



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

November 17, 2015

Statewide Medicaid Managed Care (SMMC) Policy Transmittal

Policy Transmittal: 15-23

Applicable to:

- Long-term Care (LTC) Provider Service Network (PSN)
- 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 Network Plan

Re: Express Enrollment

The federal Centers for Medicare and Medicaid Services has approved the Agency for Health Care Administration's (Agency) request to utilize Express Enrollment for the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program. The Agency will implement Express Enrollment for recipients mandatory for enrollment in the MMA program effective January 1, 2016 or later. Express Enrollment will not be utilized for enrollment in the Long-term Care (LTC) program. Express Enrollment will be used for MMA Specialty Plans if the mandatory potential enrollee has an active specialty plan eligibility indicator on file with the Agency. The purpose of this policy transmittal is to inform managed care plans of upcoming changes and plan responsibilities associated with the implementation of Express Enrollment.

Express Enrollment and MMA Plans

Applicants may pre-select an MMA plan following submission of their application for Florida Medicaid. The Agency will enroll mandatory potential enrollees in an MMA plan on the effective date of the potential enrollee's eligibility determination. The Agency will use an established algorithm to assign mandatory potential enrollees who do not select an MMA plan at the time of their Florida Medicaid application.

The Agency will inform MMA plans in the daily enrollment file (834) of new enrollees and the enrollee's plan effective date. The Agency will pay MMA plans a prorated capitation payment for the first month for recipients enrolled through Express Enrollment. The prorated capitation payment will be equal to the portion of the month the recipient is enrolled.

Enrollee Plan Changes

All MMA and LTC SMMC enrollees will have a 120-day period from the date of their initial managed care plan enrollment to change plans. Plan changes will become effective the first day of the following month. After an initial 120-day change period, mandatory enrollees may disenroll from the managed care plan only for cause. Voluntary enrollees not subject to open



enrollment may disenroll from the managed care plan at any time. (Attachment II, Section III.C.4.b.)¹ If a temporary loss of eligibility causes the enrollee to miss the open enrollment period, the Agency will enroll the person in the managed care plan in which he or she was enrolled before loss of eligibility. The enrollee will have 120 days to disenroll without cause.

Plan Responsibilities

Within five (5) days following receipt of the X12-834 enrollment file from the Agency or its fiscal agent, the managed care plan must furnish to the new enrollee materials and procedures as described in Attachment II, Section IV.A.5.a. of the contract.

All managed care plans must ensure that print and online enrollee materials are revised to reflect the new 120-day change period. The managed care plan must include the following revised language verbatim in the enrollee handbook to replace current language in Attachment II, Section IV.A.7.b.(3)²:

Enrollment:

If you are a mandatory enrollee required to enroll in a plan, once you are enrolled in [INSERT MANAGED CARE PLAN NAME] or the state enrolls you in a plan, you will have 120 days from the date of your first enrollment to try the Managed Care Plan. During the first 120 days you can change Managed Care Plans for any reason. After the 120 days, if you are still eligible for Medicaid, you will be enrolled in the plan for the next eight months. This is called "lock-in."

Open Enrollment:

If you are a mandatory enrollee, the state will send you a letter 60 days before the end of your enrollment year telling you that you can change plans if you want to. This is called "open enrollment." You do not have to change Managed Care Plans. If you choose to change plans during open enrollment, you will begin in the new plan at the end of your current enrollment year. Whether you pick a new plan or stay in the same plan, you will be locked into that plan for the next 12 months. Every year you may change Managed Care Plans during your 60 day open enrollment period.

Disenrollment:

If you are a mandatory enrollee and you want to change plans after the initial 120-day period ends or after your open enrollment period ends, you must have a state-approved good cause reason to change plans. The following are state-approved cause reasons to change Managed Care Plans: [INSERT CAUSE LIST FROM THIS SECTION].

Managed care plans must submit enrollee material and marketing materials to the Agency for review and approval prior to use. Any changes in such materials must be prior approved by the Agency before they take effect. (Attachment II, Section II.D.7.)³

¹ The contract citation for the CMSN Plan is Attachment I, Section III.C.4.b.

² The contract citation for the CMSN Plan is Attachment I, Section IV.A.7.a.(3)

³ The contract citation for the CMSN Plan is Attachment I, Section II.D.7.

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If you have any questions, please contact your Agency contract manager at (850) 412-4004.

Sincerely,

A handwritten signature in black ink, appearing to read "Beth Kidder". The signature is fluid and cursive, with a large initial "B" and "K".

Beth Kidder
Assistant Deputy Secretary for
Medicaid Policy and Quality

BK/slc