Welcome to the Agency for Health Care Administration Training Presentation for Managed Medical Assistance Recipient Eligibility Verification

The presentation will begin momentarily.

Please dial in ahead of time to:

1-888-670-3525

Passcode: 541 679 5591

Better Health Care for All Floridians
AHCA.MyFlorida.com

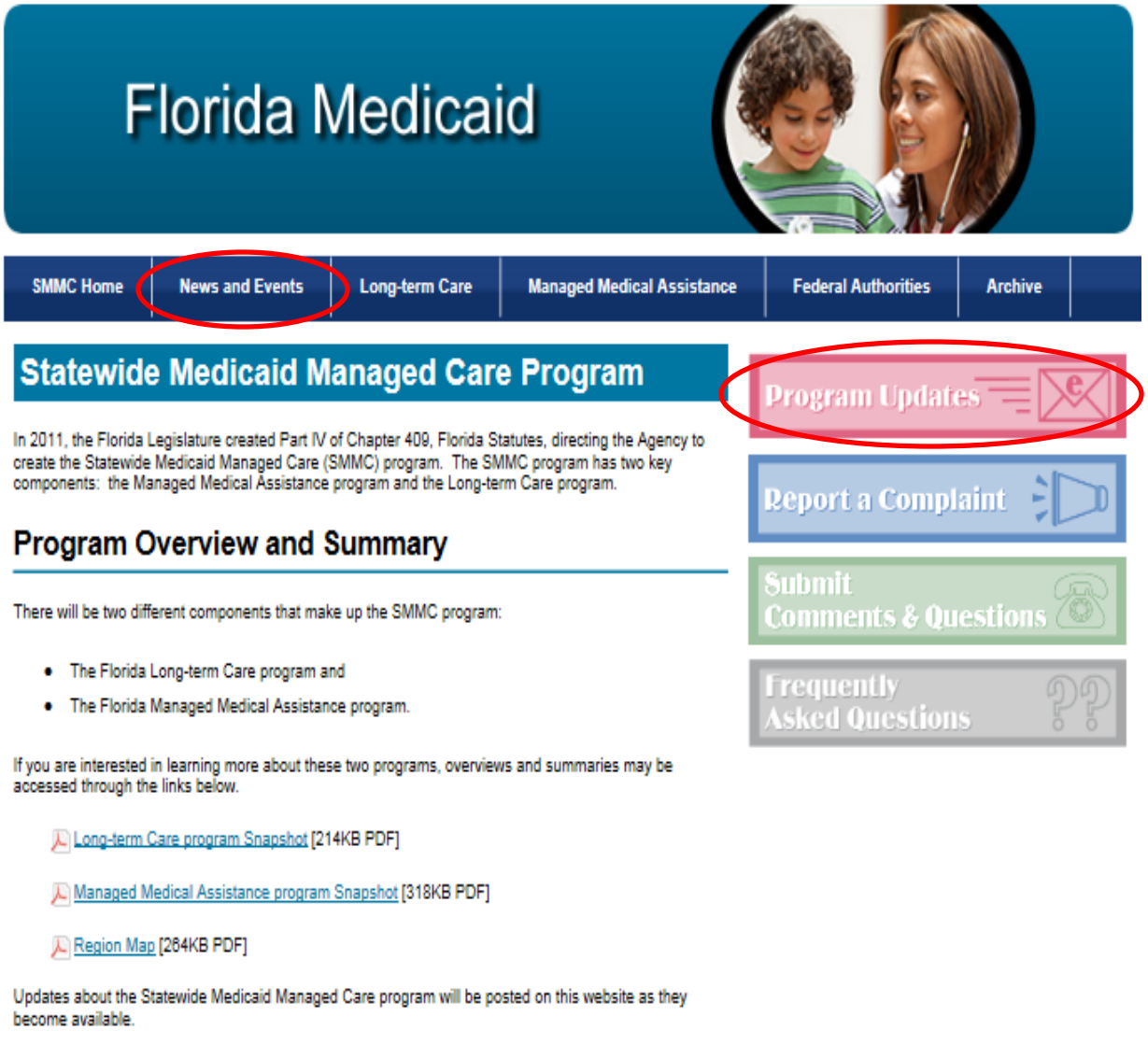
How to Verify Recipient Eligibility for the Statewide Medicaid Managed Care Managed Medical Assistance Program

August 21, 2014

Today's Presentation

Follow the link below to the SMMC Website and select the "News and Events" link under the header image.

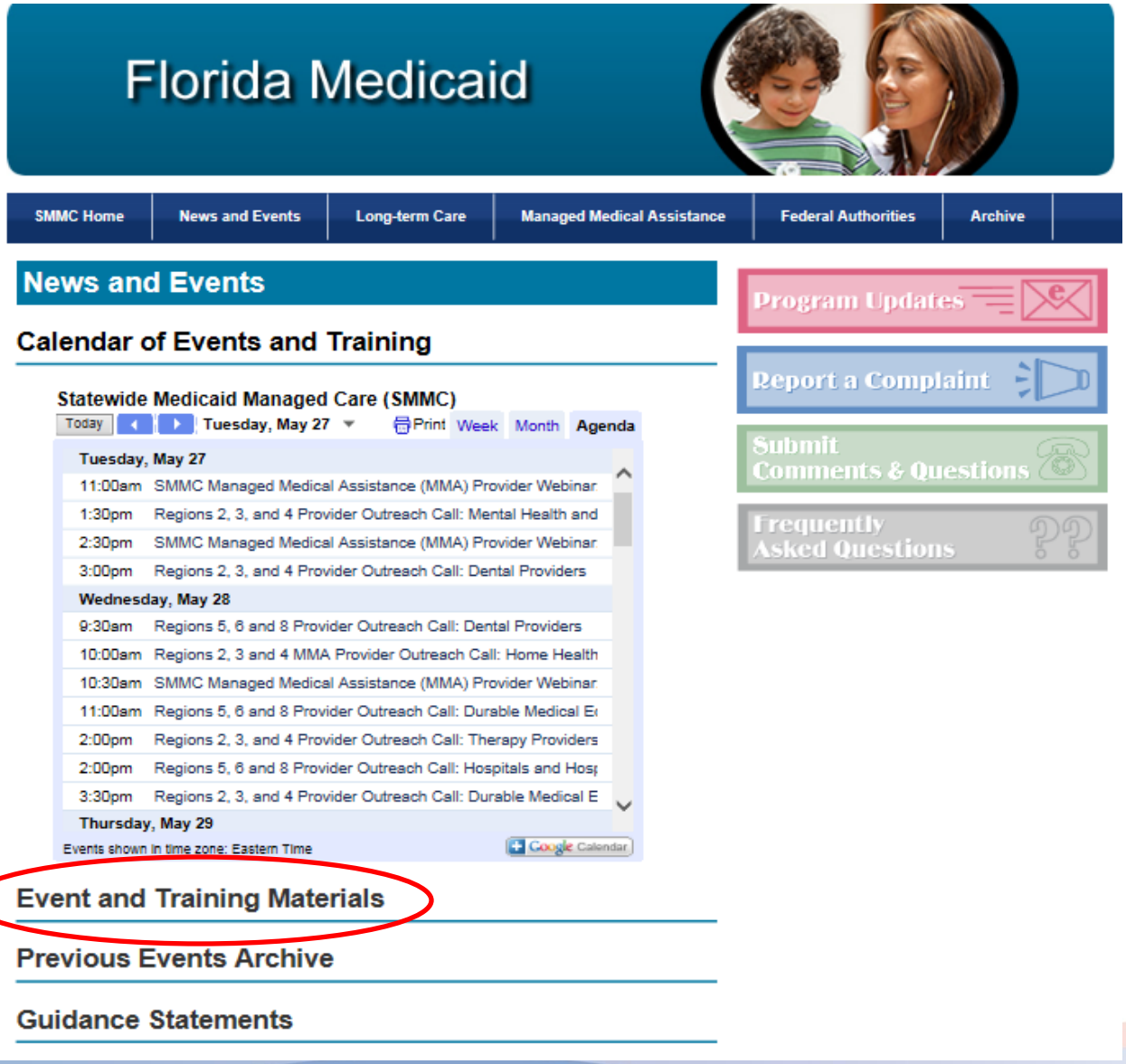
Note: You can use the red button to sign up for SMMC Program updates via e-mail.



http://ahca.myflorida.com/smmc

Today's Presentation, cont.

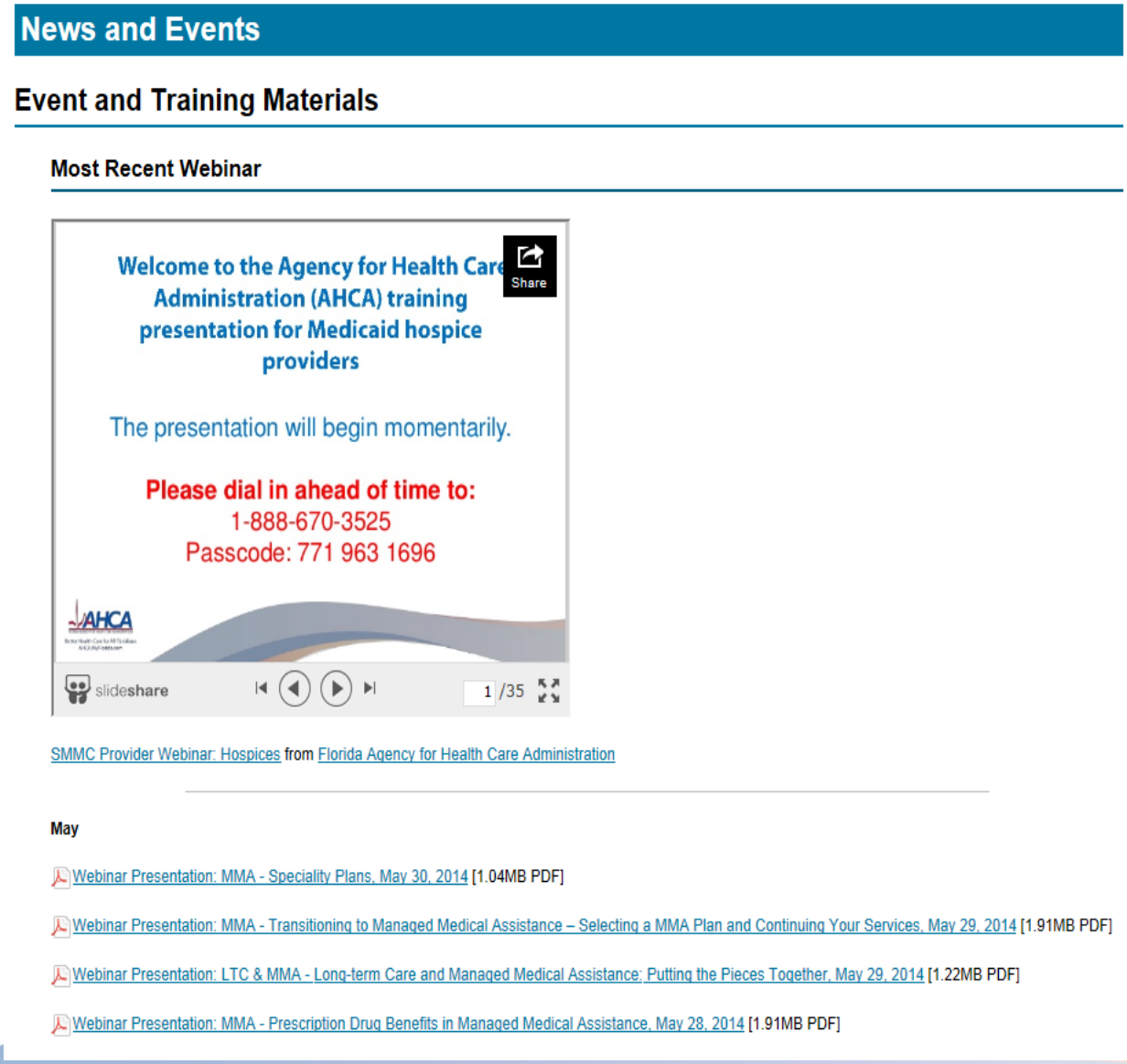
Select "Event and Training Materials" to download today's presentation.



Today's Presentation, cont.

Choose the file(s) you would like to save.

Note: You may also view files from past events and AHCA guidance statements or submit questions to be answered in future presentations.

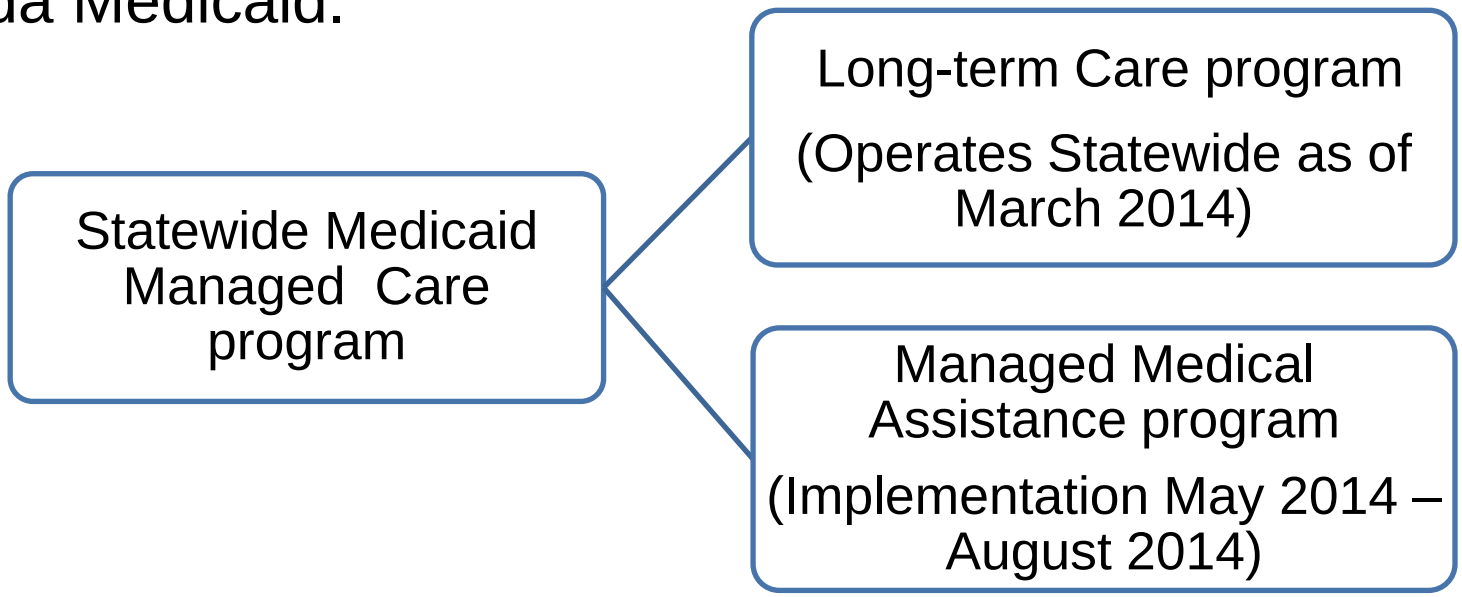


Today's Presenter

- Kelly Walsh
  - Agency for Health Care Administration

Why are changes being made to Florida's Medicaid program?

Because of the Statewide Medicaid Managed Care (SMMC) program, the Agency is changing how a majority of individuals receive most health care services from Florida Medicaid.



Managed Medical Assistance Program Roll Out Schedule

Implementation Schedule		
Regions	**Plans**	**Enrollment Date**

2, 3 and 4	• Standard Plans
	• Specialty Plans:
	  ○ HIV/AIDS
	  ○ Child Welfare
		May 1, 2014

5, 6 and 8	• Standard Plans
	• Specialty Plans:
	  ○ HIV/AIDS
	  ○ Child Welfare
		June 1, 2014

10 and 11	• Standard Plans
	• Specialty Plans:
	  ○ HIV/AIDS
	  ○ Child Welfare
	  ○ Serious Mental Illness
		July 1, 2014

1, 7 and 9	• Standard Plans
	• Specialty Plans:
	  ○ HIV/AIDS
	  ○ Child Welfare
		August 1, 2014

Statewide	• Children's Medical Services Network	August 1, 2014

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.

Managed Medical Assistance & Recipient Eligibility

SMMC & Medicaid Eligibility

Does the SMMC program change eligibility for Medicaid in Florida?

- No, the Statewide Medicaid Managed Care program does not change eligibility coverage.
- People who were eligible for Medicaid will continue to be eligible after SMMC is implemented.

Who Determines Eligibility?

The Agency for Health Care Administration (AHCA) does not determine eligibility for Medicaid. Eligibility is determined by a number of state, federal, county and private entities.

- The Florida Department of Children and Families (DCF)
- The Social Security Administration
- Florida Healthy Kids Corporation
- Florida Department of Health
- Qualified Designated Providers (presumptive eligibility for pregnant women)
- Qualified hospitals (presumptive eligibility for certain groups)

Which Medicaid Recipients Will Enroll in the MMA Program?

- With some exceptions, all Medicaid recipients must receive Medicaid covered services through the Managed Medical Assistance (MMA) program.

- Most Medicaid recipients who are enrolled in the traditional Medicaid program or who were already enrolled in a Medicaid managed care plan (HMO or Medipass) must choose an MMA plan.

Populations who will enroll in the MMA program:
Temporary Assistance to Needy Families (TANF)
SSI (Aged, Blind and Disabled)
Hospice
Low Income Families and Children
Institutional Care
Medicaid for the Aged and Disabled (MEDS-AD) designated by the Sixth Omnibus Budget Reconciliation Act (SOBRA) for children age 18 to 19
MEDS AD (SOBRA) for aged and disabled
Protected Medicaid (aged and disabled)
Dual Eligibles (Medicare and Medicaid)- Full Duals only
Dual Eligibles - Part C – Medicare Advantage Plans Only *(will enroll January 2015)*

Who May Choose to Enroll?

- Certain recipients may choose to enroll in an MMA plan to receive services.

- These recipients are not subject to mandatory open enrollment periods.
  - They may choose a plan or dis-enroll at any time.

Populations who may choose to enroll in the MMA program:
Recipients with a Third Party Liability (TPL) coverage excluding Medicare
Recipients residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID)
Individuals receiving refugee assistance
Recipients ages 65 and older residing in a State Mental Health Hospital
Recipients enrolled in the iBudget (Developmental Disabilities) home and community based services waiver & recipients on the iBudget (Developmental Disabilities) home and community based services waiver wait list (must be fully eligible)
Children receiving services in a prescribed pediatric extended care facility.
Medicaid recipients residing in a group home facility licensed under chapter 393

Populations who will NOT participate in the MMA program:
Individuals eligible for emergency services only due to immigration status
Women who are eligible ***only*** for family planning **services**
Women who are eligible through the breast and cervical cancer program
Emergency shelter/Department of Juvenile Justice (DJJ) residential
Recipients ***only*** enrolled in the Medicare limited-benefit program called Qualified Individuals 1 , QMB, SLMB
Recipients in the Health Insurance Premium Payment (HIPP) program
Presumptively eligible pregnant women
Medically Needy individuals

Ways to Access Recipient Eligibility Information

- The secure area on the Medicaid fiscal agent's Web Portal. You can contact the fiscal agent for assistance with the web portal at: www.mymedicaid-florida.com
- Automated Voice Response System (AVRS) that provides eligibility information using a touch-tone telephone: **1-800-239-7560**.
- PDA at https://evs.flmmis.com (only a registered provider with a PDA will have access to this site).
- X12N 270/271 Health Care Eligibility Benefit Inquiry and Response.
- The individual's managed care plan.

Information Available

The following recipient eligibility information is available through the listed Ways to Access Recipient Information for dates of service within the past 12 months:

- **Managed care membership**
- Medicaid program code/aid category
- Hospital and other service limitations
- Third party insurance coverage and policy number
- Medicare number
- Medicare Part A & B coverage
- Nursing home status

Benefit Plans & Program Codes/Aid Categories

What is a Benefit Plan?

- "Benefit Plan" is a term used by Medicaid to define the scope of benefits an individual is eligible to receive.
- Not all Medicaid recipients receive the same level of benefits.
- Some benefit plans have full benefits; others have limited benefits.
- An individual may be in multiple benefit plans during the same period.
  - When the individual is in more than one benefit plan, claims are processed using a Benefit Plan Hierarchy.

What is "Program Code/ Aid Category"?

- "Program Code or Aid Category" is a unique alpha identifier that identifies the Medicaid category under which a recipient is eligible.
- The "Program Code or Aid Category" may determine whether an individual can enroll in a managed care plan.
- The "Program Code or Aid Category" identifies what benefit plan the individual is put in, and therefore which services are available.
- **Some codes indicate benefit limitations**.

Benefit Plan Descriptions

Individuals participating in Managed Medical Assistance will be in **one or more** of these benefit plans:

Benefit Plan	Description
SSI	Full Medicaid benefits for Supplemental Security Income (SSI) (SSI) recipients, not in the Institutional Care Program (ICP)
Title XIX	Full Medicaid benefits, not in the Institutional Care Program (ICP)
LTC	Institutional Care Program (ICP). Full Medicaid benefits and and institutional care. Can be the only benefit plan or can exist exist with SSI or Title XIX benefit plans
Mkids	Full Medicaid benefits except Home and Community Based Services (HCBS) waiver services

Benefit Plan Descriptions, cont.

Individuals in these benefit plans may participate in Managed Medical Assistance if they are **also in another** benefit plan that allows them to participate.

Benefit Plan	Description
QI 1	Covers **only** Medicare Part B premiums
QMB	Covers payment of Medicare premiums, deductibles & coinsurance within certain limits
SLMB	Covers only Medicare Part B premiums
RXEXP	Covers only Medicare Part B copays for cancer treatment & & organ transplant drugs

Benefit Plan Descriptions, cont.

Individuals in these benefit plans will NOT participate in MMA.

Benefit Plan	Description
Alien	Only covers inpatient emergency services, labor & delivery, kidney kidney dialysis for non—citizens
MN	Medically Needy individual who must meet a monthly share of cost cost to become eligible
PEPW	Presumptive Eligibility for Pregnant Women only covers outpatient, outpatient, office services and transportation
WFP	Family Planning Waiver covers only family planning services for up for up to 2 years for women who lose Medicaid eligibility

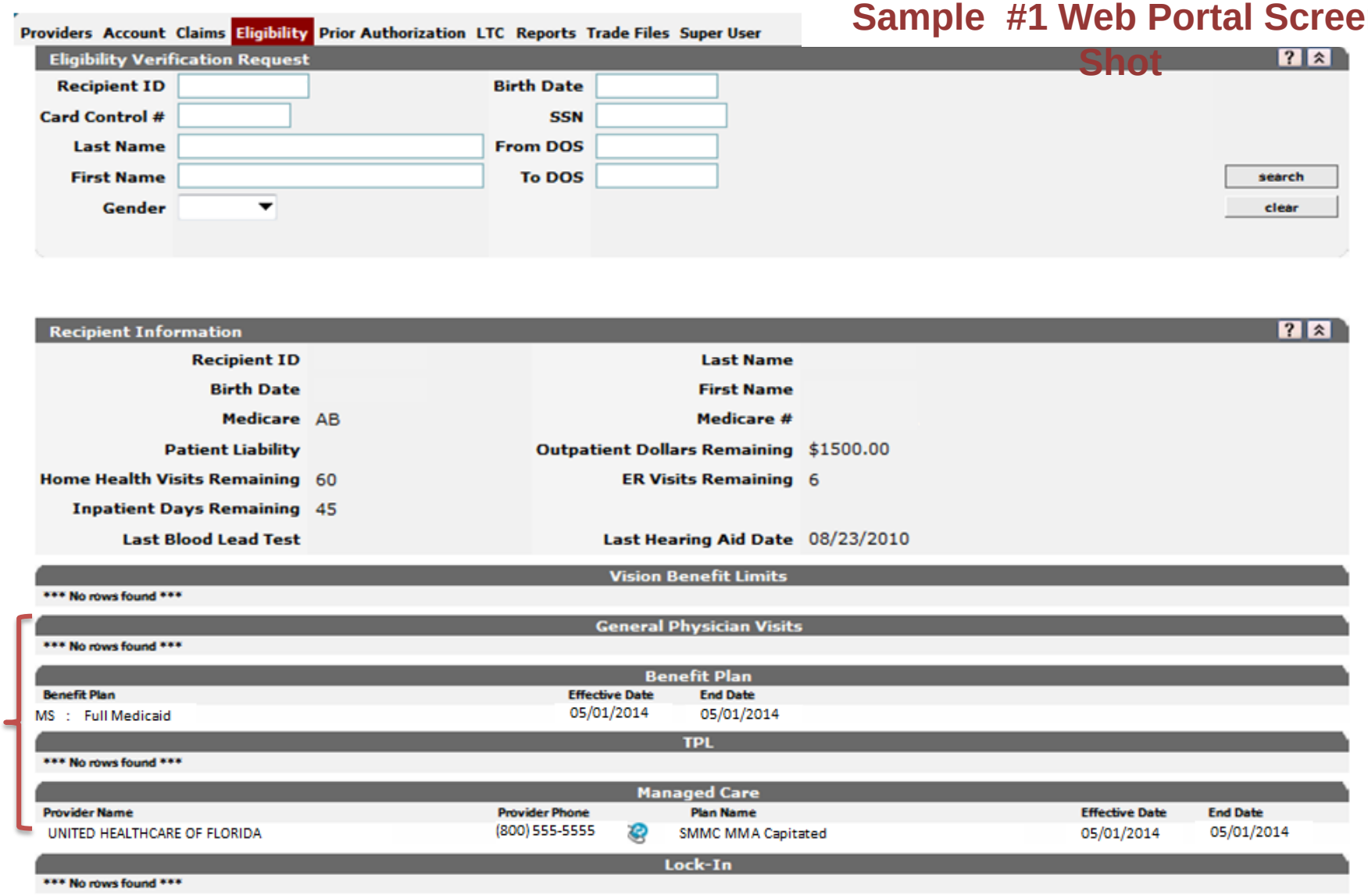
How do you know if a recipient is enrolled in the Managed Medical Assistance program?

This is a companion webinar to the MMA 101 & the LTC and MMA: Putting the Pieces Together webinars found at the Statewide Medicaid Managed Care Program website at: *http://ahca.myflorida.com/SMMC*

- Providers can check a plan member's eligibility in the FLMMIS web portal.

- The next five slides show Web Portal samples of recipients enrolled in:
  - a Managed Medical Assistance plan
  - both a Long-term Care & in a Managed Medical Assistance plan
  - both a Long-term Care plan & specialty plan
  - enrolled only in the Child Welfare specialty plan
  - enrolled in a comprehensive plan (covers both LTC & MMA services)

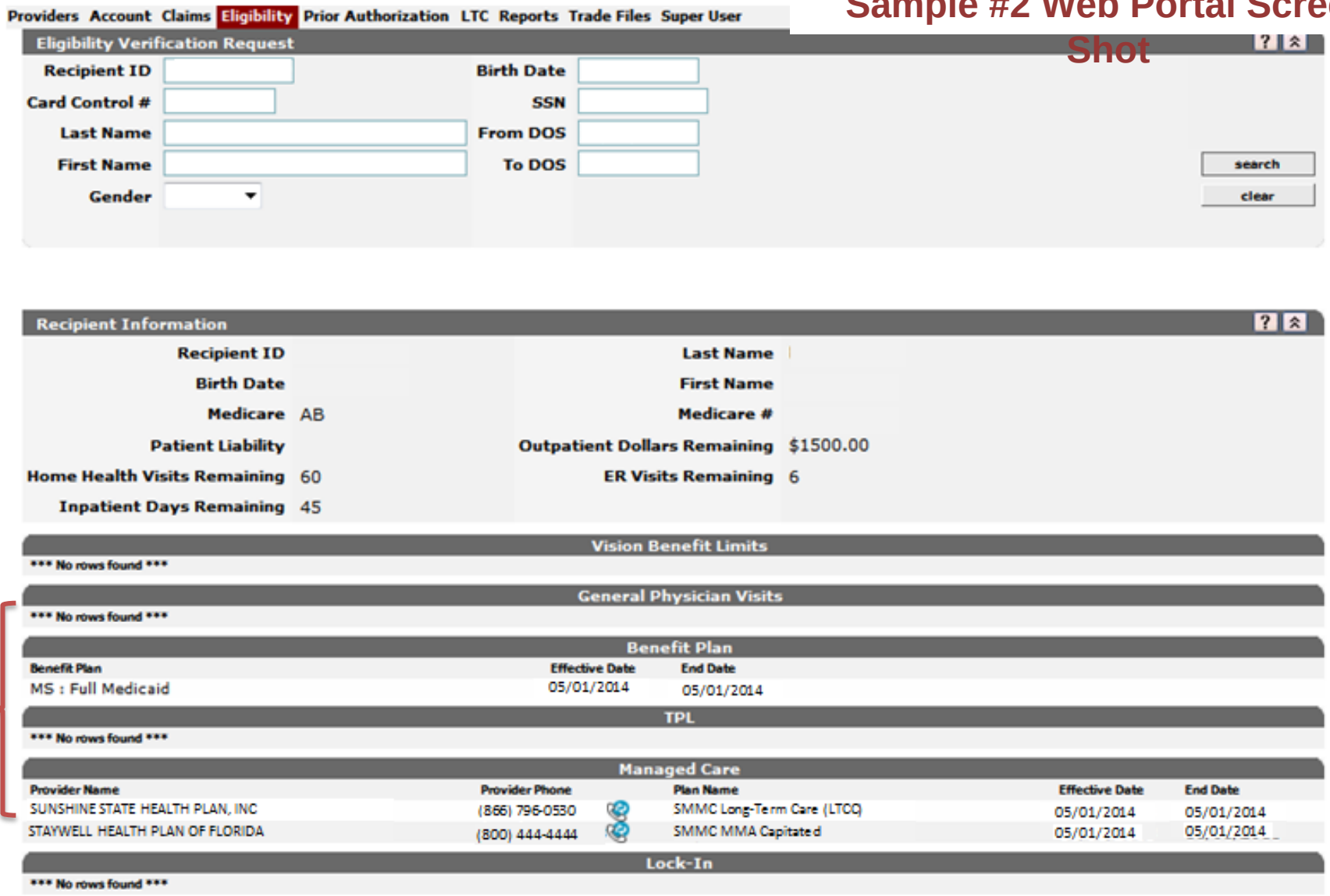
Sample #1 Web Portal Screen Shot



Review Benefit Plan panel: MS Full Medicaid

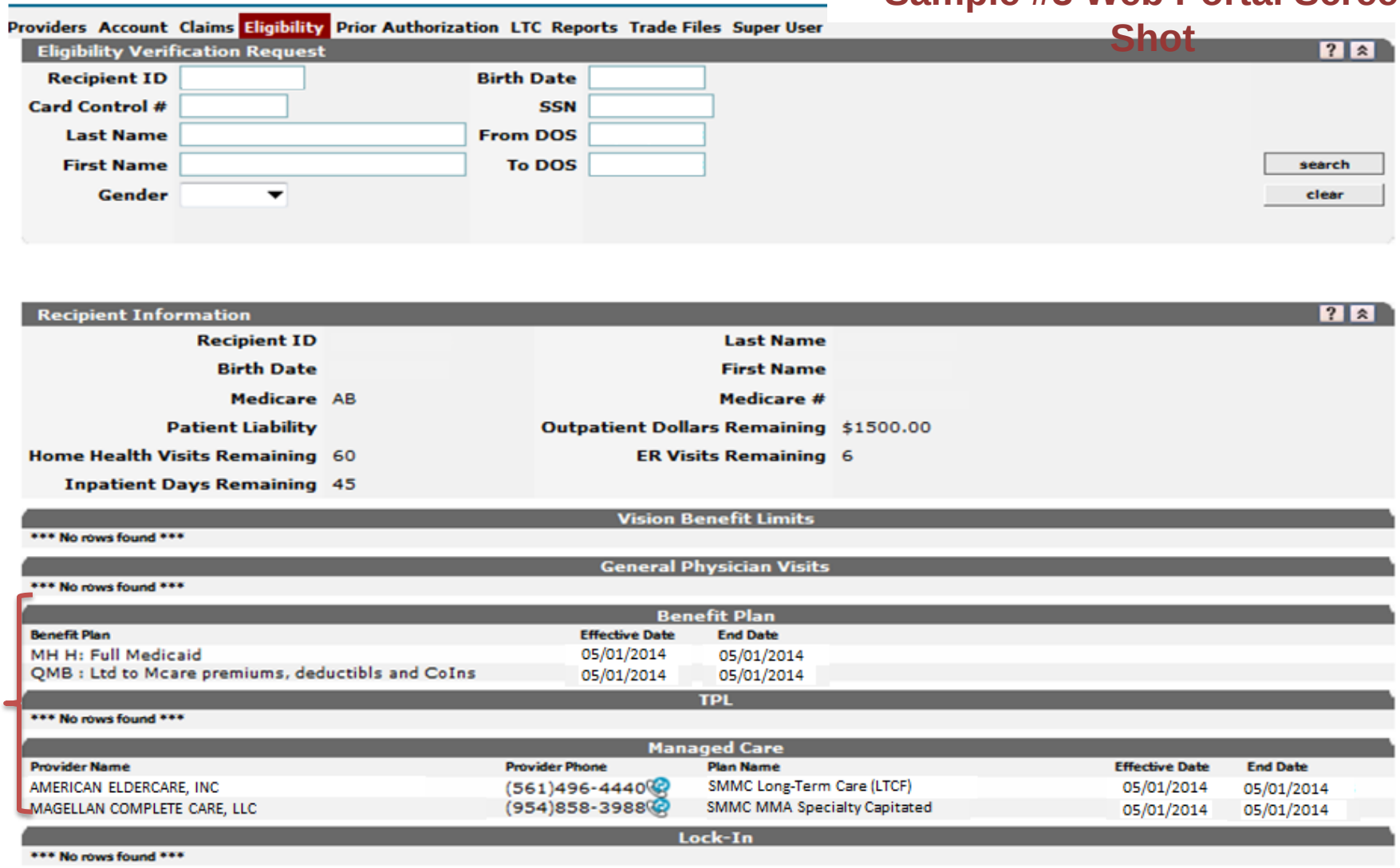
Review Managed Care Panel: Recipient enrolled in a Managed Medical Assistance Capitated (**SMMC MMA Capitated**) plan.

Sample #2 Web Portal Screen Shot



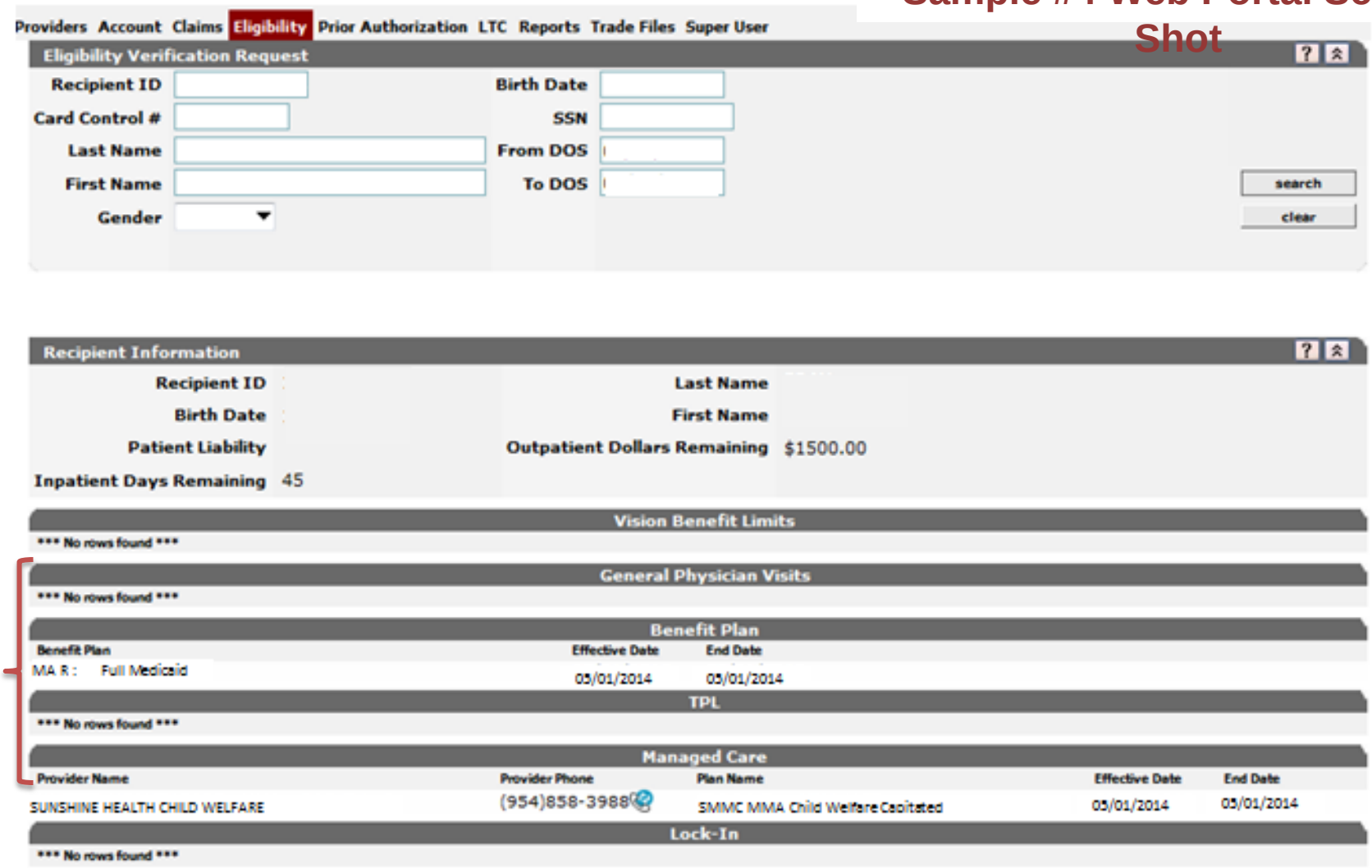
Review Managed Care Panel: Recipient enrolled in both a Long-term care capitated (**LTCC**) & a Managed Medical Assistance Capitated (**SMMC MMA Capitated**) plan.

Sample #3 Web Portal Screen Shot



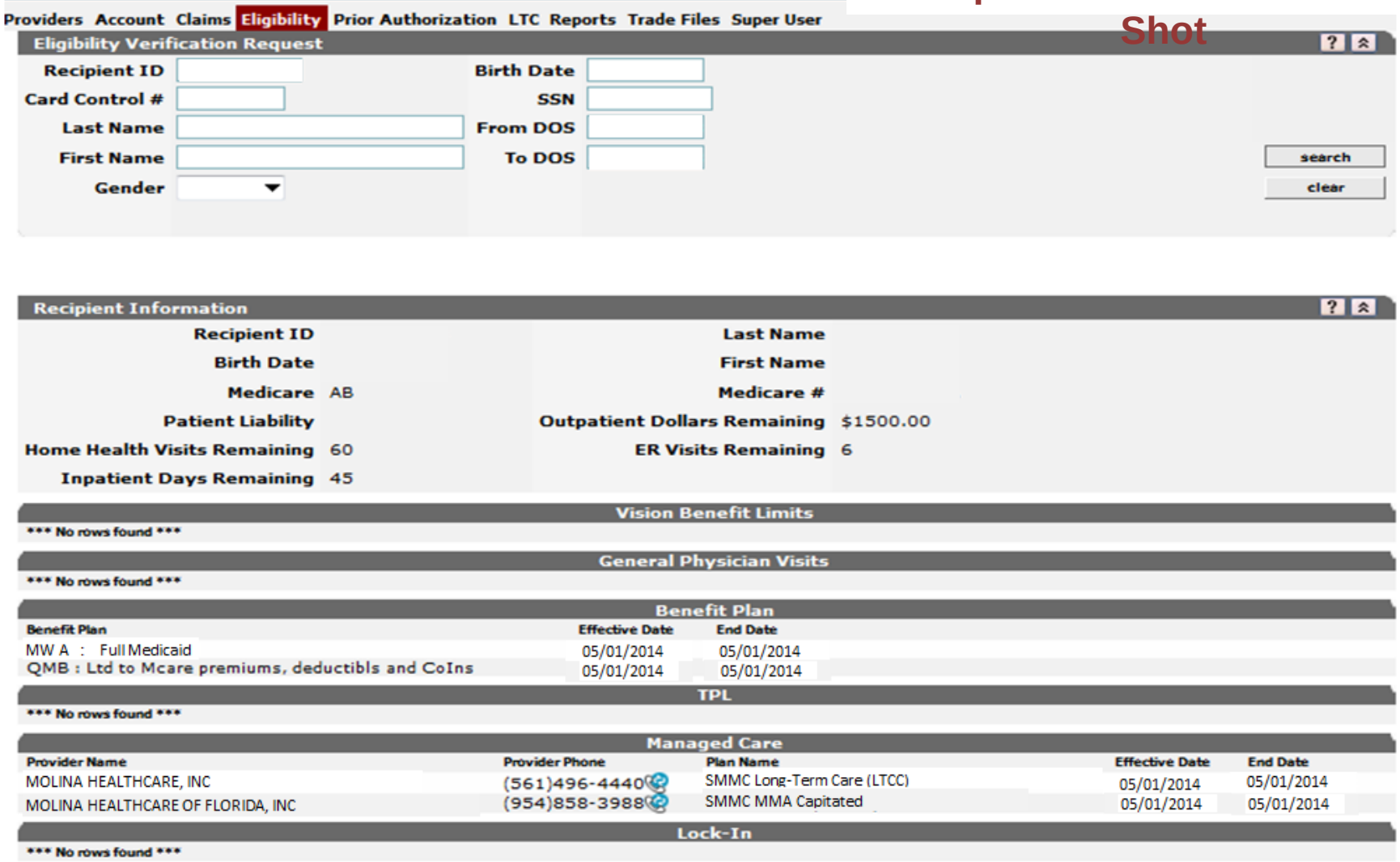
Review Managed Care Panel: Recipient enrolled in both a Long-term care fee-for-service (**LTCF**) & a Managed Medical Assistance Specialty (**SMMC MMA Specialty Capitated**) plan.

Sample #4 Web Portal Screen Shot



Recipient enrolled in the Child Welfare (**SMMC MMA Child Welfare Capitated**) plan.

Sample #5 Web Portal Screen Shot



Providers Account Claims Eligibility Prior Authorization LTC Reports Trade Files Super User

Eligibility Verification Request

Recipient ID		Birth Date	
Card Control #		SSN	
Last Name		From DOS	
First Name		To DOS	
Gender			

search clear

Recipient Information

Recipient ID		Last Name	
Birth Date		First Name	
Medicare	AB	Medicare #	
Patient Liability		Outpatient Dollars Remaining	$1500.00
Home Health Visits Remaining	60	ER Visits Remaining	6
Inpatient Days Remaining	45		

Vision Benefit Limits

*** No rows found ***

General Physician Visits

*** No rows found ***

Benefit Plan

Benefit Plan	Effective Date	End Date
MW A : Full Medicaid	05/01/2014	05/01/2014
QMB : Ltd to Mcare premiums, deductibls and CoIns	05/01/2014	05/01/2014

TPL

*** No rows found ***

Managed Care

Provider Name	Provider Phone	Plan Name	Effective Date	End Date
MOLINA HEALTHCARE, INC	(561)496-4440	SMMC Long-Term Care (LTCC)	05/01/2014	05/01/2014
MOLINA HEALTHCARE OF FLORIDA, INC	(954)858-3988	SMMC MMA Capitated	05/01/2014	05/01/2014

Lock-In

*** No rows found ***

Review Managed Care Panel: Recipient enrolled in a comprehensive plan. Recipient enrolled in both a Long-term Care Capitated (**LTCC**) & a Managed Medical Assistance Capitated (**SMMC MMA Capitated**) plan.

Self-Service Automated Voice Response System (AVRS)

Call **(800) 239-7560** and follow the prompts to verify eligibility

- You can receive a fax with a copy of the eligibility results.
- The following recipient eligibility information is available through AVRS:
  - Managed care membership
  - Medicaid program code/aid category
  - Hospital and other service limitations
  - Third party insurance coverage and policy number
  - Medicare number
  - Medicare Part A & B coverage
  - Nursing home status

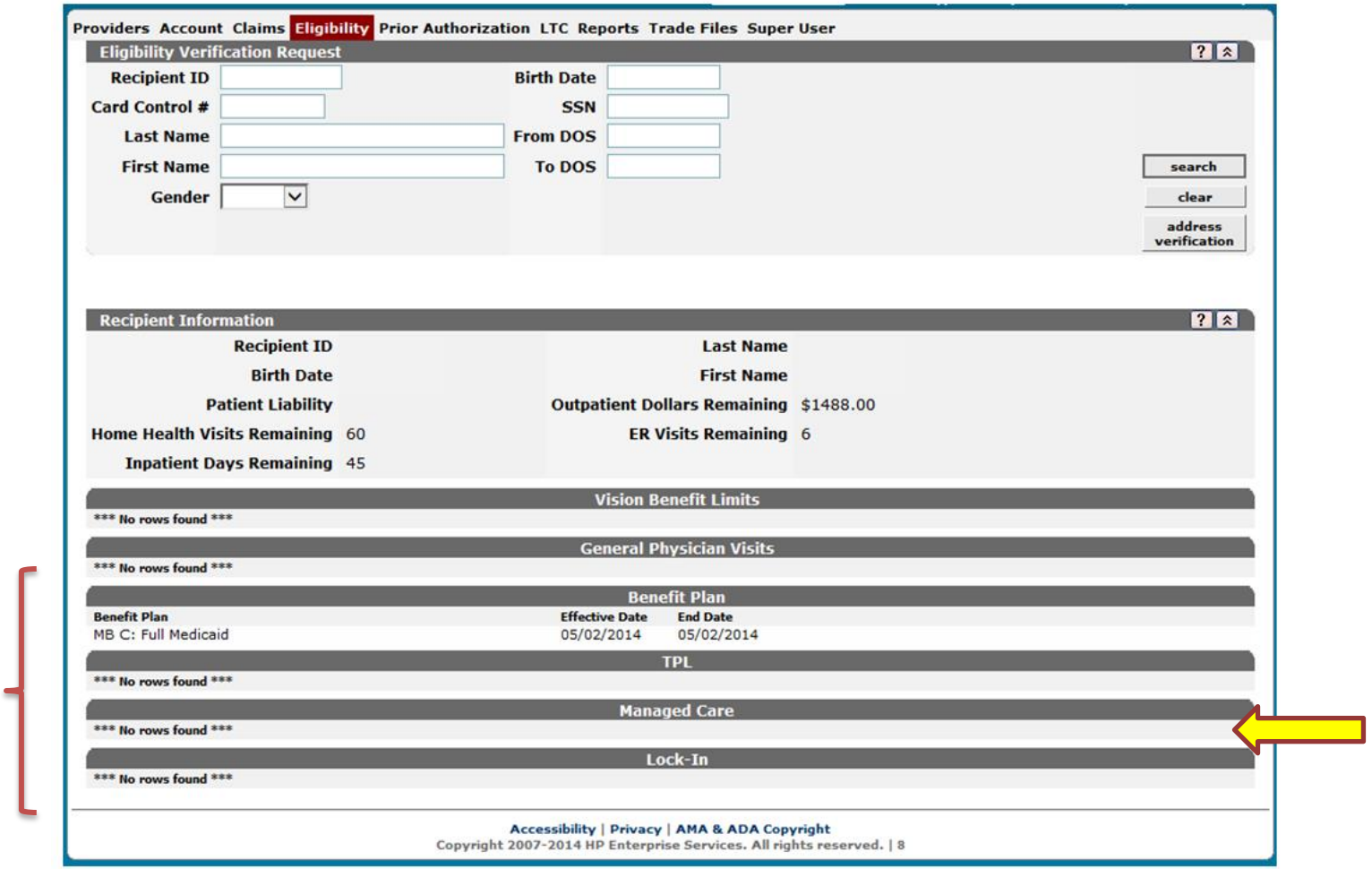
A VERY SPECIAL CAUTION

When verifying Medicaid recipient eligibility will ALL recipients show as enrolled in an MMA plan?

- **No**, when checking eligibility please remember that you will not always see a Medicaid Managed Medicaid Assistance Plan in the Managed Care panel.
- Remember, some Medicaid recipients will still receive services by fee-for-service providers, and when verifying eligibility for these individuals the **Managed Care panel won't have information.**
- For example, Medicaid recipients in the excluded populations and Medically Needy individuals won't show an MMA plan since they **will continue to receive Medicaid services by fee-for-services providers**.

Sample Web Portal Screen Shot

Recipient continues to receive Medicaid services by fee-for-services providers.

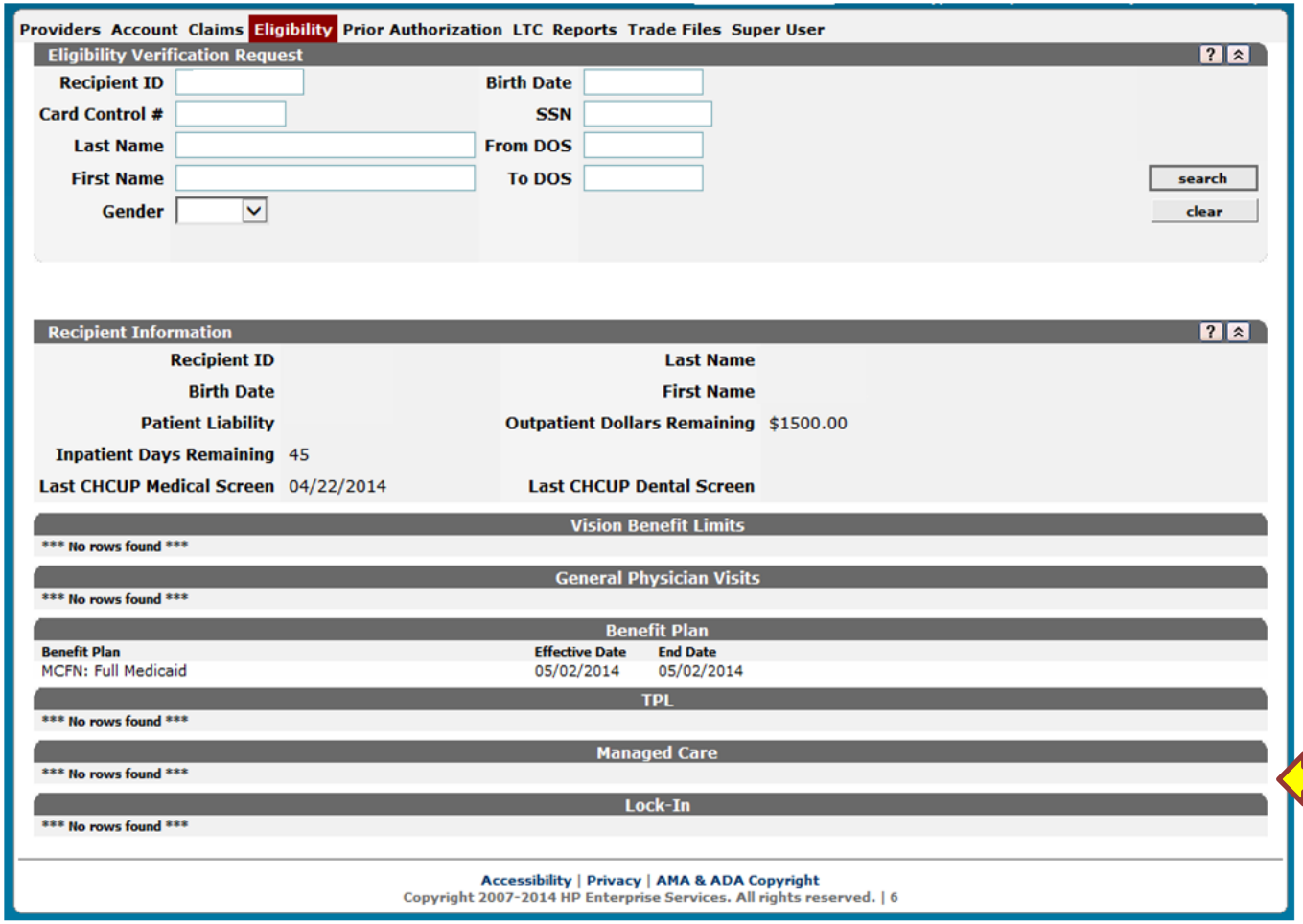


Review Benefit Plan panel: MB C: Full Medicaid

Review Managed Care Panel: Recipient is NOT enrolled in a Managed Medical Assistance plan or a Long-term Care plan. The Managed Care panel won't have information. **Recipient continues to receive Medicaid services by fee-for-services providers**.

Sample Web Portal Screen Shot

Recipient continues to receive Medicaid services by fee-for-services providers.



Review Benefit Plan panel: MCFN: Full Medicaid

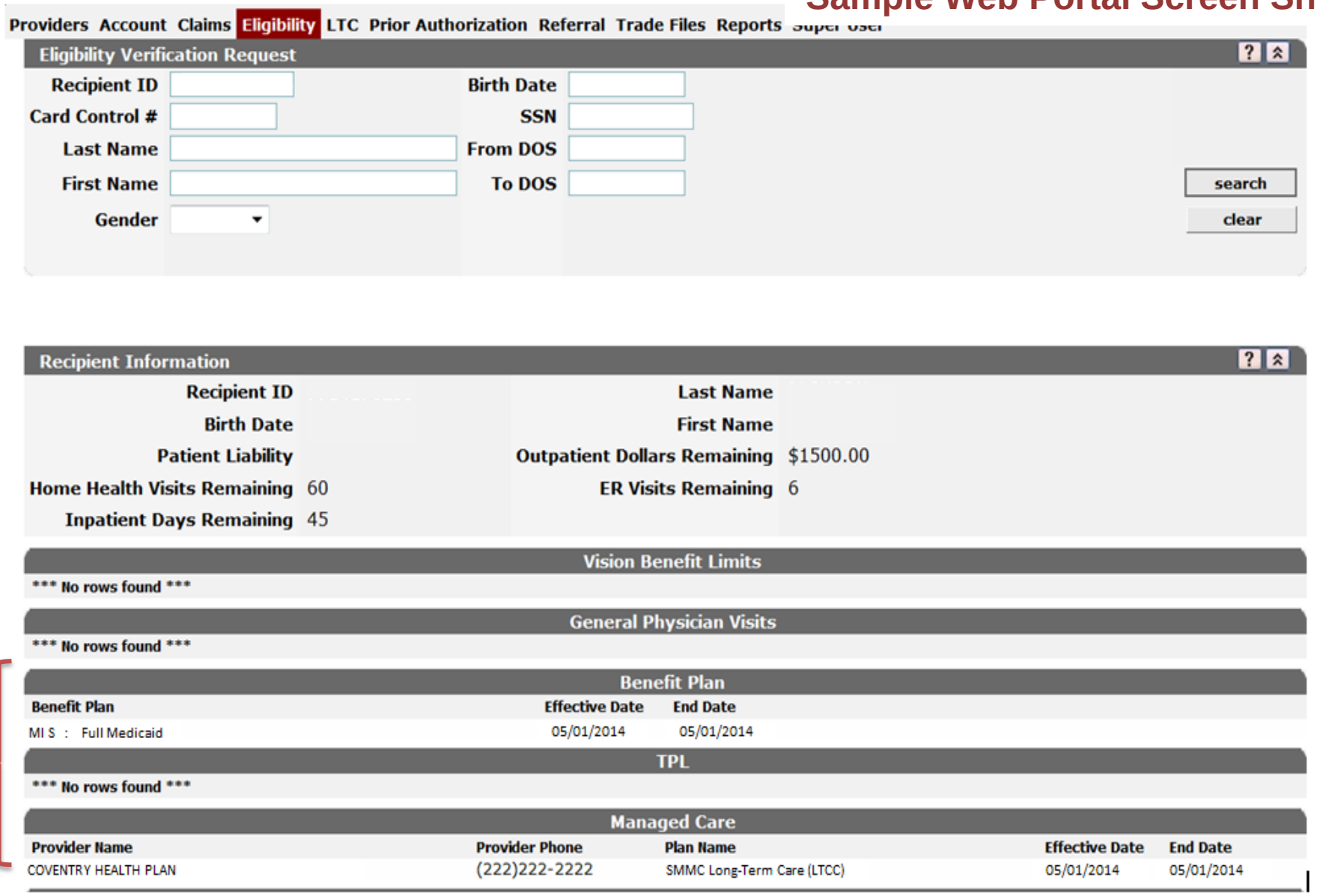
Review Managed Care Panel: Recipient is NOT enrolled in a Managed Medical Assistance plan or a Long-term Care plan. Managed Care panel won't have information. **Recipient continues to receive Medicaid services by fee-for-services providers**.

Reminder about Long-term Care Recipient Eligibility Verification

- Providers can check a plan member's eligibility in the FLMMIS web portal.

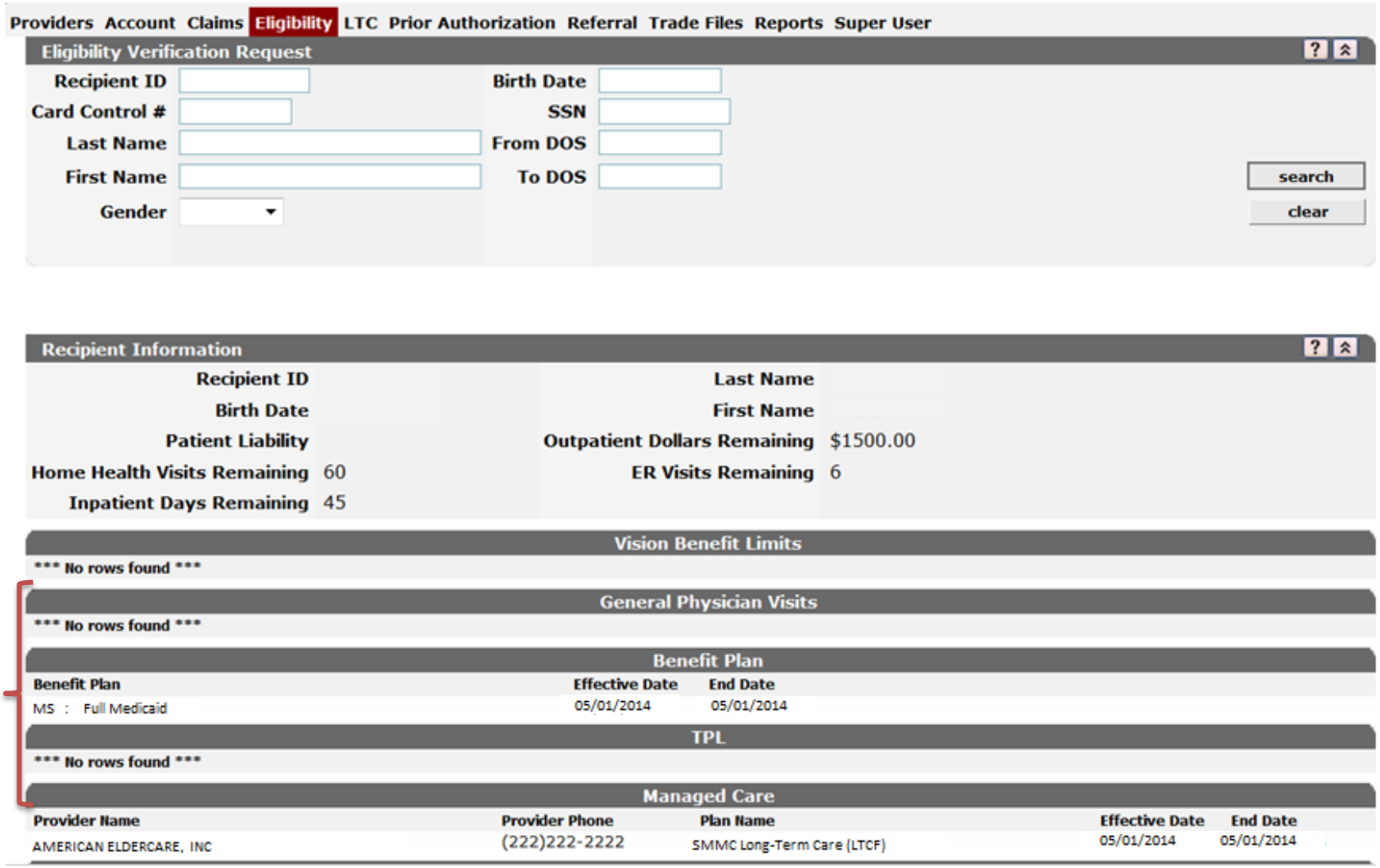
- Long-term Care plan members have either a SMMC-LTCC or a SMMC-LTCF span.
  - SMMC-LTCC: indicates that recipient is enrolled in a *capitated Long-term Care plan*.
  - SMMC –LTCF: indicates that recipient is enrolled in a *fee-for-service Long-term Care plan.*

Sample Web Portal Screen Shot



Review Managed Care Panel: Recipient is enrolled in a Long-term care capitated (**LTCC**) plan.

Sample Web Portal Screen Shot



Review Managed Care Panel: Recipient is enrolled in the fee-for-service Long-term (**LTCF**) plan, or a Provider Service Network (PSN).

New Aid Categories

These new aid categories only apply to individuals enrolled in **Long- term Care** managed care.

Aid Category	Description
MEDP	Full Home and Community Based Services (HCBS) waiver services while HCBS Medicaid application is pending, if individual chooses to receive services while application is pending. These individuals can choose to receive services before before being determined financially eligible for Medicaid by the the Florida Department of Children and Families (DCF). This option is not available to individuals in nursing facilities.
SIXT	Long-term Care plans are required to cover recipients who have have lost Medicaid eligibility for sixty days from the date of ineligibility.

How will Fee-for-Service Claims be Impacted with Only MEDP or SIXT?

- If a professional provider submits a fee-for-service claim directly to the Medicaid fiscal agent for a recipient with MEDP or SIXT, the provider's claim will be denied with Explanation of Benefit (EOB) code 0260 "Service Not Covered for Recipient Plan."

How will Fee-for-Service Claims be Impacted with Only MEDP or SIXT?

- If an institutional provider submits a fee-for-service claim directly to the Medicaid fiscal agent for a recipient with MEDP or SIXT, the provider's claim will be denied with EOB code 4227 "This Revenue Is Not Covered for This Member."

How will Fee-for-Service Claims be Impacted when the Recipient has MEDP or SIXT?

- If a provider receives either EOB code 0260 or 4227, the provider should contact the LTC plan noted in the eligibility verification response for claim submission and payment.

Billing Reminder SIXT

- Although a recipient has an eligibility category in FMMIS of SIXT, he or she does not have full Medicaid eligibility at that time.

- When an LTC enrollee loses Medicaid eligibility, LTC plans are required to continue providing covered LTC services, care coordination, and case management to the enrollee for 60 days following the enrollee's initial loss of eligibility.

- **Covered services for enrollees in SIXT are limited to their LTC services only; acute care medical, hospital, pharmacy, and behavioral health services are not covered in the SIXT period.**

- Claims submitted by providers who attempt to bill for non-LTC covered services for an enrollee with a SIXT span will be denied.

Steps to Verify Eligibility

Follow These Steps

- Read and review all the eligibility information.
- A provider must verify whether the recipient is enrolled in a managed care program or fee-for-service prior to delivering services and bill accordingly.
- Check whether recipient has full Medicaid coverage or limited benefits.
- Verify that the recipient is Medicaid eligible on the date of service and for the specific Medicaid service.

Follow These Steps, cont.

- Check whether recipient has Medicare or Third Party Liability (additional source for payment of medical expenses).
- Medicaid is the payer of last resort. If a recipient has other insurance coverage through a third party source, such as Medicare, TRICARE, insurance plans, AARP plans, or automobile coverage, the provider must bill the primary insurer prior to billing Medicaid.
- Make sure that you document the verification of recipient eligibility.

Managed Care Enrollment Verification

- Prior to delivering services, a provider must verify whether the recipient is enrolled in:
  - the Managed Medical Assistance program
  - the Long-term Care program, or
  - both, or
  - fee-for-service

- Refer to the “LTC & MMA: Putting the Pieces Together” webinar for which plan is responsible for which services.
  - You can find the presentation at the SMMC website at: http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC_and_MMA_Putting_the_Pieces_Together_Final_2014-04-17.pdf

Managed Care Enrollment Verification, cont'd

- For managed care plans such as Health Maintenance Organizations (HMOs) and Provider Service Networks (PSNs), the provider must receive authorization for the services that are included in the plan and bill the plan directly.
- For service authorization or contracting opportunities, providers should contact the plan.
- If the recipient is in a managed care plan and the provider bills Medicaid instead of the managed care plan for covered services, any resulting Medicaid fee-for-service reimbursements are overpayments.

Billing

In order to correctly bill for services provided through Managed Medical Assistance, provider must:

- have a provider agreement or contract with the managed care plan
- be fully enrolled in Medicaid or registered with Medicaid as a managed care provider at the time services are provided
- ensure that the individual is enrolled in a managed care program prior to delivering services
- receive authorization from the managed care plan to provide services, and
- bill the managed care plan directly for SMMC covered services provided to enrolled participants.

Summary

- Did you accurately check recipient eligibility?
- Does the recipient have Third Party Insurance which must be billed prior to Florida Medicaid?
- Does the recipient have full Medicaid coverage or limited benefits?
- Is the recipient eligible for the date of service and the *specific* Medicaid service?
- Is the recipient currently enrolled in Managed Care?

Summary

- Does the recipient have Managed Medical Assistance coverage?
- Do you have authorization from the MMA plan prior to rendering services?
- Does the recipient have Long-term Care coverage?
- Do you have authorization from the Long-term Care plan prior to rendering services?

Summary

- Is the service in the Medicaid fee schedule for your provider type? Or,
- Is the service specifically authorized by the recipient's managed care plan?
- Does the service require a prior authorization?
- Did you document the verification of recipient eligibility?
- Are you relying on FMMIS to deny the claim if the recipient is not eligible on the date of service?

Continuity of Care

Continuity of Care During Transition Plan Responsibility

- MMA plans are responsible for the coordination of care for new enrollees transitioning into the plan.
- MMA plans are required to cover any ongoing course of treatment (services that were previously authorized or prescheduled prior to the enrollee's enrollment in the plan) with the recipient's provider up to 60 days continuity of care period, even if that provider is not enrolled in the plan's network.

Continuity of Care During Transition Plan Responsibility, cont.

- The following services may extend beyond the continuity of care period and as such, the MMA plans are responsible for continuing the entire course of treatment with the recipient's current provider:
  - Prenatal and postpartum care (until six weeks after birth)
  - Transplant services (through the first year post-transplant)
  - Radiation and/or chemotherapy services (for the current round of treatment).

Continuity of Care During Transition

- If the services were prearranged prior to enrollment with the plan, written documentation includes the following:
  - Prior existing orders
  - Provider appointments, e.g., dental appointments, surgeries, etc.
  - Prescriptions (including prescriptions at non-participating pharmacies)
  - Behavioral health services.

Continuity of Care During Transition

- MMA plans cannot require additional authorization for any ongoing course of treatment.
- If a provider contacts the plan to obtain prior authorization during the continuity of care period, the MMA plan cannot delay service authorization if written documentation is not available in a timely manner.
- The plan must approve the service.
- However, the MMA plan may require the submission of written document (as described above) before paying the claim.

How Will Providers Know Whether to Continue Services?

Providers should keep previously scheduled appointments with recipients during transition.

Continuity of Care During Transition Provider Responsibility

- Service providers should continue providing services to MMA enrollees during the 60-day continuity of care period for any services that were previously authorized or prescheduled prior to the MMA implementation, regardless of whether the provider is participating in the plan's network.

- Providers should notify the enrollee's MMA plan as soon as possible of any prior authorized ongoing course of treatment (existing orders, prescriptions, etc.) or prescheduled appointments.

How Will Providers Be Paid?

Providers will receive payment for services provided during the transition.

Continuity of Care During Transition Provider Reimbursement

- MMA plans are responsible for the costs of continuing any ongoing course of treatment without regard to whether such services are being provided by participating or non-participating providers.

- The MMA plan must pay non-participating providers at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of 30 days, unless the provider agrees to an alternative rate. Providers will need to follow the process established by the managed care plans for getting these claims paid appropriately.

- Providers may be required to submit written documentation (as described before) of any prior authorized ongoing care, along with their claim(s) in order to receive payment from the plan.

Continuity of Care During Transition

- **If a pregnant Medicaid recipient enrolls in an MMA plan and her OB/GYN is not a part of the plan's network does the plan have to continue to pay for the services**?

- **Yes.** The MMA plan must continue to pay for services provided by her current provider for the entire course of her pregnancy including the completion of her postpartum care (six weeks after birth), regardless of whether the provider is in the plan's network.

Continuity of Care During Transition

Do the managed care plans have to honor prior authorizations that were issued (either through one of the Agency's contracted vendors or a managed care plan) prior to the recipient's enrollment in the MMA plan?

- Examples include: Home health, Dental, Behavioral Health, Durable medical equipment (rent-to-purchase equipment, ongoing rentals, etc.), Prescribed drugs

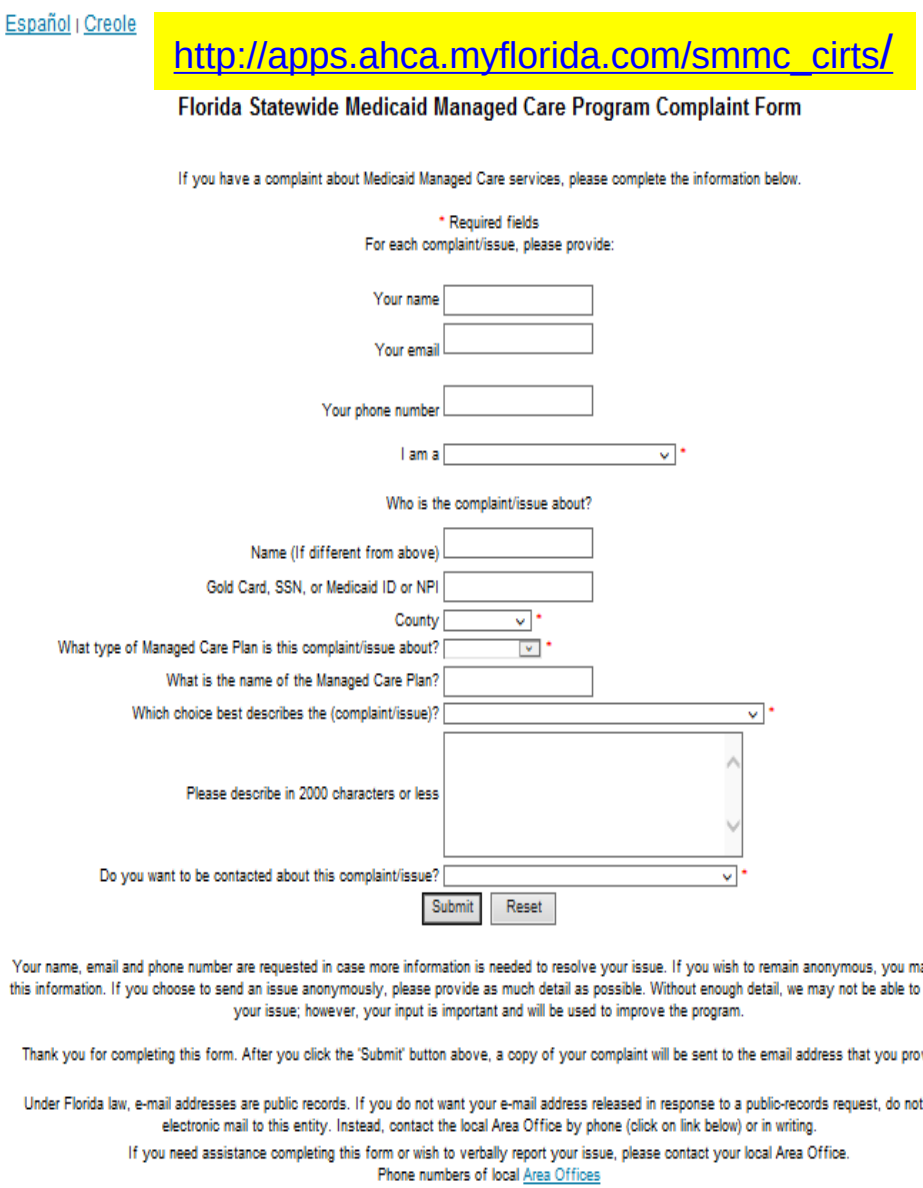
- **Yes.** During the continuity of care period, the MMA plan must continue to pay for any prior approved services, regardless of whether the provider is in the plan's network. During this timeframe, the plan should be working with the enrollee and their treating practitioner to obtain any information needed to continue authorization after the continuity of care period (if the service is still medically necessary). After the continuity of care period, if the provider is not a part of the plan's network, the enrollee may be required to switch to a participating provider.

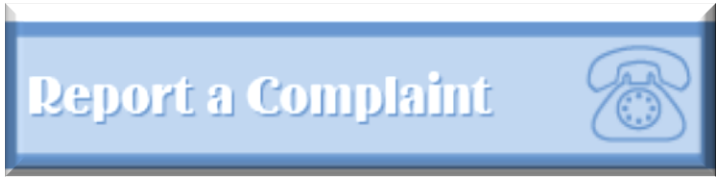
Continuity of Care During Transition-Pharmacy

- For the first year of operation, MMA plans are required to use the Medicaid Preferred Drug List (PDL) in order to ensure an effective transition of enrollees during implementation.
- For the first 60 days after implementation in a region, MMA plans or Pharmacy Benefit Managers (PBMs) are required to operate open pharmacy networks so that enrollees may continue to receive their prescriptions through their current pharmacy providers until their prescriptions are transferred to in-network providers.

Continuity of Care During Transition-Pharmacy

- MMA plans and/or PBMs must reimburse non-participating providers at established open network reimbursement rates.
- For new plan enrollees (i.e., enrolled after the implementation), MMA plans must meet continuity of care requirements for prescription drug benefits, but are not required to do so through an open pharmacy network.
- During the continuity of care period MMA plans are required to educate new enrollees on how to access their prescription drug benefits through their MMA plan provider network.

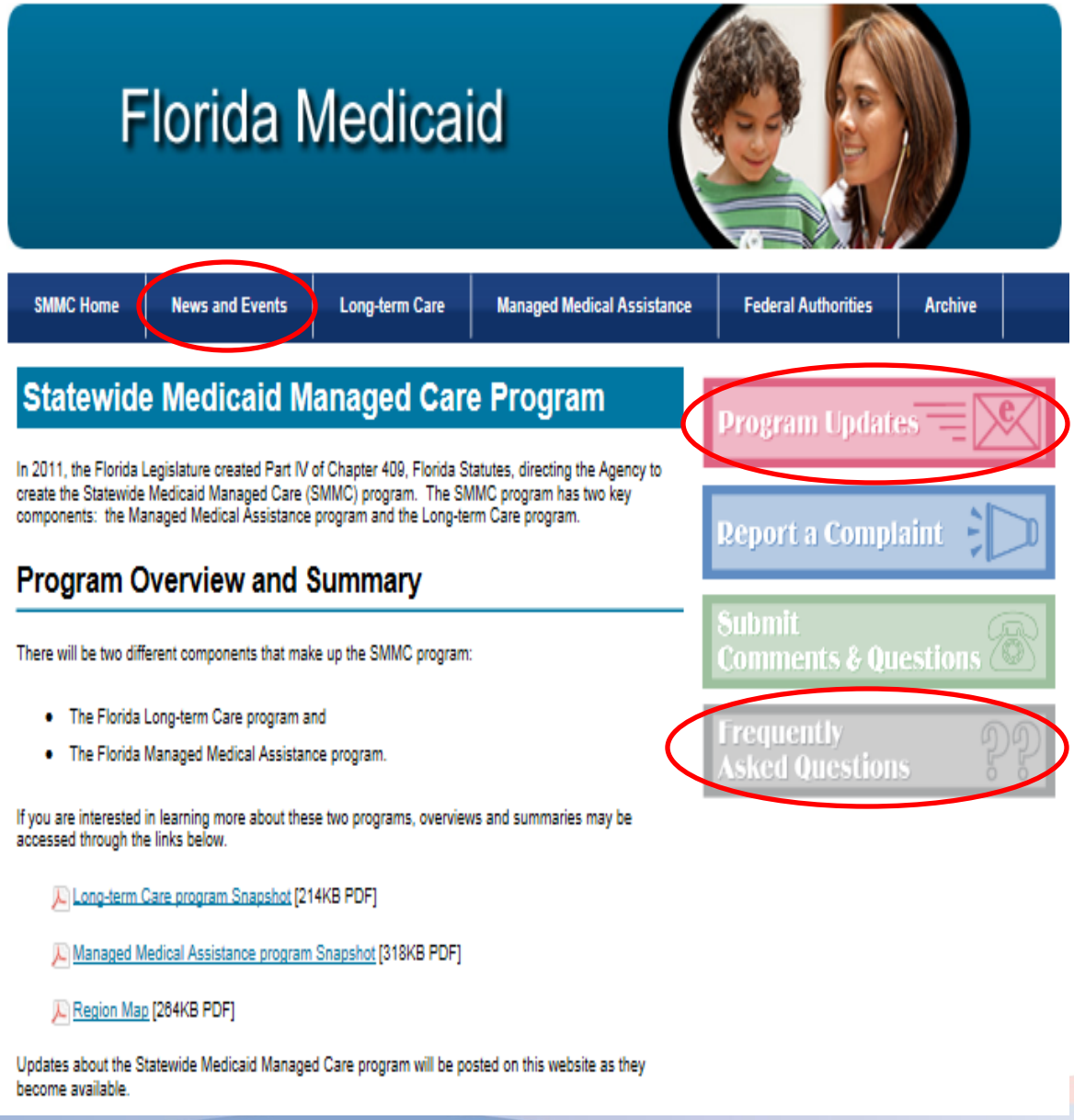




- If you have a complaint or issue about Medicaid Managed Care services, please complete the online form found at: http://ahca.myflorida.com/smmc
- Click on the “Report a Complaint” blue button.
- If you need assistance completing this form or wish to verbally report your issue, please contact your local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

Resources

- This presentation can be found on our SlideShare page at: bit.ly/MMAEligibility
- 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.



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:
  - Mental Health and Substance Abuse
  - Dental
  - Therapy
  - Durable Medical Equipment
  - Home Health
  - Physicians / MediPass
  - Pharmacy
  - Hospitals and Hospice
  - Skilled Nursing Facilities / Assisted Living Facilities / Adult Family Care Homes

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Questions?