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Florida Medicaid Provider Bulletin

AGENCY FOR HEALTH CARE ADMINISTRATION

Florida Medicaid Implementation of DRG Pricing for Inpatient Hospital Claims

The state of Florida is implementing a new inpatient hospital payment method utilizing Diagnosis-Related Groups (DRG). Once final decisions have been made, the Medicaid fiscal agent, HP Enterprise Services, will update the Florida Medicaid Management Information System (FMMIS) to process these claims. The information provided here is based on the DRG Conversion Implementation Plan which has been submitted to the Governor and Legislature and is subject to modification as directed by those parties.

Beginning July 1, 2013, all inpatient hospital claims will be priced based on DRG with two notable exceptions: (1) newborn hearing and screening; and (2) transplants currently paid via a global fee. Newborn hearing screenings will continue to be reimbursed separately, above and beyond the DRG payment. Similarly, transplants will continue to be paid using a global fee that covers all related services for a one-year period.

Although this is not a final list and is subject to change per AHCA policy decisions, the following provider types will be included in the DRG payment method:

- General acute care
- Rural hospitals, including critical access hospitals
- Children's hospitals
- Cancer hospitals
- Teaching hospitals
- In-state/out-of-state/border hospitals
- Long term acute care
- Rehabilitation hospitals and distinct part units
- Psychiatric specialty distinct part units

How DRG Pricing Is Determined and Calculated

DRG payment methods involve classifying inpatient hospital stays and then determining a price based on a combination of the classification and the hospital where the services were performed. Classification of the hospital stay is based on the diagnoses describing the patient's condition, the surgical procedures performed (if any), the patient's age, and the discharge status. Admission diagnosis code is not considered. The Agency is implementing the APR-DRG (version 30) grouping method which has over 1,200 codes including several hundred based codes separated into four levels of severity and is widely used by multiple payers. The vast majority of hospital stays are priced using the following formula, although variances can occur:

$$[\textbf{DRG Base Payment}] = [\textbf{Hospital base rate}] * [\textbf{DRG relative weight}] * [\textbf{Policy adjustor(s)}]$$

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A Message From Secretary Elizabeth Dudek

Dear Medicaid Provider,

If the first few months of 2013 are any indication of what the rest of year will be like, then we will all have a lot of important work to do! Here are just a couple of the highlights from the start of this year:

- The Agency submitted its proposed recommendations for the implementation of a new hospital inpatient payment method that uses Diagnosis Related Groups (DRGs) to determine Medicaid reimbursement. The Agency is directed by statute to begin using the new DRG payment system July 1, 2013. The recommendations were based on a comprehensive study and incorporated input from five public meetings that occurred between August 2012 and January 2013.
- Within the Division of Health Quality Assurance, the Background Screening Unit implemented fingerprint retention for individuals requiring background screening. The retention of fingerprints will allow the Florida Department of Law Enforcement to report any new arrest/registration information to the Agency. In turn, if any employee is arrested and/or added to a registry, a notification will be sent to the employing provider as soon as the Agency is notified. The retention of fingerprints will also provide a cost savings for those employees that are in the Clearinghouse, but have had a lapse in employment greater than 90 days.
- On February 1, the Centers for Medicare and Medicaid Services advised the Agency that the 1915 (b/c) waiver had been approved; allowing the Agency to move forward with full implementation of the Long-term Care program. Just a few weeks later, we were also notified that the approval of the 1115 waiver amendment would be granted in the near future. The amended 1115 waiver will allow the Agency to operate the Managed Medical Assistance program statewide.
- The Agency has selected the health plans it will contract with for the Long-term Care Managed Care program. Seven plans were selected via competitive solicitation and they will serve recipients throughout the state. The first of many webinars for potential Long-term Care plan network providers was held February 27. If you weren't able to participate, the slide presentation is under the "Events and Information" tab on the Statewide Medicaid Managed Care web page, and keep an eye out for future webinar dates that will be posted there also.
- I hosted another meeting of the children's advocates to discuss the care coordination process I mentioned in the last provider bulletin as well as update them on other Agency activities. The State continues to dialogue with the Department of Justice about the provision of medically necessary services for medically complex or medically fragile children.

All of this and the 2013 Legislative Session has just begun! I look forward to the coming year knowing we — the Agency employees and thousands of providers — will continue to make a critical difference in the more than 3.4 million individuals served by the Florida Medicaid program.

Sincerely,

Elizabeth Dudek, Secretary

Florida Medicaid Implementation of DRG Pricing for Inpatient Claims

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Payments for a specific claim may be altered by the addition of one or more policy adjustors into the pricing formula to help protect access to care for specific services by increasing (or decreasing) payment. The proposed plan will use one service adjustor to increase payment for rehabilitation services and provider adjustors to increase payments for three provider types: rural hospitals, long term acute care hospitals, and hospitals with both high Medicaid utilization and high outlier payment percentage. Once the DRG Base Rate is determined, payments will be further adjusted to account for several situations.

Billing and Prior Authorization Impact

There are no changes anticipated to the fields required on the claim form, but there are changes related to billing newborns. Newborns must always be billed separately from the mother, so the concept of concurrent and non-concurrent stays related to deliveries/births goes away.

Prior authorization procedures, system edits, and reports will be reviewed to determine how they will need to be changed because of the move from per diem to DRG payment for inpatient care. For example, under a DRG payment method, length of stay is of limited importance as it no longer affects the reimbursement amount, so authorizing a specific number of days for a hospital stay will no longer be necessary for those stays being via DRGs. Possible exceptions are scenarios in which only emergency services are covered by Medicaid, such as for undocumented non-citizens and for recipients who have reached their 45-day annual inpatient benefit limit.

Where to get DRG Information

Revisions to the Provider General, UB 04 Reimbursement, and Hospital Coverage and Limitations manuals are currently underway. Until posted handbook updates occur, providers are strongly encouraged to monitor their e-mail for important, DRG-related provider alerts. Members of the Agency, Navigant (the Agency's DRG contractor), and HP Provider Relations will also communicate DRG activities and resources through the Florida Hospital Association quarterly meetings.

DRG implementation information, including DRG Calculator and DRG Simulation Results by Provider, is available on the Medicaid Institutional Provider Cost Reimbursement web page under the DRG dropdown.

Training webinars held in the month of June will provide the hospital community with an overview of the DRG implementation, followed by a question and answer session. Members from Medicaid Services, Navigant and HP will be in attendance to assist with DRG-related questions. On-line registration details will be posted to the DRG web page on the Provider Public Web Portal.

Treating Children using Applied Behavior Analysis (ABA)

Florida Medicaid now covers Applied Behavior Analysis services for children under 21 with autism spectrum disorders.

What is Applied Behavior Analysis?

Applied behavior analysis is a specialized treatment service that uses prescriptive, scientific methods to change behavior. The behavior analyst conducts a thorough assessment of the child, develops procedures to reduce challenging behavior and then teaches new behavior. ABA includes training for parents, caregivers, and staff to implement the procedures in the child's everyday life, outside of formal treatment sessions. Services are designed to be provided for a limited time and decrease as the caregivers gain the skills and abilities to assist the child to function in more independent and less challenging ways.

Florida Medicaid's ABA Coverage

On March 26, 2012, a federal judge ordered Florida Medicaid to cover Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders for children under the age of 21. Effective April 2, 2012, Florida Medicaid now covers ABA services for children under 21 with autism spectrum disorders. If a physician determines that a Medicaid-eligible child diagnosed with an autism spectrum disorder needs ABA, the physician or behavior analysis provider must submit a request to the Medicaid area office. When submitting the request to your local Medicaid area office, documentation of a medical diagnosis of autism from the child's prescribing physician must be included. Instructions and an optional referral form can be found on the Medicaid Child Health Check-Up web page.

When the service is authorized, recipients and their families may choose from a list of ABA providers in their area. Each Medicaid area office website includes a current list of ABA providers, and Medicaid area office staff will provide additional help to families to identify a provider. Medicaid has approved three existing Medicaid provider types to render ABA services, including:

- Certified behavior analysts or licensed mental health clinicians who are contracted with the Agency for Persons with Disabilities to provide behavior analysis services and who are enrolled in Florida Medicaid as developmental disabilities waiver providers;
- Certified behavior analysts who are enrolled as early intervention service providers with the Department of Health's Early Steps program; and
- Certified behavior analysts who are employed or under contract with a Medicaid community behavioral health provider to provide the Therapeutic Behavioral On-Site Services-Behavior Management service.

ABA services are provided in community-based settings. Medicaid-approved ABA services include codes for assessment, treatment planning and review, and treatment. Treatment is provided as prescribed by a physician or other licensed practitioner and in accordance with the ABA provider's behavioral assessment as documented in the recipient's treatment plan.

The Medicaid area office website includes a current list of ABA services providers. Recipients who need additional assistance finding a provider can contact their local Medicaid area office. The phone numbers for the local Medicaid area offices are listed on the Provider Public Web Portal. Any Certified Behavior Analyst enrolled in Florida Medicaid as a qualified ABA provider may email Area8MedicaidHelp@ahca.myflorida.com and request to be added to or removed from this list.

Dental Prior Authorization Review

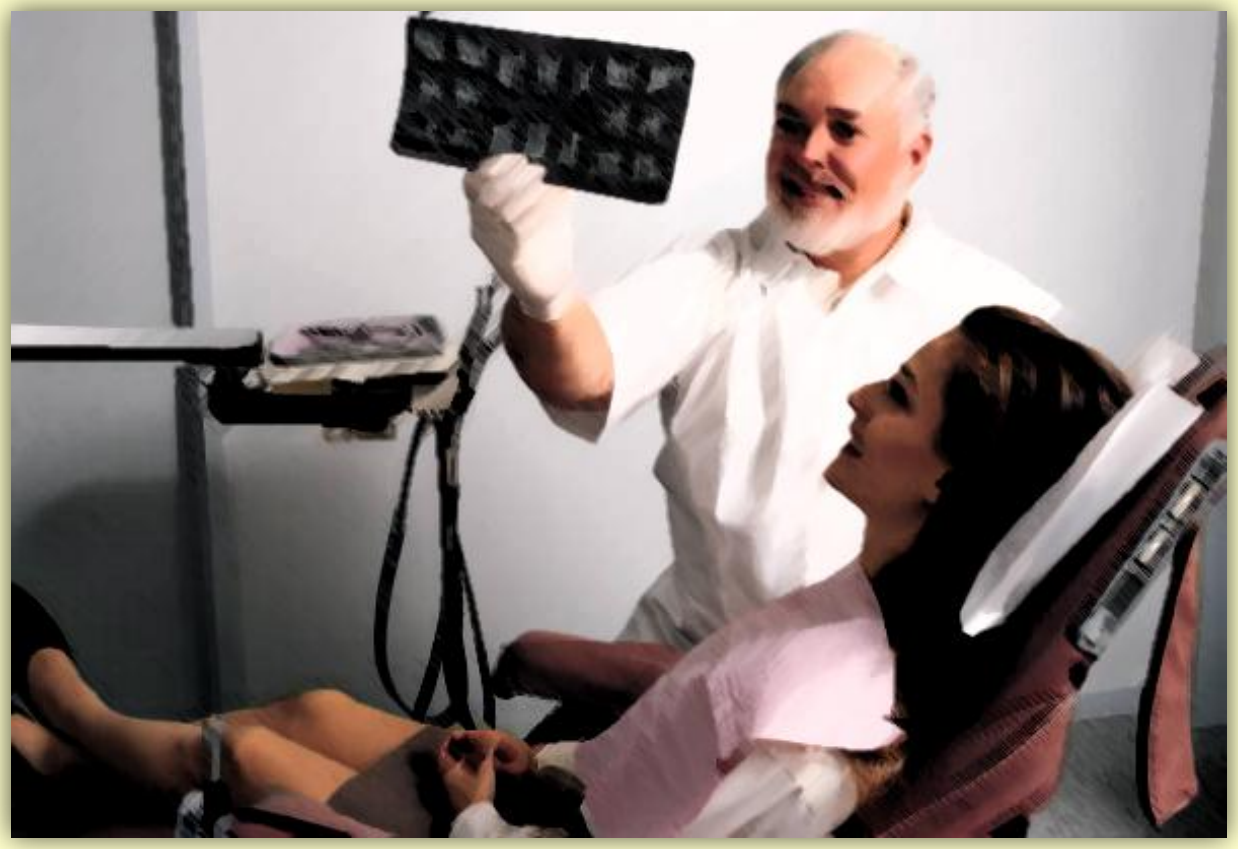
The Agency for Health Care Administration has contracted with eQHealth Solutions, Inc., (eQHealth) for prior authorization review of certain dental services.

eQHealth will only review procedure codes that require prior authorization as set forth in the Florida Medicaid Dental Services Coverage and Limitations Handbook and fee schedules. Dental procedure codes that require prior authorization are: D5211, D5212, D5213, D5214, D5820, D6985, D8070, D8080, D8090, D8210, D8220, D8670, D8692, D8999, 21208, 21230, 21235, 21248, and 21249.

This change affects Medicaid eligible recipients who are **not** enrolled in a managed care plan.

Prior authorization requests must be submitted through eQHealth's web portal. If you do not have Internet access in your office and need to submit a dental prior authorization request, please contact Nancy Calvert at 813-397-1900.

For more information, please visit the eQHealth Solutions website.



Multi-Specialty Prior Authorization Review

The Agency for Health Care Administration has contracted with eQHealth Solutions, Inc., (eQHealth) for prior and post authorization review of certain services. They will be responsible for monitoring the appropriateness, effectiveness, and quality of care provided to Medicaid recipients.

eQHealth will review all procedure codes that require authorization for the following services according to the provider's fee schedule or handbook:

- Hearing Services
- Visual and Optometric Services
- Chiropractic Services
- Physician Services.

All requests should be mailed to eQHealth Solutions, Attn: Multi-Specialty Department. Please refer to the eQHealth Solutions website for the new authorization review and contact lens forms. eQHealth's mailing address, contact information, required forms and a list of CPT codes that require authorization can be found on their website under additional resources.

Please note: This change affects Medicaid eligible recipients who are **not** enrolled in a managed care plan.

Payment Error Rate Measurement Project (2011) Update

This article is the final in a series on the 2011 Payment Error Rate Measurement (PERM) program. The Improper Payments Information Act of 2002 (HR 4878) requires federal government agencies to estimate their improper payments annually. The Agency for Health Care Administration (the Agency) is Florida's single state agency that administers the state's Medicaid program; this includes the administration and management of funding for the Children's Health Insurance Program (CHIP), also known as Florida KidCare. The Agency is cooperating with the Centers for Medicare and Medicaid Services (CMS) in this effort. These updates provide additional information on PERM as the program evolves, and program requirements are refined by CMS.

The purpose of this bulletin is to notify all Florida Medicaid providers that the 2011 PERM cycle has officially ended. All medical documentation for sampled claims submitted to the CMS federal medical review contractor, A+ Government Solutions, has been reviewed. All findings have been submitted to CMS for inclusion into the National PERM error rate. A state specific error rate was also calculated.

Over 99% of the medical records requested by A+ Government Solutions for the sampled claims were submitted by Medicaid providers within the 75 day submission requirement from the date of the received request. Florida Medicaid wants to thank all those providers that participated in the 2011 PERM project for their prompt assistance in submitting the requested records to A+ Government Solutions. Our high percentage of completed record requests would not have been possible without your cooperation.

State-specific errors that were found during the review had the following root causes:

- No custodian of records on file for Medicaid providers that closed their business
- Insufficient or illegible recipient medical records submitted by provider
- Incorrect procedure code billed for the level of services performed
- Procedure not billed in accordance with the Medicaid handbook policy.

Florida Medicaid wants to remind all providers to bill in accordance with the billing procedures outlined in the Provider General Handbook, your specific Medicaid reimbursement handbooks, and within the specific program policy handbook for the procedure being billed.

Please also 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 (page 2-44). To report a change of address, the provider must obtain and complete the Medicaid Provider Change of Address Request, AHCA Form 2200-0004, July 2008. The form is available by calling the Provider Contact Center at 1 (800) 289-7799 and selecting Option 4. It is also available from the Medicaid fiscal agent's Web Portal. Select **Secure Information for Providers** and sign in. Select **Demographic Maintenance** and then **Location Name Address**. Click on **Change Address** and then click on the link to **Print the Change of Address form**.

If you would like more information related to PERM and your role in this process, please visit the Agency's PERM web page, as well as the CMS PERM website.

Please review subsequent bulletins for additional details regarding the next Payment Error Rate Measurement cycle (2014) for Florida Medicaid, which will begin in October 2013 for Federal fiscal year 2013-2014. We will be sending out more specific information that pertains to medical record requests by the federal medical review contractor when this information has been given for the 2014 cycle.

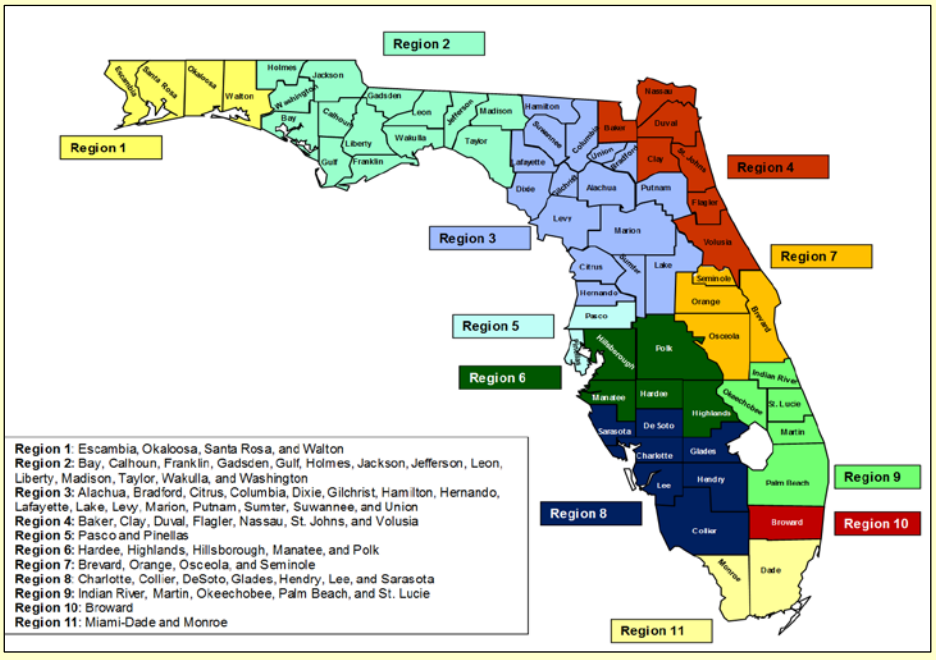
We appreciate your continued cooperation with Florida Medicaid. If you have any questions, please contact Jason Ottinger, Government Analyst II, Office of Performance, Evaluations, and Research by telephone at (850) 412-4695, or via email at Jason.Ottinger@ahca.myflorida.com.

Statewide Medicaid Managed Care is just around the corner: What it means for Long-term Care Providers

The Agency for Health Care Administration has been ramping up preparation efforts in anticipation of the Statewide Medicaid Managed Care (SMMC) roll-out later this year. This comes on the heels of the approval of Florida's long-term care waiver February 1, 2013.

The Agency selected several Managed Care Organizations (MCOs or "health plans") who were part of a competitive bidding process for regional long-term care contracts. Contracts were awarded to certain managed care plan providers based on their bid proposal and the statutory restrictions for each region. At the time of publication, all but one bid protest has been settled. The chart (below) includes which plans were selected to contract in each of the 11 regions as well as a region map.

Region	Healthcare Plans						
	American Eldercare, Inc. (PSN)	Amerigroup Florida, Inc.	Coventry Health Plan	Humana Medical Plan, Inc.	Molina Healthcare of Florida, Inc.	Sunshine State Health Plan	United Healthcare of Florida, Inc.
1	X					X	
2	X						X
3	X					X	X
4	X			X		X	X
5	X				X	X	X
6	X		X		X	X	X
7	X		X			X	X
8	X					X	X
9	X		X			X	X
10	X	X		X		X	
11	X	X	X	X	X	X	X



Now that the bidding process is complete, the Agency is shifting its focus to the assessment of plan readiness. It is important that the contracted health plans be proactive in establishing the resources and infrastructure necessary to serve all SMMC recipients in their contracted regions. AHCA is working closely with each plan to ensure that this process is going smoothly and that there will be no shortcomings as the Long-term Care program rolls out.

F.A.Q. about SMMC

Q: What is the role of the AHCA in this program?

A: AHCA has the lead on the entire SMMC program and will contract with the health plans for the delivery of SMMC long term care services.

While AHCA will manage all aspects of the SMMC contract, Department of Elder Affairs is responsible for monitoring and quality assurance components and the oversight of the Aging and Disability Resource Center and Area Agency on Aging contracted functions.

Q: Do I need to be part of a health plan network to provide services to long-term care enrollees? Do I need to contract with one of the new LTC plans?

A: In order to be reimbursed for services provided to Medicaid recipients enrolled in a long-term care plan under SMMC, you will have to be part of the plan's provider network. If you contract with the Provider Service Network, you need to be fully enrolled as a Medicaid provider.

Q: How will I know which health plan a recipient has chosen?

A: Information will be available via the eligibility verification system. You use the same eligibility verification system that you would use today to confirm Medicaid eligibility before providing services. The recipient will receive a confirmation notice of the health plan enrollment.

Statewide Medicaid Managed Care is just around the corner: What it means for Long-term Care Providers (continued)

F.A.Q. about SMMC (continued)

Q: I have heard existing waiver services must be maintained for at least 60 days after the new program starts in my region. Will I deliver these services, and do I bill FMMIS or how will I receive payment?

A: The new plan is required to continue existing services unabated for up to 60 days, OR until the recipient receives a comprehensive assessment and a new plan of care is developed. The health plan MAY choose to use you to deliver these services. If you are authorized by the plan to provide services, you should not bill FMMIS, but instead bill the managed care plan.

Q: When will recipients get notified that they have to choose a plan? How long will they have to choose?

A: For the initial transition, letters will be mailed four months in advance of enrollment in each region. Additional letters will be mailed 30 days prior to enrollment to confirm plan selection.

Ongoing after full program implementation, a new Medicaid recipient will be mailed a welcome packet, which contains a letter and brochure within 5 days of the system receiving information indicating that they have an appropriate level of care and actual Medicaid coverage or proof that a Medicaid application has been filed. Each recipient will have 30 days to select a plan.

While the health plans may be contacting providers to build their networks, providers may also contact health plans directly to discuss the opportunities available for contracting to provide long-term care services to health plan enrollees in their area. The Long-term Care program will go live on a rolling basis, starting with Medicaid Region 7 (greater Orlando area) and cycling through all other regions between August 2013 and March 2014. The implementation schedule can be seen in the chart below.

Region	Counties	Plan Readiness Deadline	Enrollment Effective Date	Estimated Eligible Population
7	Brevard, Orange, Osceola and Seminole	1-May-13	1-Aug-13	Region 1: 9,338
8 & 9	Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota, Indian River, Martin, Okeechobee, Palm Beach and St. Lucie	1-Jun-13	1-Sep-13	Region 8: 5,596; Region 9: 7,854: Total = 13,450
2 & 10	Escambia, Okaloosa, Santa Rosa and Walton, Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla and Washington, Broward	1-Aug-13	1-Nov-13	Region 2, 4,058; Region 10, 7,877; Total = 11,935
11	Miami-Dade and Monroe	1-Sep-13	1-Dec-13	Region 11: 17,257
5 & 6	Pasco, Pinellas, Hardee, Highlands, Hillsborough, Manatee and Polk	1-Nov-13	1-Feb-14	Region 5, 9,963; Region 6, 9,575: Total = 19.538
1, 3 & 4	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union, Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia	1-Dec-13	1-Mar-14	Region 3: 6,911; Region 4: 9,087: Total = 15,990

In conjunction with the ongoing readiness assessment process, AHCA has launched an outreach campaign to inform providers and recipients. Assisted living facilities, nursing homes, and other long-term care providers, especially in Regions 7 (Orlando), 8 (Sarasota, Ft. Myers) and 9 (Treasure Coast) can expect to be contacted by Automated Health Systems (AHS), AHCA's choice counseling vendor, who is also working to establish partnerships with long-term care facilities in an effort to help current and eligible long-term care recipients transition smoothly. Recipients can also find information about the Long-term Care program and their health plan options at the Statewide Medicaid Managed Care website.

The Agency is conducting a series of educational forums focused on different long-term care topics. SMMC provider orientation webinars were held in February and March and will continue to be offered as the roll-out date for Region 7 nears. Additional presentations covering homelike environment, plan of care transition and other relevant managed care topics will be forthcoming. To view the meeting materials from these presentations and a calendar detailing future events, providers are encouraged to visit the Agency's Statewide Medicaid Managed Care web page, where they can find more information under the "News and Events" tab.

As we near the roll-out date for the Long-term Care program, we will also begin planning for the Managed Medical Assistance program of Statewide Medicaid Managed Care. An agreement in principle received in February has enabled the Agency to move forward with another competitive bidding process, which has an established proposal deadline of April 2013. After evaluating the bid proposals received, AHCA will begin negotiating with the most competitive health plans and make a decision regarding those contracts later this year. We will continue to keep recipients and providers apprised of all progress made along the way.

Medicaid Providers' Licensure Obligations

As described in the Winter 2013 provider bulletin, in the *Compliance Corner*, health care practitioners must be actively licensed to practice as required in the applicable Coverage and Limitations Handbook to enroll as Medicaid providers and to remain enrolled. Medicaid will terminate providers who fail to maintain professional licensure effective the date that the license was terminated. Also, if a provider continues to receive payment for services rendered after his license has expired, the payments will be subject to recoupment; and, if applicable, the provider will be referred to the Attorney General, Medicaid Fraud Control Unit.

Over the next several months Florida Medicaid will highlight licenses that are commonly required of Medicaid providers. Non-compliance is easily avoided by ensuring that you maintain all required licenses. Last quarter's bulletin highlighted several of the license types that the Agency for Health Care Administration licenses and regulates – clinical labs, health care clinics, and personal care services, for example. The previous *Compliance Corner* reminded you that additional licensure information is available on the Agency's website, on the Health Quality Assurance (HQA) web page, as well as the websites for other state agencies with licensure responsibilities, such as the Department of Health, Department of Children & Families and Department of Business and Professional Regulation.

This *Compliance Corner* will provide further details about the licenses that fall under the regulatory responsibility of the Department of Health (DOH). DOH, through its Division of Medical Quality Assurance (MQA), determines whether health care practitioners meet minimum competency requirements. MQA, in conjunction with 22 boards and 6 councils, is responsible for regulatory activities of more than two-hundred (200) license types in 41 health care professions and 8 types of facilities. MQA's three core business processes are the licensure of health care practitioners and certain facilities, enforcement of laws and rules governing more than one million health care practitioners and facilities, as well as providing information and data to the public.

On the MQA home page, there is a link for Health Care Professions where you will find a list of practitioner types that DOH licenses—from Acupuncture to Speech Language Pathology & Audiology. Also through the MQA home page you can Look up a License; this search allows you to include a provider by name, profession, business name, county or license number.

Health care practitioners and licensure applicants can find links to check their application status, apply for a license, obtain information about continuing education, and many more valuable items that will help them become licensed and stay compliant with licensure laws. The MQA page also includes a link to understand the complaint process and the form to file a complaint regarding a DOH licensee, as well as information about upcoming professional licensure board meetings, new legislation, as well as DOH publications.

The Florida Medicaid program has an e-mail alert system to notify registered providers or interested parties of "late-breaking" health care information. Look for upcoming alerts as well as compliance-related training to further address potential non-compliance specific to licensure violations. The Medicaid provider e-Library has additional information and resources for providers; and includes the schedule for upcoming trainings. A webinar entitled "*Compliance Tips for Florida Medicaid Providers*" is expected to be launched soon.

Questions specific to Medicaid compliance efforts may be directed to Kelly Bennett via email at Kelly.Bennett@ahca.myflorida.com; to ensure a prompt response, please include the question in the email as opposed to a request for a return phone call.