Frequently Asked Questions

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Long Term Care 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?

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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?

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 as shown in the chart below. AHCA will invite 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 Managed 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 October 1, 2013. It is anticipated that the Florida Managed Medical Assistance program will be available in certain areas beginning in the last quarter of 2013, and will be 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 requested 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.

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Question:

Which home and community based waivers are included in the Long-term Care Managed Care program, and will those waivers go away once this is implemented?

Answer:

There will be no wait list for nursing facility services under the Statewide Medicaid Managed Care program. Individuals who meet the financial eligibility criteria for Medicaid as determined by the Department of Children and Families and who meet nursing home level of care criteria as determined by CARES (Comprehensive Assessment and Review for Long Term Care Services) will be eligible to receive all medically necessary services through a Long-term Care Managed Care plan in their nursing home of choice. The following are eligible for enrollment and may re-enroll for 12 months without reevaluation: The Assisted Living for the Frail Elderly Waiver; The Aged and Disabled Adult Waiver; The Adult Day Health Care Waiver; The Consumer-Directed Care Plus Program as described in s. 409.221; The Program of All-inclusive Care for the Elderly. (f) The long-term care community-based diversion pilot project as described in s. 430.705; The Channeling Services Waiver for Frail Elders. Recipients enrolled in the DD waivers are specifically excluded from mandatory enrollment in the Long-term Care or Managed Medical Assistance programs. Recipients enrolled in other waivers that are not specifically mentioned in the legislation will be voluntary for enrollment. This means that they can choose to enroll in a Long-term Care or Managed Medical Assistance plan if they wish, but will not be required to do so.

Question:

What is the role of the AHCA in this program? The role of DOEA?

Answer:

The Agency for Health Care Administration will be responsible for management of the managed long-term care plan contracts; statewide policy decisions; and interpretation of all federal and state laws, rules and regulations governing the contract. The Department of Elder Affairs will be responsible for determining clinical eligibility for long-term care services; managing any program waiting list; monitoring long-term care plan performance; and assisting enrollees and their families to address complaints with the long-term care plans.

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Question:

What are the names of the MCPs?

Answer:

For information on the selected long-term care plans and their contact information, please access the Agency for Health Care Administration's Statewide Medicaid Managed Care Program website by clicking on the following link: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#LTCMC

Question:

How does a client find a list of Dr's 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:

How will current Doctors who accept Medicaid gold fee for service be informed that most of their patients will have to be in managed Medicaid even dual eligibles?

Answer:

Physician Services is not a covered service under the long-term care program. Medicaid recipients who are enrolled in the long-term care program will continue to receive their physician services through Medicare or the Medicaid medical assistance program.

2. Agency Payment to Plans

Question:

What is the capitated rate the LTC health plans are to receive per client?

Answer:

Agency negotiated base rates with each provider, as required in Florida Statute. Final rates will be available in final contracts with LTC health plans.

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Question:

Will the MCO be reimbursed differently during the transition than the ADA?

Answer:

During and after the transition into long-term care managed care, the Agency shall pay LTC health plans the applicable monthly capitation rate for each eligible enrollee.

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3. Health Plan Contracts

Question:

Have the managed care plan sub-contracts for network providers been reviewed and approved by AHCA? When should final approved contracts be expected?

Answer:

These are currently under Agency review. All LTC health plans have a 'Plan Readiness Deadline' of which includes provider network and contracting compliance. Please see the table below for region specific deadlines.

Region	Counties	Plan Readiness Deadline	Enrollment Effective Date	Estimated Eligible Population
7	Brevard, Orange, Osceola and Seminole	1-May-13	1-Aug-13	Region 1: 9,338
8 & 9	Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota, Indian River, Martin, Okeechobee, Palm Beach and St. Lucie	1-Jun-13	1-Sep-13	Region 8: 5,596; Region 9: 7,854: Total = 13,450
2 & 10	Escambia, Okaloosa, Santa Rosa and Walton, Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla and Washington, Broward	1-Aug-13	1-Nov-13	Region 2, 4,058; Region 10, 7,877; Total = 11,935
11	Miami-Dade and Monroe	1-Sep-13	1-Dec-13	Region 11: 17,257
5 & 6	Pasco, Pinellas, Hardee, Highlands, Hillsborough, Manatee and Polk	1-Nov-13	1-Feb-14	Region 5, 9,963; Region 6, 9,575: Total = 19,538
1, 3 & 4	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee Union, Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia, Escambia, Okaloosa, Santa Rosa, and Walton	1-Dec-13	1-Mar-14	Region 1: 2,973; Region 3: 6,911; Region 4: 9,087: Total = 18,971

Question:

Can you clarify the length of the contracts for the managed programs which were selected for each region? Will they be contracting with the Agency for a five year period?

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Answer:

The anticipated term of the long-term care managed care contracts with the Agency is approximately five (5) years beginning August 1, 2013, and ending August 31, 2018.

Question:

Will the LTC health plans be allowed to contract with MSOs and or IPAs? (Management Services Organization and/ or Independent Physicians Associations)

Answer:

The LTC health plans are not prohibited from contracting with MSOs for plan management. However, the plan's ITN response should have included MSOs as part of their organizational structures. The Agency would have to approve the LTC health plan's use of the MSO if it were not included in the ITN response. As service providers, IPAs are not qualified to provide any Long-term Care Managed Care program services. The required Medical Director for each LTC health plan must be a full time FTE.

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 is 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.

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Question:

Are there true limits on the amount of Medicaid providers within region? Although the legislation states there are limits to Medicaid Providers in each region (i.e. 10 in Miami Dade), is that countered by the part of the legislation that allows companies to avoid the procurement process?

Answer:

In regard to the Long term Care Managed Care program, according to section 409.981(2), F.S., relating to Eligible Plan Selection, the Agency for Health Care Administration (Agency) shall select eligible plans through the procurement process described in s. 409.966, F.S. The Agency will provide notice of invitations to negotiate by July 1, 2012 and procure:

(a)Two plans for Region 1. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(b)Two plans for Region 2. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(c)At least three plans and up to five plans for Region 3. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(d)At least three plans and up to five plans for Region 4. At least one plan must be a provider service network if any provider service network submits a responsive bid.

(e)At least two plans and up to four plans for Region 5. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(f)At least four plans and up to seven plans for Region 6. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(g)At least three plans and up to six plans for Region 7. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(h)At least two plans and up to four plans for Region 8. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

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(i)At least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(j)At least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(k)At least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

Section 409.981(4) , F.S., relates to the Program of All-Inclusive Care for the Elderly (PACE). Participation by the Program of All-inclusive Care for the Elderly (PACE) shall be pursuant to a contract with the agency and not subject to the procurement requirements or regional plan number limits of this section. PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the General Appropriations Act.

In addition, s. 409.981(5), F.S., relates to Medicare Advantage Special Needs Plans. Participation by a Medicare Advantage Special Needs Plan shall be pursuant to a contract with the agency that is consistent with the Medicare Improvement for Patients and Providers Act of 2008, Pub. L. No. 110-275. Such plans are not subject to the procurement requirements if the plan's Medicaid enrollees consist exclusively of dually eligible recipients who are enrolled in the plan in order to receive Medicare benefits as of the date the invitation to negotiate is issued. Otherwise, Medicare Advantage Special Needs Plans are subject to all procurement requirements.

Question:

Are DME providers automatically contracted with the HMOs?

Answer:

As specified in s. 409.982(1)(c), F.S., each managed care plan must offer a network contract to all aging network service providers that have previously participated in home and community-based waivers serving elders or community service programs administered by the Department of Elder Affairs. If a DME provider fits this description and has not been contacted by the long-term care plans in their region of the state, the DME provider should reach out to the managed care plans. For information on the selected long-term care plans and their contact information, please access the Agency for Health Care Administration's Statewide Medicaid Managed Care Program website by clicking on the following link:
http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#LTCMC

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4. Home Like Environment

Question:

We will be required to have 24/7 availability to the kitchen, for our residents? The health department does not allow anyone in the kitchen, without the appropriate dietary training. In the past, residents were not permitted. Residents are allowed choices, are they allowed to not wash their hands, if they so desire? Is the health department aware of this?

Answer:

To satisfy the home-like environment and community integration requirements established by the state, assisted living facilities and adult family care homes must ensure that waiver enrollees (medical, physical, and cognitive conditions permitting) have the ability to have snacks as desired and to prepare snacks as desired. Additionally, waiver enrollees must have a choice of their eating schedule (meaning that they must be able to choose when they will eat if they are able to). These requirements do not necessitate a 24/7 availability to the kitchen per se, but instead require that enrollees have a designated area where they can obtain and/or prepare snacks, if desired. A space like this may be a station in a common area with snacks available in a mini refrigerator or communal pantry, with access to a microwave or other food preparation appliances.

Question:

Regarding access to kitchen, is this access to facility supplies or preparation area for things they have, example refrigerated drinks....concern of cross contamination.

Answer:

To satisfy the home-like environment and community integration requirements established by the state, assisted living facilities and adult family care homes must ensure that waiver enrollees (medical, physical, and cognitive conditions permitting) have the ability to have snacks as desired and to prepare snacks as desired. Additionally, waiver enrollees must have a choice of their eating schedule (meaning that they must be able to choose when they will eat if they are able to). These requirements do not necessitate a 24/7 availability to the kitchen per se, but instead require that enrollees have a designated area where they can obtain and/or prepare snacks, if desired. A space like this may be a station in a common area with snacks available in a mini refrigerator or communal pantry, with access to a microwave or other food preparation appliances.

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Question:

Would a microwave available at the care station qualify as providing a method to prepare food?

Answer:

No, a microwave alone is not sufficient. The space may be a station in a common area with snacks available in a mini refrigerator or communal pantry, with access to a microwave or other food preparation appliances, but a microwave without the refrigerator or food preparation area is not enough.

Question:

Do these requirements only apply to adult family care homes and assisted living facilities? Does this apply to adult day care centers?

Answer:

The home-like environment and community integration requirements apply to assisted living facilities and adult family care homes specifically, although all service providers (including adult day care providers) are expected to help support and facilitate enrollees' community integration.

Question:

Who will be doing the onsite monitoring? What agency and what department?

Answer:

The Department of Elder Affairs and the Agency for Health Care Administration staff will conduct the on-site monitoring, in addition to any credentialing activities undertaken by the managed care plans pursuant to their subcontract agreements with the ALFs and AFCHs.

Question:

Does the new requirement require the residents to have a private room if they request one? Who is responsible to pay for this private room for Medicaid eligible individuals?

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Answer:

To satisfy the home-like environment and community integration requirements established by the state, assisted living facilities and adult family care homes must ensure that waiver enrollees have the choice of private or semi-private rooms. This means that waiver enrollees must be presented the option of both a private and semi-private room. It may be that the enrollee is unable to afford a private room, although he or she wants one. Neither the assisted living facility/adult family care home provider nor the managed care plan is required to pay for the enrollee's private room if he or she chooses one and cannot afford it. The assisted living facility/adult family care home provider and the managed care plan are responsible for ensuring and documenting in case records that the enrollee has been offered the choice of both a private and semi-private room.

Question:

In limited mental health ALFs – will the facility be responsible to make physical plant changes to ensure there is a cooking area available that will offer something more than a microwave?

Answer:

To satisfy the home-like environment and community integration requirements established by the state, limited mental health assisted living facilities must ensure that LTC enrollees (medical, physical, and cognitive conditions permitting) have the ability to have snacks as desired and to prepare snacks as desired. Additionally, waiver enrollees must have a choice of their eating schedule (meaning that they must be able to choose when they will eat if they are able to). These requirements do not necessitate a 24/7 availability to the kitchen per se, but instead require that enrollees have a designated area where they can obtain and/or prepare snacks, if desired. A space like this may be a station in a common area with snacks available in a mini refrigerator or communal pantry, with access to a microwave or other food preparation appliances.

Question:

In large facilities how will AHCA measure "home like characteristics'?

Answer:

The state will assess the home-like environment and community integration characteristics in the same way for all facilities, no matter their size.

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Question:

Do you need to have these changes in your facility contract too or just the managed care contract?

Answer:

Facilities will need to include the right to a single room and the ability to share a room with a roommate of their choice in your facility contract. However, it may be prudent for the facility to list all the items in an addendum to their current contract and rewrite future contracts. For the most part, all the other items under the home-like requirements are objective and can be determined from a facility walk-through.

Question:

What is the Referral Agreement due June 2013

Answer:

The assisted living facilities participating in the Assisted Living Waiver Program will be provided referral agreement addenda to include the home-like environment requirements, and these will need to be executed before or by July 1st. The language for the referral agreements is in quotes below: “Assisted living facilities will support the enrollee’s community inclusion and integration by working with the managed care organization’s case manager and enrollee to facilitate the enrollee’s personal goals and community activities. Additionally, waiver enrollees residing in assisted living facilities must be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options. Choice of: Private or semi-private rooms; Roommate for semi-private rooms; Locking door to living unit; Access to telephone and length of use; Eating schedule; and Participation in facility and community activities. Ability to have: Unlimited visitation; and Snacks as desired. Ability to: Prepare snacks as desired; and Maintain personal sleeping schedule”

Question:

To meet this standard should facilities be 16 beds – 20 or 30 beds in size? What about multi use campus projects that include an array of housing options and services?

Answer:

Home-like environment and community integration requirements apply to all assisted living facilities and adult family care homes, no matter the number of beds or size of the facility.

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Question:

Does failing to meet “homelike characteristics” affect your license in any way? Is this a standard that can be cited?

Answer:

There may be licensure requirements that are similar in some ways to these home-like environment and community integration requirements, and if so, those must be met for licensure purposes. However, meeting the waiver home-like environment and community integration characteristics is not required for licensure. That is, if your facility does not meet these required characteristics, you will not be able to receive Medicaid waiver reimbursement, but you may still be able to have a license.

Question:

In managing this access to food service or preparing their own meals how is the facility to meet this requirement and balance it against the need to comply with the health and sanitation requirement for the safe handling of food?

Answer:

To satisfy the home-like environment and community integration requirements established by the state, assisted living facilities and adult family care homes must ensure that waiver enrollees (medical, physical, and cognitive conditions permitting) have the ability to have snacks as desired and to prepare snacks as desired. Additionally, waiver enrollees must have a choice of their eating schedule (meaning that they must be able to choose when they will eat if they are able to). These requirements do not necessitate a 24/7 availability to the kitchen per se, but instead require that enrollees have a designated area where they can obtain and/or prepare snacks, if desired. A space like this may be a station in a common area with snacks available in a mini refrigerator or communal pantry, with access to a microwave or other food preparation appliances. These requirements are a condition of reimbursement by Medicaid.

Question:

Does AHCA plan to make any adjustment to the risk adjusted rates with the LTC plans to compensate for the increase in costs associated with this new standard (Home like environment standard)?

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Answer:

AHCA does not have specific information that would indicate that a home like environment would result in an increased cost of providing services to Medicaid recipients. Therefore, at this time, AHCA does not plan to make any adjustments to the risk adjusted rates for home like environment standards.

5. LTC Recipient Eligibility

Question:

Will program eligibility requirements continue as we know them now?

Answer:

Recipient are mandatory for enrollment into the Long-term Care Managed Care program if they are 65 years of age or older AND need nursing facility level of care; 18 years of age or older AND are eligible for Medicaid by reason of a disability AND need nursing facility level of care; or are enrolled in the Aged and Disabled Adult Waiver (A/DA); the Consumer-Directed Care Plus for individuals in the A/DA waiver; the Assisted Living Waiver; the Channeling Services for Frail Elders Waiver; the Nursing Home Diversion Waiver; or the Frail Elder Option. Financial eligibility determination for Medicaid will continue to be the responsibility of the Social Security Administration and the Department of Children and Families and will not change because of the new SMMC program. 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. The level of care criteria will not change.

Question:

Are current SNF residents mandatory enrollees if receiving Medicaid?

Answer:

Yes, as specified in s. 409.979, F.S., Medicaid recipients ages 18 or older who reside in a nursing facility, must receive long-term care services through the Long-Term Care Managed Care Program.

Question:

Are Hospice recipients required to select a LTC health plan?

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Answer:

Hospice recipients must select a LTC health plan if they are Medicaid recipients age 18 or older residing in a nursing facility or receiving services through one of the identified home and community-based waiver programs that will be transitioning into the Long-Term Care Managed Care Program.

Question:

Will recipients newly eligible for Medicaid be required to enroll in LTC health plans?

Answer:

During initial implementation of the Long-Term Care Managed Care Program, only individuals ages 18 or older who are fully eligible for Medicaid and who are either residing in a nursing facility or receiving services from the Assisted Living Waiver, Aged and Disabled Adult Waiver, Nursing Home Diversion Waiver, the Channeling Waiver, or the Frail Elder Option will be enrolled in the program. If an individual is not currently enrolled in one of these programs, but wishes to apply for nursing facility care or home and community-based waiver services, the individual would need to select a LTC health plan, once the individual is determined eligible.

Question:

Are individuals who are receiving home health services under the State Plan required to enroll in LTC health 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 health 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 ICP Medicaid application process remain the same?

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Answer:

Yes, financial eligibility determination for ICP Medicaid will continue to be the responsibility of the Department of Children and Families. 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.

Question:

Are all residents residing in a nursing home facility required to select a LTC health plan?

Answer:

Medicaid recipients who reside in a nursing facility must participate in the Long-Term Care Managed Care Program if Medicaid is their primary payer of nursing facility services.

Question:

Not all of our Medicaid Waiver clients reside in a Nursing Facility. Are the clients who are living in the community required to select a LTC health plan?

Answer:

Individuals receiving services through the Aged/Disable Adult waiver, the Assisted Living waiver, the Channeling waiver, the Frail Elder Option, and the Nursing Home Diversion waiver will be required to select a LTC health plan to manage their Medicaid services. This is true regardless of whether they reside in a nursing facility or in a community setting.

Question:

Once individuals are released from the wait list, who will be responsible for completing the initial assessment for people under the age 60 to determine the care plan?

Answer:

DOEA's CARES staff is responsible for completing the initial assessment for individuals 18 and older, once released from the waiting list, in order to determine level of care.

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Question:

Once someone is in the Long-term Care Managed Care program and enrolled in a LTC health plan, is the LTC health plan the sole entity who determines the level of care needed?

Answer:

No, the LTC health plan does not determine Level of Care. The LTC health plan completes the annual 701B reassessment and submits the assessment to CARES. DOEA CARES staff determine the Level of Care independently of the health plans. The LTC health plan is, however, responsible for working with their enrollees to create a comprehensive plan of care that lists all needed services. If an enrollee is denied a service or is authorized for fewer services than he believes he needs, he can appeal through the plan's grievance process and/or through the Medicaid Fair Hearing process.

Question:

Will the level of care criteria change under the Long-term Care Managed Care program? If so, then how?

Answer:

Medicaid long-term care eligibility requirements for nursing facility care and home and community-based waiver services, including the level of care process, will not change with implementation of the Long-Term Care Managed Care Program.

Question:

According to CARES there is an over a year waiting list for recipients to be enrolled in a Nursing Diversion Program, since now is a mandatory regulation for recipient over 65 year old. Will this waiting list issue continue to be an issue?

Answer:

Access to Medicaid home and community-based waiver services is dependent on the availability of funding. It is expected that there will be a waiting list for home and community-based waiver services for individuals residing in the community. Medicaid recipients wishing to apply for home and community-based waiver services can continue to receive services through the Medicaid State Plan until they are able to access home and community-based waiver services. Once a recipient is able to access home and community-based waiver services, the recipient will be required to enroll in a managed long-term care plan.

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Question:

What will happen to pediatric patients who are currently residing in a nursing facility? Will they be required to select a LTC health plan?

Answer:

Medicaid recipients must be age 18 or older in order to be eligible to participate in the Long-Term Care Managed Care Program. Pediatric patients under the age of 18 will not be required to select a LTC health plan.

Question:

Are APD waiver clients (DD waiver enrollees) required to enroll in a LTC health plan?

Answer:

Medicaid recipients enrolled in the Developmental Disabilities Waiver Programs are not required to enroll in the Long-Term Care Managed Care Program.

Question:

Are individuals who are receiving home health services under the State Plan required to enroll in LTC health 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 health 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:

Does the SMMC program change eligibility for Medicaid in Florida?

Answer:

No, the Statewide Medicaid Managed Care program does not change eligibility coverage.

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Question:

Will Medicaid funding for nursing home services be limited based on available slots and funding? If an individual meets the technical and financial criteria for the Institutional Care Program and meets a nursing home level of care as determined by the CARES unit, can the individual be denied Medicaid funding to pay for nursing facility services based on slots and funding availability? Who will determine what level of care a recipient qualifies for? Will it still be CARES?

Answer:

There will be no wait list for nursing facility services under the Statewide Medicaid Managed Care program. Individuals who meet the financial eligibility criteria for Medicaid as determined by the Department of Children and Families and who meet nursing home level of care criteria as determined by CARES (Comprehensive Assessment and Review for Long Term Care Services) will be eligible to receive all medically necessary services through a Long-term Care Managed Care plan in their nursing home of choice

Question:

A facility was concerned about Temporary Loss of Eligibility for residents and how they will be able to make sure their Medicaid remains active since they can't open their mail.

Answer:

The Managed Care Plan, not the facility, is responsible for the development of a process to track Medicaid redetermination dates to ensure the enrollee will have continuous Medicaid eligibility. (See the Long-term Care managed care plan contract, Attachment II, Exhibit 4, Section 13). If enrollee experiences a Temporary Loss of Eligibility, the Managed Care Plan is responsible for assisting him/her to regain eligibility. The Managed Care Plan is also responsible for providing covered services to enrollees who temporarily lose eligibility for up to sixty calendar days.

Question:

Our facility has over 70 LTC residents - will the managed program apply to them when their annual recertification comes up?

Answer:

While all Long-term Care program enrollees will have a case manager who can assist them to remain eligible, it is in the best interest of providers to ensure that their residents continue to maintain eligibility.

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Question:

If a resident is already ICP Medicaid approved, then decided to go home. Will this affect the resident's community Medicaid eligibility? Where do we fax the discharged change form to?

Answer:

When a Medicaid recipient in a nursing facility is preparing to return home, the long-term care plan's case manager should work closely with the patient, the patient's designated representative, and the nursing facility to make sure that all community supports and services are in place prior to discharge. It will still be the responsibility of the nursing facility to notify the Department of Children and Families of the patient's discharge via the Client Discharge/Change Notice form.

Question:

So once the application is submitted and the member has not submitted their supporting documents and they have chosen a plan, the plan can assist with submitting documents?

Answer:

Yes, once an applicant residing in the community chooses the Medicaid Pending option and enrolls with a long-term care plan, the applicant's case manager can assist the applicant in making sure all information is gathered and provided to the Department of Children and Families, so that DCF's determination can be made as quickly as possible

6. Network Provider Contracts

Question:

If we want to participate with a SMMC Long-term Care plan ("LTC health plan") as part of their provider network in our region, by what date are providers required to have signed contracts with those plans in our regions?

Answer:

Providers may contract with a LTC health plan at any time, but must do so before rendering services to a LTC health plan recipient enrolled in that plan. Please see the table below for details regarding the region roll-out schedule and effective dates.

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Frequently Asked Questions

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 HMO 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:

Do all providers who wish to participate in a LTC health plan network need to contract individually with the health plan? The contracts that we have received are for the nursing home. We have both a SNF & home health agency. Should both be contracted?

Answer:

LTC health plan network service providers who want to provide services to long-term care managed care enrollees will need to contract with the selected LTC health plans in their region for each service they want to provide.

Question:

If a provider is located in a county that borders another region, should that provider consider contracting with LTC health plans in both their "home" region and the contiguous region?

Answer:

Yes, providers that operate near the border of a county or region should work with the selected LTC health plans in their respective region if the provider wants to be a part of the managed care network.

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Frequently Asked Questions

Question:

Will health plans in the SMMC program be required to have a certain number of primary care doctors and specialists?

Answer:

Yes, the Agency will establish 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 nursing home providers be required to contact the plans selected by AHCA to become a network provider or will it occur automatically because of the safeguard in the law that no nursing home can be denied participation initially?

Answer:

As specified in s. 409.982, F.S., managed care plans must offer a network contract to all nursing homes in each region of the state. Although the managed care plans will be contacting the nursing homes in the regions of the state where they are establishing their provider networks, nursing homes may wish to contact the managed care plans that have expressed an interest in the Long-term Care Managed Care program. A list of organizations that submitted a non-binding letter of intent to bid to become a Managed LTC plan is posted on the Agency for Health Care Administration's Statewide Medicaid Managed Care website at the following link: http://ahca.myflorida.com/medicaid/statewide_mc/pdf/LTC_Non-Binding_Letters_of_Intent_041912.pdf

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7. Plan Payment to Providers

Question:

Will the LTC health plans pay providers the same way that providers are currently paid under the Medicaid fee-for-service program?

Answer:

Except where specifically required by statute, LTC health plans do not have to pay the same way that providers are currently paid under the fee-for-service program. LTC health plans and their network providers will be able to negotiate mutually acceptable rates for the provision of services.

Question:

Will the LTC health plans be required to follow the same payment schedule as traditional Medicaid which is roughly 7-10 days after the initial billing of the claim?

Answer:

The long-term care managed care contract will contain specific requirements for the payment of claims by the managed care plan, that reflect the current provider reimbursement requirements specified in Florida Statute and the Medicaid Provider General Handbook. The LTC health plan shall 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. In addition, LTC health plans must ensure that electronic nursing home and hospice claims that contain sufficient information for processing are paid within 10 business days after receipt.

Question:

Once the Long-term Care Managed Care program is implemented in our region, what billing system should providers such as nursing facilities used to submit bills for their residents?

Answer:

All LTC health plans are required to use HIPAA compliant, nationally recognized billing software for the submission of claims to LTC health plans (for residents enrolled in the Long-term Care Managed Care program) or to FMMIS (for residents not yet enrolled or for their retroactive eligibility period).

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Frequently Asked Questions

Question:

Under the Long-term Care Managed Care program, will nursing facilities continue to receive the enhanced payment for patients with HIV/ AIDS?

Answer:

Yes. As specified in s. 409.982(5), F.S., LTC health plans must pay nursing homes an amount equal to the nursing facility-specific payment rates set by the Agency. However, mutually acceptable higher rates may be negotiated between the network providers and the health plans for medically complex care.

Question:

How will patient responsibility be handled under the Long-term Care Managed Care program? Will it be the same regardless of whether the LTC health plan is capitated or fee-for-service?

Answer:

All capitated and fee-for-service LTC health plans will be responsible for collecting its enrollee's patient responsibility. The LTC health plan may transfer the responsibility for collecting its enrollee's patient responsibility to the residential facilities and compensate the facilities net of the patient responsibility amount. If the plan transfers collection of patient responsibility to the provider, the provider contract must specify complete details of both parties' obligations for collection of patient responsibility. The plan must either collect patient responsibility from all of its providers or transfer collection to all providers.

Question:

On an MDS standpoint. Would we continue with the OBRA schedule or follow the PPS schedule for reimbursement once the Long-term Care Managed Care program is implemented on our region?

Answer:

The Long-term Care Managed Care program does not impact the administration of MDS in nursing facilities.

Question:

As a hospice, can we bill the Statewide Medicaid Managed Care Long-term Care plan (“LTC health plan”) for room and board directly? Or does the Nursing Home bill for the room & board

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Answer:

For qualified individuals enrolled in a capitated LTC plan, the hospice will bill the LTC plan, and then the hospice will provide the nursing facility with the room and board payment.

Question:

How will Medicaid Crossover payments be billed? Will these be billed to the LTC health plan?

Answer:

Providers will bill the LTC plans for certain Medicare crossovers for individuals who are dually eligible for Medicare and Medicaid. The LTC plan shall reimburse providers or enrollees for Medicare deductibles and co-insurance payments made by the providers or enrollees, according to Medicaid guidelines referenced in the Florida Medicaid Provider General Handbook. LTC plans are responsible for nursing facility services, durable medical equipment, home health, and therapies (occupational, physical, speech or respiratory) related crossover payments, if any, for their plan members.

Question:

Has it been determined if a uniform UB04 will be accepted by all LTC health plans?

Answer:

The Agency has not directed the LTC plans to utilize a specific billing format. The LTC plans must be able to accept electronically transmitted claims from providers in HIPAA compliant formats. The LTC 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:

Are authorizations going to be needed for SNF claims?

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Answer:

When an individual becomes fully eligible for Medicaid and is enrolled with a LTC plan, the Medicaid recipient's LTC plan will be responsible for authorizing all long-term care services, including skilled nursing facility (SNF) services. Service planning must involve the enrollee and/or enrollee representative working cooperatively with the enrollee's case manager. Service authorizations must reflect services specified in the plan of care. When service needs are identified, the enrollee must be given information about available providers, so that an informed choice of providers can be made.

Question:

Please provide a time line or clarification on who the hospice will be billing and when? Will the hospice bill Medicaid directly for the first few months and then the LTC plan? Please clarify

Answer:

For a qualified individual who has Medicaid-only, the individual's LTC plan will be responsible for paying the hospice provider from the first day the individual is enrolled with the LTC plan.

Question:

How are retro rate adjustments going to be processed by the LTC plan? Will it be a lump payment instead of individual resident?

Answer:

If the retroactive rate adjustment results in an overpayment to the nursing facility, then the State will collect money from the nursing facility independent of the LTC plan. If the retro rate adjustment results in an underpayment to the nursing facility, then the State will give a check to the LTC plan to provide to the nursing facility. Overpayments and underpayments will be calculated as one lump payment.

Question:

Relating to skilled nursing facilities: Will the cost reporting change with the new LTC plans?

Answer:

No, nursing facilities will still report their costs in accordance with the Florida Title XIX Long-Term Care Reimbursement Plan (currently Version XXXIX, effective July 1, 2011).

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Frequently Asked Questions

Question:

Will claims be sent through a single portal or submitted to each LTC plans?

Answer:

Each managed care plan will specify in the contract with their network service providers, how to submit claims for approved services.

Question:

Is there a period of time when the switch to an MCO that we can bill?

Answer:

FFS providers have 12 months from the date of service to submit a claim. Providers can continue to submit claims for dates of service prior to the launch of full managed care.

Question:

If I'm contracted with a fee for service PSN, how will I bill? Do I need to be enrolled with Medicaid?

Answer:

Claims for covered services provided to Medicaid recipients enrolled in a LTC plan should be submitted to the LTC plan (for both FFS PSN and HMOs). You will need to be enrolled as a Medicaid provider to receive payment if you are in a FFS PSN plan network. Please remember to confirm Medicaid eligibility and plan enrollment prior to providing a service.

Question:

Will provider's rates be cut?

Answer:

Managed care plans and their network providers are expected to negotiate mutually acceptable rates, methods, and terms of payment.

Question:

Once Medicaid is approved for patient in a Skilled Nursing Facility who does the facility bill for the retro months? If DCF approves months retroactively coverage on 9/12 and the managed care plan is effective on 11/1/12 and it is approved who pays 9/12 thru10/12?

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Answer:

The Medicaid eligibility determination process for individuals in nursing facilities will not change. The nursing facility will continue to bill Medicaid directly through fee-for- service for the approved months of retroactive eligibility prior to managed care enrollment.

Question:

Can a Medicaid approved company bill Medicaid for work rendered for a PSN

Answer:

A Medicaid provider serving recipients enrolled with a Provider Service Network (PSN) must be a part of the PSN's approved network of providers. In order to receive reimbursement for Medicaid long-term care services, those services must be authorized by the PSN and any claims must be submitted to the PSN for processing.

Question:

Can all nursing facilities bill all plans?

Answer:

Each selected plan must offer a network contract to all nursing facilities in a region (see s. 409.982(1) (a), F.S.) Nursing homes and hospices that are enrolled Medicaid providers must participate in all eligible plans selected by the Agency in the region in which the provider is located (see s. 409.982(2), F.S.).

Question:

Is there going to be electronic billing to the LTC HMO'S?

Answer:

Yes, all managed long-term care plans must be able to accept electronically transmitted claims from providers in HIPAA compliant formats.

Question:

What is the required turn-around time from services billed to anticipated payment?

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Answer:

For all electronically submitted claims for services, the managed care plans must:

• Within ten (10) business days of receipt of nursing facility and hospice clean claims, pay or deny the claim (see s. 409.982(5), F.S .,);

• Pay or deny the claim within ninety (90) calendar days after receipt of non-nursing-facility/non-hospice claims.

Question:

When will the managed care companies be reaching out to the LTC providers for training on billing?

Answer:

If you are a network service provider for the long-term care program, you should contact the plans in your area of the state for any necessary training, if they have not already reached out to you.

Question:

Will the HIV add on still be paid under managed care?

Answer:

The SFY 2013-2014 budget eliminates the AIDS supplemental payment for nursing facilities and adds a supplemental payment for adults who are ventilator dependent. The managed care plans will need to pay nursing facilities based on the policies that the Agency establishes to implement these changes. These changes are contingent on the budget being signed into law.

8. Provider and Recipient Appeals

Question:

Who will handle provider and/or recipient appeals under the SMMC LTC program?

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Answer:

LTC health plans must have internal grievance procedures under which Medicaid enrollees, or providers acting as authorized representatives, may challenge denial of, coverage of, or payment for services. In addition, enrollees may continue to access the Medicaid Fair Hearing process if services are reduced, denied, suspended, or terminated.

Question:

What if CARES certifies someone for skilled care but the shortly afterwards the MCO wants to transition them to a lower level of care. How is that contested? Is fair hearing required?

Answer:

Service planning must involve the enrollee and/or enrollee representative working cooperatively with the enrollee's case manager. If an enrollee's benefits are terminated, suspended or reduced, the LTC health plan must provide the enrollee with a written notice of action. If an enrollee disagrees with this action, the enrollee has the right to file an appeal with the LTC health plan. Once the LTC health plan's appeal process is complete, an enrollee can appeal an adverse decision to the Beneficiary Assistance Program (BAP). In addition, an enrollee can request a Medicaid Fair Hearing at any time.

9. Provider Enrollment

Question:

Do providers who wish to participate in a PSN provider network need to be fully enrolled Medicaid providers?

Answer:

Yes, if the PSN is a fee-for-service PSN. Currently, the one long-term care PSN is fee-for-service; therefore providers that wish to contract with the PSN must be fully enrolled as Medicaid providers.

Question:

I have a home health agency; we are a med waiver provider. Do we have to sign up again with Medicaid directly, or just with the new LTC plans?

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Answer:

Providers interested in providing services to Statewide Medicaid Managed Care Long-Term Care Program (SMMC LTC) enrollees will need to establish contract with the LTC plans in order to provide services. There are additional Medicaid provider enrollment requirements if you contract with the managed care plan that is a PSN (provider service network). You should contact Brenda Evans at American Eldercare, the PSN, about those requirements.

Question:

How does the MMA (Managed Medical Assistance program) affect ALF's HHA's SNF and Adult Family care Homes?

Answer:

If you are referring to the long-term care component of SMMC, licensed and qualified assisted living facilities, home health agencies, skilled nursing facilities, and adult family care homes may participate as providers in the network if they are contracted with a LTC plan.

Question:

I am a Home Health Care Provider and will be contracting with all the insurance companies to provide services as the transition occurs. We currently serve many members under the A/DA waiver, and have a waiver number, but are not a licensed Medicaid provider. I was told by the providers we would be able to continue operating without any issue once the transition goes through. Do I need to be licensed to service the Medicaid population even if I have been servicing them through the waiver? Thanks for your help

Answer:

The Agency held a webinar relating to Medicaid provider enrollment on April 17, 2013. The information presented at this webinar will provide answers to your questions and additional information regarding the provider enrollment process. To access the webinar presentation please click on the following link: http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/Medicaid_Provider_Enrollment_Webinar_2013-04-17.pdf

Question:

Does the State of Florida Waiver to create LTC Managed Care reform require Registries to be Medicare Certified or Medicaid Certified (both or either) to service Dual enrollment patients?

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Answer:

The Long-Term Care Managed Care 1915(c) home and community-based waiver document specifies that Nurse Registries licensed under Chapter 400.506, Florida Statutes can be qualified providers in Florida's Long-Term Care Managed Care program. Nurse Registries are currently identified as qualified providers for dually eligible recipients in our existing home and community-based waiver programs. This requirement is consistent with provider qualifications for Florida's current home and community-based waiver programs serving this same population.

Question:

When will these new provider enrollment procedures go into effect?

Answer:

These procedures have been in effect for about six years. At this time the Agency is actively working to educate the public on available resources such as the Medicaid Web Portal.

Question:

If one MCO registers a provider, is that Medicaid ID good for use with another MCO?

Answer:

Providers need to register only once for each type of service they provide. They may contract with multiple MCOs and each would use the provider's one existing Medicaid ID. Multiple registrations are necessary only if the provider supplies more than one type of service.

Question:

Is the enrollment wizard in web portal?

Answer:

Yes. Go to www.mymedicaid-florida.com. Select Public Information for Providers then Enrollment. The link to the wizard is at the bottom of the page.

Question:

How can we check to see if we are already enrolled?

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Answer:

Call Medicaid Provider Enrollment at 1-800-289-7799, Option 4.

Question:

Is it possible for a provider to be both a FFS and a MCO provider?

Answer:

Yes.

Question:

Where can I find today's Provider Enrollment presentation?

Answer:

http://ahca.myflorida.com/Medicaid/statewide_mc (that is an underscore before mc). Select News and Events and then select Event Materials to browse available presentations.

Question:

If you are currently a Medicaid provider do you still have to register to be a long term care provider?

Answer:

If you will provide the same services you currently provide under Medicaid you do not need to enroll or register again.

Question:

If we are a Medicaid waiver provider do we also need to apply for a Medicaid provider ID?

Answer:

If you will provide the same services you currently provide under Medicaid you do not need to enroll or register again.

Question:

Is it possible to find out who the other members of a group are, other than the one you participate in?

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Answer:

Providers may only view their own group relationships.

Question:

If I'm a provider for APD is my Medicaid number good for AHCA?

Answer:

If you will provide the same services you currently provide under Medicaid you do not need to enroll or register again.

Question:

How do I find enrollment wizard?

Answer:

Go to www.mymedicaid-florida.com. Select Public Information for Providers then Enrollment. The link to the wizard is at the bottom of the page.

Question:

Will a provider need to be "approved" by the PSN before registering as a provider in Medicaid?

Answer:

The MCOs are responsible for credentialing all providers with whom they contract. Providers under a capitated plan would submit the registration to the plan for approval. The plan will submit the registration to Medicaid if approved. Providers under a FFS plan need to be fully enrolled in Medicaid and may submit the full Medicaid application via the enrollment wizard on the Medicaid public portal at any time.

Question:

According to the webinar, in order for waiver providers to be part of PSN's they must be Medicaid enrolled providers. Do these waiver service providers have to enroll as fee for service providers to be part of the PSN? Also, ADA waiver enrolls Nurse Registries to be part of their waiver program. Current Medicaid Fee for Service does not enroll Nurse Registries. To be part of the PSN, will nurse registries no longer be able to be part of the PSN? I am getting many questions from the ADA providers regarding this and currently not sure what to tell them.

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Answer:

Providers under the FFS PSN must be fully-enrolled in Medicaid for either state plan or waiver depending on the type of services they provide. While the long-term care waiver programs will officially sunset, providers enrolled in those programs can continue to provide services under one of the LTC MCOs. The A/DA providers can continue to provider services under an MCO.

Question:

How does an Assisted Living Facility enroll for a Medicaid Provider Number in order to participate in the Medicaid Managed Long Term Care Program? I could not access any links from the ACHA Website to do this.

Answer:

Go to www.mymedicaid-florida.com. Select Public Information for Providers then Enrollment. The link to the wizard is at the bottom of the page. Also, be sure to review the Coverage and Limitations Handbook for your program in order to understand the services that are covered and the requirements to enroll. Handbooks are found on the public portal as described above under Provider Support.

Question:

I have a Senior Adult Day Care, I don't have a Medicaid ID #, do I need to apply for one or is it the Health Insurance companies who apply?

Answer:

To work under a fee-for-service (FFS) claims under a FFS plan, a provider must be actively enrolled in Medicaid. The provider submits the Medicaid application. To work under a capitated plan, a provider needs only to be registered by the plan.

Question:

Do physicians need to enroll in Medicaid Managed Care?

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Answer:

Physician Services are not covered service under the managed long-term care program. Medicaid recipients who are enrolled in the managed long-term care program will continue to receive their physician services through Medicare or the Medicaid medical assistance program. However, Medicaid is moving to managed care for physician services and other medical services in 2014, so physicians who wish to continue serving Medicaid patients should stay informed about the upcoming Managed Medical Assistance program . To obtain up-to-date information about the Statewide Medicaid Managed Care Program, please visit the Agency's website at: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml. When you visit this website, you may also sign up to receive periodic program alerts by clicking on the red button on the right side of the screen.

10. Recipient Enrollment and Transition

Question:

If a LTC recipient is interested in a face-to-face choice counseling session, how would they make that request?

Answer:

The recipient will be able to contact the Choice Counselor/Enrollment Broker to make the request.

Question:

After initial plan enrollment, I understand that a LTC recipient will have a 90 day period during which they are free to select a different LTC health plan for any region, is this correct? After the 90 day period, does the recipient have any other opportunity to change their plan provider if not satisfied with their current LTC health plan?

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Answer:

An enrollee may request to change their LTC health plan without cause during the 90 calendar day change period following the date of the enrollee's initial enrollment with the LTC health plan. An enrollee may request disenrollment without cause every 12 months thereafter during the annual open enrollment period. Outside of these periods, an enrollee may disenroll if approved by the state as having a “good cause.” This is determined on a case by case basis by the Agency.

Question:

Will an Aged and Disabled Adult Waiver client currently in a Medicare Advantage plan be required to change their Medicare plan to one of the assigned providers in their county?

Answer:

No, the Long-term Care Managed Care Program does not impact Medicare in any way. Individuals enrolled in a Medicare Advantage plan will stay in that plan. Medicaid LTC health plans will be responsible for coordinating services between Medicare and Medicaid for their members

Question:

How will the transition of client files/ level of care assessments occur between current waiver providers and the new LTC health plans? Is there any funding for the transition of files/ assessments to the MCOs?

Answer:

In advance of the required submission date in each region, DOEA will request current case files (care plan, service provider information, and service authorizations) from Nursing Home Diversion, ADA, Assisted Living and Channeling providers, and will provide specific instructions about how to submit the files. There is no special funding for the transfer of each enrollee's most current care plan and related documents. Providers will not be required to transfer the 701B assessments.

Question:

Is there a detailed transition plan that AHCA has put together for providers to ensure a smooth transition of LTC recipients into the new Long-term Care Managed Care program?

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Answer:

Yes, DOEA, as required by statute, and in coordination with AHCA, has developed a comprehensive transition plan.

Question:

Is there an auto enrollment process for those who do not select a LTC plan?

Answer:

Yes. Each recipient who does not choose a plan will be assigned to a plan based on a number of factors.

Question:

Is it right that the Agency will be sending letters to residents directly 60 days before LTC plans begin, letting residents know they are moving to a LTC plan?

Answer:

Recipients will receive a letter approximately four months prior to the LTC plan begin date alerting them that more information is coming soon. Approximately 60 days prior to the LTC plan begin date, recipients will receive a letter and a packet of information detailing their choice of plans and how to choose a plan.

Question:

Will all current Medicaid recipients move to a LTC plan?

Answer:

All Medicaid recipients who are currently enrolled in the Aged and Disabled Adult, Assisted Living, Channeling, and Nursing Home Diversion waivers, and in the Frail Elder program, will be transitioned and offered a choice of LTC plans in their region. In addition, all Medicaid recipients currently in a skilled nursing facility where Medicaid is paying the cost of their stay will be transitioned and offered a choice of LTC plans in their region. The regional roll out schedule can be found on AHCA's website:
http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#ltcpr

Question:

What is the waiting period for disenrollment when a recipient selects a hospice that is not participating with their current LTC plan?

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Answer:

As specified in s. 409.982(1)(b), F.S., each LTC plan must offer a network contract to all hospices in their region. As specified in s. 409.982 (2), F.S., nursing homes and hospices that are enrolled Medicaid providers must participate in all eligible plans selected by the Agency in the region in which the provider is located. Therefore, this will not be an issue, since all hospices in a given region should be network providers for all LTC plans in that region.

Question:

Are Developmental Disabilities (DD) waiver participants required to enroll with a managed care plan?

Answer:

No, DD waiver participants are specifically excluded from mandatory enrollment into a plan. DD waiver participants are eligible for voluntary plan enrollment.

Question:

Will dual eligibles (those with both Medicare and Medicaid coverage) be required to enroll in a health plan under the Statewide Medicaid Managed Care program?

Answer:

Dual eligibles will be required to select a Managed Medical Assistance plan for coverage of their Medicaid acute care benefits, which can include coverage of co-payments or premiums or coverage of additional medical services not covered under the Medicare program. Dual eligibles who qualify for enrollment in a Long-term Care Managed Care plan are required to enroll in a Long-term Care plan in order to receive Medicaid covered long-term care services However, Medicare recipients will NOT be required to make a change to their Medicare Advantage plan choice.

Question:

What happens, if a major insurer (with an advantage plan), currently has Medicaid LTC patient in Waiver or Diversion, and they do not win in the procurement process. Do they get to keep their patients? If so, for how long?

Answer:

Current providers that do not win a contract through the procurement or who do not choose to participate through non-bidding will keep their enrollees until the program goes live in their region.

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Frequently Asked Questions

Question:

Patients are required to sign up for a new health plan within 30 days of the Medicaid reform. 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? How will the state prevent the “slamming” of patients into plans?

Answer:

Section 409.969(1), F.S., relating to enrollment, requires all Medicaid recipients to be enrolled in a managed care plan unless specifically exempted. 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 shall have 30 days in which to make a choice of plans. Section 409.984(1), F.S., relating to enrollment in a long-term care managed care plan, the Agency will automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan. Further, according to section 409.969(2), F.S., relating to disenrollment and grievances, after a Medicaid recipient has enrolled in 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 good cause.

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?

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:

Will care coordinators contact current Medicaid nursing home and ALF residents before the transition and explain what they must do to select a plan? If so, what type of coordination, if any, will occur with providers?

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Answer:

The Agency for Health Care Administration in cooperation with the Department of Elder Affairs will provide outreach and education materials to Medicaid providers and recipients, including nursing home residents, prior to implementation of the Long-term Care Managed Care Program. Approximately 60 days prior to implementation of the program in each region of the state, Medicaid will mail plan selection materials to residents or their designated representatives. Individuals from the Medicaid Enrollment Broker and the local Aging and Disability Resource Centers will be available to respond to questions and assist individuals in securing the information they need to select a plan that best meets their needs. Once a Medicaid recipient selects a managed care plan and is enrolled into the program, the plan will assign a care coordinator/case manager who will meet with the enrollee to perform an assessment, develop a plan of care, and assist the enrollee in obtaining appropriate care. All Medicaid recipients, including individuals in nursing homes and assisted living facilities, will have access to care coordination/case management services.

Question:

Will there still be a wait list for home and community based (HCBS) services?

Answer:

The Statewide Medicaid Managed Care program does not provide additional funding or create additional “slots” for recipients to receive home and community based services, thus it doesn’t eliminate the wait list. The Statewide Medicaid Managed Care program provides that the Department of Elder Affairs shall make offers for enrollment to eligible individuals based on a wait-list prioritization and subject to availability of funds. Before making enrollment offers, DOEA is required to determine that sufficient funds exist to support additional enrollment into plans. Once a recipient enrolls in a Long-term Care Managed Care plan, the plan is responsible for providing appropriate services, whether in an institutional setting or in a home or community based setting.

Question:

Will plans be able to force a recipient to move out of their nursing home?

Answer:

No, a recipient residing in a nursing facility can always choose to remain in that facility, if this is the least restrictive setting that can provide the appropriate level of care for that individual

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Frequently Asked Questions

Question:

What will a Medicaid certified nursing home be required to do as the state transitions to managed care in the way of credentialing professional staff, reminding Medicaid qualified residents & their families of the change and whatever they have to do to select a plan, etc.? We are assuming that the transition would not be automatic.

Answer:

Medicaid certified nursing homes will continue to be licensed through the Agency for Health Care Administration and will still be required to meet all state licensure and certification requirements. The Agency for Health Care Administration, in cooperation with the Department of Elder Affairs, will provide outreach and education materials to Medicaid providers and recipients, including nursing home residents, prior to implementation of the Long-term Care Managed Care program. Approximately 60 days prior to implementation of the program in each region of the state, Medicaid will mail plan selection materials to residents or their designated representatives. Individuals from the Medicaid Enrollment Broker and the local Aging and Disability Resource Centers will be available to respond to questions and assist individuals in securing the information they need to select a plan that best meets their needs.

Question:

Will all recipients currently receiving LTC services throughout the state have the opportunity to receive choice counseling regarding their LTC health plan choices? If a recipient is enrolled with a health plan that has been awarded a LTC contract, will they just remain with the awarded provider?

Answer:

All Medicaid recipients receiving services in a nursing facility, or through the Nursing Home Diversion Waiver, Aged and Disabled Adult Waiver, Assisted Living Waiver, Channeling Waiver, or the Frail Elder Option will have the opportunity to receive choice counseling prior to enrollment into the Long-term Care Managed Care Program. If a recipient is currently receiving services from a LTC health plan that will also be a long-term care LTC health plan in the region where the recipient resides, the recipient can choose to remain with the original plan, or the recipient can choose to enroll with a different plan.

Question:

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

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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:

If a resident is currently Private Pay and is on the waiting list for the Nursing Home Diversion program, what will happen to them once managed care goes into effect?

Answer:

Enrollees who are currently on the waitlist for the NHD program will automatically be transferred to the waitlist for the Long-term Care program.

Question:

How will recipients find out the plan they're assigned to if they do not choose a plan?

Answer:

Recipients who are fully eligible for Medicaid will receive a packet of information which includes a letter advising them of the plan to which they will be assigned if they do not actively choose a plan. If they do not choose a plan within 30 days, they will receive a reminder notification, which also includes the name of the plan to which they will be assigned if they do not actively choose a plan. Both letters advise the recipient of the effective date that they will be assigned if they do not actively choose a plan.

Question:

If I'm serving a person now, but they enroll in a plan I'm not contracted with, can I keep serving them? How will they be transitioned to other providers? How long will I get paid to serve them?

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Answer:

When the Long-term Care program begins in your region, if you are not a network provider for the managed care plan that a Medicaid recipient selects, then you will no longer be able to be reimbursed by Medicaid for services provided to the recipient, once he or she is enrolled with a managed care plan. Enrollment into a managed care plan will become effective on the first day of the month. If you are not a network provider, the enrollee will work with their case manager to select another provider in their network that can best meet the enrollee's needs. You may be able to continue serving the recipient for up to 60 days while the enrollee switches to another provider, but you need authorization from the managed care plan to be reimbursed for this time period.

Question:

When will enrollees get notified that they have to choose a plan? How long will they have to choose? Can I help them make that choice? What if they don't have anyone to help them and they are not competent – can I help them make a choice?

Answer:

The recipient will be mailed a welcome packet, which contains a letter and brochure within five days of the system receiving information indicating that they have an appropriate level of care and actual Medicaid coverage or proof that a Medicaid application has been filed. Each recipient will have 30 days to select a plan. Recipients should make their choice independently and free of coercion or other undue influence. If the recipient is not competent, then the provider should follow proper protocol used when making other decisions for recipients who are not competent. This includes, but is not limited to, having proper documentation which provides the provider with permission to make such decisions on behalf of the recipient.

Question:

How will providers know what MCO a recipient is in?

Answer:

The recipient will receive a confirmation notice of the MCO enrollment. Additionally, information will be available via the eligibility verification system.

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Frequently Asked Questions

Question:

Who can assist when an elderly person does not have the wherewithal to submit a Medicaid application to DCF? I help most of my residents that live in HUD independent living.

Answer:

Individuals applying for Medicaid eligibility can continue to follow the same process as before. The Aging and Disability Resource Centers can assist individuals with applying for eligibility. In addition, if an applicant residing in the community chooses the Medicaid Pending option and enrolls with a managed long-term care plan, the applicant's case manager can assist this applicant in making sure that all information is gathered and provided to the Department of Children and Families, so that DCF's determination can be made as quickly as possible.

Question:

At what point does the SNF assist the now approved MD recipient in enrolling as it could be mid-month, so would this mean the 1st of the following month?

Answer:

Managed care enrollment for an individual residing in a nursing facility will not become effective until the first day of the month after the individual makes his or her plan choice.

Question:

Will people in ALFs stay with the agency that they choose?

Answer:

Individuals ages 18 and older who are fully eligible for Medicaid and who are either residing in a nursing facility or receiving services from the Assisted Living Waiver, Aged and Disabled Adult Waiver, Nursing Home Diversion Waiver, the Channeling Waiver, or the Frail Elder Option will be required to enroll in the managed long-term care program. If a Medicaid recipient residing in an assisted living facility is not enrolled in one of the waiver programs listed above, the recipient will not be required to enroll in the Long-term Care program

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Frequently Asked Questions

Question:

If a patient is approved in the community and then has to go to LTC and already has an HMO how will they be transferred to LTC?

Answer:

If a Medicaid recipient residing in the community is already enrolled with a managed long-term care plan, that plan will work with the nursing facility to arrange for admission into the facility, if this level of care is determined to be necessary.

Question:

Will the pending recipient be enrolled in the MCP in the region that they reside?

Answer:

Yes, recipients will need to choose a managed care plan that provides services in the region where they reside.

Question:

Current nursing home residents who are Medicaid ICP recipients are receiving letters from AHCA that they must choose a LTC Managed Care provider by August. What will happen for new ICP applicants in the near future? Must the applicant choose a Managed Care provider upon submitting an application for ICP with DCF?

Answer:

Nursing home residents who apply for Medicaid Institutional Care Program (ICP) benefits will be notified after their application has been filed and once they have been approved for Medicaid ICP benefits, that they will be required to make a choice or be auto-assigned to a managed long-term care plan. Their enrollment into managed care will be effective on the first day of the month following the approval of their ICP application.

Question:

If a resident is in the community and is enrolled in a Managed Care Program in a Pending Medicaid status but then enters a LTC facility, does the Managed Care Plan end?

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Answer:

If an applicant enters a nursing facility from the community while in Medicaid Pending status, the applicant's enrollment in managed care would be temporarily suspended until the Medicaid application is approved. Once the Medicaid application is approved, the individual can choose to remain with his or her original plan or choose a different managed long-term care plan going forward.

Question:

If a hospice patient resides in a LTC will they remain in the MCP plans or will they have the option to disenroll and go back to straight Medicaid?

Answer:

Individuals ages 18 and older, who reside in a nursing facility and for whom Medicaid is the primary payer, will be required to enroll in a managed long-term care plan when the program is implemented in their region of the state. Their enrollment in hospice while in a nursing facility will not exempt them from managed care.

Question:

What effect will this have on QMB benefits for Medicare co-insurance, if any? If a resident that is in a skilled nursing facility and needs to apply for ICP to cover the Medicare A co-insurance, how will that work? Will they still need to choose a Medicaid managed care plan, or will they be approved for the straight ICP Medicaid for that situation?

Answer:

If nursing home residents with QMB coverage who are not already enrolled in a managed long-term care plan are admitted to a skilled nursing facility for a brief stay, the residents may not need to apply for ICP benefits, and therefore would not enroll in managed care. If a resident needs to remain in the nursing facility after the skilled Medicare benefits have ended, then once the ICP application is filed with DCF, the resident would receive choice counseling materials instructing the resident to select a managed long-term care plan. Once the ICP application is approved and Medicaid is the primary payer, the resident would be enrolled with a managed long-term care plan, and going forward, that plan would be responsible for Medicaid payments and Medicare cross-over claims. Prior to managed care enrollment, Medicaid payments and Medicare cross-over claims would be processed through fee-for-service.

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Frequently Asked Questions

Question:

Will the Medicaid pending person in the hospital need to remain in the hospital until the level of care is obtained, as no nursing home can now accept the person until the level of care is completed?

Answer:

If an applicant is in the hospital, the decision to accept the individual prior to Medicaid eligibility determination is up to the nursing facility.\

Question:

Once the ADA waiver client selects a managed care plan when they receive letters on September 1st, will they be enrolled prior to December 1st or are all ADA waiver clients scheduled to transfer 12/1?

Answer:

All Medicaid recipients currently in a skilled nursing facility where Medicaid is paying the cost of their stay, and recipients who are enrolled in the Aged and Disabled Adult, Assisted Living, Channeling, Nursing Home Diversion, and Frail and Elder programs, will be transitioned into the long-term care program based on a regional roll-out schedule that can be found on AHCA's website at: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#LTCMC

11. Services

Question:

Are consumable medical supplies a covered service under the Long-term Care Managed Care program?

Answer:

Yes, consumable medical supplies will be covered under the Long-Term Care Managed Care Program as a component of the medical equipment and supplies service.

Question:

Are personal care services a covered service under the Long-term Care Managed Care program? Will providers be able to provide personal care when the change takes place?

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Answer:

Yes, personal care services will be covered under the Long-Term Care Managed Care Program. Personal care service providers must be a part of a LTC health plan's network of providers in order to be able to provide services to long-term care managed care enrollees.

Question:

Will the following services be covered under the Long-term Care Managed Care program? (1) pest control, (2) homemaker, (3) companion, (4) chore, (5) enhance chore, (6) home delivered meals services.

Answer:

Yes

Question:

Will pest control and CHORE be available as they are under the current ADA waiver?

Answer:

Yes, pest control and chore services will be covered under the Long-Term Care Managed Care Program as a component of homemaker services.

Question:

How will services be authorized under the Long-term Care Managed Care program?

Answer:

Service planning must involve the enrollee and/or enrollee representative working cooperatively with the enrollee's case manager. Service authorizations must reflect services specified in the plan of care. When service needs are identified, the enrollee must be given information about available providers, so that an informed choice of providers can be made.

Question:

Will the telephonic monitoring system (Sandata) continue once the Long-term Care Managed Care program?

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Answer:

The telephonic monitoring system (Sandata) will continue to operate for fee for service home health services. LTC health plans may also choose to employ electronic verification of services delivered in homes.

Question:

Will family members still be able to be employees through PDO program that is taking the place of the CDC+ program?

Answer:

Yes, participants may hire neighbors, family members, or friends to provide their long-term care services through the Participant Directed Option (PDO).

Question:

What are the requirements for the PDO program that is taking the place of the CDC program? Do participants need to have an authorized Rep? Will participants have a case manager or consultant?

Answer:

All LTC managed care enrollees who live in their own home or their family home have the choice, under the participant direction option (PDO), to self-direct the following services listed on their care plan: adult companion care, attendant care, homemaker, intermittent and skilled nursing, and personal care. Enrollees will share employer responsibilities with the LTC health plan. Enrollees will be responsible for hiring, supervising, and firing their direct service workers. They can hire any qualified person they want to provide their services, including family members, friends, and neighbors. The LTC health plan will set the pay rate for the direct service workers. Enrollees may delegate their employer responsibilities to a representative. The LTC health plan will assign a case manager, specially trained in the PDO, to train the participant and provide necessary ongoing technical assistance.

Question:

For clients that are currently enrolled in CDC will they transition to the PDO program initially in the new plan? Or will they receive traditional services initially?

Answer:

Current CDC+ consumers will be able to transition directly into the new PDO under a LTC health plan of their choice.

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Frequently Asked Questions

Question:

How does medical managed care work with LTC?

Answer:

Individuals dually eligible for Medicaid and Medicare will continue receiving their medical services primarily through Medicare. Medicaid recipients who do not have Medicare coverage will receive their medical services through the Medicaid State Plan until implementation of the Managed Medical Assistance Program.

Question:

Once the Managed Medical Assistance component of the SMMC program rolls out next year, can a member potentially have one plan for LTC, one plan for MMC and one plan for Medicare?

Answer:

If a managed care plan awarded a contract for Managed Medical Assistance (MMA) also has a contract with the Agency to provide long-term care services and a Medicare plan in the recipient's region, the recipient could choose to have one plan provide all necessary medical and long-term care services. It is possible that a member could choose to receive services from different plans. Each member will have a case manager who will be responsible for coordinating and tracking services for that member. If a member is dually eligible for Medicare and Medicaid, the member's case manager will assist that individual in navigating the system of care.

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.

Question:

Will the hospice be able to provide immediate palliative care?

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Answer:

Yes, for a qualified individual who has Medicaid-only, the individual's LTC plan will be responsible for paying the hospice provider from the first day the individual is enrolled with the LTC plan.

Question:

What is the role of assisted living in managed care? As private pay residents exhaust their funds and become eligible for Medicaid, will they be permitted to remain in ALF if the ALF is willing to continue to serve them or will that depend on the availability of a "slots," much like occurs now? We anticipate that the demand for ALF care will increase if government assistance through Medicaid is more available.

Answer:

As specified in s. 409.98, F.S., long-term care plans will be required to cover services provided to enrollees in assisted living facilities. The Agency anticipates that the Long-term Care Managed Care Program will receive the same amount of funding for home and community-based service (HCBS) as is currently appropriated for the existing HCBS programs. Therefore, there will need to be a state-wide waiting list for HCBS, including services in assisted living facilities. For individuals transitioning from nursing homes, the Agency does not anticipate that there will be a waiting list for HCBS, including services in assisted living facilities.

Question:

Will the managed care plan be able to cut hours of they disagree with the hours CARES has determined the recipient will need? For example, if CARES determines the recipient needs 20 hours of service, can the plan say they will only pay for 12 hours?

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Answer:

When CARES determines a Level of Care (LOC), it is (1) to determine if the individual meets the medical eligibility requirements using criteria that are in the Florida Administrative Code and (2) to make a program recommendation for community or nursing facility. It does not include a specific number of services hours. The Managed Care Plan, not CARES, is responsible for working with the enrollee to develop a person-centered plan for the type of services and number of service hours needed. This plan should have a basis in the assessment and LOC completed by CARES and input from the enrollee and his/her caregiver. The enrollee/caregiver then signs the Care Plan to show that he/she agrees with the number of services hours the Managed Care Plan intends to provide. Regarding the Level of Care, re-adjustments will not be made after the initial assessment has been determined by CARES.

Question:

How will I know if my service is covered by the plan?

Answer:

Each long-term care plan must, at a minimum, cover all services specified in the approved federal waiver. A listing of the services offered by the Long-term Care program and other useful information can be found in the document titled A Snapshot of the Florida Medicaid Long-term Care Managed Care Program on the Agency for Health Care Administration's Statewide Medicaid Managed Care Program website at the following address: http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot_May_29_2013.pdf

Question:

For people with Medicare primary who are in a Medicare Advantage Plan (managed care) – how does the primary coordinate with Medicaid managed care plans?

Answer:

All long-term care enrollees will have a case manager who will be responsible for communicating and coordinating services with appropriate treating providers, including the enrollee's primary care provider.

Question:

How will DME be addressed in managed care?

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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.

Question:

Will Managed Care ICP Medicaid have therapeutic or hospital leave bed holds?

Answer:

Yes, managed long-term care plans will be responsible for covering bed hold days in nursing facilities as specified in the Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook.

Question:

Do long-term care plans affect dental services?

Answer:

Dental services are included in the Medicaid medical assistance benefit package, rather than the long-term care benefit package.

12. Other

Question:

Will bed hold for SNF be the same as they are now?

Answer:

LTC plans will be responsible for covering bed hold days in nursing facilities as specified in the Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook.

Question:

Will the ALF survey process for facilities that care for mental health residents who are also Medicaid eligible be changed? Will these new requirements be part of the survey process?

Answer:

The survey process will not change

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Frequently Asked Questions

Question:

Does the AHCA have an estimate of how many dual eligibles will enroll in the Long-term Care expansion, or what percentage of that population they will make up?

Answer:

The Agency currently serves approximately 85,000 Medicaid recipients in nursing facilities and the home and community-based waiver programs identified in the authorizing legislation for the long-term care managed care program. Approximately 95% of these recipients are dually eligible for both Medicare and Medicaid.

Question:

Many providers have been approached by Univita. What is their role, since they did not win any SMMC contracts?

Answer:

It is unclear in what context this company is approaching providers. We need more information to answer this question.

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:

What is the role of the Area Agency on Aging in the Long-term Care Managed Care program?

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Answer:

The Area Agencies on Aging (AAA)will provide education about the Long-term Care Managed Care program, will screen individuals for the home and community based services waiting list, will contact individuals when funding is available and they are released by DOEA from the waiting list and will assist these individuals with the completion of their medical and financial eligibility. The AAAs will also informally assist with consumer grievance and complaints.

Question:

My community had a small amount of diversion residents, by enrolling into the managed care program what increased liability am I entering into? Could you explain the $1,000 fine that I am hearing about for the care plans and who is responsible for the care plans the program or the community?

Answer:

If you are referring to the “fine” that is a liquidated damage included in the Long-term Care program managed care plan contract, these are fines against the Managed Care Plan, not the ALF subcontractors, for failing to meet the standards of the contract with the state. If you have concerns about liability associated with participation in managed care, you should consult with an attorney.

Question:

Will the Mac Safari work as well as Explorer 9?

Answer:

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

Question:

Will there be any training for hospice providers?

Answer:

The Agency is working with the Florida Hospice and Palliative Care Association to identify training needs and to develop a plan for offering training to interested providers.

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Frequently Asked Questions

Question:

Please clarify what the fee for service situation will be. Will it be the same as the current patient liability?

Answer:

All capitated and fee-for-service long-term care plans will be responsible for collecting its enrollees' patient responsibility. The plan may transfer the responsibility for collecting its enrollees' patient responsibility to the residential facilities and compensate the facilities net of the patient responsibility amount. If the plan transfers collection of the patient responsibility to the provider, the provider contract must specify complete details of both parties' obligations for collection of patient responsibility. The plan must either collect patient responsibility from all of its providers or transfer collection to all providers.

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Frequently Asked Questions

Managed Medical Assistance 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?

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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?

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 as shown in the chart below. AHCA will invite 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 Managed 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 October 1, 2013. It is anticipated that the Florida Managed Medical Assistance program will be available in certain areas beginning in the last quarter of 2013, and will be 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 requested 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.

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Frequently Asked Questions

Question:

How does a client find a list of Doctor's 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?

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

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?

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Answer:

In order to ensure managed care plan participation in rural areas of the state, the Agency is 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.

4. MMA Recipient Eligibility

Question:

Are individuals who are receiving home health services under the State Plan required to enroll in LTC health 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 health 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:

Does the SMMC program change eligibility for Medicaid in Florida?

Answer:

No, the Statewide Medicaid Managed Care program does not change eligibility coverage.

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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.

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 HMO 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?

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Answer:

Yes, the Agency will establish 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.

6. Plan Payment to Providers

No Questions at this time

7. Provider and Recipient Appeals

No Questions at this time

8. Provider Enrollment

No Questions at this time

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?

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Answer:

No, under the Statewide Medicaid Managed Care program, those currently enrolled in MediPass will be required to enroll in a Managed Medical Assistance plan. This is how these recipients will receive their behavioral health services since 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 dual eligibles (those with both Medicare and Medicaid coverage) be required to enroll in a health plan under the Statewide Medicaid Managed Care program?

Answer:

Dual eligibles will be required to select a Managed Medical Assistance plan for coverage of their Medicaid acute care benefits, which can include coverage of co-payments or premiums or coverage of additional medical services not covered under the Medicare program. Dual eligibles who qualify for enrollment in a Long-term Care Managed Care plan are required to enroll in a Long-term Care plan in order to receive Medicaid covered long-term care services However, Medicare recipients will NOT be required to make a change to their Medicare Advantage plan choice.

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?

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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 the Medicaid reform. 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? How will the state prevent the “slamming” of patients into plans?

Answer:

Section 409.969(1), F.S., relating to enrollment, requires all Medicaid recipients to be enrolled in a managed care plan unless specifically exempted. 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 shall have 30 days in which to make a choice of plans. Section 409.984(1), F.S., relating to enrollment in a long-term care managed care plan, the Agency will automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan. Further, according to section 409.969(2), F.S., relating to disenrollment and grievances, after a Medicaid recipient has enrolled in 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 good cause.

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?

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.

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Frequently Asked Questions

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.

10. Services

Question:

How does medical managed care work with LTC?

Answer:

Individuals dually eligible for Medicaid and Medicare will continue receiving their medical services primarily through Medicare. Medicaid recipients who do not have Medicare coverage will receive their medical services through the Medicaid State Plan until implementation of the Managed Medical Assistance Program.

Question:

Once the Managed Medical Assistance component of the SMMC program rolls out next year, can a member potentially have one plan for LTC, one plan for MMC and one plan for Medicare?

Answer:

If a managed care plan awarded a contract for Managed Medical Assistance (MMA) also has a contract with the Agency to provide long-term care services and a Medicare plan in the recipient's region, the recipient could choose to have one plan provide all necessary medical and long-term care services. It is possible that a member could choose to receive services from different plans. Each member will have a case manager who will be responsible for coordinating and tracking services for that member. If a member is dually eligible for Medicare and Medicaid, the member's case manager will assist that individual in navigating the system of care.

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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.

11. Other

Question:

If a provider does not currently have Medicaid patients, but only has an advantage plan, and is recruiting these patients today, how long must the patient be qualified for Medicaid prior to the implementation of the reform or its application, must the patient be in service to establish the provider has the experience to care for that population group.

Answer:

It appears this question relates to how many months of experience a plan would need to have in order for it to count as "experience" in the procurement. The Agency cannot respond specifically to this question to ensure the integrity of the competitive bid process. Per statutory requirements experience must be considered in awarding the bids.

Question:

Just to make sure I'm looking at the right figures: the AHCA shows 275,289 dual eligibles in the state as of April 2012, correct? The Kaiser Family Foundation claims that there were 601,276 dual eligibles in the state as of 2008, but they included what they considered partial eligibles. Does the AHCA anticipate enrolling a significantly higher number of dual eligibles in managed care than the population currently in the system?

Answer:

The Agency would only enroll those known to our system. We are not aware of an expected increase.

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Frequently Asked Questions

Question:

Many providers have been approached by Univita. What is their role, since they did not win any SMMC contracts?

Answer:

It is unclear in what context this company is approaching providers. We need more information to answer this question.

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.

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