Statewide Medicaid Managed Care (SMMC) Program Snapshot: Health Plan Processes for Provider Credentialing and Claims

The Agency for Health Care Administration (Agency) contracts with health and dental plans to provide Medicaid services to enrollees through the Statewide Medicaid Managed Care (SMMC) Program. The Agency recently entered into new contracts with health and dental plans that will greatly benefit enrollees and providers.

This document highlights the processes by which the contracted SMMC plans manage claims and credentialing documentation submitted by providers. These are important processes in which the providers and the SMMC plans work together to care for recipients. As in the previous SMMC contracts, the Agency requires SMMC plans to process provider credentialing documentation and claims within set time periods using guidelines established in the SMMC contract. The SMMC plans are subject to penalties for non-compliance with these standards. These requirements promote accuracy and timeliness in provider credentialing and claims processing.

The Agency will transition to the new SMMC contracts February 1, 2025. The plans will operate in 9 regions throughout the State.

Region	Counties
A	Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington
B	Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia
C	Pasco and Pinellas
D	Hardee, Highlands, Hillsborough, Manatee, and Polk
E	Brevard, Orange, Osceola, and Seminole
F	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
G	Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie
H	Broward
I	Miami-Dade and Monroe

The SMMC Program has different plan types, including Managed Medical Assistance (MMA) plans, Long-Term Care (LTC) plans, Comprehensive plans (cover both MMA and LTC), and dental plans. The MMA, LTC, and comprehensive plans can also offer enhanced specialty care for their enrollees, such as HIV/AIDS and serious mental illness.

The SMMC contracts are designed to ensure that providers can work with SMMC plans to quickly and efficiently complete many important aspects of their shared responsibilities. This document focuses on two aspects of SMMC plan and provider interactions: the process for provider credentialing and the process for claims submission.

Provider Credentialing

The first step to becoming an in-network provider with the SMMC plan(s) is to become credentialed as a provider.

Responsibilities of Plans:

The Agency has contractual requirements that the SMMC plans must follow regarding the provider credentialing process for all providers within their network and that they intend to contract with. The SMMC plans are responsible for the credentialing and recredentialing of its provider network. The Agency will ensure compliance with the contractual requirements regarding provider credentialing.

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The SMMC Plans shall ensure that all providers are eligible for participation in the Medicaid program, consistent with provider disclosure, screening, and enrollment requirements.

The SMMC Plans shall ensure all providers have a current provider agreement with the Agency, as prescribed by the Agency. The SMMC Plans shall continuously verify all providers have a current provider agreement with the Agency at regular intervals to ensure payments are not made to ineligible providers.

SMMC plans shall fully enroll/on-board all providers they choose to contract with within sixty (60) days. To ensure compliance with this measure, SMMC plans are required to submit the date they receive <u>full and complete</u> provider applications to the Agency on the Provider Network Verification (PNV) file.

If the SMMC Plan declines to include individual or group providers in its provider network, the SMMC Plan shall provide written notice to the affected provider(s) of the reason for its decision.

Failure to meet provider credentialing requirements, including background screening requirements, specified in the contract may result in liquidated damages of five thousand dollars ($5,000) per occurrence for the SMMC plan.

Other standards that SMMC plans are held to include, but are not limited to:

- Ensuring that providers are credentialed and recredentialed based on written procedures that include the following:
    - Formal delegations and approvals of the credentialing process
    - A designated credentialing committee
    - Identification of providers who fall under its scope of authority
    - A process that provides for the verification of the credentialing and recredentialing criteria
    - Approval of new providers and imposition of sanctions, termination, suspension, and restrictions on existing providers
    - Identification of quality deficiencies that result in the SMMC plan's restriction, suspension, termination, or sanctioning of a provider
- Participating in workgroups with other SMMC plans, the Agency, and additional stakeholders to focus on reducing SMMC program redundancies in the provider onboarding process.
- Terminating a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of the sixty (60)-day period without enrollment of the provider (with consideration given for delays caused by the SMMC plan).

<u>Responsibilities of Providers:</u>
To fully credential a provider, the SMMC plans will educate providers on the process and requirements of provider credentialing. This process for provider credentialing includes, but is not limited to:

- Confirming eligibility for participation in the Medicaid program, consistent with provider disclosure, screening, and enrollment requirements.
- Having a current provider agreement with the Agency, as prescribed by the Agency.
- Having the following qualifications or criteria, at a minimum:
    - An NPI in accordance with s. 1173(b) of the Social Security Act
    - A current license or authority to do business
    - No sanctions imposed on the provider by Medicare or Medicaid, without proof of reinstatement
    - A level II background check pursuant to Section 409.907, F.S.

Please note that each SMMC plan's credentialing process may differ. Please find a list of each plans' provider network webpages.

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Provider Network Contracting Webpages by SMMC Plan	
Aetna	Join Our Provider Network | Aetna Medicaid Florida
FCC	Join our Network – Form - Florida Community Care
CCP	Community Care Plan - Become a Provider
Molina	Contact Us
Humana	Join Our Network - Humana
Simply	Join Our Network
Sunshine	Network Participation Request Form
United	Join our network - Medical providers | UHCprovider.com

For more general information about and resources for Medicaid provider enrollment, please visit https://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_Enrollment/tabId/42/Default.aspx.

Claims Submissions

Once providers are fully credentialed and are part of the SMMC plan network(s), they can then submit claims for reimbursement from the SMMC plans.

Responsibilities of SMMC Plans:

The Agency requires SMMC plans to comply with specific standards when processing claims and provider payments as outlined in the chart below:

Complying with the following standards regarding timely claims processing for all providers:	
SMMC Health Plans:	*SMMC Dental Plans:*
• Pay eighty-five percent (85%) of all clean claims submitted within seven (7) days. • Pay ninety-five percent (95%) of all clean claims submitted within ten (10) days. • Pay ninety-eight percent (98%) of all clean claims submitted within twenty (20) days.	• Pay seventy-five percent (75%) of all clean claims submitted within seven (7) days. • Pay one hundred percent (100%) of all clean claims submitted within fifteen (15) days.

Failure to comply with claims processing as described in the contract may result in liquidated damages of ten thousand dollars ($10,000) per month for the SMMC plan.

Additional standards that the SMMC plans are required to uphold include, but are not limited to:

- Complying with the federal and State requirements, whichever is more stringent.
- Having claims payment performance metrics for quality, accuracy, and timeliness.
- Using electronic transmission of claims, transactions, notices, documents, forms, and payments to the greatest extent possible.
- Providing electronic acknowledgement of the receipt of the claim within twenty-four (24) hours after the beginning of the next business day after receipt of the claim.
- Maintaining a claims payment accuracy percentage of ninety-five percent (95%) or higher for each measure of accuracy established by the Agency.

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Responsibilities of Providers:

The standards expected of providers outlined in the contracts for claims submissions include, but are not limited to, the following:

- A provider shall only submit claims to the SMMC plan for services available under the SMMC contract, except in specific circumstances outlined in the contract.
- The provider must mail or electronically transfer (submit) the claim to the SMMC plan within six (6) months after:
  - The date of service or discharge from an inpatient setting; or
  - The date that the non-participating provider was furnished with the correct name and address of the SMMC plan, if applicable.
- When the SMMC plan is the secondary payer and the primary payer is an entity other than Medicare, the provider must submit the claim to the SMMC plan within ninety (90) days after the final determination of the primary payer.
- When the SMMC plan is the secondary payer and the primary payer is Medicare, the provider must submit the claim to the SMMC plan within three (3) years of the date of service.

For more information on the SMMC program, visit: ahca.myflorida.com/medicaid/statewide-medicaid-managed-care.