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October 19, 2018

Statewide Medicaid Managed Care (SMMC) Policy Transmittal

Policy Transmittal: 18-19

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: Coverage of and Payment for Services Provided Outside the Disaster Grace Period in Florida Counties Affected by Hurricane Michael

The purpose of this policy transmittal is to notify the managed care plan of requirements for continuity of care and payment of services during and after the disaster grace period for Hurricane Michael. The requirements in this policy transmittal are in addition to the requirements stated in Policy Transmittal: 18-17, *Provision of and Payment for Services During the Disaster Grace Period for Hurricane Michael,* issued on October 9, 2018.

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."*

The Agency is extending the "disaster grace period" for Hurricane Michael through November 9, 2018 for the following twelve counties that the Federal Emergency Management Agency (FEMA) has designated as a major disaster area: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Leon, Liberty, Taylor, Wakulla, and Washington. (Refer to DR-4399.). The Agency may extend the disaster grace period in a subsequent policy transmittal if it is deemed necessary to protect the health, safety, and well-being of Medicaid managed care enrollees.

Requirements during the Disaster Grace Period in the FEMA Designated Counties:

I. Coverage and Authorization Provisions

The managed care plan must furnish all Medicaid services during the disaster grace period to an enrollee whose permanent address is in the FEMA designated disaster area:

- Without any form of authorization;

- Without regard to service limitations stated in the Florida Medicaid Coverage Policies; and

- Whether or not the enrollee has temporarily relocated to a different region or state.

The managed care plan must ensure the ongoing provision of covered services to its impacted enrollees without burden to new providers.

II. Network Provisions

The managed care plan must ensure that enrollees are able to see non-participating providers if enrollees have a permanent address in a FEMA declared disaster area and are unable to access covered services from participating providers.

The managed care plan must ensure that providers not known to Florida Medicaid that rendered services during Hurricane Michael complete the Agency's provisional (temporary) enrollment process to obtain a provider identification number for services rendered to enrollees who evacuated to other states. The process for provisional provider enrollment is located at http://www.mymedicaid-florida.com.

To ensure the provision of prescribed drug services in the FEMA designated counties, the managed care plan must reimburse for services provided by a mobile pharmacy when all requirements stated in the Department of Health Emergency Order 18-276 are met and when the mobile pharmacy is one of the following:

- A participating pharmacy provider in the plan's network and is known to Florida Medicaid (e.g., Walgreens, CVS, etc.).

- A non-participating provider in the plan's network but is currently a Medicare participating pharmacy provider and is provisionally (temporarily) enrolled in the Florida Medicaid program.

III. Claims and Provider Payment Provisions

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

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 period, unless other rates are mutually agreed upon by the provider and the managed care plan and otherwise permitted under the Contract.

The managed care plan must post information related to Hurricane Michael and the exceptions process on its website. The managed care plan must inform the Agency contract manager of any updates to its Hurricane Michael web page with the information prescribed in this transmittal, by October 22, 2018.

Requirements After the Disaster Grace Period

Beginning November 10, 2018, 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 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.

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

Sincerely,

Shevaun Harris
Assistant Deputy Secretary for
Medicaid Policy and Quality

SH/dvp