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June 18, 2021

**Statewide Medicaid Managed Care (SMMC) Policy Transmittal: 2021-20**

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

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

**Re: COVID-19 State of Emergency: Ending Temporary Flexibilities**

The Agency for Health Care Administration (Agency) previously required managed care plans to establish certain provider flexibilities to help respond to the 2019 novel coronavirus (COVID-19). As the State commences with the reopening, the Agency will evaluate each flexibility that was enacted to determine the potential end date. The purpose of this policy transmittal is to communicate the details regarding ending the following temporary flexibilities granted during the state of emergency effective July 1, 2021, unless stated otherwise in the below.

Reinstatement of Preadmission Screening and Resident Review (PASRR) Requirements

The Agency waived PASRR processes until further notice through the issuance of PT 2020-15 on March 18, 2020. All required PASRR processes are reinstated effective with any admission on or after July 1, 2021. Retroactively performed screenings or resident reviews must document the reason for the delay in the completion of PASRR requirements. The managed care plan may deny payment based upon the lack of completion of PASRR requirements for new admissions to a nursing facility with an admission date on or after July 1, 2021.

Reinstatement of Interfacility Transfer Prior Authorization Requirements

With the issuance of PT 2020-41 on July 14, 2020, the Agency waived service authorization requirements prior to admission for hospital transfers, including:

- inter-facility transfers:
- transfers to a long-term care hospital; and
- transfers to a nursing facility.

In addition, to facilitate non-emergency transportation services needed to aid in these transfers, the Agency waived the need for prior authorization for non-emergency ambulance transportation services for hospital transfer scenarios as described above. Prior authorization requirements for the services listed above are reinstated for dates of service on or after July 1, 2021.

This guidance does not apply to prior authorization and service limit flexibilities put in place to appropriately evaluate and treat individuals diagnosed with COVID-19. The Agency will continue to waive prior authorization and service limits for the treatment of COVID-19 through the end of the federal public health emergency.

Reinstatement of Prior Authorization and Service Limits for Behavioral Health Services

The Agency waived Medicaid prior authorization requirements and service limits (frequency and duration) for behavioral health services (this includes targeted case management services) through the issuance of PT 2020-31 on May 5, 2020 and PT 2020-35 on June 12, 2020. Behavioral health services:

- Prior authorization requirements must be reinstated for dates of services on or after **July 15, 2021**; and
- Service limits must be reinstated for dates of service on or after July 1, 2021.

As prior authorizations and service limits are reinstated, the managed care plan must work with providers to ensure continuity of care for medically necessary courses of treatment. In the event an enrollee is receiving an ongoing course of treatment with a participating or non-participating provider when that treatment was begun during the authorized flexibilities for COVID-19 where prior authorization was not required, the managed care plan must be responsible for the continuation of that course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or non-participating providers for up to sixty (60) days after July 15, 2021.

Ending Provisional Provider Enrollment

The Agency allowed provisional enrollment for in-state and out-of-state providers to address potential workforce shortages in the State through the issuance of PT 2020-15 on March 18, 2020. The availability of provisional enrollment ends on July 1, 2021, prohibiting providers from enrolling through that provisional enrollment process effective July 1, 2021.

Providers currently enrolled through the provisional enrollment process have through **December 31, 2021** to enroll in Medicaid. Providers who do not complete the enrollment process by that date will be terminated from Florida Medicaid.

Ending Provisions for Extended Time for Managed Care Plan Appeals and Fair Hearings

The Agency provided that enrollees could receive extended time to submit an appeal through their managed care plan or request a fair hearing through the issuance of PT 2020-15 on March 18, 2020. The availability of extended time ends on July 1, 2021, and the standard timeframes available to enrollees to submit an appeal or request a fair hearing are reinstated effective July 1, 2021.

Ending Temporary Expansion of LTC Service Providers

The Agency provided the temporary expansion of LTC provider qualifications and temporary modification to services during the state of emergency through the issuance of PT 2020-16 on March 20, 2020. The managed care plan must no longer enroll any new LTC service providers under this temporary expansion during the state of emergency effective July 1, 2021. The managed care plan has sixty (60) days from July 1, 2021 to terminate all provider enrollments under this temporary expansion.

Reinstating LTC Face-to-Face Case Management Requirements

The Agency waived all face-to-face case management requirements for LTC enrollees, allowing virtual visits or telephonic contact instead during the pandemic through the issuance of PT 2020-12 on March 12, 2020. Starting **October 1, 2021**, the managed care plan must reinstate face-to-face visits for new enrollees, annual assessments, and for any enrollee experiencing a significant change. Effective **January 1, 2022**, the managed care plan must also resume the quarterly face-to-face visits.

Between October 1, 2021 and December 31, 2021, LTC enrollees may still have concerns regarding face-to-face visits and can request that a virtual visit be done instead. Therefore, at the

member's request, a virtual visit or telephonic contact will be allowed until the end of the federal public health emergency. The managed care plan must document in the member's case record the reason for the virtual visit or telephonic contact rather than the face-to-face visit for the initial, significant change, or annual assessment.

At least thirty (30) days prior to scheduling a face-to-face visit, the managed care plan must send the LTC enrollee/authorized representative a letter explaining the Agency approved return to the field, the process to report signs/symptoms of potential COVID-19, and how to request a virtual visit if that is the enrollee's preference. By **August 1, 2021**, the managed care plan must submit the enrollee letter template to their Agency contract manager for review and approval, in addition to revised trainings for case managers regarding the face-to-face visits and revised policies and procedures.

If you have questions, please contact your Agency contract manager at (850) 412-4004.

Sincerely,

Tom Wallace
Deputy Secretary for Medicaid

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