A Snapshot of Statewide Medicaid Managed Care 3.0

- Since 2013-2014, most Florida Medicaid recipients have been required to enroll in the Statewide Medicaid Managed Care program (SMMC) to receive services.
- Of the 4.4 million Floridians enrolled in Medicaid, 3.1 million are enrolled in the MMA program, 140,000 in the LTC program and 3.3 million in the Dental program.
- The SMMC program has two key components:
  - Integrated Managed Medical Assistance (MMA) and Long-Term Care (LTC)
  - Dental

What's New with SMMC 3.0?

- Family focused plans and programs:
  - Supporting Hope Florida
  - Supporting Strong Families
- Significant new ways to improve your health:
  - Providing Enhanced Access to Specialized Care Coordination
  - Providing Additional Member Benefits
- Fully Integrated Incentives for Quality Performance
  - New innovative Quality Performance program for health plans
  - Involving all providers in Quality Improvement through Value Based Purchasing

What types of plans are available in SMMC 3.0?

Comprehensive Plus	Provides MMA services to MMA eligible recipient; Provides LTC services to LTC eligible recipients; Provides Specialty product to all specialty population enrollees.
Managed Medical Assistance Plus	Provides MMA services to MMA eligible recipient; Cannot provide services to LTC-only recipients; Provides Specialty product to all specialty population enrollees.
Select Comprehensive	Provides MMA and LTC services to eligible recipients enrolled in LTC; Cannot provide services to MMA-only recipients; Does not provide a Specialty product.
Dental	Provides preventative and therapeutic dental services to all recipients in managed care and all fully eligible fee-for-service individuals.

What are Specialty Products?

- A "Plus" Plan may provide one or more of the following specialty products: include **HIV/AIDS**, Serious Mental Illness (**SMI**), and Child Welfare (**CW**)
- Information on each specialty product is available through the choice counseling website: flsmmc.com.

Who is required to enroll in the SMMC program?

- Most Medicaid recipients must enroll in the MMA program and in the Dental program. Individuals wishing to receive Medicaid covered Long-Term Care services must enroll in the LTC program. These are both known as "mandatory."
- Certain individuals, known as "voluntary", can choose whether to enroll in MMA or LTC, and some, known as "excluded", are not allowed to enroll in the MMA, LTC or Dental programs.

Who Must, Who Can, and Who Cannot Participate in MMA, LTC and Dental Programs	Dental	MMA	LTC
Emergency Medicaid for Non-Citizen Enrollees	E	E	E
Family Planning Waiver Enrollees	E	E	E
Breast and Cervical Cancer Program Enrollees	E	E	E
Program of All-Inclusive Care for the Elderly Enrollees	E	M (if not E/V)	E
Medically Needy Program Enrollees	M	E	E
Refugee Assistance Enrollees	M	V	E
Presumptively Eligible Pregnant Women	E	E	E
Partial Dual Eligibles	E	E	E
Recipients who have other health coverage (excluding Medicare)	M	V	M (if LTC)
Prescribed Pediatric Extended Care Center patients	M	V	N/A
Recipients who have elected to enroll in a home and community-based waiver other than LTC*	M	M (if not E/V)	E
iBudget Enrollees and Waitlist Population*	M	V	E
Residents of a developmental disability center	M	V	E
Residents in a group home facility licensed under chapter 393.	M	V	N/A
Residents of a treatment facility as defined in s. 394.455(47)	M	M (if not E/V)	E
Residents of a DJJ residential commitment facilities	E	E	E
Residents of a State Mental Hospital	E	E	E

*Waiver enrollees (not on a waitlist) are voluntary for LTC, but they must have a nursing facility level of care and disenroll from the other

E=Excluded, **M**=Mandatory, **V**=Voluntary

How Do I Choose and Enroll in a Plan?

- Recipients will be assigned a plan upon enrollment.
- Recipients have about 45 days to change their initial plan assignment.
- Recipients have 120 days after enrollment to change plans.
- After 120 days, enrollees must stay in their plan for the remainder of the 12-month period before changing plans again.
- Enrollees can change providers within their plan at any time.

What Region am I in?

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

What Health and Dental Plans are available in my region?

	A	B	C	D	E	F	G	H	I
Aetna				C	C				C
FCC	C	C	C	C	S	S	S	S	C
Humana	C	C	C	C	C	C	C	C	C
Molina									C
Simply	C	C	C	C	C	C	C	C	C
CC Plan					M	M	M	M	M
Sunshine	C	C	C	C	C	C	C	C	C
United		C		C					C
DentaQuest	D	D	D	D	D	D	D	D	D
Liberty	D	D	D	D	D	D	D	D	D

C = Comprehensive Plus Plan **M** = Managed Medical Assistance Plus Plan
S = Select Comprehensive **D** = Statewide Prepaid Dental Plan

What Services Are Covered in my Plan?

MMA Minimum Covered Services	
Advanced registered nurse practitioner services	Hospital Inpatient & Outpatient Services
Ambulatory surgical treatment center services	Laboratory and Imaging Services
Assistive Care Services	Medical supply, equipment, prostheses and orthoses
Behavioral Health	Medical Foster Care
Birthing center services	Mental health services
Chiropractic services	Nursing care
Early Intervention Services	Nursing facility services for enrollees not in the LTC program
Early periodic screening diagnosis and treatment services for recipients under 21	Optical services and supplies
Emergency services	Optometrist services
Family planning services and supplies (some exception) Healthy Start Services (some exceptions)	Physical, occupational, respiratory, and speech therapy
Hearing services	Podiatric services
Home health agency services	Physician services, including physician assistant services
Hospice services	Rural health clinic services
Prescription drugs	Transportation to access covered services
Renal dialysis services	Substance abuse treatment
Respiratory equipment and supplies	

LTC Minimum Covered Services	
Adult companion care	Intermittent and skilled nursing
Adult day health care	Medical equipment and supplies
Assisted living	Medication administration
Assistive care services	Medication management
Attendant care	Nursing facility
Behavioral management	Nutritional assessment/ risk reduction
Care coordination/ Case management	Personal care
Caregiver training	Personal emergency response system
Home accessibility adaptation	Respite care
Home-delivered meals	Therapies: occupational, physical, respiratory and speech
Homemaker	Transportation, Non-emergency
Hospice	

Dental Minimum Covered Services	
Ambulatory Surgical Center or Hospital-based Dental Services	Orthodontics
Dental Exams	Periodontics
Dental Screenings	Prosthodontics (dentures)
Dental X-rays	Root Canals
Extractions	Sealants
Fillings and Crowns	Sedation
Fluoride	Space Maintainers
Oral Health Instructions	Teeth Cleanings

What if I'm already receiving medical care or long-term care services?

The health and/or dental plan is responsible for coordinating care for new enrollees transitioning into managed care or who are changing plans. If a member is already receiving a prior authorized ongoing course of treatment with any provider, the plan is responsible for the costs of continuing that treatment, without any form of authorization and without regard to whether the services are being provided by non-Medicaid or non-network providers.

Similarly, members receiving long-term care (LTC) services will continue to receive LTC services until the member receives an assessment, a plan of care is developed, and services are arranged and authorized as required to address the long-term care needs of the member. This has to occur no more than sixty (60) days after the effective date of enrollment.

What benefits not otherwise covered by Medicaid are available from plans?

- Health and dental plans cover expanded benefits which are offered in addition to the standard benefit package offered by Medicaid.
- A list of expanded benefits, by plan, will be available on the Agency's website soon here: ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/new-smmc-program.

What if I have a complaint?

- We encourage any individual with a complaint or issue relating to the program to contact a Medicaid representative by phone at 1-877-254-1055.
- You may also complete the online complaint form created by the Agency to provide expedited handling: ahca.myflorida.com/Medicaid/florida-medicaid-complaints

Where can I find more information?

- Visit our SMMC website at: ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/new-smmc-program.
- Keep up to date by signing up to receive program updates by clicking the red "Sign Up for Medicaid Alerts" box on the right-hand side of the page.

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