RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

January 11, 2018

Statewide Medicaid Managed Care (SMMC) Contract Interpretation

Contract Interpretation: 18-01

Applicable to:
- ☐ Comprehensive Long-term Care (LTC) Plan
- ☒ Managed Medical Assistance Health Maintenance Organization
- ☒ Managed Medical Assistance Provider Service Network
- ☒ Managed Medical Assistance Specialty Plan
- ☐ Children's Medical Services (CMS) Plan

Applicable to enrollees in:
- ☒ Managed Medical Assistance (MMA)
- ☐ Long-term Care (LTC)

Re: Institutions for Mental Diseases (IMD) Reimbursement Clarification and Ad Hoc Data Request

The managed care plan may be required to provide the Agency or its agents information or data relative to this contract. In such instances, and at the direction of the Agency, the managed care plan must fully cooperate with such requests and furnish all data or information in a timely manner, in the format in which it is requested. The managed care plan must have at least thirty (30) days to fulfill such ad hoc requests, unless the Agency directs the managed care plan to provide data or information in less than thirty (30) days. The managed care plan must verify that data and information it submits to the Agency is accurate. (Attachment II, Exhibit II-A, Section II.D.2.)

The SMMC Contract provides that the Agency may only make a monthly capitation payment to the managed care plan for an enrollee aged twenty-one (21) to sixty-four (64) years receiving inpatient treatment in an IMD (as defined in 42 CFR 435.1010) if the length of stay in the IMD is for a short-term stay of no more than fifteen (15) days during the period of the monthly capitation payment. (Attachment II, Exhibit II-A, Section IX.B.4.) The purpose of this contract interpretation is to provide clarification regarding coverage and payment provisions to managed care plans providing reimbursement for services provided in an IMD and to notify managed care plans of an ad hoc reporting requirement regarding IMD service utilization.

The SMMC Contract includes three approved provider types that qualify as IMDs to provide services for up to fifteen (15) days during a month in lieu of inpatient hospital care. Crisis stabilization units and freestanding psychiatric specialty hospitals may be used in lieu of inpatient psychiatric hospital care. Detoxification or addictions receiving facilities licensed under s. 397, F.S. may be used in lieu of inpatient detoxification hospital care. (Attachment II, Exhibit II-A, Section V.A.2.b. and c.) The Agency will not pay for, and will recoup, the portion of the capitation payment for days when the state is ineligible to receive FFP for an enrollee, ages twenty-one (21) to sixty-four (64) in an IMD setting. The managed care plan is eligible for the

entire capitation payment if enrollee has been in an IMD for fifteen (15) or fewer days within the month. If the enrollee stay in an IMD exceeds fifteen (15) days, the Agency will recoup a portion of the capitation payment originally made to the managed care plan.

In August of 2017, the Centers for Medicare and Medicaid Services (CMS) published a policy guidance document, Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) Frequently Asked Questions (FAQs) – Section 438.6(e); the publication is attached to this contract interpretation. The CMS guidance clarifies that states may make a pro rata capitation payment if an enrollee has been in an IMD for more than fifteen (15) days in a month but has spent a portion of the month in a non-IMD setting (e.g. the community). The Agency may not claim Federal financial participation (FFP) when the enrollee is in an IMD for more than fifteen (15) days in a month, but the state may claim FFP for a portion of the pro rata capitation payment for the number of non-IMD days in a month.

The managed care plan must submit to the Agency a quarterly report on any enrollees receiving services in an IMD, using the attached template. The managed care plan must submit the initial report by February 15 for the calendar quarter beginning October 1, 2017 and ending December 31, 2017. Subsequent quarterly reports are due by the fifteen (15th) calendar days of the month after the quarter ends. The managed care plan must upload the requested template to the managed care plan's ad hoc report folder on the Medicaid Data Analytics (MDA) SFTP site, using the following naming convention: IMDDATA***YYYYQ, where *** is the managed care plan's three-character identifier, YYYY is the four-digit year, and Q is the quarter for which the report is due. The managed care plan must include an attestation with the report submission. If the managed care plan does not have a report to submit, the managed care plan must submit an attestation to the Agency to certify that the managed care plan does not generate a claims adjudication accuracy report. The managed care plan must complete and submit the attestation as described in Chapter 2 of the SMMC Report Guide, effective October 1, 2017.

Pursuant to Attachment II, Section XII.I.1. Disputes, the managed care plan must submit, within twenty-one (21) days after the interpretation of the contract, a written dispute of the contract interpretation directly to the Deputy Secretary; this submission shall include all arguments, materials, data, and information necessary to resolve the dispute (to include all evidence, documentation and exhibits). All other provisions in this section apply.

Please submit such written requests to the following address:

Attn: Ms. Beth Kidder
Deputy Secretary for Medicaid
Agency for Health Care Administration
Managed Care Appeals/Disputes, MS #70
2727 Mahan Drive
Tallahassee, FL 32308

If you have any questions, please contact D.D. Pickle at (850) 412-4646.

Sincerely,

Shevaun Harris
Assistant Deputy Secretary for
Medicaid Policy and Quality

SH/mf
Attachment 1: Institutions for Mental Diseases Quarterly Report
Attachment 2: Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) Frequently Asked Questions (FAQs) – Section 438.6(e)