



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

September 21, 2017

Statewide Medicaid Managed Care (SMMC) Policy Transmittal

Policy Transmittal: 17-18

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: Provision of and Payment for Services During and Outside the Disaster Grace Period for Hurricane Irma

The purpose of this policy transmittal is to notify the managed care plan of requirements for continuity and payment of services during and outside of the disaster grace period for Hurricane Irma.

Section (s.) 252.34, Florida Statutes (F.S.), defines a disaster as:

“[A]ny natural, technological, or civil emergency that causes damage of sufficient severity and magnitude to result in a declaration of a state of emergency by a county, the Governor, or the President of the United States.

For the purposes of this policy transmittal, the Agency is defining the “disaster grace period” for Hurricane Irma as 12:01 a.m. on September 7, 2017 through 11:59 p.m. on September 21, 2017.

Requirements During the Disaster Grace Period

The managed care plan must furnish covered services to an enrollee during the disaster grace period:

- Without any form of authorization;
- Without regard to whether such services are provided by a participating or non-participating provider; and
- Without regard to service limitations.



The managed care plan must ensure that providers not known to Florida Medicaid that rendered services during the disaster grace period complete the Agency's provisional (temporary) enrollment process to obtain a provider identification number.

The managed care plan must reimburse non-participating providers at the rates established in the applicable [Medicaid fee schedules](#) incorporated by reference in Rule 59G-4.002, F.A.C. and the provider [reimbursement rates/reimbursement methodologies](#) published on the Agency's web page for services rendered to the enrollee during the disaster grace period, unless other rates are mutually agreed upon by the provider and the managed care plan.

Requirements Outside the Disaster Grace Period

Beginning Friday, September 22, 2017, the managed care plan may resume its normal operations, except as specified below:

- Managed care plans licensed by the Office of Insurance Regulation must comply with s. 252.358, F.S., governing the suspension of early refill edits.
- The managed care plan must implement expedited authorization processes (as described in Attachment II, Section VII.G.) for new authorization requests submitted beginning September 22, 2017 through September 30, 2017, for durable medical equipment and supplies (DME) and home health services.
- The managed care plan must reimburse for services furnished outside of the disaster grace period without prior authorization and without regard to service limitations or whether such services are provided by a participating provider in those instances where the provider and/or enrollee could not comply with policy requirements because of storm-related impacts. Services provided **before** the disaster grace period qualifying under this provision must be attributable to early evacuations in parts of the state which resulted in the enrollee receiving care in a different region or out-of-state.

Claims Payment Exceptions Process

The managed care plan must develop and implement a claims payment exceptions process for reimbursement of any medically necessary service furnished to impacted enrollees during and outside the disaster grace period that normally would have required prior authorization, that were rendered by a non-participating provider, or that exceeded normal policy limits for the service.

The managed care plan's claims payment exceptions process must include the following minimum elements and be made publicly available on the managed care plan's website:

- Submission instructions for providers that include provider enrollment requirements, including waiver of non-applicable provider credentialing requirements;
- Minimum documentation requirements for managed care plan decision making;
- Claims submission requirements; and
- Telephone and email contact information for a specific unit or division within the managed care plan that is familiar with the claims payment exceptions process for Hurricane Irma.

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The managed care plan must post information related to Hurricane Irma and the exceptions process on its website. The managed care plan must provide a direct link to its Hurricane Irma web page to its Agency contract manager by September 25, 2017.

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

Sincerely,

A handwritten signature in black ink that reads "Shevaun Harris". The signature is written in a cursive style with a prominent loop at the end of the name.

Shevaun Harris
Assistant Deputy Secretary for
Medicaid Policy and Quality

SH/dp