RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

February 15, 2019

Statewide Medicaid Managed Care (SMMC) Contract Interpretation: 2019-02

Applicable to the **2018-2023 SMMC contract benefits** for:

- ☒ Managed Medical Assistance (MMA) and MMA Specialty
- ☐ Long-Term Care (LTC)
- ☐ Dental

Re: MMA Coverage of Nursing Facility Services Prior to Enrollment in the LTC Program and Monthly Ad Hoc Report

The managed care plan is responsible for providing coverage of nursing facility services under the MMA benefit to enrollees who are not enrolled in the LTC program, in accordance with Section VI., Coverage and Authorization of Services, of Attachment II and Exhibit II-A. The purpose of this contract interpretation is to clarify the responsibility for coverage and payment of nursing facility services for MMA enrollees in a long-term nursing facility stay prior to their enrollment in the LTC program, and to inform the managed care plan of an ad hoc request for reporting MMA-only enrollees receiving nursing facility services.

The first general amendment to the SMMC contract will provide managed care plans with greater detail on coverage provisions for nursing facility services for MMA enrollees ages eighteen (18) years of age and older who have not transitioned to the LTC program. The provisions of the amendment will require managed care plans to provide coverage for up to one hundred twenty (120) days from the date of the most recent nursing facility admission, regardless of payer, when:

- The enrollee is in need of long-term nursing facility services and is not receiving nursing facility services in lieu of inpatient hospital services nor admitted for rehabilitation services;
- The enrollee has completed all PASRR requirements;
- The Department of Children and Families has determined the enrollee is eligible for Institutional Care Program (ICP) Medicaid; and
- The enrollee is not yet enrolled in the LTC program.

Prior to the transition of enrollees under this contract, the Agency identified Medicaid recipients enrolled in the MMA program who have ICP eligibility and have been residing in a nursing facility for more than one hundred twenty (120) days, but who are not enrolled in the LTC program. The Agency will be working diligently to transition these enrollees into the LTC program by March 1, 2019. The Agency will provide the managed care plan with a list of these enrollees, and the managed care plan does not need to take any action to effectuate these enrollees' transition to the LTC program. However, the managed care plan may identify other MMA-only enrollees not on the Agency's list and must report such enrollees to the Agency using the ad hoc Nursing Facility Services report template included with this contract interpretation.

While the Agency works to transition these enrollees into the LTC program, managed care plans are responsible for coverage of nursing facility services for MMA-only enrollees from the time of

plan enrollment until those enrollees' transition into the LTC program. Please note that the Agency and its actuaries contemplated this subset of enrollees in the development of capitation rates for contract year 2018-2019. For the first contract year, the Agency transitioned funding into the MMA capitation rates for the nursing facility costs for enrollees who have been in the nursing facility for greater than one hundred twenty (120) days.

The managed care plan must submit the attached ad hoc Nursing Facility Services report to the Agency using the following naming convention "ABC_NFSVCSREPT_YYYYMM". The managed care plan must submit the completed report template to the Agency's SFTP site at https://sftp.ahca.myflorida.com:4443/EFTClient/Account/Login.htm in the AdHoc folder located within the managed care plans' designated folder path. The managed care plan must use the aforementioned naming convention, where ABC is the managed care plan's three-character identifier; and YYYY is the four-digit year and MM is the two-digit month for which the template is being submitted. The managed care plan must submit its first report to the Agency by 5:00 P.M., Eastern Time, on Friday, March 15, 2019. Thereafter, the Managed Care Plan shall submit this report to the Agency on a monthly basis by the fifteenth (15th) day of each month.

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: Ms. Beth Kidder
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,

Shevaun Harris
Assistant Deputy Secretary for
Medicaid Policy and Quality

SH/dp
Attachment