Florida’s Medicaid Reform

Plan Workshop
Macclenny
December 11, 2006
Introductions

Lisa Broward
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Medicaid Area 4
Technical Assistance for Filling out the Application

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FLORIDA MEDICAID
Timeline/ Dates for the Application Process (estimated timeframes)

- The revised Reform Health Plan Application will be posted December 2006.
- The revised Model contract will be posted December 2006.
- The data book is available on the Reform Website.
- The plan evaluation tool is available on the Reform Website.
- Applications for New Reform Plans submitted by February 2006 will be processed with expected contract execution July 2006.
- Applications for Reform Expansion submitted by March 2007 will be processed with expected contract execution July 2007.
Letters of Intent

Letters of Intent have been received for Baker, Clay and Nassau from the following:

- Florida NetPass, LLC (PSN).
- PhyTrust of Florida LLC, d/b/a Access Health Solutions (PSN).
- Better Health, LLC (PSN).
- United Healthcare of Florida, Inc. (HMO).
- Wellcare of Florida Inc. d/b/a/ Staywell Health Plan of Florida (HMO).
- HealthEase Health Plans of Florida, Inc. (HMO).
- Citrus Health Plan (HMO).
- USMD, LLC/ FLMD, LLC (PSN).
- Universal Health Care, Inc. (HMO).
- Children’s Medical Services (Specialty PSN).
Application Process Outline

- Phase I (Concurrent with Phase II).
  - Organizational Review.
  - Desk Review of Materials Submitted.
  - Concurrent with Phase II.
  - Approximately four to six weeks.
- Phase II (Concurrent with Phase I).
  - Fiscal Review / Comprehensive Review.
  - Desk Review of Materials Submitted.
  - Concurrent with Phase I.
  - Approximately six to eight weeks.
- Phase III.
  - Site Visit.
    - May be required for Expansion Request.
  - Three to Five days onsite.
  - Approximately Three to Six weeks for final report and approval.
- Phase IV.
  - Contract and Execution.
  - Approximately four weeks to route and execute.
Phase I
Application Process Outline

- **Phase I (Concurrent with Phase II):**
  - Four to Six Weeks to Complete.
  - Organizational Review:
    - Organizational Structure.
    - Authority to Operate.
    - Certificate of Good Standing.
    - Minority Recruitment and Retention.
    - Disaster Plan.
  - Medicaid Provider Application:
    - Background Check.
Application Process Outline
Phase I (Concurrent with Phase II)

- Phase I (Concurrent with Phase II): Background Screening:
  - Fingerprint cards
    - Fingerprint cards must be legible and fully completed according to the "Guide for Completing a Florida Medicaid Provider Enrollment Application" (This includes full name, title, position and SSN).
  - Required screening fees.
    - Required screening fee $47.00 per screening.
Application Process Outline
Phase I (Concurrent with Phase II)

- Who Needs Fingerprint Cards?
- Managers:
  - Contract Manager,
  - Full-Time Administrator,
  - Medical Director,
  - Medical Records Review Coordinator,
  - Data Processing and Data Reporting Coordinator,
  - Marketing Oversight Coordinator,
  - Quality Improvement (QI) and Utilization Management (UM) Professional (who will oversee the Health Plan's QI and UM processes),
  - Grievance System Coordinator, Compliance Officer,
  - Case Management Manager/Coordinator,
  - Behavioral Health Services Oversight Manager,
  - Board certified or board eligible, licensed staff psychiatrist, and for Prepaid Health Plans only, the Claims/Encounter Manager.
Application Process Outline

Phase I (Concurrent with Phase II): Background Screening.

- Licensure Screen Prints from the Dept. of Health
  - May be submitted in lieu of fingerprint cards for licensed individuals holding management positions. The screening completed by the Department of Health for licensure meets the Medicaid background-screening requirement.
  - Licensed individuals are considered Medical, Osteopathic, Podiatric, and Chiropractic Physician as well as Advanced Registered Nurse Practitioner and Registered Nurse applicants who are active licensed by the Department of Health.
  - Submit an Internet screen print showing the current, active status of the license from the Department of Health web site, http://www.doh.state.fl.us/IRMOOPRAES/PRASLIST.ASP
Application Process Outline
Phase I (Concurrent with Phase II)

- Background Check: Who Needs Fingerprint Cards?
- Partners of your business and subcontractors.
- Individual officers and Directors.
- Financial records custodian, and
  - Individuals who hold signing privileges on the depository account.
    - In addition: Third Party Administrator.
- Shareholders (five percent or more ownership).
Application Process Outline
Phase I (Concurrent with Phase II)

- Phase I (Concurrent with Phase II).
- Additional Documentation.
  - Note: The Documents below MUST be submitted with Original Signature – no copies will be processed for Application approval:
  - Non-Institutional Medicaid Provider Agreement (MPA):
    • Signed by Individuals who hold signing privileges on the depository account.
    • The CEO or President may sign in lieu of the above.
Application Process Outline
Phase I (Concurrent with Phase II)

- Phase I (Concurrent with Phase II).
- Additional Documentation.
  - Authorization Agreement for Electronic Funds Transfer (EFT)
    - Attach letter from financial institution verifying the name on the account as well as the account and routing numbers.
    - Anyone who signs the EFT form must meet background screening requirements.
  - Electronic Claims Submission (ECS) Agreement
  - Electronic Remittance Voucher (ERV) Agreement
    - Note: Submit these four forms to HSD. HSD will forward them to Provider Enrollment. Forms submitted directly to ACS will be returned to HSD and will delay the application approval process.
Phase II
Application Process Outline
Phase II (Concurrent with Phase I)

- Six to Eight Weeks to complete.
- Desk Review of Materials Submitted.
- Fiscal Review / Comprehensive Review.
- Review of Policies and Procedures related to all contractual requirements.
- Geo Access Mapping of Provider Network.
- Review of Model Contracts.
- Review of Executed Provider contracts.
Application Process Outline
Phase II (Concurrent with Phase I)

- Fiscal Review / Comprehensive Review.
  - Pro forma based on Florida Operations.

- Policy and Procedures:
  - The plan must have policies and procedures approved by the Agency for provision of services and compliance with contract provisions. Policies are the "what" and procedures are the "how".
  - Copies of policies and procedures must be provided with Application, even if Policies and Procedures approved within last (one) year.
Application Process Outline
Phase II (Concurrent with Phase I)

- Provider Network:
  - The plan must have all providers necessary to provide covered services to Medicaid beneficiaries under contract.
  - It is expected that the plan will contract with providers in the local communities.
  - For rural areas, the Agency will take into consideration normal referral patterns for specialty care in counties without sufficient specialists.
  - Letter of Agreement with provider(s) sufficient to submit with Application.
  - Signed Contract with provider(s) must be submitted prior to Medicaid Reform Contract execution.
Medical Services/ Covered Services

- Covered Services - Section V of Model Capitated Health Plan contract.
- Plan Application information will be reviewed by the Bureau of Managed Health Care during Phase II.
- Plan may provide medical services directly or subcontract for service provision.
  - Plan must provide copies of signed provider contracts prior to Health Plan contract execution.
Medical Services/ Covered Services

- **Plan services:**
  - Certain services must be provided at least to current coverage levels.
  - Other services must be provided at least to meet standards set by the Agency.
  - Remaining services must be offered, but amount, scope and duration are flexible within boundaries established by the Agency.

- Reform plans can offer services above current levels.
  - For Example: Several existing Reform plans offer expanded adult vision benefit (up to $125 per year for upgrades such as scratch resistant lenses).

- Reform plans can add services not currently covered.
  - For Example: Several existing Reform plans offer over the counter drug benefit ($10-25/Month).
Medical Services/ Covered Services

- Physician and physician extender services.
- Hospital inpatient care.
- Emergency care.
- EPSDT and other services to children.
- Maternity care and other services to pregnant women.
- Transplant services.
- Medical/drug therapies (chemo, dialysis).
- Family planning.
- Outpatient surgery.
- Laboratory and radiology.
- Transportation (emergent and non-emergent).
- Outpatient mental health services.

Required at least to current limits:
Medical Services/ Covered Services

- Required and tested for benefit sufficiency:
  - Hospital outpatient services.
  - Durable medical equipment.
  - Home health care.
  - Prescription drugs.

- Existing Reform plans offer a range of services:
  - For Example:
    - To meet the sufficiency standards, existing plans were required to provide a minimum of 9 prescriptions/month to the Children and Families group and a minimum of 16 prescriptions/month to the Aged and Disabled group.
    - However, many plans offered a prescription benefit above the minimum determined to be sufficient.
Medical Services/ Covered Services

- Required to be offered, but amount, scope and duration are flexible.
  - Chiropractic services.
  - Podiatry services.
  - Outpatient therapy services for adults.
  - Adult dental services.
  - Adult vision services.
  - Adult hearing services.
- Existing Reform plans offer a range of services:
  - For Example: Podiatry services offered by different plans range from 6 visits to 24 visits per year.
Behavioral Health Services - Section VI of the Model Capitated Health Plan contract.
- Plan is required to provide medically necessary Behavioral Health Services to all Enrollees and shall provide a full range of services authorized under the State Plan and specified in the contract.

Plan Application information will be reviewed by the Bureau of Managed Health Care during Phase II.

Plan may provide behavioral health services directly or subcontract for service provision.
- Plan must provide copies of signed provider contracts prior to Health Plan contract execution.
Behavioral Health Services

- Information to be Provided to the Bureau of Managed Health Care for Desk Review.
- Letter Requesting Counties of operation
- If services are Subcontracted:
  - Provide copies of Subcontracts with Managed Behavioral Health Organizations.
- Behavioral Health Policies and Procedures based on Contract.
- Model Contracts with Individual Providers, Groups, Facilities, and Community Mental Health Center’s.
- Selected Pages from all Provider contracts.
- Provider Network Listing.
Behavioral Health Services

- Provider Directory.
- Credentialing File Review, including Specialty Information.
- Copies of Health Plan & Managed Behavioral Health Organization Chart.
- Quality Improvement Program Description.
- Utilization Management Program Description.
- Behavioral Health Member Handbook.
Behavioral Health Services

- Model Notification Letter to Enrollees.
- Model Notification Letter to Contracted Providers.
- Plan’s Training Process for Providers: Claims, Authorization, etc.
- On-Site Reviews will be scheduled as needed.
Transportation Services

- Transportation Services – Section V, F - Covered Services / Coverage Provisions of the Model Capitated Health Plan contract.
  - Plan is required to provide emergent and non-emergent transportation services to all Enrollees per the Medicaid Transportation Handbook.

- Plan may provide services directly or subcontract transportation services.
  - Plans must submit signed provider subcontract prior to Health Plan contract execution.
Transportation Services

- Review of Provider Contracts.
- Review of oversight policies and procedures.
- Possible On-Site visit.
Phase III
Site Visit
Application Process Outline

Phase III: Site Visit

- Site Visit.
- Review of Data systems, record keeping.
- Review of provider credentialing files.
- Call Center Monitoring.
- Three to Five days on site:
  - Primarily corporate office
    - Can include visit to ancillary offices/provider offices.
  - Bureau of Managed Care and Health Systems Development staff.
- You will be notified if and when a site visit is required.
Phase IV
Contract Execution
Application Process Outline
Phase IV: Contract Execution

- **Phase IV:**
  - Contract and Execution.
  - Approximately Four Weeks to route and execute.
  - Model Contract available on Medicaid Reform web site.
  - Draft version sent to Plan for review and approval.
    - Please Review Carefully:
      - Approved Plan Benefit grid (Attachment I),
      - Plan contact information, signatory (CEO or other) (Standard Contract), and
      - Expanded Benefits (Attachment II).
  - After Legal approval, final version to Plan for signature
    - Two copies for original signature.
    - One copy returned to Plan upon Agency execution.
Lessons Learned

- Submit fingerprint cards early in application process.
- Submit evidence of adequate Provider Network:
  - Letter of Agreement with provider permissible to submit at time of Plan Application submission.
  - Signed provider contracts must be submitted prior to Plan contract execution.
- Submit full copy of Policy and Procedures:
  - Work closely with BMHC staff to answer questions and submit necessary documentation.
- Review Frequently Asked Questions (FAQ) on Medicaid Reform website:
  http://ahca.myflorida.com/Medicaid/medicaid_reform/provider/index.shtml#three
Contact Information for Questions

- If you have specific questions or are interested in one-on-one meetings with AHCA staff, call Melanie Brown-Woofter at (850) 487-3881.
- All general questions may be emailed to: medicaidreform@ahca.myflorida.com
Florida’s Medicaid Reform
Choice Counseling and Plan Responsibilities

Melanie Brown-Woofter
AHC Administrator
Division of Medicaid
Bureau of Health Systems Development
Choice Counseling

- Provider ID Activation
  - Allow 10 days from contract execution to activate the Provider ID in the Choice Counseling system.
  - Must happen at least 10 days prior to monthly magic to be included in mandatory assignments.
    - See Choice Counseling Monthly Calendar
Choice Counseling

- **Provider Files:**
  - *May be sent weekly to Choice Counselor (ACS).*
  - *Must be sent at least monthly to Choice Counselor (ACS).*
  - *May include Providers from adjacent counties.*
    - Transportation must be covered for enrollees who obtain services from these providers.
Choice Counseling

Enrollment Files:
- Accessed via secure FTP site.
- Monthly download.
Florida’s Medicaid Reform
Rural Health Plan
Start-up Funds Application

Lisa Gill
AHC Administrator
Health Systems Development
Rural PSN Development Grant Application

- $600,000 appropriated in Specific Appropriation 197 to assist entities in developing clinical and administrative infrastructure necessary to become a Provider Service Network in a rural county(ies).
- Must be a non-profit organization.
- Reform and Non-Reform Counties.
Rural PSN Development Grant Application

- Provider Service Networks are:
  - Networks established or organized and operated by a health care provider or group of affiliated health care providers, including minority physician networks and emergency room diversion programs that meet the requirements of s. 409.912(4)(d), F.S., and
  - Health care providers must have a controlling interest in the governing body of the provider service network organization.
Rural PSN Development Grant Application

- Rural Counties are counties that meet the definition of rural specified in Section 381.0406, F.S.

- BAKER
- BRADFORD
- CALHOUN
- COLUMBIA
- DESOTO
- DIXIE
- FRANKLIN
- GADSDEN
- GILCHRIST
- GLADES
- GULF
- HAMILTON
- HARDEE
- HENDRY
- HIGHLANDS
- HOLMES
- JACKSON
- JEFFERSON
- LAFAYETTE
- LEVY
- LIBERTY
- MADISON
- MONROE
- NASSAU
- OKEECHOBEE
- PUTNAM
- SUMTER
- SUWANNEE
- TAYLOR
- UNION
- WAKULLA
- WALTON
- WALTON
- WASHINGTON
Rural PSN Development Grant Application

- Maximum of $200,000 per award, maximum of five awards.
- Defined deliverables and performance measures.
Rural Provider Service Network Start-Up Funds Timeline

- February 2007: Applications evaluated and awards made.
- March 2007: Contracts executed and rural PSN development begins.
- June 2007: All deliverables must be met/funds encumbered.
Marketing of Plans Under Reform

Tom Warring, Chief
Division of Health Quality Assurance, Bureau of Managed Care
Marketing Under Reform

- The general provisions for marketing have not changed in the transition from non-reform to reform.
- The requirements are in Section IV B of the Model Capitated Health Plan contract and Section IV B of the Model PSN FFS contract.
Marketing Definitions

Marketing — Any activity or communication conducted by or on behalf of any Health Plan to a Medicaid Beneficiary who is not Enrolled with the Health Plan, that can reasonably be interpreted as intended to influence the Medicaid Beneficiary to enroll in the particular Health Plan, or either to not enroll in, or disenroll from, another Health Plan.
Cold Call Marketing — Any unsolicited personal contact (person to person, telephone, mail, e-mail) with a Medicaid Beneficiary by the Health Plan, its staff, its volunteers or its vendors with the purpose of influencing the Medicaid Beneficiary to enroll in the Health Plan or either to not enroll in, or disenroll from, another Health Plan.

Market Area — The geographic area in which the Health Plan is authorized to market and/or conduct pre-enrollment activities.
Marketing Definitions (continued)

Marketing Representative — A person who provides information, pre-enrollment assistance, or otherwise promotes a Health Plan. Marketing Representatives shall be limited to licensed insurance agents.

Pre-Enrollment — The provision of marketing and educational materials to a Medicaid Beneficiary and assistance in completing the Request for Benefit Information (RBI).
Marketing Definitions (continued)

Health Fair — An event conducted in a setting that is open to the public or segment of the public (such as the "elderly" or "schoolchildren") during which information about health-care services, facilities, research, preventative techniques or other health-care subjects is disseminated. At least two (2) health-related organizations that are not affiliated under common ownership must actively participate in the Health Fair.
Consequences of Marketing Violations

- Plans in violation of this provision will be fined, proportionate to the offense.
- Refer to the Medicaid HMO Contract.
- Refer to the Florida Statutes.
- Refer to HMO Rule 59A-12.0073 HMO and PHC Penalty Categories.
Marketing Provisions

- For each new Contract period, the Health Plan shall submit to the Agency for written approval, pursuant to section 409.912, F.S., its Marketing plan and all Marketing and pre-Enrollment materials no later than sixty (60) Calendar Days prior to Contract initiation or renewal.
- The Marketing materials shall be distributed in the Health Plan’s entire Service Area in accordance with 42 CFR 438.104.
Marketing Provisions (continued)

- **Marketing materials include, but are not limited to:**
  - all solicitation materials,
  - forms,
  - brochures,
  - fact sheets,
  - posters,
  - lectures,
  - ad copy for radio or television,
  - Medicaid recruitment materials and presentations, and
  - Request for Benefit Information forms (previously known as pre-enrollment applications).
Examples of Prohibited Activities

- Overly aggressive solicitation, such as repeated telephoning.
- Granting or offering of any monetary or other valuable consideration for Enrollment.
- Enlisting the assistance of any employee, officer, elected official or agent of the State.
Example of Permitted Activities

- Leave Agency approved referral cards:
  - Provider offices.
  - Public Events.
  - Health Fairs.
Marketing Approval Process

- The Health Plan shall submit a detailed description of its Marketing plan and copies of all Marketing materials, the Health Plan or its Subcontractors plan to distribute, to the Agency for prior approval.

- A Health Plan shall submit its bi-monthly Marketing schedule to the Agency, two (2) weeks in advance of each month.

- The Agency will approve or deny the Health Plan's Marketing requests no later than five (5) Business Days from receipt of the of marketing requests.

- The Health Plan shall use the standard, or new, Agency format.
Other Marketing Provisions

- The Health Plan shall ensure its health care Providers comply with the Marketing requirements.
- The Health Plan shall not Subcontract with any brokerage firm or independent agent for purposes of Marketing.
- The Health Plan shall register each Marketing Representative with the Agency on or within two (2) business days of their appointment date.
- The Health Plan shall refer Potential Enrollees interested in enrolling in the Health Plan to the Choice Counselor/Enrollment Broker.
Lessons Learned

- All materials to be distributed to potential beneficiaries as information or enticement to join a plan must be approved by the Agency.
- Any participation in a public event, health fair must be approved prior to the plan participating.
- Providers may not steer or recommend to beneficiaries a specific plan for any reason.
Question and Answer