Florida Medicaid
Provider Bulletin

AGENCY FOR HEALTH CARE ADMINISTRATION

A Message from Secretary Elizabeth Dudek
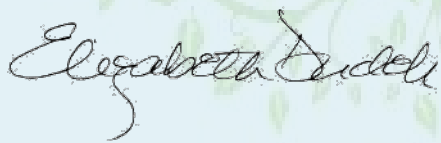
Dear Medicaid Provider:

It's been a busy time at the Agency with plenty to update you on since our last bulletin. Recently, the Agency reached an agreement with the federal Centers for Medicare and Medicaid Services (CMS) to continue the Low Income Pool program for two years. We will now work with CMS to develop the Special Terms and Conditions for the term of the waiver.

The 2015 special session ended with lawmakers passing a budget and reaching an agreement on how to distribute the Low Income Pool funds to hospitals. In addition, Governor Rick Scott signed his 2015-2016 *Keep Florida Working* budget, which included continued support for graduate medical education in our state so we can continue to keep our best and brightest here to practice when they finish their training.

The important work of the Governor's Commission on Healthcare and Hospital Funding is also under way. Created to review hospital finances in detail and make them more transparent for Florida's taxpayers, the Commission has already held three meetings. Last month, the Commission kicked off their *"Spotlight Transparency Tour"* in Tampa with further meetings scheduled in Jacksonville and Miami. The Commission is visiting different regions to hear from local hospital executives and industry experts on efforts to provide greater transparency for Florida's taxpayers at publically-financed hospitals. Further information on those meetings can be found online on the health and hospital commission website.

As you enjoy your summer, please also remember that it is hurricane season and you need to make sure your business and family has a plan. Please visit our Hurricane Preparedness page for important information about how to prepare for a natural disaster.

Have a great summer!

Elizabeth Dudek
Secretary

Non-Emergency Transportation Update

The Agency for Health Care Administration (Agency) has contracted with two transportation vendors to provide non-emergency transportation (NET) services to Medicaid recipients **not** enrolled in a Managed Medical Assistance Plan (MMA). This change was implemented statewide effective March 1, 2015. The vendors are LogistiCare Solutions, LLC and Medical Transportation Management (MTM), Inc.

The Agency contracted with LogistiCare Solutions, LLC in Medicaid Regions 1, 2, 9, 10, and 11. The Agency contracted with MTM in Medicaid Regions 3, 4, 5, 6, 7, and 8. These vendors will provide NET services to recipients **not** enrolled in an MMA plan.

When you are checking a Medicaid recipient's eligibility, you will see Capitated Non-Emergency Transportation (CNET) and a transportation vendor's name if the recipient is **not** enrolled in an MMA plan. ***The CNET vendors are responsible for non-emergency transportation only***.

The medical, behavioral or dental providers should **not** contact the CNET vendors to verify eligibility or request authorization for services other than for non-emergency transportation services. The CNET providers are not a new Managed Medical Assistance plan.

If you have any questions about this change, please contact Medicaid at 1-877-254-1055.

LogistiCare   **◍ MTM**

National Health Care Observances

July
Cleft & Craniofacial Awareness & Prevention Month

August
Immunization Awareness Month

September
Newborn Screening Awareness Month

For more information visit

healthfinder.gov
Live well. Learn how.

Changes to Medicaid Summary of Services

The Agency for Health Care Administration (Agency) has been working to change the way we deliver what was previously known as the "Medicaid Summary of Services." We are happy to announce that an overview of services and home and community based services (HCBS) waivers covered by Florida Medicaid is now available online. To access an index of these pages, please click the following link: Florida Medicaid's Covered Services and HCBS Waivers

This resource is not intended to be a replacement for specific provider or coverage handbooks, which should always be used as the definitive source of program information. However, the new pages can serve as a quick reference for basic information regarding covered services in the Florida Medicaid program.

Medicaid Eligibility for Newborn Babies

A baby has presumed 12 month Medicaid eligibility when born to a mother who is eligible for Medicaid on the date of the baby's birth. This includes a mother on Emergency Medicaid for Aliens (MLA, MLS), or eligible as Medically Needy (N) who has met her share of cost on or before the date of birth. This does not include a mother only eligible as a Presumptively Eligible Pregnant Woman (MU) or under the Family Planning waiver (FP).

Unborn Activation Process

In an effort to expedite the process of adding a baby to the Florida Medicaid system, a pregnant mother may obtain a Medicaid identification number and gold card for her unborn baby. Providers can use the gold card to inquire about the unborn baby's eligibility with the card control number. However, the baby's Medicaid number will not be active until after the baby is born. Activation of the baby's Medicaid coverage can be done by providers through the following steps:

1. Using the card control number, look up the baby's eligibility record using the Web portal, MEVS, FaxBack, or AVRS.
2. If the message tells you that the baby is eligible, no further action is needed.
3. If the baby's number is inactive, verify the mother was eligible for full Medicaid on the baby's date of birth by using the Web portal, MEVS, FaxBack, or AVRS. The Medicaid fiscal agent will not activate the baby's coverage if the mother is not Medicaid eligible.
4. Complete an Unborn Activation Form. This form and instructions can be found on the Medicaid Newborn Eligibility Policy page under the **Unborn Activation Process** section. Fill out the form completely as incomplete forms will be returned to you. Photocopies of this form are acceptable.
5. Completed forms can be faxed to the Medicaid fiscal agent, HP Enterprise Services, at 1-877-231-2170.
6. Forms can also be mailed to: HP Enterprise Services, Recipient Support Contact Center, P.O. Box 7090, Tallahassee, Florida 32314-7090.
7. Within 2 working days of receiving the completed form, HP will update the baby's information and activate the coverage. A new Medicaid gold card will be issued with the updated name.

Enrollment in a Managed Medical Assistance (MMA) Plan

- MMA plans are responsible for the coverage and payment of services provided to the baby *from the date of birth*.
- Most Medicaid services are covered by the MMA plan, but a few, such as newborn hearing screening, are fee-for-service, and should be submitted for payment to the Medicaid fiscal agent.
- Claims should **not** be submitted to HP for services covered by the MMA plans. Providers should submit claims for payment of MMA covered Medicaid services to the baby's MMA plan.

Enrollment in an MMA Specialty Plan

If the mother is enrolled in an MMA plan, the baby will automatically be enrolled in the mother's plan retroactively back to the date of birth, unless the mother is enrolled in an MMA specialty plan. If the mother is in an MMA specialty plan, the baby will be fee-for-service initially. The baby will then be mandatorily assigned to an MMA plan unless a voluntary choice is made, and the assignment will begin the first of the next month. Providers should always check the baby's eligibility and MMA plan enrollment for the specific date of service.

Medicaid Eligibility for Newborn Babies (continued)

Voluntary Change of MMA Plan for Baby

The mother can also choose to enroll her baby in a different MMA plan. If the mother chooses a different MMA plan, the baby is retroactively enrolled in the same plan as the mother back to the first of the month of birth, and the voluntary assignment will begin on the first day of the following month. Providers should always check the baby's eligibility and MMA plan enrollment for the specific date of service.

Not Enrolled in MMA Plan

If the mother has full Medicaid coverage but is **not** enrolled in any MMA plan on the baby's date of birth, the Unborn Activation Process is the same. Providers should submit claims to the Medicaid fiscal agent directly for payment of covered Medicaid services until the baby is enrolled in an MMA plan in a future month. Providers should always check the baby's eligibility and MMA plan enrollment for the specific date of service.

Unborn Does Not Have a Medicaid Number

- If the pregnant mother is Medicaid eligible but her unborn baby does not have a Medicaid number, providers may request eligibility for the baby by emailing a completed and password protected "Master Unborn Provider Spreadsheet" to the Department of Children and Families.
- The spreadsheet and instructions can be found on the Medicaid Newborn Eligibility Policy page under the **Provider Inquiry Newborn Spreadsheet** section.

Need Help?

- You can contact a Medicaid representative by phone at 1-877-254-1055 (8:00 am ET – 5:00 pm ET).
- If you have a complaint about not getting reimbursed by an MMA plan for services provided to a baby, or about the baby not getting retroactively enrolled to the mother's plan back to the date of birth, you may report your complaint at 1-877-254-1055 or through the Florida Statewide Medicaid Managed Care Program Complaint Form. Medicaid staff will assist you in resolving your issue.

The full overview document on Medicaid Eligibility for Newborn Babies, which includes Frequently Asked Questions, can be found on the Medicaid Newborn Eligibility Policy page.

Facts about Medicare Part D

Medicare

Medicare is a federal program for people who are age 65 or older, persons with a disability, or those with end-stage kidney disease. Medicare eligibility is not based on income, and basic coverage is the same in each state. For information and questions call Medicare's toll-free number (800) 633-4227 or TTY (877) 486-2048 or visit the Medicare website.

When recipients enroll in Medicare there are choices to make about coverage. Recipients can remain in the original Medicare Plan or enroll in a Medicare Advantage Plan. Recipients may also choose a Medicare Prescription Drug Plan and/or a Medigap policy. Following are descriptions of these options.

Medicare Prescription Drug Plan

Medicare prescription drug coverage is insurance provided by private companies that have been approved by Medicare. On January 1, 2006, Medicare prescription drug coverage was made available to everyone with Medicare Part A or B.

Medicare Part D – Prescription Drug Benefit

Part D - Optional benefits for prescription drugs available to all people with Medicare for an additional charge. Covered drugs are defined as: drugs available only by prescription used and sold in the United States, and used for a medically accepted indication; biological products; insulin; and vaccines. The definition also includes medical supplies associated with the injection of insulin (syringes, needles, alcohol swabs, and gauze). Certain drugs or classes of drugs, or their medical uses, are excluded by law from Part D coverage. These drugs or classes of drugs are listed in the Medicare Prescription Drug Benefit Manual, Chapter 6 – Part D Drugs and Formulary Requirements.

While these drugs or uses are excluded from basic Part D coverage, drug plans may choose to include them as part of supplemental benefits, not covered by Medicare.

People with limited income and resources may qualify for extra help under Medicare Part D. To learn more contact the Social Security Administration's toll-free number (800) 772-1213 or TTY (800) 325-0778, or visit their Extra Help with Medicare Prescription Drug Plan Costs webpage. If recipients receive Medicaid, they automatically qualify for the extra help.

Facts about Medicare Part D
(continued)

If recipients enroll in Medicare Part D they should compare drug plans prior to choosing one. Doing so will allow recipients to see which drug plans cover the prescription medicines they take; how much coverage they offer; the cost of deductibles, co-payments and the monthly premium; and which pharmacies they can use with each plan. To learn more visit the Medicare website.

Prescriptions that are eligible for coverage through the Part D Medicare program for Medicare/Medicaid dual eligibles are not covered by Medicaid. Under section 1927(d)(2) of the Act, some drugs excluded from Part D may be billed to Medicaid.[1] Medicaid will not pay for any drugs for beneficiaries who have both Medicare and Medicaid (dual eligible) with the exception of:

Over the counter products:

- Aspirin, arthritis strength acetaminophen, vaginal antifungals, guaifenesin as single agent, calcium products as phosphate binders for renal dialysis patients, iron preparations, and smoking deterrent products.

Prescription products:

- Prescription strength folic acid as a single entity and prescription strength vitamin/mineral supplements for dialysis patients.

Medicaid does not reimburse for Medicare Part D drug copayment or for prescriptions not covered due to the Medicare Part D coverage gap. Medicaid will not pay any deductibles and coinsurance for drugs covered by Medicare Part D.

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[1] Section 1927(d)(1) and (d)(2) Limitations on Coverage of Drugs Permissible Restrictions.

Payment Error Rate Measure Project (2014) Update

Since medical reviews by A+ Government Solutions began in August 2014, approximately 90% of the Medicaid medical record requests have been completed. In April 2015, A + Government Solutions finished sending out medical record requests to all sampled CHIP and Medicaid providers in Quarters 1 through 4 of the 2014 Federal Fiscal Year. We would like to remind all sampled providers that the 2014 cycle cutoff is July 15, 2015. All medical records will need to be submitted prior to this date to avoid an error. To date, the Agency has not received an error for provider non-compliance with medical record submissions. We want to thank all providers for their cooperation with this continued effort and encourage those sampled CHIP and Medicaid providers (recently notified) to provide medical records as requested by A+ Government Solutions within the required 75 calendar days.

We will continue to send out specific information that pertains to medical record requests by A+ Government Solutions as the information becomes available. Please look for additional details in upcoming Provider Bulletins and on the Florida Medicaid PERM webpage regarding the 2014 PERM cycle.

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 last year, please take a moment to view a recorded video of this training by accessing it:

- On YouTube
- On the Florida Medicaid PERM under **Provider Education**
- On the Florida Medicaid Provider Training e-Library under **Videos**

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 Medicaid Public 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. 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.