

# Statewide Medicaid Managed Care (SMMC): Webinar Q&A

## Contracts

1. 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.

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: <u>9,338</u>
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; <u>Total = 13,450</u>
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; <u>Total = 11,935</u>
11	Miami-Dade and Monroe	1-Sep-13	1-Dec-13	Region 11: <u>17,257</u>
5 & 6	Pasco, Pinellas, Hardee, Highlands, Hillsborough, Manatee and Polk	1-Nov-13	1-Feb-14	Region 5, 9,963; Region 6, 9,575; <u>Total = 19,538</u>
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 and Volusia	1-Dec-13	1-Mar-14	Region 3: 6,911; Region 4: 9,087; <u>Total = 15,990</u>

## **Statewide Medicaid Managed Care (SMMC): Webinar Q& A**

2. 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 above for region specific deadlines.

3. 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.

4. 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.

5. 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?

## **Statewide Medicaid Managed Care (SMMC): Webinar Q& A**

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.

6. 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?

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.

7. 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.

8. Question:

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

Answer:

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

# **Statewide Medicaid Managed Care (SMMC): Webinar Q& A**

## **Eligibility:**

1. 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.

if 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.

2. 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.

3. Question:

Are Hospice recipients required to select a LTC health plan?

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.

## **Statewide Medicaid Managed Care (SMMC): Webinar Q& A**

4. 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.

5. 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.

6. Question:

Will the ICP Medicaid application process remain the same?

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.

7. Question:

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

Answer:

## **Statewide Medicaid Managed Care (SMMC): Webinar Q& A**

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.

8. 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.

9. 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.

10. 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 determines 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.

## **Statewide Medicaid Managed Care (SMMC): Webinar Q& A**

11. Question:

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

12. 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.

13. 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.

14. 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?

## **Statewide Medicaid Managed Care (SMMC): Webinar Q& A**

Answer:

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

15. 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.

### **Provider Reimbursement:**

1. 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.

2. 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.

## **Statewide Medicaid Managed Care (SMMC): Webinar Q& A**

3. 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.

4. 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).

5. 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.

6. 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.

7. 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?

## **Statewide Medicaid Managed Care (SMMC): Webinar Q& A**

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.

8. 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.

### **Recipient Transition:**

1. 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.

2. Question:

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

## **Statewide Medicaid Managed Care (SMMC): Webinar Q& A**

Answer:

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

3. 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?

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.

4. 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

5. 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.

# **Statewide Medicaid Managed Care (SMMC): Webinar Q& A**

6. 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?

Answer:

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

## **Regions:**

1. Question:

I see that region 1 is in litigation. When do you expect this to wrap up and will it push back enrollment dates?

Answer: Due to formal protest that have been filed in Region 1, all plan readiness deadlines for that Region are postponed pending resolution of the formal protest.

2. Question:

Is region 9 also pushed back due to litigation?

Answer: No.

## **Roles and Responsibilities:**

1. Question:

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

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.

# **Statewide Medicaid Managed Care (SMMC): Webinar Q& A**

## **Services:**

1. 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.

2. 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?

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.

3. 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...

4. 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.

5. Question:

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

Answer:

## **Statewide Medicaid Managed Care (SMMC): Webinar Q& A**

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.

6. Question:

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

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.

7. 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).

8. 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.

## **Statewide Medicaid Managed Care (SMMC): Webinar Q& A**

9. 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.

### **Appeals:**

1. Question:

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

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.

2. 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.

# **Statewide Medicaid Managed Care (SMMC): Webinar Q& A**

## **MMA:**

1. 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.

2. 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.