RON DESANTIS
GOVERNOR

SIMONE MARSTILLER
SECRETARY

March 24, 2022

Statewide Medicaid Managed Care (SMMC) Contract Interpretation: 2022-01

Applicable to the **2018-2023 SMMC contract benefits** for:
- ☒ Managed Medical Assistance (MMA) and MMA Specialty
- ☐ Long-Term Care (LTC)
- ☐ Dental

Re: Transition of Care

The managed care plan must ensure referrals with the required medical documentation needed to complete the clinical eligibility process for the LTC program are submitted to the Comprehensive Assessment and Review for Long-Term Care Services (CARES) program as follows: (1) Six (6) months prior to an enrollee turning the age of eighteen (18) years for enrollees residing in a nursing facility; and (2) Six (6) months prior to an enrollee turning the age of twenty-one (21) years for enrollees receiving private duty nursing services, if the enrollee or their authorized representative has expressed a desire to enroll in the LTC program. (Attachment II, Exhibit II-A, Section VI.E.8.b.) In response to a recent legal challenge asserting that the Agency has an unadopted rule policy that contains requirements that are more restrictive than the requirements of s. 409.979(3)(f)1., F.S. and 59G-4.193, F.A.C., the Agency is issuing this contract interpretation to clarify that the above language does not, and was never intended to, modify or replace the legal requirements found in s. 409.979(3)(f)1., F.S.

While the contract requires the managed care plan to make referrals to CARES for an enrollee turning the age of twenty-one (21) years for enrollees receiving private duty nursing services, if the enrollee or their authorized representative has expressed a desire to enroll in the LTC program, nothing in the contract prohibits the managed care plan from complying with the provisions of s. 409.979(3)(f)1., F.S. It remains the Agency's intention for each plan to fully comply with the requirements of s. 409.979(3)(f)1., F.S. Specifically, the managed care plan must ensure referrals with the required medical documentation needed to complete the clinical eligibility process for the LTC program are submitted to the CARES program upon request by an enrollee, or their authorized representative, as described in s. 409.979(3)(f)1., F.S.

For enrollees eighteen (18), nineteen (19), or twenty (20) years of age requesting priority enrollment into the LTC program pursuant to s. 409.979(3)(f)1., F.S., the information in the CARES Long-Term Care Transition Referral Form and Instructions attached to this contract interpretation shall be submitted to the CARES program. This optional form, or the required information in another format, shall be submitted along with AHCA Form 5000-3008 to the CARES program in accordance with its instructions.

Pursuant to Attachment II, Section XV.I.1., 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 must 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: Mr. Tom Wallace
Deputy Secretary for Medicaid
Agency for Health Care Administration
Attn: Managed Care Appeals/Disputes, MS #70
2727 Mahan Drive
Tallahassee, FL 32308

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

Sincerely,

Tom Wallace
Deputy Secretary for Medicaid

TW/sar
Attachment: CARES Long-Term Care Transition Referral Form and Instructions