA plans must provide transportation services in accordance with the Medicaid Transportation Services Coverage and Limitations Handbooks.

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Question: What do Medicaid recipients not enrolled in an MMA plan do for emergency transportation?

Answer: If a recipient is not enrolled in an MMA plan, he or she will receive any medically necessary emergency transportation services through fee-for-service Medicaid.

Question: When will mental health and substance abuse services (including targeted case management) become payable under Managed Medical Assistance plans?

Answer: All mental health and substance abuse services must be covered by MMA standard and specialty plans. Mental health and substance abuse services will be covered by the MMA plan upon the recipient’s enrollment into the MMA plan. This includes mental health targeted case management services.

Question: Are there any changes in coverage for dialysis patients?

Answer: No. MMA plans will cover renal dialysis services. The services include in-center hemodialysis, in-center administration of the injectable medication Erythropoietin (Epogen or EPO), other Agency approved drugs, and home peritoneal dialysis.

Question: Are enrolled adults eligible for dental services under their plans?

Answer: Most MMA plans chose to offer adult dental services as an expanded benefit. For a quick review of plans that are providing the adult dental expanded benefit, please see the Managed Medical Assistance Snapshot, located at http://ahca.myflorida.com/SMMC. Select the Managed Medical Assistance tab, and the Snapshot will be the first available link. In addition, to see what each MMA plan has chosen to include in the adult dental expanded benefit, please visit http://flmedicaidmanagedcare.com. Select Welcome, then enter your zip code or county to find your area. Select Managed Medical Assistance. In the ribbon below the AHCA logo, select 2. Plan Information. This will show you all of the MMA plans in your area and describe how each plan is covering the expanded benefits.

Question: How does CMS cover therapy services (PT, OT, ST)?

Answer: The Children’s Medicaid Services Network (CMSN) plan is required to provide physical, occupational, and speech language pathology therapy services.
Question:
Will CMS patients have to follow the Statewide PDL?

Answer:
Yes, CMS is required to follow the Agency’s Medicaid Preferred Drug List (PDL).

Question:
Will we have to receive authorizations from a PCP if patient needs to see a specialist?

Answer:
Each MMA plan must provide its enrollees with an Enrollee Handbook that explains the procedures for obtaining required services, including second opinions at no expense to the enrollee, and authorization requirements, including any authorization or referral requirements to see a specialty physician.

Question:
Will authorization for diagnostic imaging be required and will it still come from outside contractors such as Care Core National Medsolution or Simply Better Health?

Answer:
MMA plans will cover medically necessary laboratory, portable x-ray, and advanced diagnostic imaging services. Prior authorization procedures are determined by each plan. If a recipient is not enrolled in an MMA plan, prior authorization for advanced diagnostic imaging services must continue to be obtained from MedSolutions, the Agency’s contracted vendor.

Question:
How will transplants be handled through the new managed care plans?

Answer:
Organ transplant services covered by Medicaid, with the exception of intestinal/multivisceral transplant services, will be provided and reimbursed through the enrollees’ MMA plan.

MMA enrollees requiring an intestinal/multivisceral transplant service can receive the service through fee-for-service Medicaid. Facilities that perform intestinal/multivisceral transplant services must continue the current policy of notifying the Medicaid transplant coordinator within 3 days of the transplantation surgery. Additionally facilities performing these transplantation services must also use the current policy for global payment reimbursement; reimbursement packages must be sent to the Medicaid transplant coordinator.

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Managed Medical Assistance Frequently Asked Questions

Question:
For HIV patients eligible for Part B case management, will there be cooperative case management with the managed care case manager and the Ryan White case manager?

Answer:
Yes, the managed care plan’s case manager will work with the enrollee’s service providers to provide coordinated care.

Question:
Does the residential care that is indicated in the MMA contract cover adults? I realize that acute inpatient psychiatric hospitalizations are covered for adults but how about residential treatment for mental health or substance abuse?

Answer:
With approval of the Agency, Managed care plans may implement mental health short-term residential treatment for adults as a substitution service for other more costly institutional care. Residential treatment for substance abuse is only covered for pregnant women.

Question:
Based on the webinar, PAC recipients will be required to enroll in a plan and continue to receive PAC waiver benefits. How would we find out if that will impact the $100.00 per month per patient we bill for case management? Our case manager coordinates the added in-home services. The one plan that is targeting HIV (Clear Health Alliance) in our area includes case management.

Answer:
Case management services provided under the PAC waiver are separate and distinct from the MMA Specialty plan case management services. Providers rendering services to PAC waiver enrollees should continue to bill as usual for case management services.

Question:
Is PIC program going to be covered under MMA? What is the roll out date?

Answer:
The Program for All-Inclusive Care for Children (PACC), sometimes called the Partners in Care Together for Kids (PIC: TFK) program, will continue to be provided on a fee-for-service basis to recipients enrolled in the Children’s Medical Services Network (CMSN) Plan. The CMSN Plan will be implemented statewide on August 1, 2014.

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Managed Medical Assistance Frequently Asked Questions

Question:
Are mental health services going to be provided by MMA non-specialty plans?

Answer:
Yes. Behavioral health (including mental health and substance abuse) services are a minimum covered service for all MMA plans, including standard and specialty plans.

Question:
Will pregnant women need to find primary care doctor before being referred to an OB?

Answer:
MMA plans allow pregnant enrollees to choose plan obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a primary care physician. For pregnant women who transition into an MMA plan, the plan must continue to pay for services provided by her current provider for the entire course of her pregnancy including the completion of her postpartum care (six weeks after birth), regardless of whether the provider is in the plan’s network. The MMA plan must pay non-participating providers at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of 30 days, unless the provider agrees to an alternative rate.

Question:
Currently we experience 2-3 weeks delay in authorization for therapy services with managed care plans. How will this transition impact the processing of even more requests?

Answer:
During a recipient’s transition into an MMA plan, MMA Managed Care Plans must provide continuation of MMA services until the enrollee’s primary care provider or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the enrollee’s treatment plan, which shall be no more than sixty (60) days after the effective date of enrollment. For more information about the continuity of care period, please see the webinar, “Transitioning to Managed Medical Assistance – Selecting a MMA Plan and Continuing Your Services.” This presentation is located at http://ahca.myflorida.com/SMMC. Select News and Events, and then Events and Training Materials.

For assistance with plan issues, providers can contact the LTC or MMA Plan directly or use the Agency’s complaint process by submitting an issue online at: http://ahca.myflorida.com/SMMC. Select the blue “Report a Complaint” button and complete the online form. If you need assistance completing this form or wish to verbally report your issue, please contact your local Medicaid area office. Find contact information for the Medicaid area offices at: http://ahca.myflorida.com/AreaOffices.

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Question:
With the 60-day continuation of previously authorized services, what information will the provider be responsible to provide to the new MMA?

Answer:
Providers may be required to submit written documentation of any prior authorized ongoing care, along with their claim(s) in order to receive payment from the plan. Providers will need to work directly with the MMA plans in their region to obtain specific requirements for payment.

Question:
The Agency says in the Continuity of Care document that plans must cover prior authorized services during the continuity of care period, but certain Medicaid services may not require a prior authorization (for example, individual therapy provided under fee-for-service Medicaid). How will behavioral health services be covered during the transition?

Answer:
The managed care plan must accept the mental health treatment plan, which identifies services authorized by the treating practitioner, as proof of authorization for services that do not undergo a utilization management review.

Question:
I notice that on the 2 MMA plans for Region 2 they both offer unlimited home visits. Does that mean that as a primary care Provider our Doctors now have to make house calls?

Answer:
No. The managed care plan may authorize physician visits as often as needed at an enrollee’s place of residence for an enrollee who is unable to leave the home.

Question:
Will there still be a limit of 45 days for Mental Health acute inpatient admission per year with the managed Medicaid rollout?

Answer:
For all non-pregnant adults, MMA plans are responsible to cover forty-five (45) days of inpatient (medical and behavioral health) coverage in accordance with the Medicaid Hospital Services Coverage and Limitations Handbook, for each state fiscal year.

Question:
What are the specific requirements for providers to conduct mental health services using Telehealth?
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Answer:

MMA plans may use telemedicine for behavioural health services. MMA plan’s telemedicine policies and procedures must comply with both Contract and State Plan requirements. When providing services through telemedicine, MMA plans must ensure that:

- the equipment used meets the definition of telecommunication equipment as defined in the Contract;
- the telecommunication equipment and telemedicine operations meet the technical safeguards required by 45 CFR 164.312, where applicable;
- telemedicine services are provided only to enrollees in a provider office setting; that providers using telemedicine comply with HIPAA and other state and federal laws pertaining to patient privacy;
- facilitate provider training regarding the telemedicine requirements.

Additionally, MMA plans must ensure the enrollee has a choice of whether to access services through a face-to-face or telemedicine encounter.

Question:

Do the managed care plans need to request that a release of information is signed by an enrollee admitted inpatient or receiving outpatient Psychiatric services in order to notify the PCP of an Inpatient admission or when trying to assist an enrollee in coordinating care between and enrollee’s PCP and mental health provider?

Answer:

Yes. Within thirty (30) days of enrollment, MMA plans will ask the enrollee to authorize release of the medical/case and behavioral health clinical records to the new PCP or other appropriate provider and will assist by requesting those records from the enrollee’s previous provider(s).

Question:

For Hospice can you clarify that authorization is not required for a change in level of care? (ie: from Routine care to in patient?)

Answer:

Hospice providers should contact the recipient’s managed care plan to obtain more information on any service authorization requirements. Each managed care plan has its own authorization process and will provide instructions on prior authorization to providers through contracts and/or provider handbooks.

Question:

Will the MMA plans cover any genetic services such as genetic testing?

Answer:

The MMA plans are required to provide genetic screening services that are already covered and specified in the Medicaid State Plan and/or respective Medicaid Coverage and Limitations Handbook.
Managed Medical Assistance Frequently Asked Questions

Question:
If someone is being funded by DCF for an residential substance abuse treatment or any other level of care admission that predates the start date of Managed Medicaid for a client who has current Medipass or a Medicaid managed care plan that did not include SA benefits previously, will the funding for that current admission shift to managed Medicaid as of the start date or will DCF continue to fund the current admission?

Answer:
Upon a recipient’s enrollment into the MMA program, MMA plans will be responsible for all medically necessary mental health and substance abuse treatment services covered under the Medicaid State Plan and/or respective Coverage and Limitations Handbooks. If the service is not covered under the Florida Medicaid program, the recipient will need to continue to access the service (if still available) through DCF or another funding source. For additional information about how care will be transitioned from current plans to MMA plans, please read the summary on Continuity of Care Requirements at http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Continuity_of_Care_Requirements.pdf

Question:
Will enrollees who have Medicare part D prescription coverage be required change pharmacies?

Answer:
Medicare coverage is the primary payer for recipients who are dually eligible and receiving Medicare Part D coverage. Recipients enrolled in Medicare part D plans will continue to receive their medications through their Medicare part D plan and should not be required to change their pharmacy. Prescribers should follow the Medicare part D formulary for those recipients.

Question:
I am a targeted case manager and would like to know how this change with Medicaid to the MMA and HMO's will affect my children/clients that are awaiting placement into a SIPP/Residential Treatment Facility, or are already in a facility. Are there certain plans that will not cover this type of intensive placement?
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Answer:

All MMA plans will cover Statewide Inpatient Psychiatric Program (SIPP) services. While the pre-admission requirements for SIPP will not change, enrollees and their caregivers must work with the MMA plan to determine the prior authorization requirements to receive the SIPP service. Each MMA plan have the ability to adopt their own prior authorization process for SIPP services. For recipients who are already in SIPP treatment at the time of their enrollment into an MMA plan, the MMA plan must honor any written documentation of prior authorization of ongoing covered services for a period of sixty (60) days after the effective date of enrollment, or until the enrollee's PCP or behavioral health provider (as applicable to medical care or behavioral health care services, respectively) reviews the enrollee's treatment plan, whichever comes first. For more information about the 60-day continuity of care period, please review the Agency’s statement on Continuity of Care Requirements at our website: http://ahca.myflorida.com/SMMC. Select Managed Medical Assistance, and then scroll down to locate the document in the list.

Question:

How will recipients receiving Prescribed Pediatric Extended Care (PPEC) be handled under the Managed Medical Assistance (MMA) program?

Answer:

Medicaid recipients receiving Prescribed Pediatric Extended Care (PPEC) services are voluntary for participation in the MMA program, unless they are Medikids recipients. Florida law requires all MediKids recipients to enroll in an MMA plan with no exceptions [see section 409.8132, F.S.]. Regardless of enrollment in an MMA plan, all PPEC services will be covered by fee-for-service Medicaid.

PPEC recipients who choose not to enroll in an MMA plan will continue to access all medically necessary services, including therapy services, through fee-for-service Medicaid.

MMA plans are required to cover all medically necessary services, including therapy services, rendered by providers in their network after the end of the continuity of care period.

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Question:
With the changes that took place in regards to Medicaid moving into the Medical Managed Assistance program, a few questions have come up if the patient exceeds their 45 Inpatient days under their Managed Care plan, will these still move over to Medicaid to bill for a BBA as they did in the previous world?

Answer:
The MMA plans are responsible for up to 45 days of inpatient coverage and up to 365 days of emergency inpatient, including behavioral health, for non-pregnant adults, per fiscal year. Requests for coverage of inpatient care for non-pregnant adults who have exceeded the 45 day inpatient service limitation must be submitted to the recipient’s MMA plan. The only BBA authorizations that will be issued by the Agency’s peer review organization vendor, eQHealth, are for fee-for-service recipients over the age of 21 who have an inpatient stay and have exceeded the 45 day inpatient service limitation.

The MMA plans are responsible for providing up to 365 calendar days of medically necessary, health-related inpatient care for Medicaid recipients under the age of 21.
11. Other

Question:
I understand that network providers will be required to check the MEV system to verify eligibility for customers to be enrolled in this managed care plan. Currently we verify eligibility through FLMMIS. Is there a specific system which we have to access that is different than FLMMIS to verify eligibility?

Answer:

The Florida Medicaid Management Information System (FMMIS) and the Medicaid Eligibility Verification System (MEVS) will continue to be available to verify Medicaid eligibility.

Question:
Will the Mac Safari work as well as Explorer 9?

Answer:

The public portal is certified for IE, FireFox and Opera.

Question:
Will ACHA be doing a presentation to discuss how transportation will be done under Managed care?

Answer:

There are no trainings planned specifically for transportation at this time, however, providers should participate in the trainings and webinars offered to all Medicaid providers. In addition, information and frequently asked questions are available on the AHCA internet portal at the following link: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#NEWS. If you have specific transportation questions, please submit them.