

Children's Medical Services Network Specialty Plan & The Managed Medical Assistance Program

May 20, 2014



Presentation Outline

- Introduction
 - Children's Multidisciplinary Assessment Team (CMAT) Services
 - Medical Foster Care (MFC) Services
 - Child Welfare Population
 - Recipient Enrollment Process and Assistance
 - Information for Providers
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INTRODUCTION



Background CMS

- Under the Managed Medical Assistance (MMA) program, the Florida Department of Health (DOH) Children's Medical Services (CMS) will operate a statewide specialty plan for children from birth up to age of 21 with special health care needs and chronic conditions.
 - This plan will be the Children's Medical Services Network (CMSN) specialty plan.
 - The start date for this statewide plan is August 1, 2014.

CMSN Specialty Plan

- The CMSN plan is responsible for covering comprehensive medical, dental, **and** behavioral health services.
- Behavioral health services new to managed care include:
 - Substance abuse services
 - Statewide Inpatient Psychiatric Program (SIPP), and
 - Behavioral Health Overlay Services (BHOS).
- The CMSN plan must limit services to those available under the Medicaid fee-for-service program and cannot offer expanded benefits.

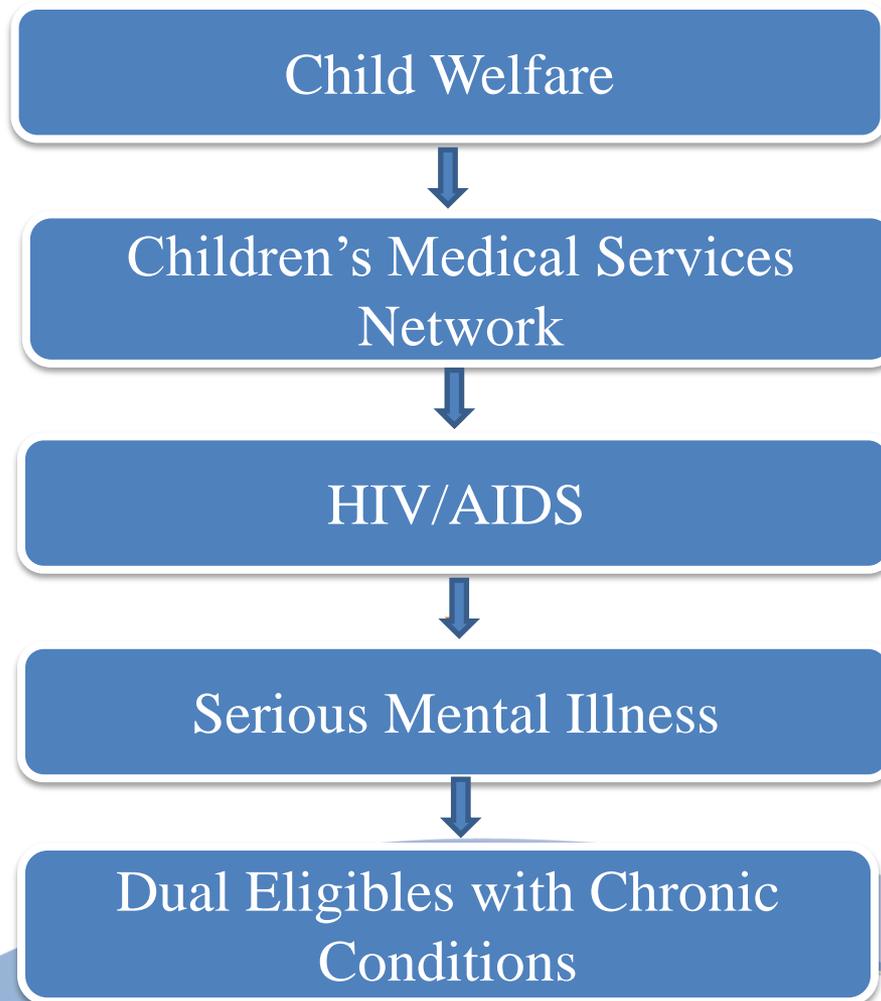
Specialty Plans

- A specialty plan is a managed care plan that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis.
- When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the Agency will assign the recipient to that plan.
- The CMSN plan and the child welfare specialty plan (Sunshine) will be available statewide.

Specialty Plan Assignment

- The Agency is required by Florida law to automatically enroll Medicaid recipients into a managed care plan if they do not voluntarily choose a different plan.
- When a specialty plan is available to serve a specific condition or diagnosis of a recipient, the Agency is required to assign the recipient to that plan.
- If a recipient qualifies for enrollment into more than one specialty plan the Agency employs a hierarchy for assignment to specialty plans.

If a recipient qualifies for enrollment in more than one of the available specialty plan types, and **does not choose a different plan**, the recipient will be assigned to the plan for which they qualify that appears highest in the chart below:



**What will Happen
with Children who
are Currently
Enrolled in CMS?**

- Medicaid recipients who are enrolled in the current CMS program **and who are clinically eligible for the program** can continue to participate in CMS until the statewide implementation of the CMSN plan on August 1, 2014.
- At that time, they will be assigned to the CMSN plan, but can choose a different MMA plan if they desire.
- All recipients must meet the clinical eligibility criteria for enrollment into the CMSN plan. (Siblings can no longer enroll unless they also meet clinical criteria.)

**What will Happen
with Children who
are Currently
Enrolled in CMS?**

- Siblings who are **not clinically eligible** for the CMSN plan will need to choose a different MMA plan.
- Children who are clinically eligible for CMS, but who receive a letter in error requiring them to choose another plan should call the Statewide Medicaid Managed Care hotline toll-free at 1-877-711-3662 or TTY/VCO: 1-800-955-8771 to remain in the current CMS program.

Background

Discontinued Programs

- Once the MMA program is implemented, some programs that were previously part of the Medicaid program will be discontinued. This includes the following programs:
 - MediPass
 - Prepaid Mental Health Plans
 - Prepaid Dental Health Plans
- Upon implementation of the MMA program in each region, these programs will cease operation.

CHILDREN'S MULTIDISCIPLINARY ASSESSMENT TEAM (CMAT) SERVICES



What are CMAT Services?

- CMAT is an interagency coordinated effort of Medicaid in the Agency for Health Care Administration; Office of Family Safety in the Department of Children and Families; the Agency for Persons with Disabilities; and Children's Medical Services in the Department of Health.
- Certain Medicaid services for children under age 21 require a recommendation from the CMAT for reimbursement:
 - Nursing Facility Services
 - Medical Foster Care
 - Model Waiver

CMAT Services & MMA

- Most children in Medicaid will now be required to enroll in a managed care plan through the Managed Medical Assistance program (MMA).
- A level of care recommendation developed by the CMAT is still required for a child enrolled in an MMA plan if the following services are being recommended:
 - Nursing Facility Services
 - Medical Foster Care
 - Model Waiver

The MMA Plan Will:

- Work with the parent/legal guardian to initiate a referral for a CMAT level of care recommendation, if any of the above services/programs are needed.
- Coordinate with the local CMAT staff.
- Attend the CMAT staffing for their enrollees.
- Coordinate the services for their enrollees and ensure that all medically necessary care is authorized and provided timely.

The CMAT Will:

- Complete the intake process of a referral.
- Complete a psychosocial and nursing assessment.
- Schedule the CMAT staffing in coordination with the parent/legal guardian and plan in which the child is enrolled.
- Make a level of care recommendation.
- Conduct a Level I PASRR screening for all children entering a nursing facility.

MEDICAL FOSTER CARE (MFC) SERVICES

What are MFC Services?

- MFC services enable medically-complex children under the age of 21, who are in foster care to live and receive care in licensed foster homes rather than in hospitals or other institutional settings.
- DCF licenses foster homes and reimburses the foster parents for the child's room, board, and other living expenses.
- Medicaid reimburses Medicaid-enrolled MFC providers (parents) for medically necessary services rendered by the provider.
- MFC providers (parents) are available 24 hours per day to provide medically necessary services and personal care.

MFC Services & MMA

- The Department of Health, Children’s Medical Services will *continue* to be responsible for managing the MFC program in cooperation with the DCF and the Agency.
 - However, children do not need to be enrolled in the Children’s Medical Services Network (CMSN) plan in order to receive MFC services.
- Children who are enrolled in any MMA plan and who also qualify for MFC services can continue to receive MFC services after the implementation of the MMA program. This includes:
 - a standard MMA plan
 - a specialty MMA plan, or
 - the CMSN plan.
- MFC services will be reimbursed fee for service.

Process to Access MFC Services

- The Children's Multidisciplinary Assessment Team (CMAT) will authorize MFC services and establish the level of reimbursement for MFC services upon admission into the program and every six months thereafter.
- The MMA plan will be responsible for coordinating all other medically necessary services that the child is receiving.
- In addition, the MMA plan will:
 - Coordinate with the local CMAT team and attend staffing meetings for MFC children enrolled in the plan.
 - Coordinate with the child's MFC provider parents to ensure the child is receiving the services needed and to avoid duplication of services.

CHILD WELFARE POPULATION

Managed Care Plan Options for the Child Welfare Population

- Children who are in the care of DCF can choose to enroll in one of the following:
 - A standard MMA plan in their region
 - The statewide Child Welfare Specialty plan
 - The Children’s Medical Services Network plan if the child **also has an eligible chronic condition.**
- When the child receives his/her welcome letter, the parent or legal guardian must follow the instructions in the letter to make a plan selection. **If a choice is not made,** the child will be enrolled to the Child Welfare Specialty plan.

Children Eligible for Both the CMSN Plan & the Child Welfare Specialty Plan

What will happen with children who have an open case in the Florida Safe Families Network?

- These children will receive a letter approximately 60 days prior to the MMA rollout for their region. The letter will inform them of their options.
- At that time they can choose:
 - to enroll in the child welfare specialty plan
 - to stay in the CMSN plan, or
 - choose from any of the other MMA plans available in their region.

Children Eligible for both the CMSN Plan & the Child Welfare Specialty Plan

- If a choice is not made within the required time frame, the child will be assigned to the child welfare specialty plan.
- To remain in the current CMS program until the new CMSN plan is available on August 1, 2014, the recipient or their representative must call the Statewide Medicaid Managed Care hotline toll-free at 1-877-711-3662 or TTY/VCO: 1-800-955-8771.

Covered Services

- All MMA plans are responsible for covering medical, dental, and behavioral health services for children.
- All MMA plans are also responsible for covering the following specialized health services:
 - Statewide Inpatient Psychiatric Program (SIPP)
 - Behavioral Health Overlay Services (BHOS) for Child Welfare settings
 - Substance Abuse Services
 - Therapeutic Group Care Services (TGC)
 - Specialized Therapeutic Foster Care Services (STFC); and
 - Comprehensive Behavioral Health Assessment (CBHA)

In the past, many of these services have only been available through fee-for-service Medicaid.

RECIPIENT ENROLLMENT PROCESS & ASSISTANCE

Choice Counseling

- Choice counseling is a free service offered by the Agency, through a contracted enrollment broker, to assist recipients in understanding:
 - available plan choices and plan differences
 - the enrollment and plan change process.
- Counseling is unbiased and objective.

How Do Recipients Choose an MMA Plan?

- Recipients may enroll in an MMA plan or change plans:

- Online at : www.flmedicaidmanagedcare.com

Or

- By calling **1-877-711-3662** (toll free) and
 - speaking with a choice counselor

OR

- using the Interactive Voice Response system (IVR)

- Choice counselors are available to assist recipients in selecting a plan that best meets their needs.
- This assistance will be provided by phone, however recipients with special needs can request a face-to-face meeting.

A Closer Look at the Choice Counseling Cycle

Welcome Letter:

- Approximately 60 days prior to the plan begin date, recipients will receive a letter and a packet of information detailing their choice of plans and how to choose a plan.
 - Letter
 - Brochure that provides plan information specific to the recipient's region
 - Information on how to make a plan choice
 - The plan to which they'll be assigned if they don't make a choice

A Closer Look at the Choice Counseling Cycle

- **Reminder Letter:** Reminds fully eligible recipients of their need to make an enrollment choice by a specific cut-off date, (this information was also included in the original letter).
- **Confirmation Letter:** Mailed after a voluntary plan choice or change to confirm the recipient's selection and to inform of next steps and rights.
- **Open Enrollment:** Mailed 60 days prior to the recipient's plan enrollment anniversary date to remind them of the right to change plans.

When Can Recipients Change Plans?

- Recipient who are required to enroll in MMA plans will have 90 days after joining a plan to choose a different plan in their region.
- After 90 days, recipients will be locked in and cannot change plans without a state approved good cause reason or until their annual open enrollment.

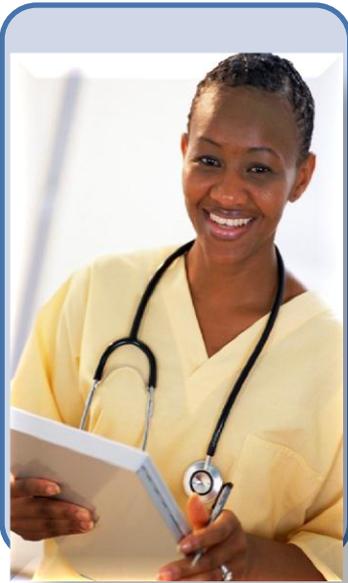
INFORMATION FOR PROVIDERS



Enrolling with a MMA Plan

- Providers interested in providing services to Medicaid MMA enrollees will need to contract with the MMA plans to provide services.
- To find the [Children's Medical Services Network, Provider Liaison County Assignments](#) (click CTRL to link to the list). Or,
- Go to:
http://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/CMS_Provider_Liaison_County_Assignments.pdf
- The MMA plans are responsible for the credentialing and re-credentialing their providers. The plans establish criteria for all providers that, at a minimum, meet the Agency's Medicaid participation standards.

How Will Providers Know Whether to Continue Services?



Health care providers should not cancel appointments with current patients. MMA plans must honor any ongoing treatment that was authorized prior to the recipient's enrollment into the plan for up to 60 days after MMA starts 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 MMA starts in each region, and must pay providers at the rate previously received for up to 30 days (with the exception of CMSN, which may only pay Medicaid rates).

Prescriptions Will Be Honored



- Plans must allow recipients to continue to receive their prescriptions through their current provider, for up to 60 days after MMA starts in their region, until their prescriptions can be transferred to a provider in the plan's network.

http://apps.ahca.myflorida.com/smmc_cirts/

Florida Statewide Medicaid Managed Care Program Complaint Form

If you have a complaint about Medicaid Managed Care services, please complete the information below.

* Required fields

For each complaint/issue, please provide:

Your name

Your email

Your phone number

I am a

Who is the complaint/issue about?

Name (if different from above)

Gold Card, SSN, or Medicaid ID or NPI

County

What type of Managed Care Plan is this complaint/issue about?

What is the name of the Managed Care Plan?

Which choice best describes the (complaint/issue)?

Please describe in 2000 characters or less

Do you want to be contacted about this complaint/issue?

Submit

Reset

Your name, email and phone number are requested in case more information is needed to resolve your issue. If you wish to remain anonymous, you may omit this information. If you choose to send an issue anonymously, please provide as much detail as possible. Without enough detail, we may not be able to resolve your issue; however, your input is important and will be used to improve the program.

Thank you for completing this form. After you click the 'Submit' button above, a copy of your complaint will be sent to the email address that you provided.

Under Florida law, e-mail addresses are public records. If you do not want your e-mail address released in response to a public-records request, do not send electronic mail to this entity. Instead, contact the local Area Office by phone (click on link below) or in writing.

If you need assistance completing this form or wish to verbally report your issue, please contact your local Area Office.
Phone numbers of local [Area Offices](#)



Report a Complaint



- If you have a complaint or issue about Medicaid Managed Care services, please complete the online form found at: <http://ahca.myflorida.com/smmc>
- Click on the “Report a Complaint” blue button.
- If you need assistance completing this form or wish to verbally report your issue, please contact your local Medicaid area office.
- Find contact information for the Medicaid area offices at: <http://www.mymedicaid-florida.com/>

Resources

- Questions can be emailed to:
FLMedicaidManagedCare@ahca.myflorida.com
- Updates about the Statewide Medicaid Managed Care program are posted at:
www.ahca.myflorida.com/SMMC
- Upcoming events and news can be found on the “News and Events” link.
 - You may sign up for our mailing list by clicking the red “Program Updates” box on the right hand side of the page.
- Continue to check our Frequently Asked Questions button, as we make updates on a regular basis.

The screenshot shows the Florida Medicaid website. At the top, there is a header with the text "Florida Medicaid" and a circular image of a woman and a child. Below the header is a navigation bar with links: "SMMC Home", "News and Events" (circled in red), "Long-term Care", "Managed Medicaid Assistance", "Federal Authorities", and "Archive". The main content area is titled "Statewide Medicaid Managed Care Program". Below this title is a paragraph of text: "In 2011, the Florida Legislature created Part IV of Chapter 409, Florida Statutes, directing the Agency to create the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two key components: the Managed Medical Assistance program and the Long-term Care program." Below this text is a section titled "Program Overview and Summary" with the text: "There will be two different components that make up the SMMC program:" followed by a bulleted list: "• The Florida Long-term Care program and" and "• The Florida Managed Medical Assistance program." Below the list is a paragraph: "If you are interested in learning more about these two programs, overviews and summaries may be accessed through the links below." followed by three links: "Long-term Care program Snapshot [214KB PDF]", "Managed Medical Assistance program Snapshot [318KB PDF]", and "Region Map [264KB PDF]". At the bottom of the page, there is a paragraph: "Updates about the Statewide Medicaid Managed Care program will be posted on this website as they become available." On the right side of the page, there are four buttons: "Program Updates" (circled in red), "Report a Complaint", "Submit Comments & Questions", and "Frequently Asked Questions" (circled in red).

Resources

- Weekly provider informational calls regarding the rollout of the Managed Medical Assistance program will be held. Please refer to our SMMC page, ahca.myflorida.com/smmc, for dates, times, and calling instructions.
- Calls will address issues specific to the following provider groups:
 - Dental
 - Durable Medical Equipment
 - Home Health
 - Hospitals and Hospice
 - Mental Health and Substance Abuse
 - Physicians / MediPass
 - Pharmacy
 - Skilled Nursing Facilities / Assisted Living Facilities / Adult Family Care Homes
 - Therapy

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Questions?

