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Florida Medicaid

Provider Bulletin

AGENCY FOR HEALTH CARE ADMINISTRATION

Web Portal Renewal for Medicaid Providers

Medicaid providers should watch for the launch of the new online provider renewal process on July 11, 2014. Providers will be able to renew their enrollment in Florida Medicaid online via the secure [Web Portal](#).

This timesaving feature will expedite the renewal process. Through the online renewal process, providers can verify information currently on their provider file such as provider name, tax ID, and owners and managing employees along with their demographic information. Providers can also submit any necessary changes or corrections directly online and simply upload any supporting documentation including a signed Medicaid Provider Agreement and proof of a current, Medicaid eligible background screening.

The renewal form is available online in the secure Florida Medicaid Web Portal in the Quick Links dialog box.

The screenshot shows a web portal interface with a navigation bar at the top containing the following links: Providers, Account, Claims, Eligibility, Prior Authorization, LTC Reports, Trade Files, and Super User. Below the navigation bar, the text 'demographic maintenance' is visible. In the center of the page, there is a table with the following content:

Name	Test provider
Provider ID	#####

To the right of the table is a 'Quick Links' menu with the following items:

- Certification and Attestation
- Print Enrollment Fax Cover Page
- Print Enrollment Verification Letter
- **Renewal Application**

The 'Renewal Application' link is highlighted with a red rectangular border.

NOTE: The Renewal Application link only appears if the provider is eligible for renewal at this time.

Click the Renewal Application quick link to begin. Providers are guided through each step in the Renewal Application and will be prompted when to upload any supporting documentation. If at any time the provider has questions about completing the online provider enrollment application, they can click the *Florida Medicaid Provider Renewal Guide* link at the top of the page for additional instructions.

After providers have completed and submitted the Renewal Enrollment Application, they can track the status of the renewal by clicking the Renewal Application quick link again to display the Renewal Status page. There providers can upload documents, view their current renewal status, and print a copy of their renewal application.

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National Health Care Observances**July**

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A Message From Secretary Elizabeth Dudek

Dear Medicaid Provider,

The Managed Medical Assistance (MMA) program rollout is going smoothly. Thanks to your cooperation, recipients in eight regions have already started receiving services and we expect to expand into the remaining counties by August 1.

We encourage you to visit the Agency's Statewide Medicaid Managed Care (SMMC) website for more information about the webinars the Agency is offering to assist with the transition. As a precaution, the Agency has put several requirements in place to ensure Medicaid recipients receive continued services during the MMA transition. It is crucial that you read these requirements on the [SMMC website](#).

The Agency has also created a centralized complaint/issues hub as a way to streamline and better track and respond to all complaints and issues received by the Agency related to the SMMC program. The hub handles issues related to both the Long-term Care and the MMA program. Anyone encountering difficulties in their interactions with the managed care plans is encouraged to inform the Agency immediately so the issue can be handled in an expedited manner. Complaints can be submitted through the [SMMC website](#) or contact your [local Medicaid Office](#).

Thank you for your continuous commitment to serving the Florida Medicaid population.



Elizabeth Dudek
Secretary



Medicaid Provider Secure Web Portal Account

The Florida Medicaid Secure Web Portal (Web Portal) provides communication, data exchange, and self-service tools to the Florida Medicaid Management Information System (FMMIS) provider communities. The Web Portal helps eligible providers maintain comprehensive current and historical information. The establishment and maintenance of a single provider data repository with provider demographic, certification, rate, and financial summary information, recipient eligibility, and third-party liability, supports accurate and timely claim records processing, enhanced management reporting, and utilization review reporting.

The Web Portal meets the requirements for the Health Insurance Portability and Accountability Act (HIPAA) and conforms to the National Provider Identifier (NPI) standard. This standard includes identifying all locations, provider types, specialties, authorizations, certifications, licensing for services, and other required data for a provider with one unique provider identifier.

Providers must successfully log in to the Web Portal in order to use the services available within the secure portal. Each provider receives a letter in the mail containing a Personal Identification Number (PIN) that will allow registration for access to the Web Portal. Before using the Web Portal, providers must create an account by registering your Medicaid Provider ID and PIN that is provided in your registration letter. Once the account has been created, click the **Account Management** option on the Florida Medicaid Home page to finish setting up the account.

On the **Account Home** page, there are four options for managing an account: **My Information**, **Change Password**, **View Agent Roles**, and **Add Agent**.

In **My Information**, providers can modify account information, such as changing phone numbers and e-mail addresses or selecting a new security question and answer.

In **Change Password**, providers can change their Web Portal account password. Providers are prompted to change their password every 60 days. The password must be eight characters in length and contain alpha/numeric values, including at least one uppercase letter. The Password Manager panel automatically displays when it is time to enter a new password. The home page displays the length of time until expiration of the password at the bottom of the screen. After 60 days of inactivity, the account is locked. When the account has been locked for more than 120 days, it is automatically terminated. To unlock, or to reactivate a terminated account, contact Provider Services at 1-800-289-7799, Option 5.

In **Add Agent**, providers can add an agent to the account. An agent is any person or entity that has permission to access your account. After adding the agent's information, click the **Add & Manage Agent** button to set restrictions on the agent's roles. Note: Only allow an agent access to the **Account Management** system if the agent is to have the ability to grant Web Portal access to other agents. The additional agents they create will be granted access up to the same permissions the approving agent has been granted. As a result, the additional agents can then assign access to the provider's Web Portal to other agents, so consider this when assigning roles to agents. Use **View Agent Roles** to monitor the roles assigned to approved agents.

For additional assistance with the Web Portal, other than unlocking an account, please contact the HP Provider Support Contact Center (PSCC) at 1-800-289-7799, Option 7.

Payment Error Rate Measure 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. From the date of contact, you must submit these medical records within 75 calendar days.

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 universe of 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 be required 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:

"...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.

Payment Error Rate Measure Project (2014) (continued)

Look for additional details in upcoming Provider Bulletins and on the Agency's [PERM](#) website regarding the 2014 PERM cycle. Medical reviews by A+ Government Solutions will begin in the fall of 2014. CMS will offer four PERM provider education webinars this June and July. For more details related to these upcoming provider webinars, please check out the current provider alert entitled "Webinar: PERM 2014 Provider Education Call for Medicaid & CHIP Providers". Also, if you did not get a chance to attend one of the PERM education training webinars for Florida Medicaid and CHIP providers offered by the Agency in January and February of this year, please take a moment to view a recorded video of this training by accessing it:

- On YouTube at: <http://www.youtube.com/AHCAFlorida>
- On the Florida Medicaid PERM webpage under "Provider Education" at: <http://ahca.myflorida.com/Medicaid/perm/index.shtml>
- On the Florida Medicaid Provider Training e-Library under "Videos" at: <http://ahca.myflorida.com/Medicaid/e-library/index.shtml>

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 [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 at <http://www.cms.hhs.gov/perm/>. 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, in the Medicaid Performance, Evaluation, and Research Unit by telephone at (850) 412-4695 or via email at Jason.Ottinger@ahca.myflorida.com.

Required Forms for Assisted Living Facilities (ALF)

The Agency for Health Care Administration (AHCA, also referred to as “Agency”) consists of many components regulating health care in Florida. The Division of Medicaid is the largest division in the Agency and expends approximately 30% of the State’s entire annual budget to provide health care to more than three million Florida residents. Medicaid is funded by both state and federal monies (with the majority being provided by the federal government) and therefore is subject to both state and federal regulations, policies and procedures, as well as rules promulgated through Florida’s Administrative Code.

The Division of Health Quality Assurance (HQA) is also part of AHCA. HQA is tasked with protecting Floridians through the oversight of licensed health care providers. HQA also operates under federal and state statutory regulations in their responsibility of licensing, certifying and regulating more than 40 different types of health care providers, including hospitals, nursing homes, assisted living facilities and home health agencies. It is important to note that HQA does not enforce specific Medicaid laws, rules or policies.

Medicaid Program Integrity (MPI) is also a unit within the Agency. MPI is charged with ensuring that the claims submitted to Medicaid for payment are:

- Submitted by an eligible, enrolled Medicaid provider in good standing;
- For services that are medically-necessary;
- For services that were actually rendered as appropriate and as stated; and
- For a current eligible Florida-Medicaid recipient.

MPI has the responsibility and authority under s. [409.913, F. S.](#), to enter any Medicaid provider location (during reasonable and normal office hours) and request records on Medicaid recipients for review, inspect the facilities and to ensure that Medicaid laws, rules and policies are being enforced. MPI is not a unit within the Division of Medicaid; it is a component of AHCA’s Office of Inspector General. As a state Medicaid program integrity unit, it must meet all requirements in federal law, which includes: methods for the identification, investigation, and referral of Medicaid fraud; fraud and abuse reporting requirements; and collaboration with state and federal law enforcement. MPI is not responsible for creating Medicaid laws and policies – MPI is responsible for ensuring that the Medicaid providers are compliant with the laws, rules and policies currently in place. When providers are not compliant, MPI has the responsibility and authority to assess sanctions which are outlined in Florida Administrative Code ([FAC 59G-9.070](#)), including suspending or terminating, with cause, providers from the Medicaid program.

Often times, representatives from these three AHCA units will work together to review a health care facility to create as little interruption to the business as possible. However, that is not always possible, and the different divisions will perform separate reviews that may seem redundant and duplicative to the provider. It is important to recognize that not all residents of an ALF are Medicaid recipients and are not subject to both HQA and Medicaid compliance.

An example of a perceived duplicative policy would be in the HQA requirement that ALF’s maintain Form 1823 (Health Assessment Form) in each resident’s file, which is good for three years, unless a significant change has occurred. This requirement is in Rule 58A-5. Paragraph 4 references that it is due for renewal every **three** years. The same form is required by Medicaid on an annual basis.

Required Forms for Assisted Living Facilities (ALF) (continued)

The Medicaid *Assistive Care Services Coverage and Limitations* Handbook requires the following forms to be maintained in each **Medicaid** recipient's file:

- Copies of all eligibility documents;
- Health Assessment Forms, AHCA Form 1823 or AHCA Form 3110-1023 (AFCH-1110) and reassessments forms;
- Certification of Medical Necessity for Medicaid Assistive Care Services, AHCA-Med Serv Form 035;
- The Resident Service Plan for Assistive Care Services, AHCA-Med Serv Form 036; and
- The Resident Service Log, AHCA-Med Serv Form 037.

"The service plan must be reviewed and updated to reflect the current needs of the recipient."

A new service plan (AHCA-Med Serv Form 036) is required on an annual basis or sooner if a significant change in the recipient's condition occurs. The new service plan must be completed no more than 15 days after the annual assessment (documented on the AHCA-Med Serv Form 035) or an assessment because of a significant change in the recipient's condition.

The above referenced list is taken directly from the Medicaid Assistive Care Services Coverage and Limitations handbook, section 2-10, promulgated by reference into rule.

The Agency is aware providers may think these rules are duplicative, but it is important to understand that not all licensed ALF facilities are participating Medicaid providers. Medicaid laws, rules and policies are created for the protection and care of Medicaid recipients, as well as to support the fiduciary responsibility of the State in its administration of the Medicaid budget. The Agency has posted the following two forms on its website to assist Medicaid assistive care service providers in achieving full compliance with the required documentation: (http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/alf.shtml):

- [Resident Health Assessment for ALFs AHCA Form 1823](#)
- [Resident Health Assessment for ALFs](#) Recommended for Medicaid recipients that are also required to have the AHCA Form 035-Certification of Medical Necessity and AHCA Form 036-Medicaid Service Plan.

Please note that you may use the Resident Health Assessment for ALFs for Medicaid recipients **when** you include all parts of the form which have the Certification of Medical Necessity attached, and that you reassess **annually**, rather than every three years as required by HQA. The Agency will accept the recommended Form 1823 for Medicaid compliance if the Certification of Medical Necessity is attached, and when it is reassessed annually. As a licensed provider, and as a Medicaid provider, you are responsible for complying with all applicable laws, rules and policies. Medicaid recipients are among Florida's most vulnerable citizens, and the Agency is committed to protecting its citizens as well as ensuring they receive quality health care.

If you have questions regarding the requirement of these forms, please contact the Agency at the following numbers:

- Medicaid: Contact the [Field Office](#) in your area or call 850-412-4000
- Health Quality Assurance, Assisted Living Unit: 850-412-4304
- Medicaid Program Integrity: 850-412-4600

Compliance with Fraud, Abuse and Waste Requirements within Managed Care

As the Agency for Health Care Administration (AHCA, also referred to as the “Agency”) moves the majority of Medicaid recipients into the State Medicaid Managed Care program (SMMC), here is a review of a few of the requirements the contracted Managed Care Organizations (MCOs) need to abide by to avoid fraud, abuse and overpayments within Florida Medicaid.

The Agency expects each Medicaid provider and Medicaid managed care plan to know and understand the requirements contained within state and federal laws as well as the contracts they have with the State of Florida. The contracts encompass many aspects of health care delivery and administrative duties, and all points of these contracts will be enforced by the State. AHCA’s Office of Medicaid Program Integrity (MPI) is responsible for ensuring compliance with [Section VIII, Item F, of the contract](#), which addresses fraud and abuse prevention.

Each managed care plan must submit a compliance plan and anti-fraud plan, including its fraud and abuse policies and procedures, and any changes to these items, to the Office of Medicaid Program Integrity (MPI) for written approval. At a minimum, the managed care plan’s compliance plan, anti-fraud plan, and fraud and abuse policies and procedures must comply with [s. 409.91212 \(1\) F. S.](#)

Chapter 6 of the [Statewide Medicaid Managed Care \(SMMC\) Managed Care Plan Report Guide](#) discusses requirements of submitting an *Annual Fraud and Abuse Activity Report (AFAAR)*. The purpose of this report is to provide the Agency a summarized annual report on the managed care plan’s experience in implementing its anti-fraud plan and conducting or contracting for investigations of possible fraudulent or abusive acts for the prior State Fiscal Year (SFY). The *Annual Fraud and Abuse Activity Report* is due to MPI by September 1 each year.

Each managed care plan is required to submit a *Quarterly Fraud and Abuse Activity Report (QFAAR)* to MPI. This report should detail all efforts by the plan to detect, investigate and prevent fraud and abuse within its organization. Plans should regard this report as an effective tool to demonstrate due diligence and fiscal responsibility in their oversight of federal and state health care dollars as well as a means to ensure that their members are receiving appropriate and necessary services. The QFAAR is due within 15 calendar days of the end of the quarter being reported, but does not replace the statutory requirement that **all suspected and confirmed** cases of fraud and abuse be reported to MPI within 15 calendar days of detection.

The reports mentioned within this article are tools to provide an overview for the managed care plans and the Agency to monitor activities within the Medicaid managed care program. These reports may show trends and patterns that will help detect variances within the managed care plan.

The Agency may audit the plan’s provider complaint system. The Agency looks carefully at complaints submitted by a plan’s contracted provider as these complaints can be indicative of situations whereby a Medicaid recipient is not receiving a necessary service because the managed care plan is not performing as contracted. Several complaints regarding the same issue, such as a provider not being able to receive a prior authorization in a timely manner, may signal that a recipient is not receiving medically necessary care or prompt medical services. The Agency may impose sanctions on a managed care plan for not responding timely and appropriately to complaints.

Compliance with Fraud, Abuse and Waste Requirements within Managed Care (continued)

It is also important that the managed care plans report their current network providers weekly and remove anyone who is not currently contracted with their managed care plan. This will allow the Agency to provide accurate, updated provider network information.

Managed care plans are responsible for credentialing their network providers, as described in the [SMMC Model Agreement, Section VI, Part C. Provider Credentialing and Contracting](#):

c. The Managed Care Plan must establish and verify credentialing and recredentialing criteria for all providers that, at a minimum, meet the Agency's Medicaid participation standards. The Agency's criteria include not paying, employing or contracting with individuals on the state or federal exclusions lists.



In addition to statutory and contract compliance expectations, it should be noted that any failure to report instances of suspected or confirmed Medicaid fraud and abuse to MPI is a violation of law and is subject to the penalties provided by law. Notwithstanding any other provision of law, failure to comply with these specific reporting requirements will subject the plan to sanctions. Furthermore, if the failure to report suspected or confirmed Medicaid fraud and abuse is designed to cover-up a criminal scheme to defraud the Medicaid program by the plan, expect serious consequences. Recently top management personnel from a large managed care plan received prison sentences for health care crimes committed against Medicaid, and in a related qui tam action, this same plan agreed to pay \$137.5 million in fines and penalties. The fines and the prison sentences meted out in this particular case could have been much more severe, had the company not acted swiftly upon learning of the wrongdoing and separating key individuals involved.

This article is intended only to serve as a reminder to plans and providers about their obligations to remain diligent in their responsibilities to provide quality health care to the Florida Medicaid population and to comply with all anti-fraud contractual requirements, state and federal laws, rules and policies.