

Statewide Medicaid Managed Care Service Authorization Procedures

Agency for Health Care Administration
(AHCA)

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Today's Presenters

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Today's Goals

By the end of this presentation you will know:

- The requirements for authorizing services in the Statewide Medicaid Managed Care (SMMC) program
- The requirements for notifying enrollees of changes to their service authorizations
- Additional service authorization requirements for the SMMC Long-term Care (LTC) program



Program Overview

- The requirements for SMMC health plans' service authorization systems and utilization management programs are established by the federal government, Florida Statutes, Florida Administrative Code, and the SMMC contract.
- All health plans must maintain a system for authorizing services, determining over- and under-utilization of services, and identifying and reporting fraud and abuse.
- Health plans must provide written notice to service providers and enrollees of all denials, limitations and reductions in services.



Terminology

- **Adverse Benefit Determination** - The denial or limited authorization of a requested service, or a reduction, suspension or termination of a previously authorized service.
- **Covered Services** — Those services provided by the health plan in accordance with its contract with the Agency, and as outlined in Section V, Covered Services of its contract with the Agency, and the MMA or LTC Exhibits to its contract with the Agency, respectively.
- **Medically Necessary or Medical Necessity** — Services as defined by Rules 59G-1.010 and 59G-4.192, F.A.C.
- **Notice of Adverse Benefit Determination (NABD)** – A written notice sent by the health plan to the enrollee when an adverse benefit determination has been made by the plan.



Terminology (cont.)

- **Prior Authorization** — The act of approving specific services before they are rendered.
- **Service Authorization** — The health plan's approval for services to be rendered. The process of authorization must at least include an enrollee's or a provider's request for the provision of a service.
- **Service Delivery Systems** — Mechanisms that enable provision of certain health care benefits and related services for Medicaid recipients as provided in s. 409.973, F.S., which include but are not limited to the Medicaid fee-for-service program and the Statewide Medicaid Managed Care Program.



Utilization Management Program Description

- All health plans must submit a written utilization management (UM) program description to the Agency, that addresses all of the following:
 - Identifying patterns of over-utilization and under-utilization of services and addressing problems
 - Reporting fraud and abuse identified through the UM program
 - Providing access to a second medical opinion
 - Prior authorization and denial of services
 - Evaluating initial and continuing authorization



Utilization Management Program Description (Continued)

- Using objective evidence-based criteria to support authorization decisions
- Ensuring consistent application of review criteria for authorization decisions
- Consulting with the requesting provider when appropriate
- Conducting physician profiling
- Conducting retrospective reviews



MMA SERVICE AUTHORIZATIONS



General Requirements for the MMA Program

- The MMA program provides medical, dental, and behavioral health services to infants, children and adults on Medicaid.
- Approximately 85% of Florida Medicaid recipients are required to receive their health services through an MMA health plan. Florida law specifies the Medicaid recipients who cannot enroll in a health plan (or those who are excluded from participation) and those who may choose to enroll in an MMA health plan, but are not required to do so.



Service Authorization System

- Health plans must have automated service authorization systems.
- The service authorization system must provide written notice to service providers and enrollees of all:
 - service denials,
 - limitations of services, and
 - reductions of services
- Health plans may not delay a service authorization because written documentation (like a referral or other supporting documentation) is not available timely.
 - The health plan is not required to approve a claim for a service for which it has not received documentation but should cite in the notice the specific facts used to make its decision.



Timeframes for Authorization Requests

- Health plans must authorize requests in a timely manner.
- The Agency prescribes the following authorization timeframe standards that are measured monthly:
- 95% of all standard authorizations must be processed within 14 days
 - The average turnaround time for standard authorization requests must not exceed seven days
- 95% of all expedited authorization requests must be processed within three business days
 - The average turnaround time for expedited authorization requests must not exceed two business days.



Practice Guidelines

- Health plans must use objective, evidence-based practices and criteria when making decisions about service authorizations.
- These practice guidelines must:
 - Be based on valid and reliable clinical evidence or the consensus of relevant health care professionals
 - Consider the needs of the enrollee
 - Be adopted in consultation with service providers
 - Be reviewed and updated periodically



Clinical Decision-Making

- Sometimes, a health plan will deny an enrollee's request for a particular service, or will limit, suspend, or terminate a previously authorized service.
- For these decisions, health plans must ensure that the decision is made:
 - by a licensed physician, psychiatrist, or dentist, as appropriate, or other professional as approved by the Agency, who has the appropriate clinical expertise in treating the enrollee's condition or disease, and
 - using the acceptable standards of care, state and federal laws, the Agency's medical necessity definition, and the clinical judgment of a licensed physician, psychiatrist, or dentist, as appropriate, or other professional as approved by the Agency.



Clinical-Decision Making (cont.)

- Health plans may utilize a national standardized set of criteria (e.g. Interqual) or other evidence-based guidelines approved by the Agency when deciding whether or not to approve services.
- These criteria and guidelines may be used as evidence of generally accepted professional medical standards which support the basis of a medical necessity determination to authorize a service.
- But health plans may not solely use these criteria and guidelines to deny, reduce, suspend or terminate a good or service. **Health plans must use the Agency's medical necessity criteria to deny, reduce, suspend, or terminate a good or service.**



Medical Necessity

- In addition to using clinical decision-making criteria **when denying, limiting, suspending, or terminating a service, health plans must use the Agency's medical necessity criteria.** Medical Necessity is defined in Rule 59G-1.010, Florida Administrative Code.
- Medical Necessity or medically necessary means that the medical or allied care, goods, or services furnished or ordered must:
 - Meet the following conditions:
 - Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
 - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
 - Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
 - Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
 - Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.



Timeliness of Service Provision

- Health plans must provide all medically necessary services to enrollees timely and with **reasonable promptness**
- To provide services with reasonable promptness, health plans must take any action necessary, including:
 - Using service providers outside of the health plan’s provider network
 - Using financial incentives to motivate service providers to accept enrollees as clients and provide all medically necessary services
- Health plans which do not provide medically necessary services with reasonable promptness may be sanctioned by the Agency



Adverse Benefit Determination

- Sometimes, a health plan will deny an enrollee's request for a particular service, or will limit, suspend, or terminate a previously authorized service. This is called an adverse benefit determination.
- Health plans must notify enrollees of all adverse benefit determinations in writing. This written notification is called the Notice of Adverse Benefit Determination (NABD).
- Health plans must use the Agency's prescribed NABD template.



Notice of Adverse Benefit Determination (NABD)

- The **NABD** is mailed to the enrollee by the health plan for standard authorization decisions **within seven days of the request for service.**
- For termination, suspension or reduction of previously authorized services, the **NABD** is mailed no later than ten (10) days before the adverse benefit determination is to take effect. Certain exceptions apply under federal law.
- The **timeframe can be extended up to seven additional days** if the enrollee or the provider requests extension or the health plan justifies how the extension is in the enrollee's interest.
- The **timeframe can be shortened to 48 hours** if the standard timeframe could seriously jeopardize the enrollee.



Notice of Adverse Benefit Determination (NABD) – (continued)

- The **NABD must contain the following components:**
- The adverse benefit determination and the reason it was made.
- The enrollee's right to receive case records and medical necessity criteria free of charge and how to ask for these.
- The enrollee's right to request a plan appeal and the process for exercising those rights.
- The enrollee's right to request a fair hearing, only after completing the plan's appeal process.
- The procedures for requesting a plan appeal and a fair hearing.
- The circumstances under which a plan appeal can be expedited and how to request it.
- The enrollee's right to have benefits continue pending resolution of the plan appeal and how and when to request it, and the circumstances under which the enrollee may be required to pay the cost of those services.



Examples of Inappropriate NABD: MMA Program

- Prior to the Agency prescribing a standard NABD template and requiring health plans to use it, health plan notices were not uniform and were often confusing, missing required information, or the like.
- Included in the next few slides are examples of common mistakes discovered in MMA plans' NABDs.



MMA Example 1

Dear [REDACTED]

[REDACTED] has reviewed your request for [REDACTED] which we received on [REDACTED]. After our review, this service has been: DENIED as of [REDACTED]. We made our decision because:

We determined that your requested services are not medically necessary because the services do not meet the reason(s) checked below: *(See Rule 59G-1.010)*

Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain.

Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.

Must meet accepted medical standards and not be experimental or investigational.

Must be able to be the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.

Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider. *(The convenience factor is not applied to the determination of the medically necessary level of private duty nursing (PDN) for children under the age of 21.)*

The requested service is not a covered benefit.

X Other authority: The drug that your doctor asked for [REDACTED] is denied. The health plan's criteria was not met [REDACTED]. This medication is considered investigational. The FDA has not given final approval for this medication. Your doctor has also been given this information.



MMA Example 2

Dear JANE SMITH:

MANAGED CARE PLAN ABC has reviewed your request for STERILE WATER, 1000 mL BAG, which we received on 01/01/2017. After our review, this service has been:

DENIED as of 01/05/17

We made our decision because:
(Check all boxes that apply)

We determined that your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: (See Rule 59G-1.010)

Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain.

Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.

Must meet accepted medical standards and not be experimental or investigational.

Must be able to be the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.

Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider.

(The convenience factor is not applied to the determination of the medically necessary level of private duty nursing (PDN) for children under the age of 21.)

The requested **service is not a covered benefit**.

Other authority <<explain and cite authority>>

The facts that we used to make our decision are:

Services that are not medically necessary are not covered under the member's health benefit plan.



LTC PROGRAM SERVICE AUTHORIZATIONS



General Requirements for the LTC Program

- LTC covered services include nursing facility services and in-home services like home delivered meals, help with bathing and dressing, therapies, and medical equipment and supplies
- To be eligible for the LTC program, individuals must meet nursing facility level of care, a clinical eligibility determination that means that the individual requires 24-hour supportive care to remain safe
- LTC enrollees receive LTC services following a comprehensive needs assessment and supplemental assessment that the health plan uses to develop a person-centered care plan
- Because of the supportive nature of the services provided, LTC health plans must comply with additional service authorization requirements
- See also the Statewide Medicaid Managed Care Long-term Care Program Coverage Policy



Medical Necessity in the LTC Program

- The Agency's medical necessity criteria is different for service authorizations and denials, limitations, reductions, or terminations in the Long-term Care program.
- **In the Long-term Care program, the service must meet either of the following criteria:**
 - Nursing facility services and mixed services must meet the medical necessity criteria defined in Rule 59G-1.010, F.A.C.;
 - All other LTC supportive services must meet all of the following:
 - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
 - Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
 - Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider
 - **And, one of the following:**
 - Enable the enrollee to maintain or regain functional capacity; or
 - Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice.



Utilization Management Program Description – Additional LTC Procedures

- In addition to the general UM program description, health plans providing LTC services must submit a written utilization management (UM) program description to the Agency, that also addresses the following:
 - Ensuring that entities reviewing service authorization requests for LTC services have access to enrollees' plan of care and information obtained from the comprehensive assessment
 - Evaluating service authorization requests utilizing objective LTC evidence-based criteria
 - Describing the responsibilities and scope of authority of case managers in authorizing LTC services and in submitting service authorization requests (when applicable)



Utilization Management Program Description – Additional LTC Procedures (Continued)

- Describing the process for authorizing and implementing services based on an incomplete plan of care
- Ensuring service authorization decisions are consistent with the goals documented on the plan of care
- Ensuring that there are no gaps in service authorization for enrollees requiring ongoing services



Service Authorization Requirements in the LTC Program

- LTC service authorizations must be consistent with the services listed on the enrollee's plan of care, including the frequency and duration necessary to adequately and safely support the enrollees in the setting of their choice (their own home, assisted living facility, adult family care home, or nursing facility).
- Health plans cannot deny a request for a covered LTC service because the care plan is not completed at the time of request
- Ongoing LTC services must be authorized for the amount of time specified in the enrollee's plan of care



Service Authorization Requirements in the LTC Program (cont.)

- Health plans may not deny covered LTC services solely because the enrollee's caregiver is at work or is unable to participate in the enrollee's care because of their own medical, physical, or cognitive impairment
- Health plans may not deny medically necessary services required for the enrollee to remain safely in the community, instead of living in a nursing facility, because of cost.



Timeliness of Service Provision in the LTC Program

- Health plans must authorize and begin LTC services identified on the enrollee's plan of care no later than **fourteen (14) days after the plan of care has been developed or updated.**
- LTC services must be implemented with reasonable promptness, consistent with the needs of the enrollee, and as medically necessary.



Duration of LTC Service Authorizations

- Health plans may determine the amount of time for an LTC service authorization, except for the following:
 - Maintenance therapies, as defined in proposed Rule 59G-4.192, F.A.C., must be authorized for no less than six (6) months on the enrollee’s plan of care.
 - The need for maintenance therapy must be supported by the results from the enrollee’s comprehensive assessment or objective long-term care evidence-based criteria.
 - All other covered services that are authorized for a time period of less than six (6) months must be for the treatment of an acute illness or a condition that will be resolved within six (6) months.
 - The decision must be supported by the primary care provider’s (PCP) prescription of the service for a shorter duration or, in the case of services that do not require a PCP’s prescription, the decision must be supported by objective evidence-based criteria.
 - The authorization time period must be consistent with the end date of the services as specified in the plan of care.



LTC Program-Specific Notice Requirements

- Health plans must notify the enrollee or their authorized representative in writing of any denial, reduction, termination or suspension of services that varies from the type, amount, or frequency of services detailed on the plan of care that the enrollee or their authorized representative has signed.
- Each time the health plan changes a LTC service (e.g., authorizes fewer units or days of the service) after the service was initially authorized, the health plan must provide an NABD to the LTC enrollee notifying them of the change in service provision.
- If the enrollee disagrees with a LTC service authorized by the health plan (including the service itself, or the amount or timeframe of the service) **and** has the right to file a grievance, appeal or fair hearing regarding the service, **the health plan must provide the enrollee with a written NABD** that explains the enrollee's right to challenge regarding the service decision.



Examples of Inappropriate NABD: LTC Program

- Prior to the Agency prescribing a standard NABD template and requiring health plans to use it, health plan notices were not uniform and were often confusing, missing required information, and sometimes misleading.
- Included in the next few slides are examples of common mistakes discovered in LTC plans' NABDs.



LTC Example 1

Dear [REDACTED]

[REDACTED] has reviewed your request for Personal Care (The person who helps bathe, dress and feed you) – 21rs per week, Homemaker Service (The person that cleans and helps prepare meals for you) – 7 hrs per week and Companion Care (The person that helps assist and watch over you) - 7 hrs per week, which we received on [REDACTED]. After our review, this service has been: **TERMINATED** as of [REDACTED]. We made our decision because:

We determined that your requested services are not medically necessary because the services do not meet the reason(s) checked below: *(See Rule 59G-1.010)*

Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain.

Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.

Must meet accepted medical standards and not be experimental or investigational.

Must be able to be the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.

Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider. *(The convenience factor is not applied to the determination of the medically necessary level of private duty nursing (PDN) for children under the age of 21.)*

 The requested service is not a covered benefit.

Other authority: Member Request. 

The facts that we used to make our decision are: LTC [REDACTED]



LTC Example 2

NOTICE OF ADVERSE BENEFIT DETERMINATION

Dear JOHN SMITH:

LTC PLAN XYZ has reviewed your request for ADULT DAY HEALTH CARE for 5 DAYS WEEKLY, which we received on 01/01/17. After our review, this service has been:

DENIED as of 01/05/17.

We made our decision because:
(Check all boxes that apply)

We determined that your requested services are **not medically necessary** because the services do not meet either of the reason(s) checked below: (See Rule)

- Meet all of the criteria as defined in Rule 59G-1.010(166), F.A.C., for all nursing facility services and mixed services; OR
- Meet all of the following criteria for all extended state plan services used for the purposes of maintenance therapy and all other home and community-based services:
1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
 2. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
 3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;

and one of the following:

1. Enable the enrollee to maintain or regain functional capacity; or
 2. Enable an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.
- The requested **service is not a covered benefit.**
- Other authority** <<explain and cite authority>>

The facts that we used to make our decision are:

Your care plan is based on your needs. Needs are defined by Florida law. For a service to be needed it must treat a problem. It must not be for the convenience of your caregiver. Adult day health care is for socialization and helping you with activities of daily living. Being alone in your home is not, in and of itself, a reason for adult day health care.



Questions?

