Statewide Medicaid Managed Care (SMMC) New Program Highlight: Behavior Analysis Services Inclusion in the Statewide Medicaid Managed Care (SMMC) Program

The Agency for Health Care Administration (Agency) contracts with health and dental plans to provide Medicaid 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 contracts, recipients enrolled in a managed care plan who receive Behavior Analysis (BA) services will have BA services reimbursed through their managed care plan. Recipients not enrolled in a managed care plan will continue to have BA services reimbursed through traditional fee-for-service (FFS). Parents and guardians should confirm their child's provider is enrolled in their child's managed care plan.

The Agency will transition to the new contracts in February of 2025. The plans will operate in 9 Regions throughout the state.

Region	*Counties*
A	Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington
B	Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia
C	Pasco and Pinellas
D	Hardee, Highlands, Hillsborough, Manatee, and Polk
E	Brevard, Orange, Osceola, and Seminole
F	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
G	Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie
H	Broward
I	Miami-Dade and Monroe

Florida Medicaid has a program called the Managed Medical Assistance (MMA) program. This program provides Medicaid state plan services through a health plan.

The Florida Medicaid state plan covers Behavior Analysis (BA) services for eligible Florida Medicaid recipients under the age of 21 years requiring medically necessary BA services to address behavior that impairs a recipient's ability to perform a major life activity. To date, BA services have been reimbursed only through the Medicaid FFS delivery system.

Under the new phase of SMMC, BA services will be reimbursed through both the Florida MMA program, for enrollees who have chosen to enroll in managed care, and the Medicaid FFS delivery system.

What does this mean for recipients of BA services?

Recipients will continue to receive all medically necessary BA services through their health plan. To ensure care continues to be reimbursed by Florida Medicaid, parents and guardians should confirm their child's provider is enrolled in their child's health plan. If the provider is not enrolled in the health plan, parents or guardians should contact the plan to identify enrolled providers.

There is no change for recipients not enrolled in a health plan; services will continue to be reimbursed through the FFS delivery system.

What does this mean for BA providers?

To be reimbursed for services for recipients enrolled in a health plan, providers must contract with the recipient's health plan. Claims (i.e. encounters) will be submitted to recipients' health plan and providers will be reimbursed through the plan.

Health plans are required to ensure continuity of care (COC). Plans must honor any ongoing treatment that was authorized prior to the recipient's enrollment into a new plan for up to 90 days after the effective date of the new enrollment.

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 90 days after the effective date of enrollment.
- **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 90 days after the effective date of enrollment and must pay providers at the rate previously received for up to 60 days.
- **Providers will be paid promptly**. During the continuity of care period, plans are required to follow all timely claims payment contractual requirements. The Agency will monitor complaints to ensure that any issues with delays in payment are resolved.

Following the COC period, BA services will continue to need prior authorization. Prior authorization will occur either through the health plans' utilization management programs (for managed care enrollees) or by the Agency's vendor (Acentra, previously known as eQHealth Solutions) for recipients who are not enrolled in a health plan.

Where can I find more information?

The Agency's Behavior Analysis Information webpage will have updates regarding the transition to managed care.

How does a BA provider contract with a health plan?

Medicaid providers that render services to Health Plan recipients, must be enrolled in the Health Plan's provider network. Plans have dedicated staff serving as provider relations contacts for providers in their networks. Providers who wish to contract with plans in their area should refer to the following list:

Plan Name	Provider Relations Contact
Aetna Better Health	786-209-5362
Children's Medical Services	866-595-8116
CCP	954-622-3315
FCC	786-761-4512
Humana	LTC: 803-315-0115 MMA: 812-987-4031
Molina Healthcare	305-317-3152
Simply Healthcare	954-308-9410
Sunshine Health	866-595-8116
United Healthcare	LTC: 407-659-7258 MMA: 407-659-7047