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Florida Medicaid

Provider Bulletin

AGENCY FOR HEALTH CARE ADMINISTRATION

Agency Completes Implementation of Statewide Medicaid Managed Care

In 2011, the Florida Legislature directed the Agency for Health Care Administration (Agency) to create and implement the Statewide Medicaid Managed Care (SMMC) program. The intent of this program was to transition Florida's Medicaid recipients from a traditional fee-for-service program into a managed care delivery model. Three years later, the Agency has completed the rollout of the SMMC program.

"This was certainly a team effort," said Agency Secretary Elizabeth Dudek. "Without the support of our legislative sponsors and the contributions made by advocates, community partners and health care providers, none of this would have been possible. We are truly thankful for all of the effort that went in to providing better health care for Florida's Medicaid recipients."

The rollout began on August 1, 2013, when the Long-term Care subset of the SMMC program went live in the Orlando area. Since that day, the program has continued to roll out in a sequential manner, with recipients from one or more Medicaid regions entering their enrollment period each month. The implementation of the Long-term Care and Managed Medical Assistance subsets included several planned pauses, eventually completing with three regions that cover much of North Florida on August 1, 2014.

The Agency will continue to engage in outreach activities for recipients, providers and health plans in these regions through the 90-day post-enrollment continuity of care period. Information about the program can be found by visiting the [Statewide Medicaid Managed Care](#) website. Those who are interested can view a series of recorded provider webinars by visiting the Agency's [YouTube channel](#) or access the slidedecks by visiting the Agency's [Slideshare profile](#). As the SMMC program moves toward "steady state," the Agency will continue to focus on supporting program stakeholders and enforcing the provisions set forth in Florida Statute.

Those who have questions about the program can receive assistance by sending an email to FLMedicaidManagedCare@ahca.myflorida.com. For those who would like to submit an issue or complaint, please fill out our brief [complaint submission form](#) to create a ticket in our tracking system.



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National Health Care Observances

October – National Breast Cancer Awareness Month

November – National Family Caregivers Month

December – National Influenza Vaccination Week (7 – 13)

For more information visit



A Message from Secretary Elizabeth Dudek

Dear Medicaid Provider,

I hope you had a great summer! I am happy to share that the federal government has approved a three year extension of the 1115 Managed Medical Assistance (MMA) waiver through June 30, 2017. As part of this approval, the Low Income Pool program will be extended for one year to help provide stability for providers as we transition to the Statewide Medicaid Managed Care program.

In addition to the MMA waiver extension, the Agency successfully completed rolling out the MMA program statewide on August 1. The final regions to roll out were Regions 1, 7 and 9. We are proud to report that recipients were enrolled into plans without any service interruptions. We would have not been able to reach this major milestone without your cooperation. Thank you! If you have an issue with a Medicaid managed care plan that you need help resolving (e.g., delayed authorization or payment, etc.), please inform us as soon as possible so the issue can be handled in an expedited manner. You can submit a complaint through our [complaint submission form](#).

The Agency is also making some changes to how we pay providers. Effective October 10th, the Agency will start using a more secure payment method to pay providers that receive their Medicaid payments by electronic funds transfer. This change will result in weekly Medicaid payments to providers to occur on Fridays instead of Thursdays. We ask that you please be patient with us during this transition.

As always, thank you for all that you do for the Florida Medicaid population.

Sincerely,

Elizabeth Dudek
Secretary

Are You Signed Up for Florida Medicaid Health Care Alerts?

The Florida Medicaid program has an email alert system to notify registered providers or interested parties of "late-breaking" health care information.

Once signed up, you will receive updates on policy, billing, and news for the provider type(s) and geographic areas you select. You will control what information you receive and will be able to easily update your email address and preferences, as needed.

Here's how you sign up:

Go to the [Agency for Health Care Administration website](#).

Under Agency Alerts click on **"Sign Up for Medicaid Health Care Alerts"**.

On the Florida Medicaid Health Care Alerts page complete the form with your email address (required), first name and last name (optional). You can then choose to receive all areas and all messages/provider types, or as many individual provider types and areas as you wish. Once you have completed the form, click **"Submit"**.

*Email

 First Name

 Last Name

 *Field Office
 All Field Offices
 Field Office 1
 Field Office 2
 Field Office 3
 *Provider Type
 00 - All Messages/Provider Types
 01 - General Hospital
 04 - State Mental Hospital
 05 - Community Behavioral Health Services
 06 - Ambulatory Surgical Center
 07 - Mental Health Practitioner
 08 - District Schools
 09 - Skilled Nursing Unit
 * = Required Field

A confirmation email will be sent to your mailbox to avoid fraudulent subscription requests. You must click on the link **"Confirm to list: Medicaid Alerts"** in the confirmation email to complete your subscription. If you do not wish to be added to the alert list, do not click on the link.

You can unsubscribe or add/change email addresses at any time by clicking on the **"Manage Your Subscription"** link located at the bottom of any health care alert email you receive.

If you have any questions on subscribing or unsubscribing to health care alerts, please contact Medicaid.Alert@ahca.myflorida.com.

To see previous health care alerts please visit the [Provider Message Archive](#) webpage and follow the instructions on how to search for an alert.

Medicaid Compliance Corner: Provider Compliance and Education

A compliance program is a formal measure used by health care providers to identify aberrant business practices. Compliance programs have become commonplace in today's health care industry; incorporated into the daily routine of conducting health care business. The [Centers for Medicare & Medicaid Services](#) (CMS) has published a number of compliance program guidance articles that Medicaid providers are encouraged to review. Additionally, the Agency for Health Care Administration's Medicaid [e-Library](#) contains training materials, a schedule of upcoming trainings, and educational videos, including several videos about Medicaid provider compliance and compliance programs.

A compliance program can assist providers in preventing and deterring health care fraud, abuse, and waste. Most importantly, for the provider, a compliance program can help identify problems before they are detected by government health care regulators. By detecting problems before the auditors/inspectors arrive, in many cases a provider can avoid costly overpayments and sanctions.

Health care providers that serve Medicaid recipients should consider implementing a health care compliance program to ensure compliance with federal and state regulations governing the Medicaid program. To do this, a provider should start by familiarizing, or re-familiarizing themselves with the Medicaid policies that govern their practice. All Florida Medicaid handbooks, forms, provider notices, and other important Medicaid information are available on the [Medicaid fiscal agent's website](#). After familiarizing yourself with the policies, consider creating checklists about the provisions of the policy that could be reviewed by government regulators; then consider conducting your own review.

This minimal effort of creating some level of a compliance program will prove beneficial for any provider. By incorporating a system of ongoing monitoring of your everyday business, you can focus on areas of concern, correct deficiencies, and develop trainings for your staff. An additional benefit of having a provider compliance program is that it shows your intention to comply with federal and state laws and regulations applicable to the Medicaid program; which may serve your interest if you are later audited. Providers who have compliance programs also often identify claims they have misbilled or failed to bill, many times resulting in additional reimbursements.

No compliance program would be complete, however, without some level of ongoing provider education; it is critical to the success of your compliance program. Providers and their staff are required to perform (and document) services or provide goods in accordance with Medicaid policy. Providers should take the time to make sure their staff understands these governing laws. Without proper training about the policies your staff is likely to perform in a manner that is not in compliance with the rules. Providers should also educate their staff about their different payor sources and make a point of understanding the distinctions. For example, some Medicaid policies may vary from Medicare or other commercial insurance. If your staff doesn't understand the distinctions they may make mistakes in documentation or billing.

Another way to educate yourself and your staff is to pay attention to changes in policy. Periodically, the state Medicaid office will communicate to the provider community via provider alert messages. Provider alerts typically contain new policies and/or pertinent Medicaid information relevant to the provider community. The Agency posts recent and historical Medicaid provider alerts on the [Provider Message Archive](#) page. To subscribe to receive these alerts, please visit the [Provider Alerts](#) page and complete the online form.

Medicaid Compliance Corner: Provider Compliance and Education (continued)

In conducting a review of your practice, providers will want to look at both the claims submitted to Medicaid for reimbursement as well as the processes and protocols used within your practice. Making sure that you minimize billing for medically unnecessary or duplicate services is another way to reduce the chance of being audited by government officials. Providers should also look at patient outcomes and ensure that their practices are resulting in better quality of care for their patients. The Agency routinely discovers instances where providers have billed for services not rendered, billed for unnecessary services, failed to maintain required documentation, or the documentation maintained is outdated or incomplete. There have been billing and coding errors, and personnel file non-compliances such as background screening or training requirements. Providers who institute compliance plans and conduct routine reviews of their claims to Medicaid in conjunction with their records (both medical records and business records) are at a much lower risk for being audited and if audited, to have adverse findings.

During FY 2014-15 Medicaid providers should anticipate additional onsite and desk reviews to be conducted by both the Agency and managed care plans connected with the Agency. The Agency's Office of Inspector General, Medicaid Program Integrity, intends to conduct compliance site visits to providers of different specialties throughout the state of Florida. The Agency will continue to monitor for providers who have changed addresses and either failed to update their provider enrollment information altogether, or have updated only their primary provider identification number and failed to ensure that all provider identification numbers are updated as applicable. Compliance reviews also include compliance regarding professional licenses, any local government licensure such as: business tax receipts, accuracy of service address on Medicaid's enrollment files, and compliance in regard to confidentiality and record storage.

During a compliance site visit, Agency staff will determine if the providers are rendering, billing, and documenting services in accordance with Medicaid policy. They will determine if services are being rendered by qualified and properly trained staff, and identify quality of care issues for referrals to the appropriate regulatory entities. Additionally, the Agency will collaborate with Medicaid managed care plans to ensure providers in their networks are complying with Medicaid policy and providing all of the required and necessary services to Florida's Medicaid recipients.

DME providers should be aware of the statewide monitoring that has been taking place and will continue. Some of the specific issues the Agency will monitor have been specified in a number of provider alerts over the past twelve months. These alerts can be found on the [Provider Message Archive](#) page. Behavioral health providers, such as those rendering community behavioral health services or targeted case management services, should be aware that the Agency's representatives will focus reviews on the medical necessity, quality of services provided, and physical environment. Emphasis will be placed on suitability of goals according to client's diagnosis and needs. As a reminder, service objectives must be clearly defined and must also specify the duration and frequency of treatment. Other areas of anticipated focus include Assistive Care Services, Home & Community-Based Waiver Services, and Therapy Services.

Finally, with further resources being utilized through data analytics, providers should anticipate a significant increase in overpayment audits. Providers can avoid the risk of an audit by completing their own internal review (through the use of internal or contracted resources), often referred to as a self-audit. The Agency has information on the Medicaid page related to [Fraud and Abuse](#) which includes information about how to conduct a self-audit. Self-audits are a great way to minimize the risk of a government-conducted audit, which will often result in overpayments and sanctions.

Payment Error Rate Measure Project (2014)

The Improper Payments Act of 2002 (HR 4878) requires federal government agencies to provide an estimate of their improper payments annually. The Centers for Medicare and Medicaid Services (CMS) have tested the process and methodology to implement a nationwide effort to measure improper payments in the Medicaid program. The Agency for Health Care Administration (Agency), as the single state agency responsible for administering the Medicaid program in Florida, will be participating in this effort.

CMS will measure the accuracy of Medicaid and Children's Health Insurance Program (CHIP) payments made by states for services rendered to recipients through the Payment Error Rate Measurement (PERM) program. Under the PERM program, CMS will use two national contractors to measure improper payments in Medicaid and CHIP. The first contractor, The Lewin Group, will provide statistical support to the program by selecting a sample of claims to be reviewed and then calculating Florida's error rate. The second contractor, A+ Government Solutions, will provide documentation/database support by collecting medical policies from the state and medical records from the providers. This contractor will also conduct medical and data processing reviews of the sample claims.

If a claim for a service that you rendered to either a Medicaid or CHIP recipient is selected to be in the sample, A+ Government Solutions will contact you for a copy of your medical records to support the medical review of that claim. Medical records will be needed for these reviews to determine if fee-for-service Medicaid and CHIP claims were correctly paid. From the date of contact, you must submit these medical records within 75 calendar days.

Consequences of Non-Response

If the requested supporting medical documentation is not submitted, the claim will be coded as an error and any monies paid will be recouped. Since dollars estimated as being paid in error from the sample will be projected to the total universe of claims, the actual impact of each claim error will be magnified several times. This will result in an exponentially negative impact on the Florida Medicaid program. If the error rate is excessive, the Agency may be required to add controls or other limitations to address problem areas that are identified. It must be emphasized that even small claim amounts identified as payment errors can have a significant impact on how a particular service area is perceived. Therefore, it is important that providers submit requested medical records in a timely manner.

Medical Record Requests

Please note that providers are required by section 1902(a)(27) of the Social Security Act to retain the records necessary to disclose the extent of services provided to individuals receiving assistance, and to furnish CMS with information regarding any payments claimed by the provider for rendering services. Furnishing information includes submitting medical records for review.

The collection and review of protected health information contained in individual-level medical records is permissible for payment review purposes via the Health Information Portability and Accountability Act of 1996 (HIPAA), as stated in 45 Code of Federal Regulations, parts 160 and 164:

"...a covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits...or other activities necessary for the appropriate oversight of (1) the health care system; (2) government benefit programs for which health information is relevant to beneficiary eligibility; (3) entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or (4) entities subject to civil rights laws for which health information is necessary for determining compliance."

In addition, Medicaid providers are required to comply with any medical records request from the CMS contractor. Follow-up contact regarding these medical record requests may be made by Florida Medicaid staff if any request is nearing the 75 calendar day time limit.

Payment Error Rate Measure Project (2014) (continued)

Look for additional details in upcoming Provider Bulletins and on the [Florida Payment Error Rate Measurement \(PERM\)](#) website regarding the 2014 PERM cycle. Medical reviews by A+ Government Solutions began in August 2014. Those providers sampled are being contacted by A+ Government Solutions as the quarterly Medicaid and CHIP samples are finalized by the Lewin Group. If you did not get a chance to attend one of the PERM education training webinars for Florida Medicaid and CHIP providers offered by the Agency in January and February of this year, please take a moment to view a recorded video of this training at these locations:

- Agency's [YouTube channel](#)
- Florida Medicaid PERM [Provider Education](#) webpage
- Florida Medicaid Provider Training e-Library [Videos](#) webpage

We will continue to send out specific information that pertains to medical record requests by A+ Government Solutions as the information becomes available. If your claim has been selected as part of the sample, the billing and treating provider offices on the claim will be notified by a letter from the Agency. You will then need to provide medical records as requested by A+ Government Solutions.

Florida Medicaid reminds all providers to bill in accordance with the billing procedures outlined in the Provider General Handbook and within the program policy handbook for the specific procedure being billed.

Please note, if you have changed your address or telephone number and have not updated your information with the Agency, this is a good opportunity to do so, as you are required to report any changes per the Provider General Handbook (Section 2, Page 49):

“Providers must promptly notify Medicaid of any change of address by calling the Medicaid fiscal agent’s Provider Services Contact Center at 1-800-289-7799 and selecting Option 4.

The following four addresses may be housed on the provider file: service address, pay-to-address, mail-to or correspondence address, and home or corporate office address. To ensure accurate communication, including prompt payment for services rendered, providers must report address changes.”

Please continually check the [Web Portal](#) for Provider General Rule and Handbook updates for upcoming changes on how to report a change of address.

If you have updated or need to assign a delegated custodian of records, this is a perfect time to make note of this change as well. Please notify the Medicaid fiscal agent of any changes when updating your address change information. If closing out a former custodian, list the individual’s name and the date of their departure. If adding a new custodian, list the individual’s name, home address, date of birth, SSN, whether they are the financial or medical custodian, and the date they started. Background screening is required. Please view the Background Screening page under Enrollment on the Medicaid Public [Web Portal](#) for more information.

If you would like more information related to PERM, and your role in this process, please visit the [CMS PERM](#) website. All documentation specific to 2014 participating states will be located under “**Cycle 3**”. General state provider information will be located under “**Providers**”.

We appreciate your continued cooperation with the Florida Medicaid program. If you have any questions, please contact Jason Ottinger, in the Medicaid Performance, Evaluation, and Research Unit by telephone at (850) 412-4695 or via email at Jason.Ottinger@ahca.myflorida.com.

GOING DIGITAL:

Florida's Health Information Technology Initiatives

Florida continues to be a leader in the development and adoption of Health Information Technology (Health IT). In 2010, the Agency for Health Care Administration (Agency) began developing the foundation for the Florida Health Information Exchange (Florida HIE) through a contract with Harris Corporation. The Agency supports the adoption and use of electronic health records through the administration of the Medicaid Electronic Health Record Incentive Program. Florida's Health IT initiatives continue evolving to meet the needs of Florida providers and the health care community at large.

Direct Messaging

The Florida Health Information Exchange (Florida HIE) offers a Direct Messaging service through Inpriva, a Direct Trust accredited vendor. The service expands the capacity for Direct Messaging users to securely share protected health information with providers that have Direct Trust accredited messaging capabilities within their electronic health record (EHR) system. The service can also be integrated into EHR systems to assist providers in meeting meaningful use requirements. You can learn more about [Direct Messaging \(DM\)](#) at HIE's website.

Event Notification Service

The Event Notification Service (ENS) provides health plans with timely notifications about their members' hospital encounters. The ENS matches information from participating hospitals' internal admit-discharge-transfer (ADT) feeds to a member list submitted by a health plan. If a match is found, the health plan will receive an encounter notification that includes information about the patient and the nature of the encounter. The notification allows better coordination of care and health plan participants are required to notify a member's primary care provider if a notification is received.

Hospital participation in the ENS as a data source is a requirement for funding for the 2014/2015 Low Income Pool (LIP) program. Hospitals participating in LIP can learn more about ENS [every Thursday morning at 10:00 AM EST](#). Information for health plans interested in participating can be found at the [ENS](#) website.



Patient Look-Up

The number of organizations connected to the Florida HIE's Patient Look-up (PLU) service continues to expand. There are currently 8 organizations in production, with two more expected to connect this Fall. PLU now covers close to 20% of hospital beds in Florida. As the number of connections grow, so does the ability for smaller organizations and even individual practitioners to participate in the PLU service. Smaller practices can utilize PLU by connecting directly through other participating organizations or through participation in PLU Hybrid services. Hybrid Patient Look-Up services allow providers without EHRs, or those with EHRs that are not connected to a hospital or healthcare system that would provide access to the Florida HIE, to have query access to the PLU service.

For more information, visit the Florida HIE's [PLU](#) or [PLU Hybrid services](#) pages.

Electronic Health Record (EHR) Incentive Program

Participation in Florida's EHR Incentive Program continues to grow with approximately 40% of providers returning from one program year to the next. To date, a total of 8,718 payments have been made to eligible professionals and 431 payments to hospitals for a total of \$440,552,347. The last program year to begin participation is 2016 for both eligible professionals and hospitals. If you are not sure whether you qualify or need guidance on program requirements visit the [EHR Incentive Program website](#).