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Florida Medicaid Provider Bulletin

AGENCY FOR HEALTH CARE ADMINISTRATION

An Update on Statewide Medicaid Managed Care

~As Long-term Care continues to roll-out, Agency gears up for Managed Medical Assistance~

The Florida Agency for Health Care Administration (Agency) has continued outreach efforts supporting the rollout of Statewide Medicaid Managed Care (SMMC) around the state. To date, the Long-term Care component of the SMMC program has gone live in six of the eleven Medicaid regions, affecting over 50,000 long-term care recipients and the thousands of providers that care for them.

During the rollout process, the Agency placed an emphasis on proactive outreach, sending representatives from both regional offices and Agency headquarters to each region about 90 days ahead of its designated go-live date. These events serve to educate long-term care providers in the region by giving them an overview of the Long-term Care program, information regarding requirements for provider participation, and a listing of online resources available to them and their residents. The Agency also facilitated numerous live enrollment events for recipients at long-term care facilities by partnering with the contracted choice counseling vendor on this outreach initiative.

In addition to live outreach events, the Agency conducted provider webinars on programmatic topics such as recipient eligibility verification and enrollee and provider protections. These sessions are recorded and published on the Agency's YouTube channel. Once a region goes live, the Agency hosts provider calls where nursing homes, assisted living facilities and other long-term care providers can discuss their experiences with the Long-term Care program thus far. To sign up for notification of these calls and other outreach initiatives, please visit the Statewide Medicaid Managed Care program web pages and select the red button labeled **Program Updates**.

The Long-term Care program will continue with its rollout schedule, going live in the greater Tampa region and much of North Florida during February and March of 2014. The total anticipated enrollment for the program upon completion is about 90,000 recipients.

For more information on the Long-term Care program, please visit the Statewide Medicaid Managed Care program web pages or reference the frequently asked questions document.

As the Long-term Care rollout nears completion, the Agency is beginning to focus on preparation for the larger segment of Statewide Medicaid Managed Care, the Managed Medical Assistance (MMA) program. We completed a competitive bidding process, which resulted in the selection of 14 general health plans and five specialty plans to participate in the MMA program. The specialty plans are designed to better serve certain populations with a specific diagnosis such as HIV/AIDS, serious mental illness, congestive heart failure, diabetes or chronic obstructive pulmonary disease, as well as the child welfare population. There are at least two general and two specialty health plans in each Medicaid region.

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Inside This Issue:

A Message from Secretary Elizabeth Dudek

I hope you had a wonderful fall season and are preparing for what I'm sure will be an exciting and successful New Year. As we continue to implement the Long-term Care program according to our regional rollout schedule, we are also planning ahead for the implementation of the Managed Medical Assistance (MMA) program, which we anticipate will begin rolling out in May 2014.

Similar to our outreach for the Long-term Care program, the Agency plans to host information sessions for partners and specific provider groups throughout the state. Don't forget to sign up to receive email alerts about training opportunities and program updates. You can do that via the Statewide Medicaid Managed Care website. In addition to in-person meetings, we plan to increase the use of webinars. You can view the videos of previously presented webinars via the Agency's YouTube account (youtube.com/AHCAFlorida) or read the PowerPoint presentation used via the Agency's SlideShare account (slideshare.net/AHCAFlorida).

I know with your continued support, the MMA implementation will run as smoothly as the LTC program has been thus far. We appreciate all you do to help provide better health care to the residents in our state and we value your commitment to serving the Medicaid population.

I wish each of you a Happy Holiday!

Sincerely,

Elizabeth Dudek
Secretary

An Update on Statewide Medicaid Managed Care

(continued from page 1)

The health plans involved in the MMA program will be contractually obligated to provide a foundation of acute and behavioral health care services such as primary care services, hospital inpatient/outpatient services, dental and hearing services, substance abuse treatment, and prescription drugs. Plans will also provide expanded benefits like additional adult dental, hearing and vision services, over the counter pharmacy benefits, and waived co-payments to their enrollees.

The rollout schedule for the Managed Medical Assistance program will begin with North Florida in May 2014 and progress down the Gulf Coast (June 2014), around Miami-Dade and Monroe Counties (July 2014) and up the Atlantic Coast (August 2014). In total, the MMA program will affect over 3 million recipients and nearly all of the currently-enrolled Florida Medicaid providers.

The Agency intends to mirror the outreach efforts conducted for Long-term Care throughout the Managed Medical Assistance rollout. The central hub for information can be located on the Statewide Medicaid Managed Care program web pages. The **News and Events** tab includes a calendar that outlines any forthcoming webinars or live outreach events. By navigating to the **Managed Medical Assistance** tab, providers can find maps and tables that visually depict the rollout schedule, plan coverage areas and benefits offered by each plan as well as a developing MMA frequently asked questions document. Please check back regularly or use the red button in the right margin to sign up for program updates.

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Medicaid Compliance Corner

Each quarter the Medicaid Director's Fraud Prevention and Compliance Unit prepares an article intended to assist providers with increasing compliance with Medicaid program rules. This article will provide you with helpful tips and information/resources to aid you in those efforts. The focus of this article is an upcoming change in Medicaid policy as it relates to health care clinics. The article will conclude with additional tips related to compliance.

In previous Compliance Corner articles, including the Fall 2012 Bulletin, the Agency has provided information about licensure obligations for Medicaid providers. There are increasing enforcement actions with regard to unlicensed activity and Medicaid participation. Providers who are not properly licensed may be required to repay payments and may be terminated from the Medicaid program.

With regard to health care clinics, Medicaid policy is being amended to ensure that providers who fall within the definition of a health care clinic are required to submit a copy of their health care clinic license as a part of the enrollment process. Health care clinics, unless specifically exempt from the requirement, are required to be licensed pursuant to Chapter 400, Part X and Chapter 408, Florida Statutes. A clinic is "an entity where health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider." Because a health care clinic can be exempt from the licensure requirement, Medicaid policy is also being amended to allow exempt clinics to submit a certificate of exemption, which may be obtained from the Agency's Health Care Clinic Unit, in lieu of the health care clinic license.

It is the responsibility of the provider to know if their clinic is required to be licensed. It is improper to operate without a health care clinic license when one is required by law. Providers who are required to be licensed and who are not presently licensed are engaged in unlicensed activity, which is subject to sanctions. Furthermore, Medicaid reimbursements to unlicensed entities are subject to recoupment. For more information about whether a license is required or whether you qualify for an exemption, visit the Agency's website, on the Health Care Clinic web page.

At this time we are asking Medicaid providers to self-assess whether they meet an exemption or require the license. In doing so, if a provider determines that they *do not* meet an exemption (thus require a license) they should immediately work toward obtaining a license. If the provider determines that they meet an exemption from the licensure requirement, they should maintain the documentation of how they meet the exemption in anticipation of a future request to obtain a certificate of exemption. Again, providers who require the health care clinic license but do not presently hold the license, are encouraged to immediately remedy this non-compliance by (1) obtaining the health care clinic license and (2) voluntarily repaying any Medicaid reimbursements that were improperly paid during the period of unlicensed activity. Providers are encouraged to conduct self-audits and void any claims that fail to meet payment criteria specified in their Medicaid provider handbooks as well as licensure laws. Additionally, information about self-audits and other compliance-related issues may be found on the Agency's website, including Medicaid Fraud and Abuse and the Medicaid Training e-Library.

Medicaid Compliance Corner (continued)

With regard to other compliance issues (not related to the health care clinic licensure laws):

- The Agency is increasing statewide monitoring of DME providers and all DME providers should take measures to ensure they are fully compliant with policy. Some of the specific issues the Agency will be monitoring include:

  - Must be easily accessible to the local public served during its scheduled, posted business hours.
  - Must operate no less than 5 hours per day and no less than 5 days per week.
  - Must have signage that can be easily read from a distance of twenty feet, which readily identifies the business location as a business that furnishes durable medical equipment.
  - Must be in compliance with the American with Disabilities Act (ADA), regarding parking and public access requirements.
  - Must hold accreditation from an authorized accrediting organization.
  - Must hold a current surety bond.
  - Must have current county and municipality Business Tax Receipts displayed appropriately.

- In early 2014, the Fraud Prevention and Compliance Unit expects to conduct statewide compliance reviews in the area of Behavioral Health. Our goal for this project is to help educate Community Behavioral Health providers to be in full compliance with Medicaid policy. While on-site, some of the main issues of focus will be:

  - Treatment Plan Development includes amount/frequency/duration.
  - Target dates are present on Treatment Plans.
  - Treatment Plans demonstrate progress related to goals/objectives.
  - Objectives listed on Treatment Plans are measurable.
  - Signature of parent/guardian (for minors) is present and written explanation is listed on Treatment Plan.
  - Treatment Plan is signed by treating practitioner.
  - Treating practitioner of Medicaid recipient is enrolled.

- A final area for consideration for providers is to ensure that you keep your provider information up to date with the Agency. This includes ensuring that individuals who are no longer a part of the group are removed in a timely manner. By submitting the appropriate information to the fiscal agent, individuals no longer associated with a Medicaid provider file will be end dated on your file. This can be done by submitting a dated letter on letterhead to the fiscal agent stating which individual has left, the provider ID affected, the individual's tax ID information as listed on the file, and include a signature by an individual that is currently listed in the panel.

Payment Error Rate Measurement 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) has 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. You must submit these medical records within 75 calendar days from the date of contact.

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 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 have 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:

Payment Error Rate Measurement Project (2014) (continued)

"…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.

Look for additional details in upcoming Provider Bulletins regarding the 2014 PERM cycle and PERM web pages, during the Federal fiscal year 2013-2014. Medical reviews by A+ Government Solutions will begin in the fall of 2014. 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 (page 2-49):

"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 Medicaid Public 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 they departed. 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, Office of Medicaid Performance, Evaluation, and Research by telephone at (850) 412-4695 or via email at Jason.Ottinger@ahca.myflorida.com.

Florida Medicaid Provider Training e-Library

The Florida Medicaid Provider Training e-Library continuously offers training to providers on Medicaid policy. We communicate to providers about topics, training dates and how to access upcoming training opportunities via the Medicaid Provider Alert system.

The training materials are posted on the Florida Medicaid Provider Training e-Library web pages. The e-Library enhances existing training opportunities about the Medicaid program and its policies by providing 24/7 access to online training materials.

Once you access the e-Library, you can review the list of available PowerPoint presentations and videos and select those that interest you. Among the benefits of using this site is the possibility to choose the time when it is convenient for you to review the self-paced learning materials. Providers can build their knowledge of Medicaid policy decreasing the risk of non-compliance.

Training Resources

The e-Library contains multiple educational resources from previous webinar sessions. You can find information about:

- Medicaid Coverage & Prior Authorization for Applied Behavior Analysis (ABA) Services
- Florida Medicaid Provider General Handbook, Chapter 5: Medicaid Abuse and Fraud
- Top Findings from the Community Behavioral Health On-Site Reviews
- Verify Medicaid Recipient Eligibility
- Home & Community-Based Characteristics: Home-Like Environment and Community Integration for Medicaid Waiver Recipients in Assisted Living Facilities
- Compliance Tips for Florida Medicaid Providers Training
- Florida Medicaid Recipients with Other Medical Insurance
- Medicaid Provider Compliance Program & Provider Self Audits
- Lessons Learned from the Miami-Dade Home Health Pilots - Home Health Visits Policy
- Top Findings from the AHCA Review of Submitted Claims for Physician Services in Nursing Facilities

- Highlights of the following Florida Medicaid Services Coverage and Limitations Handbooks:
    - Practitioner Services
    - Ambulance Transportation Services
    - Policy Reminders Florida Medicaid Dental Services
    - Home Health Services
    - Ambulatory Surgical Center Services
    - Child Health Services Targeted Case Management

Florida Medicaid Provider Training e-Library (continued)

Videos

The following videos posted on the e-Library are linked to the AHCA YouTube channel at: youtube.com/AHCAFlorida

- Compliance Tips for Florida Medicaid Providers
- Medicaid Provider Compliance Program and Provider Self Audits, Fraud Prevention and Compliance Unit
- Verify Medicaid Recipient Eligibility
- Overview of the Florida Medicaid Assistive Care Services and Assisted Living

Reference Information

The reference section contains training materials developed by the Centers for Medicare and Medicaid Services (CMS) on:

- **Managed Care Plan Critical Partners in the Fight against Fraud, Waste, and Abuse in Medicaid**. The training described the elements of an effective compliance plan. It also listed the steps to prevent, detect, and report fraud, waste, and abuse in a managed care context.
- **Do you know where the drugs are going? Partners in Integrity**

Upcoming Training Sessions (December 2013 - January 2014)

- Highlights of the Prescribed Pediatric Extended Care (PPEC) Services Coverage and Limitations Handbook
- Reminders on Documentation Requirements Project AIDS Care (PAC) Waiver Services
- Verifying Medicaid Recipient Eligibility: this is an ongoing training delivered on a quarterly basis
- Overview of the Florida Medicaid Therapy Services Coverage and Limitations Handbook

If you have a request for a specific training topic or questions concerning the e-Library, please contact Yolanda Sacipa via email at: Yolanda.Sacipa@ahca.myflorida.com.

2014 Updates Affordable Care Act Primary Care Fee Increase and Physician Attestation Process

Section 1202 of the Affordable Care Act (ACA) raised Medicaid primary care reimbursement rates to Medicare levels for evaluation and management and immunization administration procedure codes. The new rates apply to eligible Medicaid enrolled physician providers, as well as eligible physicians who are contracted with Medicaid managed care plans.

Physicians, including those who attested for calendar year 2013, must attest or re-attest to receive the fee increase for calendar year 2014. Eligible physicians must attest for each calendar year that the fee increase is in effect.

Physicians who complete the self-attestation process prior to January 31, 2014, will be eligible for the fee increase for dates of service beginning January 1, 2014. Physicians may begin attesting for the fee increase beginning December 1, 2013.

Physicians who self-attest after January 31, 2014, will be eligible for the increase on the first day of the month of self-attestation, and may reprocess/adjust claims retroactively to the first of the month. For example, if a physician attests for the increase February 10, 2014, the physician will be able to attest retroactive to February 1, 2014.

Physicians are encouraged to visit the Florida Medicaid Web Portal page for information on eligibility for the fee increase and instructions on how to complete the attestation form via the secure Web Portal. Please access the "Instructional Guide for Completing the Attestation Form." This guide provides information on where to locate the electronic attestation form on the secure Web Portal, and the steps necessary to complete it. Additionally, the guide provides instructions about the paper attestation form.

Physicians who participate with managed care plans but do not serve fee-for-service populations may attest directly to the managed care plans rather than through the Medicaid web portal.

The Agency is responsible for validating managed care claim information. Once validated, the Agency calculates the reimbursement amount and distributes payments to the managed care plans. The plans are then responsible for distribution to providers; however, plans can pay providers prior to receiving reimbursement from the Agency.

The Physician Primary Care Rate Increase Fee Schedule Effective: July 1, 2013 has been posted with the enhanced rates for the primary care CPT codes on the Medicaid Public Web Portal fee schedule web page.

Information about eligibility for the fee increase is also available at Medicaid.gov under the Affordable Care Act/Provisions/Provider Payments section.

It's That Time – 2014 Attestation!

In accordance with Section 1202 of the Patient Protection and Affordable Care Act (ACA), Florida Medicaid will increase reimbursement rates to eligible physicians for primary care services provided to Medicaid eligible recipients. The fee increase is effective for dates of services from January 1, 2014 through December 31, 2014.

To continue to receive the enhanced rate, eligible physicians must complete the attestation form each year and meet eligibility requirements. Physicians who complete the self-attestation process between December 1, 2013 through January 31, 2014 will be eligible for the primary care fee increases for dates service beginning January 1, 2014. Physicians who self-attest after January 31, 2014 will be eligible for the fee increase on the first date of the month of self-attestation, and may reprocess/adjust primary care service claims retroactively to the first of that month.

Need more information? The Completing the Attestation Quick Reference Guide on the Medicaid public Web Portal provides information on where to access the Attestation form in the secure Web Portal, and detailed instructions on how to complete the form. For the latest information on attestation eligibility, click here.

Place of Service (POS) for Clinic Services

County Health Department (CHD), Federally Qualified Health Center (FQHC), and Rural Health Center (RHC) clinic services cannot be reimbursed if the service is rendered in a doctor's office (POS 11).

Services must be rendered within the CHD, FQHC, RHC clinic, or recognized satellite clinics. The appropriate POS for CHDs is 71. The appropriate POS for FQHCs and RHCs is 72.

For more information regarding CHD, FQHC, and RHC services, please visit our Medicaid Public Web Portal. Select **Public Information for Providers**, and then **Provider Support**. Under Provider Support, choose **Provider Handbooks**. Select the appropriate program's handbook.

Dental Treatment in Ambulatory Surgical Centers (ASC)

Medicaid reimburses for dental treatment provided in an ASC. Any treatment provided in an ASC setting must be related to at least one of the following conditions:

- The recipient's health is in jeopardy; therefore the procedures cannot be performed safely in a dentist's office.
- The procedure cannot be safely performed due to the recipient's emotional instability or developmental disability and sedation has proven to be an ineffective intervention.

The necessity for dental treatment in an ASC must be clearly documented in the recipient's record. The procedure code designated to bill dental treatment furnished in an ASC is code D9420 (Hospital Call). Code D9420 is all-inclusive and may only be used once per claim, per recipient encounter. Medicaid reimbursement for code D9420 is payment group 2.