Statewide Medicaid Managed Care (SMMC) Newly Covered Services

The Agency for Health Care Administration (Agency) contracts with Medicaid health and dental plans to provide services to health plan enrollees. The Agency recently entered into new contracts with health and dental plans that will greatly benefit enrollees and providers. This document is part of a series that highlights the program changes in the new Statewide Medicaid Managed Care (SMMC) health and dental plan contracts. Under the new SMMC contracts, the Agency has focused on fully integrated health care. As such, health plans will be responsible for covering services previously paid for through the fee-for-service program. These services include:

- Early Intervention Services
- Medical Foster Care
- Nursing Facility Services
- Child Health Services Targeted Case Management

The benefits described in this document will be offered under the new SMMC health plan contracts. The Agency will transition to the new contracts through a regional phased roll-out. Recipient letters will start mailing out approximately 30-45 days prior to each phase going live. Below is when the Agency will transition to the new contracts and when letters will begin mailing for each Medicaid region.

Phase	Transition Date	Recipient Letter Date	Region	Counties
1	12/01/18	Mid-October	9	Indian River, Martin, Okeechobee, Palm Beach, St. Lucie
			10	Broward
			11	Miami-Dade, Monroe
2	01/01/19	Mid-November	5	Pasco, Pinellas
			6	Hardee, Highlands, Hillsborough, Manatee, Polk
			7	Brevard, Orange, Osceola, Seminole
			8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota
3	02/01/19	Mid-December	1	Escambia, Okaloosa, Santa Rosa, Walton
			2	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington
			3	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union
			4	Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia

Early Intervention Services

Early intervention services (EIS) provide for the early identification and treatment of recipients under the age of 3 years (36 months) with developmental delays or related conditions. EIS promotes a parent-coaching model intended to support the child in meeting certain developmental milestones. Children receiving EIS are currently enrolled in Medicaid health plans, but these services have historically been paid through the fee-for-service delivery system (outside of managed care). The inclusion of EIS in the SMMC program is intended to facilitate an integrated health care delivery system where the health plans are responsible for coordinating, providing, and paying for all services that their enrollees need. More information about EIS can be found on the EIS snapshot.

Child Health Services Targeted Case Management

Targeted Case Management services consist of assessing recipient needs, developing care plans, referring to medical and social services, and monitoring recipient progress to assist specific populations of children with sustaining themselves in a community setting. The health plans are responsible for covering Child Health Targeted Case Management for enrollees who are eligible to receive these services.

Medical Foster Care Services

Medical Foster Care (MFC) services provide family-based care for children, under the age of 21 who are in the care and custody of the Department and Children and Families (DCF) who have complex medical needs. Medical foster care providers are foster care parents licensed by DCF who have received special clinical training through the Department of Health (DOH) to meet the medical needs of the child. MFC providers are responsible for performing most of the day-to-day functions necessary to meet the child's needs.

Children receiving MFC services are currently enrolled in Medicaid health plans, but MFC services have historically been paid through the fee-for-service delivery system (outside of managed care). The inclusion of MFC services in the SMMC program is intended to facilitate an integrated health care delivery system where the health plans are responsible for coordinating, providing, and paying for all services that their enrollees need. More information about MFC services can be found on the MFC snapshot.

Nursing Facility Services

Nursing Facility services provide 24-hour medical and nursing care in an institution or a distinct part of an institution. The health plans will be responsible for paying for nursing facility services, when their enrollee needs such services and is not yet enrolled in the Long-Term Care (LTC) program. Health plans will be responsible for payment for up to 120 days under the MMA benefit for enrollees who meet the eligibility requirements stated in the Nursing Facility Services Coverage Policy (e.g., meet Institutional Care Program Medicaid requirements). The majority of enrollees for whom health plans will be responsible for this benefit are awaiting enrollment in the LTC program.

How will adding these services to the list of SMMC health plan covered services impact recipients?

Recipients will continue to be eligible for Medicaid services and will continue to have access to these services.

This change is intended to facilitate an ***integrated*** health care delivery system where the health plan is responsible for coordinating and paying for all of the services that the enrollee needs.

What does this mean for providers?

Providers are required to go through the health plan's credentialing process in order to join the plan's network to provide these services.

Do the continuity of care requirements apply to these services?

Yes. Continuity of Care (COC) requirements ensure that when enrollees transition from one health plan to another, one service provider to another, or one service delivery system to another (i.e., fee-for-service to managed care), their services continue seamlessly throughout their transition.

The Agency has instituted the following COC provisions:

- **Health care providers should not cancel appointments with current patients.** Health plans must honor any ongoing treatment that was authorized prior to the recipient's enrollment into the plan for up to 60 days after the roll-out date in each region.
- **Providers will be paid.** Providers should continue providing any services that were previously authorized, regardless of whether the provider is participating in the plan's network. Plans must pay for previously authorized services for up to 60 days after the roll-out date in each region, and must pay providers at the rate previously received for up to 30 days.
- **Providers will be paid promptly.** During the continuity of care period, plans are required to follow all contract requirements, including those that require timely claims payment. The Agency will closely monitor complaints to ensure that any issues with delays in payment are rapidly resolved.
- **Prescriptions will be honored.** Plans must allow recipients to continue to receive their prescriptions through their current provider, for up to 60 days after the roll-out date in each region, until their prescriptions can be transferred to a provider in the plan's network.

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