STATEWIDE MEDICAID MANAGED CARE PROGRAM

FREQUENTLY ASKED QUESTIONS

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DOCUMENT PURPOSE

Florida law requires the Agency for Health Care Administration (Agency) to select health plans for participation in the SMMC program every five years. The Agency recently selected health plans for participation in the second five year contract term.

In addition, in 2016, the Florida Legislature directed the Agency to implement a statewide Medicaid prepaid dental program by no later than March 1, 2019. The Agency recently selected dental plans for participation in the SMMC program.

This document is intended to provide responses to frequently asked questions related to the transition to new SMMC plans. Please note, this document does not take the place of the health plan contract or Medicaid coverage policies that are promulgated in rule.

GENERAL QUESTIONS

Q: When will the newly contracted SMMC plans be available in my county?

A: To view the roll-out schedule for each region/county, please visit the Agency's website at the following link: www.ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/Regional_Roll_Out_Schedule_062618.pdf or by visiting www.ahca.myflorida.com/smmc. Once on the website, click on the Plan Roll-out Schedule document in the SMMC Program Changes box.

Q: What plans will be providing services in each region?

A: For a complete listing of health plans, by region, please visit the Agency's website at the following link: www.ahca.myflorida.com/medicaid/statewide_mc/pdf/Reprocure_Final_Plan_Chart.pdf or by visiting www.ahca.myflorida.com/smmc. Once on the website, click on the Plans by Region document in the SMMC Program Changes box.

Q: Who should providers contact at each plan?

A: For a complete listing of provider relations contacts for provider network purposes for each plan, please visit the Agency's website at the following link: www.ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/SMMC_Provider_Plan_Contacts_External_10.22.18.pdf or by visiting www.ahca.myflorida.com/smmc. Once on the website, click on the Plan Contacts for Providers document in the SMMC Program Changes box.

COVERAGE

Q: What are expanded benefits, and what expanded benefits are offered by each plan?

A: Expanded benefits are extra goods or services medical and dental plans will provide to Florida Medicaid recipients, free of charge. Expanded benefits are specific to each plan. For a complete listing of expanded benefits offered by each plan, please visit the Agency's website at the following link: www.ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/EB_Chart_Revised_101618.pdf

or by visiting www.ahca.myflorida.com/smmc. Once on the website, click on the Outreach and Presentations link in the SMMC Program Changes box and look for the Expanded Benefits by Plan Chart document.

Q: What services are new to SMMC?

A: Services that are currently provided in the fee-for-service delivery system that will be covered by Statewide Medicaid Managed Care (SMMC) plans beginning December 1, 2018 include:

- Early Intervention Services (EIS)
- Medical Foster Care Services
- Child Health Services/Targeted Case Management Services
- Nursing Facility Services provided by Managed Medical Assistance (MMA) plans

PLAN TYPES

Q: What plan types are being offered in the new SMMC program, and how do I know which type to enroll in?

A: Most individuals eligible for Medicaid will be required to enroll in an SMMC plan. An individual will not have to know which types of plans they are eligible for. When they go online to enroll or call a choice counselor, only the plans for which they are eligible will show as available options.

The type of health plan a recipient can choose depends on whether they are eligible for:

- MMA services only
- LTC services only
- Both MMA & LTC services
- Whether they have certain conditions

MMA Plan – Provides MMA services to eligible recipients, and cannot provide services to recipients who are eligible for Long-Term Care services.

Long-Term Care Plus Plan – Provides MMA services and Long-Term Care services to recipients enrolled in the Long-Term Care program. The plan type cannot provide services to recipients who are only eligible for MMA services.

Comprehensive Plan – Provides MMA services and Long-Term Care services to eligible recipients. Comprehensive plans can serve recipients only eligible to receive MMA services and those eligible to receive MMA **and** LTC services.

Specialty Plan – Provides MMA services to eligible recipients who are defined as a specialty population. Recipients eligible for LTC services cannot enroll in specialty plans.

Dental Plan – Provides preventive and therapeutic dental services to all recipients in managed care and all recipients who have full Medicaid coverage and currently receive their services

through the Medicaid fee-for-service delivery system (sometimes referred to as "straight Medicaid". The following individuals are not required to enroll in a dental plan:

- Individuals eligible through emergency medical assistance for aliens
- Presumptively eligible pregnant women
- Individuals enrolled in the Program of All-inclusive Care for the Elderly (PACE)
- Individuals eligible through the family planning waiver
- Partial dual eligible (QMB, SLMB, QI1).

CONTINUITY OF CARE

Q: What is Continuity of Care (COC)?

A: COC requirements ensure that when enrollees transition from one health plan to another, one service provider to another, or one service delivery system to another (i.e., fee-for-service to managed care), their services continue seamlessly throughout their transition.

Q: Please provide an overview of how the continuity of care (COC) period works.

A: Health plans are responsible for COC for new enrollees transitioning into their plan. If a new enrollee is receiving a prior authorized ongoing course of treatment with any provider, including those services previously authorized under the fee-for-service delivery system, the new health plan is responsible for the costs of continuation of such course of treatment. The new plan cannot require any form of authorization and cannot require that the services be provided by a participating (in network) provider. The new plan must provide services in this way for up to 60 days after the effective date of enrollment.

Q: Is an enrollee's new health plan required to continue a service previously provided by the enrollee's old health plan?

A: If an enrollee was receiving a service prior to moving to a new health plan, the enrollee's new health plan must continue to provide that service for up to 60 days after enrollment or until a new treatment plan has been developed by the new health plan.

Q: What happens with pregnant women who deliver within the 60 day COC period? Will the child be automatically enrolled in the mother's current plan?

A: Pregnant women must be allowed to continue their current course of prenatal care with their existing provider for the duration of their pregnancy through six weeks post-partum. If the mother has not chosen a health plan for her baby prior to the baby's birth, the baby will be automatically enrolled in the same health plan as the mother. If the parents would like to change their baby's health plan, they will have 90-days to change plans.

Q: How does the COC period effect non-participating providers?

A: The health plan must reimburse non-participating providers at the rate they received for services rendered to the enrollee, immediately prior to the enrollee transitioning, for a

minimum of 30 days, unless the provider agrees to an alternative rate. After the first 30 days of the COC period, the health plan will pay the provider a mutually agreed upon rate.

CHOICE COUNSELING/ENROLLMENT

Q: How do I enroll in a health plan?

A: There are several ways for Medicaid recipients to enroll in the SMMC program, including online and by phone. Additionally, recipients with special needs can request a face-to-face meeting to discuss health plan options. To enroll, recipients will need the Florida Medicaid number or Social Security Number and birth year for each person being enrolled.

Online

- Visit the SMMC Member Portal at the following link: https://members.flmedicaidmanagedcare.com/account/login

Automated Phone System (open 24/7)

- Call 1-877-711-3662 with your pin
  - Follow the steps to enroll via the Automated Phone System

Call-In

- Medicaid Choice Counselors are available to help recipients enroll in a plan that best fits their needs.
- Speak with a choice counselor via phone at 1-877-711-3662 Monday – Thursday 8:00am – 8:00pm and Friday 8:00am – 7:00pm.
- TDD users ONLY call 1-866-467-4970

Q: When must I choose a plan, and can I change plans once a selection has been made?

A: Recipients must choose a plan by the date listed in the state-issued welcome letter that is sent to all recipients 30-45 days prior to the roll-out date for their region.

- If no plan selection is made, the recipient will be enrolled in the health plan listed in the welcome letter.
- Recipients have a 120-day change period, in which they can change their plan, which begins on the effective date of their enrollment in the plan.

Additionally, once a year, recipients will have a chance to change plans during the Open Enrollment period.

- Open Enrollment is the 60-day period each year when you can change plans without state approval, and occurs yearly on the anniversary date of your first enrollment into the plan.

PROVIDER NETWORKS

Q: Are health and dental plans allowed to refuse to contract with a provider?

A: Yes, SMMC plans are allowed to limit the providers in their network. Health plans are contractually required to have a sufficient number of providers to provide all covered services to enrollees and to ensure that each medically necessary covered service is accessible and provided with reasonable promptness. Additionally, the health plan's contract with the Agency specifies the minimum number of providers each plan must use in order to effectively provide services.

Q: How often does the Agency receive updates related to plan's networks?

A: At a minimum, health plans submit a provider network file of all participating providers on a weekly basis.

Q: If a provider has a current contract with an SMMC plan, do they need to renew their contract for the new roll-out of the SMMC program?

A: There is no Agency requirement for providers to renew contracts with the newly selected plans. Providers should contact the health plan to inquire about requirements related to contracting.

CREDENTIALING

Q: Please explain the 60-day credentialing requirement.

A: Health plans are required to fully enroll/on-board all providers it chooses to contract with within 60 days. Once the health plan receives a complete and accurate provider application, it has 60 days to complete the onboarding process. Health plans are allowed to execute network provider agreements pending the outcome of the on-boarding process, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or at the expiration of the 60-day period.

PROVIDER PAYMENT

Q: How will the Agency ensure providers are paid in a timely manner?

A: Health plans have strict contractual requirements to ensure providers are paid timely and accurately. Health plans are required to process claims and pay providers in compliance 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. To view the requirements related to claims and provider payment, please refer to Section VIII.E. of the SMMC Model Contract, which can be found at the following link: http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2018-08-01/MODEL_Attachment_II_2018-08-01.pdf or by visiting www.ahca.myflorida.com/smmc. Once on the website, click on the 2012-2018 Model Contract link in the Health Plans box and click on the Core Contract Provisions link.

Q: What is the MMA Physician Incentive Program (MPIP), and are providers paid above the Medicaid rate?

A: The MPIP is designed to increase compensation for designated physician types who meet certain qualifying criteria, primarily associated with key access and performance measures. Eligible physicians who meet the plan's qualifying criteria receive payment rates that are equal to or exceed the Medicare rate for services rendered.

For additional information on the MPIP, including a listing of eligible provider types, please visit the Agency's webpage at the following link: https://ahca.myflorida.com/medicaid/statewide_mc/mma_physician_incentive.shtml or by visiting www.ahca.myflorida.com/smmc. Once on the website, click on the MMA Physician Incentive Program link in the Providers box.

Q: Is there a published rate table for SMMC services?

A: The Agency does not dictate the rate that plans must pay providers, but rather allows plans to negotiate mutually agreed upon rates with providers. Plans must cover all the services listed in the fee-for-service provider reimbursement schedules, but they do not have to pay the fees listed.

To view fee-for-service provider reimbursement schedules and billing codes related to the SMMC program, please visit the Agency's website at the following link: www.ahca.myflorida.com/medicaid/review/fee_schedules.shtml or by visiting www.ahca.myflorida.com/smmc. Once on the website, click on the Coverage Policies link in the Providers box and then click the Fee Schedules and Billing Codes link.

CMS PLAN

Q: Will Children's Medical Services (CMS) Plan continue to be a plan option?

A: Yes, CMS Plan will continue to be a managed care plan for children with special health care needs in all regions of the state. For additional information related to the CMS Plan, please visit the Department of Health's CMS Plan website at the following link: http://www.floridahealth.gov/programs-and-services/childrens-health/cms-plan/

DENTAL

Q: What is the SMMC Dental program?

A: The Florida Legislature directed the Agency to implement a stand-alone dental component of the SMMC program. Beginning in December 2018, all Medicaid eligible recipients will be required to select a dental plan for their dental services. This means that most recipients who are receiving dental services through FFS, and those who are already enrolled in a health plan, will have a separate dental plan that will be responsible for their dental services.

Q: What dental plans are available in my region?

A: DentaQuest, LIBERTY, and MCNA will each be available statewide and will coordinate and cover all child and adult dental services.

Q: Who is required to enroll in the SMMC Dental program?

A: Most Medicaid recipients who are currently in the fee-for-service and SMMC delivery systems will be required to enroll in a dental plan. This includes Medically Needy and iBudget enrollees. The following recipients are not eligible to enroll in a dental plan:

- Individuals eligible through emergency medical assistance for aliens
- Presumptively eligible pregnant women
- Individuals enrolled in the Program of All-inclusive Care for the Elderly (PACE)
- Individuals eligible through the family planning waiver
- Partial dual eligible (QMB, SLMB, QI1).

Q: What services are covered by the Dental plan?

A: For children, all medically necessary dental services will be covered. For adults, all state plan plus expanded benefits will be covered. Dental services for adults are:

- Dental exams (limited to emergencies and dentures)
- Dental X-rays (limited)
- Prosthodontics (dentures)
- Extractions
- Sedation
- Ambulatory Surgical Center or Hospital-based Dental Services provided by a dentist
- Expanded benefits for adults include: diagnostic, preventive, and restorative treatment/care.

Q: How will the Dental plans coordinate with the Medical plans to ensure recipients receive appropriate dental care?

A: To ensure coordination between the health and dental plans, the following four contractual requirements were created:

1) Designated Employee – Dental plans will have a designated employee to serve as a point of contact for health plans in helping to resolve operational (i.e., sharing of data/information) and care coordination /issues, and will work directly with the Agency.
2) Communication Strategy - Dental plans will work with the Agency and the health plans to foster enhanced communication, strategic planning, and collaboration in coordinating benefits.
3) Coordination of Benefits Agreement - Dental plans will enter into a coordination of benefits agreement with the health plans that includes data sharing and coordination protocols to support the provision of dental services.

4) New performance measures - Dental plans must contact each enrollee who went to the Emergency Department within 7 days of discharge and implement strategies to ensure follow up care is obtained by the enrollee. All dental plans will participate in the Florida Health Information Exchange Event Notification Service in order to be promptly notified when its enrollees access the emergency department.

Q: What amount will dental providers be paid?

A: The Agency does not establish payment rates for network providers. All payment rates are negotiated through each provider's contract with the dental plan.

Q: Who should I contact if I want to provide services for a dental plan?

A: Providers wishing to contract with a dental plan should contact the plan directly. Below is a table identifying the provider contacts at each dental plan:

PLAN NAME	PROVIDER RELATIONS CONTACT
DentaQuest	Vanessa Guerrero Email: Vanessa.Guerrero@dentaquest.com Phone: (305) 894-8755
LIBERTY	Betty Gilbert Email: prinquiries@libertydentalplan.com Phone: 1 (888) 352-7924 ext. 393
MCNA	Mercedes Linares Email: prdepartment@mcna.net Phone: 1 (855) 698-6262

EARLY INTERVENTION SERVICES

Q: Where can I find additional information about early intervention services being covered by health plans?

A: The Agency is in the process of developing frequently asked questions specifically related to Early Intervention Services (EIS). The Agency will post the EIS FAQs to the SMMC website this week: www.ahca.myflorida.com/smmc. Once on the website, click on the outreach and presentations link and look for the EIS FAQ document.