RON DESANTIS
GOVERNOR

SHEVAUN L. HARRIS
ACTING SECRETARY

November 12, 2020

Statewide Medicaid Managed Care (SMMC) Contract Interpretation: 2020-02

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

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

Re: Update to CI 2019-02 - MMA Coverage of Nursing Facility Services Prior to Enrollment in the LTC Program and Monthly 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.

The first general amendment to the SMMC contract provided the managed care plan with greater detail on coverage provisions for nursing facility services for MMA enrollees eighteen (18) years of age and older who had not transitioned to the LTC program. The provisions of this amendment required the managed care plan to provide coverage for up to one hundred twenty (120) days from the date of nursing facility admission or the date of receiving Institutional Care Program (ICP)[1] Medicaid, whichever is later, 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 ICP Medicaid; and
- The enrollee is not yet enrolled in the LTC program.

Transition Population

Enrollees eligible under Medicaid ICP, residing in a nursing facility and enrolled in MMA prior to execution of the current contract are considered the “transition population”. The managed care plan is responsible for coverage of nursing facility services for the transition population from the time of plan enrollment until their LTC program enrollment (even if the transition exceeded one hundred twenty (120) days). It is important to note that the Agency ensured that the costs for this subset of enrollees were factored into the development of the managed care plan’s capitation rates, recognizing that transition may exceed one hundred twenty (120) days.

[1] Enrollees who are eligible for ICP Medicaid include those with an aid category code beginning with MI but exclude code MI T.

Referrals to DOEA/CARES
When the managed care plan refers enrollees, who are in a nursing facility and not enrolled in an LTC plan, to the Department of Elder Affairs' Comprehensive Assessment and Review for Long-Term Care Services (CARES), the following information must be included with the referral to CARES:

1. A completed and signed Informed Consent Form (template attached).
2. A completed and signed Medical Certification for Medicaid Long-term Care Services and Patient Transfer Form, AHCA Form 5000-3008. The form and instructions can be found at http://elderaffairs.state.fl.us/doea/cares_3008ppp.php.

Completed AHCA 5000-3008 forms must be sent to the CARES office for the county in which the enrollee resides. CARES contact information can be found at http://elderaffairs.state.fl.us/doea/cares/CARES_Directory.pdf

Monthly Report
The Agency has revised the ad hoc report template for use in identifying LTC-eligible enrollees who have not yet been enrolled in the LTC program. The purpose of this ad hoc report is for the managed care plan to notify the Agency when a referral has been made to DOEA/CARES for an SMMC LTC level of care and the enrollee has not successfully transitioned into the LTC program.

The managed care plan must submit the attached ad hoc report to the Agency using the following naming convention "ABC_MMA_NF.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 Ad Hoc folder located within the managed care plan's 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 report template is being submitted. The managed care plan must continue to submit this report to the Agency by 5:00 P.M., Eastern Time, by the fifteenth (15th) day of each month for the previous 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 me at 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.

Sincerely,

Beth Kidder
Deputy Secretary for Medicaid

SH/dp
Attachment 1: Informed Consent Form Template
Attachment 2: MMA Nursing Facility Report Template