

Medicaid and Medicaid Managed Care

Child Protection Summit September 3, 2014

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BASICS OF MEDICAID



Who is eligible for Medicaid?

- To qualify for Medicaid, an individual must meet specific eligibility requirements, such as income, assets, age, citizenship or resident alien status, and Florida residency.
- Not all recipients are eligible for all services.
- The individual must have a social security number or proof of having applied for one.
- Eligibility for Medicaid is determined by the Florida Department of Children and Families (DCF) and by the federal Social Security Administration (SSA).

Levels of Income Considered when Calculating Eligibility

Children Under Age 1	200% FPL	
Children 1 through 18	133% FPL	These figures reflect an expansion of Medicaid to children aged 6 through 18 with incomes up to 133% of the Federal Poverty Level (previously capped at 100% FPL).
Pregnant Women	185% FPL	
Parents, Caretakers, Children 19-20	19% FPL	

Periods of Eligibility

- Periods of Medicaid coverage are not the same among Medicaid eligibility types.
- Depending on the Medicaid program, the recipient's eligibility may begin:
 - On the first day of the month of application, or
 - On a specific day within the month and may end before the last day of the month.
- Medicaid eligibility may be approved retroactively for up to three months prior to the month of application.

Mandatory Eligibility Groups in Florida

Low income families with children

- Parents and other caretaker relatives
- Pregnant women
- Infants and children under age 19

Children receiving foster care or adoption assistance under title IV-E

Individuals that aged out of Foster Care up to age 26

Supplemental Security Income (SSI) recipients

- Florida residents who have been determined eligible for SSI benefits are automatically entitled to Florida Medicaid. However, the individual must meet additional Title XIX requirements in order to be entitled to the Medicaid benefit of institutional care.
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Mandatory Eligibility Groups in Florida

Certain people on Medicare:

QMB (Part A and Part B), SLMB (Part A), QI1 (Part A), WD (Part A)—but not for full Medicaid—for payment of Medicare premiums and some cost sharing depending on the group.

Emergency Medicaid Assistance to Noncitizens:

The noncitizen must meet all technical (including residency) and financial requirements for a Medicaid coverage group.

Medicaid Cost-Sharing

- For certain Medicaid services, the recipient is responsible for a set copayment or coinsurance that is to be paid directly to the provider.
- Recipients under the age of 21 years are not required to pay copayments or coinsurance.

Medicaid Payment is Payment in Full

- A provider who bills Medicaid for reimbursement of a Medicaid-covered service must accept payment from Medicaid as payment in full.
 - This does not include Medicaid copayments and Medicaid coinsurance.
- An exception is if a third party liability payment or Medicare payment exceeds the Medicaid payment so that no Medicaid payment is made, then the Medicaid copayment or coinsurance cannot be deducted.
- If the provider has collected the Medicaid copayment or coinsurance, it must be reimbursed to the recipient.
- A provider who fails to bill Medicaid correctly and in a timely manner cannot bill the recipient.

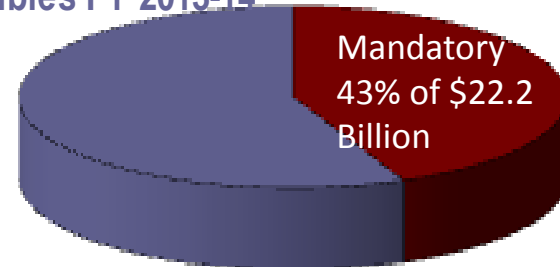
FLORIDA MEDICAID SERVICES



Florida Medicaid Mandatory Services*

- Advanced Registered Nurse Practitioner Services
- Early & Periodic Screening, Diagnosis and Treatment of Children (EPSDT)/Child Health Check-Up
- Family Planning
- Home Health Care
- Hospital Inpatient
- Hospital Outpatient
- Independent Lab
- Nursing Facility
- Personal Care Services
- Physician Services
- Portable X-ray Services
- Private Duty Nursing
- Respiratory, Speech, Occupational Therapy
- Rural Health
- Therapeutic Services for Children
- Transportation

Florida Medicaid Mandatory Services for All Eligibles FY 2013-14

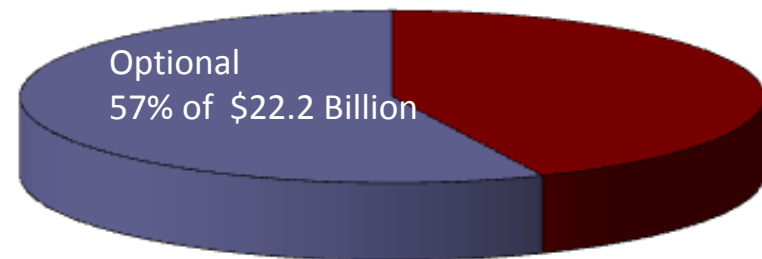


***States are required to provide any medically necessary care required by eligible children. Managed Care Organizations are required to cover these services.**

Florida Medicaid Optional Services**

- Adult Dental Services
- Adult Health Screening
- Ambulatory Surgical Centers
- Applied Behavior Analysis
- Assistive Care Services
- Birth Center Services
- Hearing Services
- Vision Services
- Chiropractic Services
- Community Mental Health
- County Health Department Clinic Services
- Dialysis Facility Services
- Durable Medical Equipment
- Early Intervention Services
- Hospice Care
- Healthy Start Services
- Home and Community-Based Services
- Intermediate Care Facilities/ Developmentally Disabled
- Intermediate Nursing Home Care
- Optometric Services
- Physician Assistant Services
- Podiatry Services
- Prescribed Drugs
- School-Based Services
- State Mental Hospital Services
- Statewide Inpatient Psychiatric Program for Children
- Targeted Case Management

Florida Medicaid Optional Services for All Eligibles FY 2013-14



***States are required to provide any medically necessary care required by eligible children.**

****Managed Care Organizations must cover these services and may offer additional services.**

STATEWIDE MEDICAID MANAGED CARE



What is Managed Care?

- Managed care is when health care organizations manage how their enrollees receive health care services.
- Managed care organizations work with different providers to offer quality health care services.
- Managed care organizations also work to make sure enrollees have access to all needed doctors and other health care providers for covered services.
 - People enrolled in managed care receive their services from providers that have a contract with the managed care plan.

What is SMMC?

- SMMC is the **Statewide Medicaid Managed Care program**.
- The Statewide Medicaid Managed Care (SMMC) program changed how a majority of individuals receive most health care services from Florida Medicaid.
- The SMMC program has two key components:
 - the Long-term Care (LTC) program, and
 - the Managed Medical Assistance (MMA).

What is SMMC?

- **The LTC program** provides long-term care services, including:
 - nursing facility
 - home and community based services, to recipients age 18 and older eligible for enrollment.
- **The MMA program** provides:
 - primary care
 - acute care, and
 - behavioral health care services to recipients eligible for enrollment.
- Some recipients are eligible to enroll in BOTH LTC and MMA.

Who is Providing Services under SMMC?



Types of plans:

- Standard MMA
- Specialty MMA
- Comprehensive
- Long-term Care only

Managed care plans can provide the following services:

Standard Plans

- Only MMA services, or
- Only LTC services

Comprehensive Plans

- Cover all LTC and MMA services.
- Plan care coordinator(s) coordinates with all of the recipient's medical and long-term care providers.

Specialty Plans

- The MMA plan serves Medicaid recipients who meet specified criteria based on:
 - age
 - condition, or
 - diagnosis

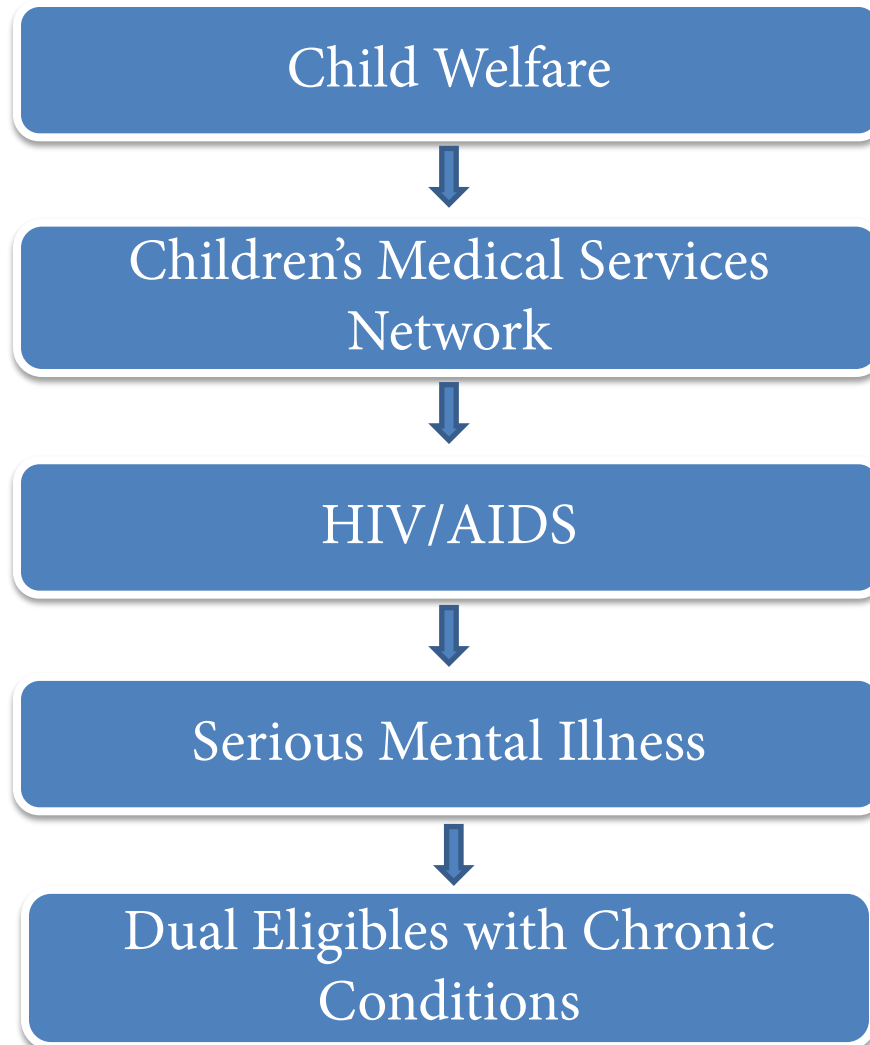
Specialty Plans

- A specialty plan is a managed care plan that serves Medicaid recipients who meet specified criteria based on age, 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) are 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:



Standard Managed Medical Assistance Plans

Region	Standard MMA Plans													
	Amerigroup	Better Health	Coventry	First Coast Advantage	Humana	Integral	Molina	Preferred	Prestige	SFCCN	Simply	Sunshine	United Healthcare	Staywell
1					X	X								
2									X					X
3									X			X	X	X
4				X								X	X	X
5	X								X			X		X
6	X	X			X	X			X			X		X
7	X						X		X			X	X	X
8						X			X			X		X
9					X		X		X			X		
10		X			X					X		X		
11	X		X		X		X	X	X		X	X	X	X

MMA Specialty Plans

MMA Specialty Plans

Region	Positive Healthcare Florida	Magellan Complete Care	Freedom Health, Inc.	Freedom Health, Inc.	Freedom Health, Inc.	Freedom Health, Inc.	Clear Health Alliance	Sunshine State Health Plan, Inc.	Children's Medical Services Network
	Specialty: HIV/AIDS	Specialty: Serious Mental Illness	Specialty: Cardiovascular Disease	Specialty: Chronic Obstructive Pulmonary Disease	Specialty: Congestive Heart Failure	Specialty: Diabetes	Specialty: HIV/AIDS	Specialty: Child Welfare	Specialty: Children with Chronic Conditions
1							X	X	X
2		X					X	X	X
3			X	X	X	X	X	X	X
4		X						X	X
5		X	X	X	X	X	X	X	X
6		X	X	X	X	X	X	X	X
7		X	X	X	X	X	X	X	X
8			X	X	X	X	X	X	X
9		X	X	X	X	X	X	X	X
10	X	X	X	X	X	X	X	X	X
11	X	X	X	X	X	X	X	X	X

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.

Covered LTC Services

Adult companion care	Intermittent and skilled nursing
Adult day health care	Medical equipment and supplies (includes incontinence 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 (PERS)
Home accessibility adaption	Respite care
Home-delivered meals	Therapies: occupations, physical, respiratory and speech
Homemaker	Transportation, non-emergency (for long-term care related services)
Hospice	

NOTE: Each recipient will not receive all services listed. A case manager helps to determine the necessary services.

Managed Medical Assistance Services

Minimum Required Covered Services: Managed Medical Assistance Plans

Advanced registered nurse practitioner services	Medical supplies, equipment, prostheses and orthoses
Ambulatory surgical treatment center services	Mental health services
Birthing center services	Nursing care
Chiropractic services	Optical services and supplies
Dental services	Optometrist services
Early periodic screening diagnosis and treatment services for recipients under age 21	Physical, occupational, respiratory, and speech therapy
Emergency services	Physician services, including physician assistant services
Family planning services and supplies (some exceptions)	Podiatric services
Healthy Start Services (some exceptions)	Prescription drugs
Hearing services	Renal dialysis services
Home health agency services	Respiratory equipment and supplies
Hospice services	Rural health clinic services
Hospital inpatient services	Substance abuse treatment services
Hospital outpatient services	Transportation to access covered services
Laboratory and imaging services	

Expanded Benefits

List of Expanded Benefits	Amerigroup	Better	Coventry	First Coast	Humana	Integral	Molina	Preferred	Prestige	SFCCN	Simply	Staywell	Sunshine	United
Adult dental services (Expanded)	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Adult hearing services (Expanded)	Y	Y			Y		Y	Y	Y		Y	Y	Y	Y
Adult vision services (Expanded)	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Art therapy	Y				Y		Y					Y	Y	
Equine therapy												Y		
Home health care for non-pregnant adults (Expanded)	Y	Y	Y	Y	Y		Y		Y	Y	Y	Y	Y	Y
Influenza vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
Medically related lodging & food		Y			Y		Y		Y		Y	Y	Y	
Newborn circumcisions	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y
Nutritional counseling	Y	Y			Y	Y		Y	Y		Y	Y	Y	
Outpatient hospital services (Expanded)	Y	Y			Y		Y	Y	Y		Y	Y	Y	Y
Over the counter medication and supplies	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y
Pet therapy					Y		Y					Y		
Physician home visits	Y	Y			Y		Y		Y		Y	Y	Y	Y
Pneumonia vaccine	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y
Post-discharge meals	Y	Y			Y	Y	Y	Y			Y	Y	Y	Y
Prenatal/Perinatal visits (Expanded)	Y	Y			Y	Y	Y	Y	Y		Y	Y	Y	Y
Primary care visits for non-pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Shingles vaccine	Y	Y	Y	Y	Y		Y		Y		Y	Y	Y	Y
Waived co-payments	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

NOTE: Details regarding scope of covered benefit may vary by managed care plan.

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.

Eligibility for Child Welfare Specialty Plan

- (1) A child, 20 years old or younger
- (2) Has a child welfare case open for services as identified in the Florida Safe Families Network (FSFN) database; and
- (3) Has a FSFN eligibility indicator in FMMIS.

Child Welfare Plan Enrollment

- The Agency identifies children eligible for enrollment in the CW plan based on a monthly file of active cases from FSFN.
- Once the child is identified as having a FSFN indicator on the eligibility file, the Agency mails a letter to inform the recipient of the availability of the Child Welfare Specialty Plan.
- The letter is mailed to the address listed in the **Payee Address** field in the DCF ACCESS system.
 - For most children in the child welfare system, this is the CBC address.
 - If the child is receiving in home services, the address is the parent's address.

The Agency contracted with Sunshine Health Plan as a specialty plan to serve children in the care and custody of the state

Statewide: Regions 1-11

<http://www.sunshinehealth.com/>



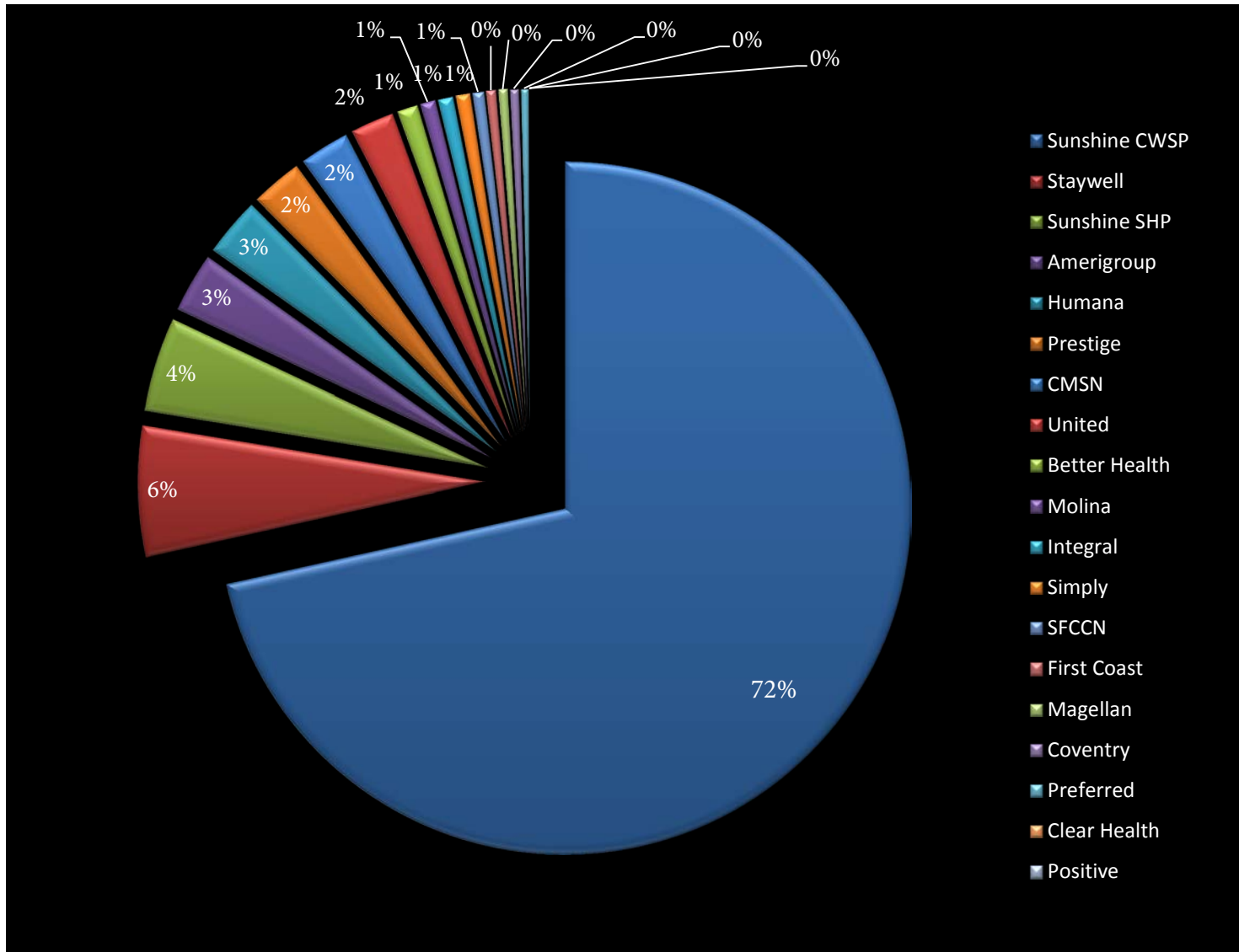
The screenshot shows the Sunshine Health website homepage. At the top left is the Sunshine Health logo. To the right are links for Search, [español], Contact Us, Events, Newsroom, and Careers. Below these are navigation links for Login, Find Doctors / Providers / Hospitals, For Members, For Providers, Healthy Kids, Advantage Medicare, and Long Term Care / Tango. The main content area features a large image of a doctor examining a child held by a parent. To the left of this image is a 'For Members' section with a list of links: Login / Register / ID Cards, Find Doctors / Hospitals, Handbooks / Resources, Stay Healthy / Rewards, and Pharmacy Services. To the right of the image is a 'For Providers' section with 'Login' and 'Join Our Network' buttons. Below that is an 'ambetter' advertisement with the text 'from Sunshine Health' and 'Make Ambetter your family health insurance plan today!' and a 'Learn More' button.

As of August 22, 2014, the total number of Medicaid recipients enrolled in the **Child Welfare Specialty plan (Sunshine)** is 21,901 individuals.

Children in Child Welfare – Enrollment by Plan and Region as of August 2014

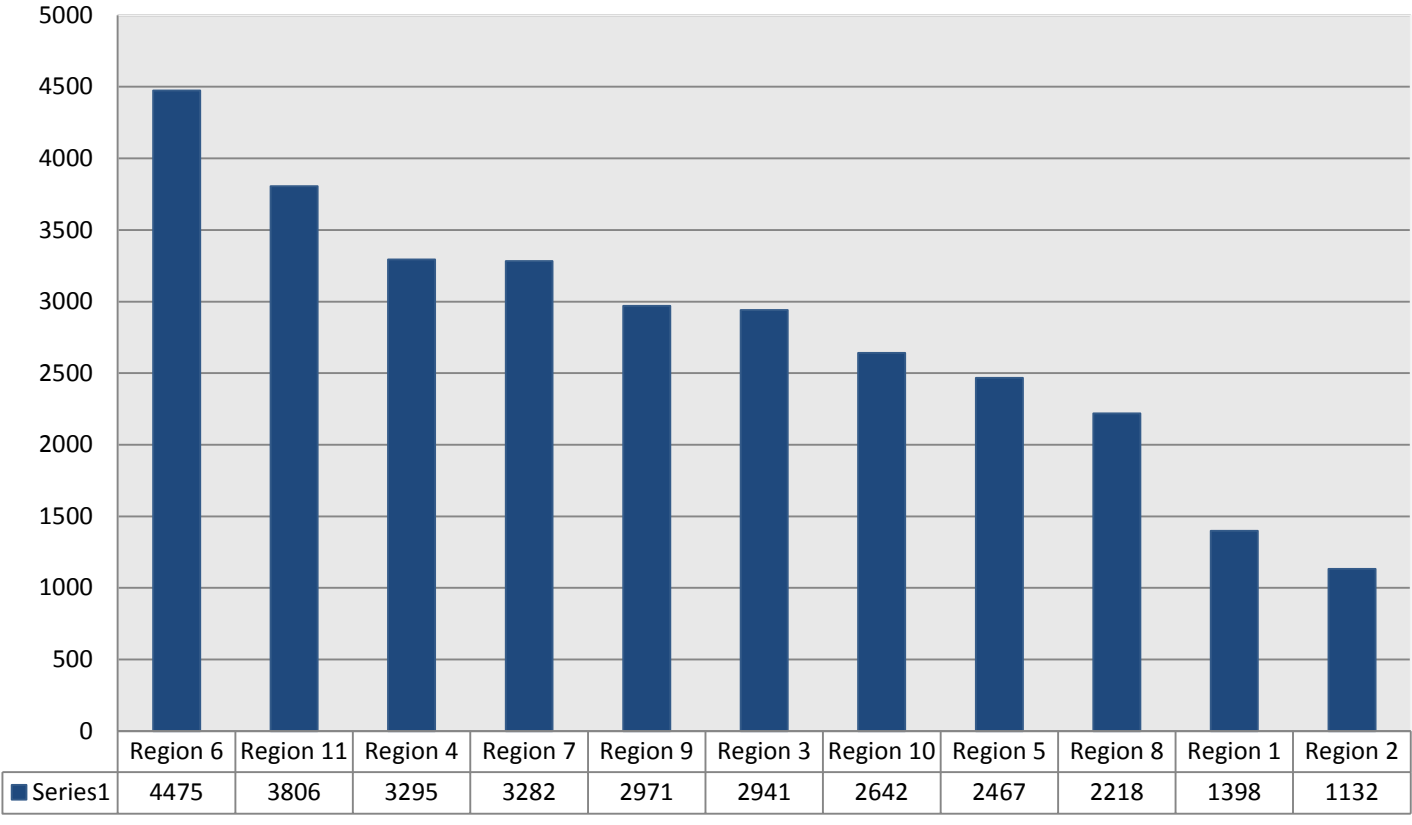
Plan Name	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11	Total
Amerigroup					288	336	56				177	857
Better Health						80				225		305
CMSN	18	50	69	152	41	42	163	38	34	53	63	723
Coventry											139	139
First Coast				150								150
Humana	242					53			179	147	227	848
Integral	87					44		96				227
Molina							8		161		59	228
Preferred											117	117
Prestige		187	127		53	27	44	101	148		56	743
SFCCN										173		173
Simply											214	214
Staywell			279	84	201	410	180	326			387	1867
Sunshine			83	147	111	160	72	47	398	205	128	1351
United			162	116			69				286	633
Sunshine-Child Welfare	1051	895	2221	2646	1773	3323	2677	1610	2023	1791	1891	21901
Positive											4	4
Magellan							12		27	46	57	142
Clear Health							1		1	2	1	5
Total By Region	1398	1132	2941	3295	2467	4475	3282	2218	2971	2642	3806	30627

Child Welfare Enrollment by plan as of 8/22/14



Source: Enrollment Processing System August 22, 2014

Child Welfare Enrollment by Region as of 8/22/14



Source: Enrollment Processing System August 22, 2014

CHILDREN'S MEDICAL SERVICES NETWORK (CMS)



Children's Medical Services Network

- The Children's Medical Services (CMS) Network is a statewide Medicaid specialty plan for children with chronic conditions operated by the Florida Department of Health.
- Enrollment into the Children's Medical Services plan occurred statewide on August 1, 2014.
- Children enrolled in Title XXI CMS transitioned to Title XIX CMS statewide plan on August 1, 2014, if the family income was under 133% of the federal poverty level.

CMSN Specialty Plan

- The CMSN plan is responsible for covering comprehensive medical, dental, **and** behavioral health services.
- The CMSN plan must limit services to those available under the Medicaid fee-for-service program and cannot offer expanded benefits.

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

- At the time of rollout in their region, they could 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.
- If a choice is not made within the required time frame, the child will be assigned to the child welfare specialty plan.

CHOOSING A MANAGED CARE PLAN



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.

CASE MANAGEMENT /SUPPORT COORDINATOR'S ROLE



Case Management/Care Coordination

- The plans are responsible for care coordination and case management for all enrollees.
 - When a recipient is enrolled in both the LTC and MMA programs, the plans must coordinate all services with each other to ensure mixed services are not duplicative.
- When a recipient is enrolled in both LTC and MMA, the LTC case manager is primary.
- The plans must also coordinate with any other third party payor sources to ensure mixed services are not duplicative.

CW Specialty Plan & Care Coordination

- The Specialty Plan will provide care coordination/case management to enrollees appropriate to the needs of child welfare recipients.
- The Specialty Plan will develop, implement and maintain an Agency-approved care coordination/case management program specific to a child welfare specialty population.

CW Specialty Plan & Care Coordination

- The Specialty Plan will coordinate services with the Child Welfare Community-based Care Lead Agencies, as well as other public or private organizations that provide services to dependent children and their families to ensure effective program coordination and no duplication of services.

ENROLLEE RIGHTS



Enrollee Appeal Rights

- Enrollees maintain the right to disagree with any change in their services.
- Plans must notify enrollees in writing of their right to challenge a denial, termination, suspension or reduction of services.

Enrollee Appeal Rights (Continued)

- Case managers will help enrollees file complaints, grievances, and appeals.
- Plans will contact the enrollee in writing to confirm receipt of the appeal and to notify the enrollee of the plan's response to the appeal.
- Enrollees have the right to continue receiving their current level of services while the appeal is under review.

CHILDREN'S MULTIDISCIPLINARY ASSESSMENT TEAM (CMAT) SERVICES



What are CMAT Services?

- CMAT is an interagency coordinated effort:
 - Agency for Health Care Administration, Medicaid
 - DCF, Office of Family Safety
 - Agency for Persons with Disabilities
 - Dept. of Health, Children's Medical Services.
- 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 an MMA plan.
- 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.

Frequently Asked Questions



Once a child is no longer actively receiving services from DCF, how long do they stay eligible for the CW Specialty Plan?

- The enrollees will lose their eligibility for the CW Specialty Plan once their open Florida Safe Families Network (FSFN) span is closed in Florida Medicaid Management Information System (FMMIS).
 - When a recipient's case is closed in FSFN, the recipient's eligibility for the Child Welfare Specialty Plan ends and the recipient will be notified to make a different plan choice.
- The recipient will be able to choose any standard MMA plan in their region or any other Specialty Plan for which the recipient qualifies.
- The recipient will remain in the Child Welfare Specialty Plan until the effective date of enrollment in the new plan.

Some of these families receive DCF services for a relatively short period of time. Will the family have to change plans several times?

- Recipients have a choice of whether or not to change plans.
- The parent can determine whether remaining in the child's current MMA plan is the best option.
- All MMA plans are required to provide the same basic array of services under their contracts, which includes 72-hour access to a physical health screening after being brought into protective custody and access to child welfare behavioral health services (comprehensive behavioral health assessment, specialized therapeutic foster care, and behavioral health overlay services for child welfare settings).
- The recipient will be able to access all medically necessary services through their current plan or the Child Welfare Specialty Plan.

Some of these families receive DCF services for a relatively short period of time. Will the family have to change plans several times?

- In addition, the Child Welfare Specialty Plan must coordinate services with the Community Based Care Lead Agencies (CBCs) and DCF, as well as other public or private organizations that provide services to dependent children and their families to ensure effective program coordination and no duplication of services.
- The Child Welfare Specialty Plan's care coordination/case management program description must include protocols and other mechanisms for accomplishing such program coordination.
- The Child Welfare Specialty Plan must collaborate with the Agency and DCF to develop such protocols and other mechanisms as may be required for effective program coordination.

Is there a way to accelerate the choice process so that children brought into protective custody can be enrolled in a plan sooner?

- Once the child is identified as having an FSFN indicator on their eligibility file, the child will receive a letter to inform the recipient of the availability of the Child Welfare Specialty Plan in their region.
- The recipient or their legal guardian will be given 30 days to choose a plan.
- If the recipient or their guardian contacts the choice counseling call center before the second-to-last Saturday of the month, the choice counselor will be able to enroll the recipient in the plan of their choice, effective at the beginning of the following month.
- During that choice period, the recipient may access services under fee-for-service if they are not already enrolled in an MMA plan, or they may continue to access services through their current MMA plan.
- All MMA plans are required to provide the same array of State Plan services, which includes 72-hour access to a physical health screening after being brought into protective custody and access to child welfare behavioral health services (comprehensive behavioral health assessment, specialized therapeutic foster care, and behavioral health overlay services for child welfare settings).

How is SIPP, which ends at 18 years of age, provided for the extended foster care population?

- Recipients under the age of 21 are eligible for SIPP services in qualifying facilities.
- SIPP providers may include acute care hospitals, freestanding psychiatric hospitals, and residential treatment centers for children and adolescents (which meet federal qualifications for a Psychiatric Residential Treatment Facility).
- Providers must render treatment in accordance with the draft Medicaid Statewide Inpatient Psychiatric Program Services Coverage and Limitations Handbook.
- SIPP providers serving recipients enrolled in fee for service Medicaid must enroll as a Medicaid provider type 16 to receive reimbursement for services.
- For MMA enrollees, SIPP services will be prior authorized by the recipient's MMA plan and provided through eligible Medicaid-enrolled or registered providers in the MMA plan's network or operating under an agreement with the plan.

Why would the welcome packet go to the CBC CM if the member's parents have decision authority?

- The Community Based Care Lead Agency (CBC) is responsible for coordinating care for children in custody.
 - This includes consulting member parents and caregivers.

How will suitability assessments be performed in this new system?

- The process for suitability assessments will not change.
- The CBC will continue to determine the need for a request for a suitability assessment in accordance with DCF Children and Families Operating Procedure (CFOP) 155-10/175-40, located on the Department of Children and Families' website.
- The Agency for Health Care Administration has not changed the vendor responsible for conducting suitability assessments.

Children's Medical Services ends at 21 years of age, and for the extended foster care population who are disabled, it ends at 22 years of age. How should skilled nursing facility and other services for the 21+ population be managed?

- Medicaid recipients age 21 years or older are not eligible to enroll into the Child Welfare Specialty Plan or Children's Medical Services.
- Instead, they may be eligible for enrollment into standard or other specialty MMA plans, all of which also cover temporary nursing facility services and other covered Medicaid services.
- If a recipient age 18 or older is Medicaid eligible by reason of a disability and resides in a skilled nursing facility for more than 30 days, the recipient will also be mandatorily enrolled in the Statewide Medicaid Managed Care Long-term Care program, through which they will receive their nursing facility services and assistance with transitioning to the community with long-term care supports under the Long-term Care program.

Note: The young adult's change in status may require an eligibility redetermination by the Department of Children and Families or Social Security Administration in order to be eligible for Medicaid services. Additional information should be sought from the Department of Children and Families' ACCESS program.

How are services such as personal care or private duty nursing provided to disabled children - Medicaid fee-for-service or Sunshine?

- If a child is enrolled in an MMA plan, personal care and private duty nursing services will be provided by the MMA plan.
- Almost all Medicaid services, including personal care and private duty nursing, are provided by the MMA plans.
- This is true for both standard plans and specialty plans (e.g., the CMSN Plan and the Child Welfare Specialty Plan).
- If the recipient is 18 years or older and enrolled in a Long-term Care (LTC) plan, the recipient's LTC plan will be responsible for covering personal care and intermittent and skilled nursing services.

FOR MORE INFORMATION





ahca.myflorida.com/smmc

AGENCY FOR HEALTH CARE ADMINISTRATION

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Statewide Medicaid Managed Care Program

Program Updates



Report a Complaint



Submit
Comments & Questions



Frequently
Asked Questions



Visit the Statewide Medicaid Managed Care Program (SMMC) Web site at: ahca.myflorida.com/smmc for information on news and events, program updates, to submit questions and comments, and report a complaint.

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

Florida Statewide Medicaid Managed Care Program Complaint Form

[Español](#) | [Creole](#)

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

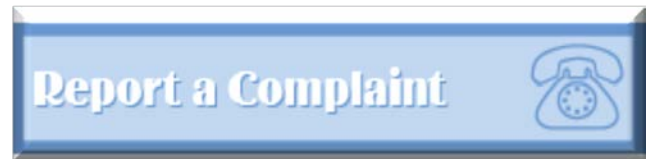
What type of Managed Care Plan is this complaint/issue about?

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?



- 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/>