RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

September 18, 2019

Statewide Medicaid Managed Care (SMMC) Contract Interpretation: 2019-06

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

Re: Electronic Visit Verification (EVV) System, Update to Policy Transmittal 2018-01

The managed care plan's compliance plan, anti-fraud plan, and fraud and abuse procedures must include detailed procedures for verifying enrollees' identity and that enrollees actually received services billed by providers. In addition, the managed care plan must describe the process by which the delivery of personal care services and home health services are monitored and validated via an Electronic Visit Verification (EVV) system effective January 1, 2019 (as required by federal law in the "21st Century Cures Act"). (Attachment II, Section X.F.4.d.(4)) The purpose of this contract interpretation is to update requirements previously issued to the managed care plan in Policy Transmittal 2018-01 and to clarify the application of EVV to Long-Term Care (LTC) enrollees receiving certain services under the Participant Direction Option program.

Implementation of EVV

The Agency is delaying the implementation of EVV as required in the SMMC Contract from October 1, 2019 to December 1, 2019. Further guidance will be forthcoming regarding any additional requirements related to this implementation date.

EVV and Live-in Caregivers

On August 8, 2019, the Centers for Medicare & Medicaid Services issued guidance to clarify the applicability of EVV requirements to Medicaid recipients with live-in caregivers[1]. When personal care or home health care services are delivered under the LTC benefit, the managed care plan may require the use of EVV requirements for the delivery of personal care or home health care services when the caregiver providing the personal care services or home health services and the LTC enrollee live together, but the managed care plan is not mandated to do so. This provision applies to enrollees receiving personal care or home health visits through the Participant Direction Option under the LTC benefit.

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

[1] CMCS Informational Bulletin Additional EVV Guidance, https://www.medicaid.gov/federal-policy-guidance/downloads/cib080819-2.pdf

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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 questions or concerns, please contact your Agency contract manager at (850) 412-4004.

Sincerely,

Shevaun Harris
Assistant Deputy Secretary for
Medicaid Policy and Quality

SH/sr