Department of
ELDER AFFAIRS
STATE OF FLORIDA

ADRC Training

Long-Term Care Program Education

Division of Statewide Community-Based Services
Bureau of Long-Term Care and Support

Richard Prudom, Secretary

Training Objectives

- To present a high-level overview of Medicare and Medicaid
- To take an in-depth look at Florida's Statewide Medicaid Managed Care Program (SMMC)
- To detail the role and responsibility of the Aging and Disability Resource Centers (ADRCs) as it relates to the Statewide Medicaid Managed Care Long-term Care Program (SMMC LTC)

Presentation Sections

- Medicare 101
- Medicaid 101
- SMMC
  - Managed Medical Assistance (MMA) and Long-term Care (LTC)
  - Dental Benefits
- The Aging and Disability Resource Centers (ADRCs)
- Enrollment Management System (EMS)
- The Enrollment Broker
- Referrals and Resources
- Independent Consumer Support Program (ICSP)

Medicare and Medicaid

In 1965, the federal Social Security Act was amended to establish two major national health care programs:

- Title XVIII (Medicare)
  - Eligibility based upon age or disability
- Title XIX (Medicaid)
  - Eligibility based upon income

The full Social Security Act text can be found at:

- Title XVIII (Medicare): http://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- Title XIX (Medicaid): http://www.ssa.gov/OP_Home/ssact/title19/1900.htm

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Medicare 101

Overview, Parts, and Referral Resources

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Medicare Overview

- **Medicare is federal health insurance for elders and persons with disabilities.**
- **Medicare covers:**
  - **People age 65 and older who have earned sufficient work credits.**
  - **Individuals with disabilities receiving Social Security benefits for at least 24 months.**
  - **People of any age diagnosed with End-Stage Renal Disease (ESRD).**

Medicare Parts

- **Part A is hospital insurance**
- **Part B is medical insurance**
- **Part C is a combination of Parts A and B provided through private insurance companies approved by Medicare**
- **Part D is stand-alone prescription drug coverage**

Medicare Referral Resources

- **Contact Medicare at 1-800-633-4227 for the following:**
  - Replacement Medicare card needed
  - Information/questions about Medicare and Medicare plans
  - Information/questions about Medicare Prescription Drug Plan costs
- **Contact SHINE (Serving Health Insurance Needs of Elders) toll-free at 1-800-96-ELDER (1-800-963-5337)**
  - TDD/TTY 1-800-955-8770
  - Fax 850-414-2150
  - Email information@elderaffairs.org
  - Website: http://www.floridashine.org/

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Medicaid 101

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Medicaid: A State and Federal Partnership

- **Medicaid provides health coverage to low-income individuals with income and assets as the main eligibility criteria.**
- **Medicaid programs through Title XIX of the Social Security Act are state-administered programs funded by both the federal and state governments.**
- **All states administer separate programs under federally approved Medicaid state plans.**
- **Medicaid state plans must follow specific rules and regulations set forth by federal law.**
- **The Centers for Medicare and Medicaid Services (CMS) is the federal authority over Medicaid programs in the United States.**

State Medicaid Authorities

- **The Agency for Health Care Administration (AHCA) is Florida's designated Medicaid agency.**
- **The Department of Children and Families (DCF) determines financial Medicaid eligibility for Florida's Medicaid benefit plans.**
  - **DCF may need to work with other state agencies to determine eligibility when special eligibility requirements are needed to participate in a Medicaid program.**
- **The Social Security Administration (SSA) determines eligibility for federal supplemental security income (SSI) benefits.**
  - **Individuals determined eligible for SSI by the SSA are automatically considered eligible for state Medicaid benefits in Florida.**
  - **Specific program eligibility criteria may still need to be met in order to be considered eligible for a specific Medicaid program, such as long-term care.**

Medicaid Waivers

- **In addition to the submission of a Medicaid state plan, a state may request a "waiver" or "exception" to the Medicaid rules and regulations established and approved by CMS.**
- **There are several types of Medicaid waivers, each of which has a separate set of criteria.**
- **A state submits a Medicaid waiver application(s) to CMS for approval.**
  - **The Medicaid waiver application(s) must outline specific elements of how the state wishes to provide Medicaid services and to whom the services would be available.**
  - **Each Medicaid waiver application will list the specific criteria related to eligibility, service delivery, performance measurement, and funding.**

Medicaid Enrollment in Florida

- **As of November 2018, Florida total Medicaid enrollment was 3,867,802**
- **Of the total Medicaid enrollments, there were 3,039,665 SMMC enrollments (MMA and LTC)**
- **Of those enrolled in SMMC, 108,024 were SMMC LTC enrollments**
  - **Enrollees receiving home and community-based services (HCBS) = 60,057**
  - **Enrollees receiving non-HCBS = 47,967**

SMMC enrollment information can be found on AHCA's website at:
http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/enrollment_report/index.shtml

Who is eligible for Medicaid?

- To qualify for Medicaid in Florida, an individual must meet specific eligibility requirements, such as income, assets, age, citizenship or resident alien status, and Florida residency.
- An individual must have a social security number or proof of having applied for one.
- Not all individuals are eligible for all services.

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 individuals 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.**

Medicaid Benefit Plans

- **The following benefit plans are considered full Medicaid benefits:**

Benefit Plan	Description
SSI	Full Medicaid benefits for Supplemental Security Income (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 institutional care. Can be the only benefit plan or can exist with SSI or Title TXIX benefits plans.
Mkids	Full Medicaid benefits except Home and Community-Based Services (HCBS) waiver services.

Medicaid Benefit Plans (Part 2)

- **The following Medicaid benefits are considered partial Medicaid benefits:**

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

Medicaid Benefit Plans (Part 3)

- **The following benefits plans are specialty benefit plans:**

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

Primary Differences Between Medicaid and Medicare

	Medicaid	Medicare
Who is eligible?	**Low-income children and families, elders, and individuals with disabilities.**	**Anyone age 65 years and older with sufficient work credits and some individuals with disabilities under the age of 65.**
Is there an income limit?	**Yes, for all eligibility groups.**	• **Not for eligibility** • **Yes, to determine monthly premium amounts.**
What are the costs to receive health care services?	• **No monthly premiums.** • **Minimal co-payments for services.**	• **Possible monthly premiums depending on income/assets.** • **Co-payments for services.**

Florida Medicaid Long-Term Care Programs

- **The state of Florida offers several programs that use Medicaid benefits to provide long-term care services to Floridians.**
- **Long-term care Medicaid programs provide nursing facility services, as well as home and community-based services.**
- **Home and community-based services (HCBS) are designed to provide services in an individual's community residence that help him or her with everyday activities such as bathing, dressing, eating, and doing household chores.**

HCBS Medicaid Programs

- **Although AHCA is the single statewide Medicaid agency and DCF determines who is eligible for Medicaid benefits, several state agencies administer HCBS Medicaid programs that provide services to unique populations of individuals.**
- **Medicaid programs require an individual to be Medicaid eligible to receive services, but each program has a different set of eligibility criteria that an individual needs to meet in order to receive services.**
- **Individuals may be eligible for more than one HCBS Medicaid Program, but they cannot receive services from more than one program at a time.**
  - **If an individual is enrolled in an HCBS Medicaid Program other than SMMC LTC, they will have to disenroll from their current HCBS Medicaid Program prior to enrolling in SMMC LTC.**

Examples of HCBS Medicaid Programs

- The Statewide Medicaid Managed Care Long-term Care Program (SMMC LTC) – Administered by AHCA
- Developmental Disabilities (DD) Waiver or iBudget Waiver – Administered by the Agency for Persons with Disabilities (APD)
- Familial Dysautonomia Waiver – Administered by AHCA
- Model Waiver – Administered by AHCA
- The Program of All-Inclusive Care for the Elderly (PACE) – Administered by the Department of Elder Affairs (DOEA) in consultation with AHCA

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Program of All-Inclusive Care for the Elderly (PACE)

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PACE

- **The Program of All-Inclusive Care for the Elderly (PACE) is a unique service model that provides a vast array of medical and social services to individuals residing in the community that would be otherwise be placed in a nursing home.**

- **The hallmark of the program is within the PACE center itself, which functions as an adult day care, as well as a clinic. Participants can attend the center as often as five (5) days per week – depending on their plan of care – and must first use the PACE physician as their primary care physician (PCP).**

- **The PACE Organization employs a variety of professionals to form an interdisciplinary team (IDT) that oversees the care and individual needs of each participant.**

PACE Eligibility

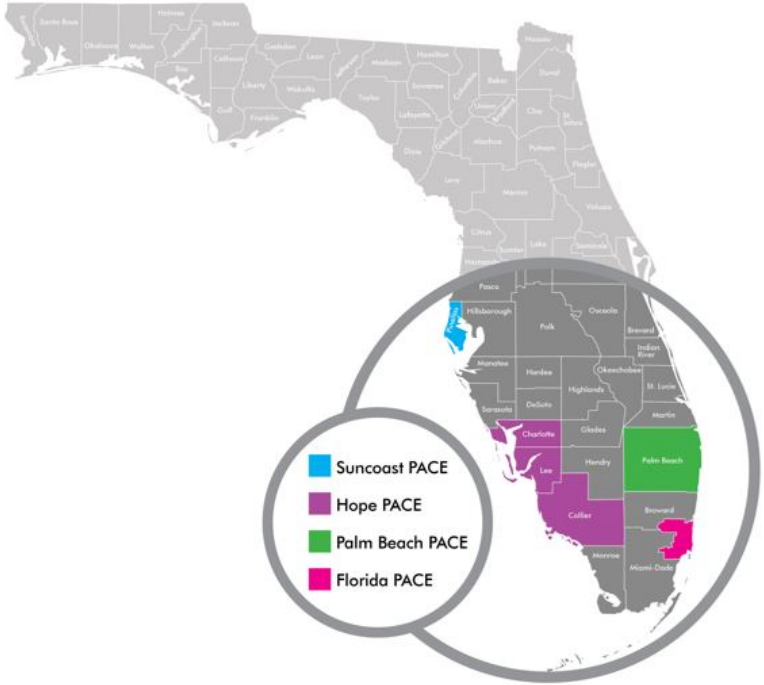
- **To be eligible for PACE, an individual must:**

  - Be 55 years of age or older;
  - Live within the defined service area of the PACE Center;
  - Meet medical eligibility requirements as determined by CARES; and
  - Be able to live safely in the community at the time of enrollment.

  Note: PACE accepts Medicaid, Medicare, and private pay individuals.

PACE Sites in Florida

- Currently, Florida has four (4) PACE Organizations.
- These organizations serve participants in 6 counties (based on ZIP Code service areas).
- There are 10 centers around the state.



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PACE Sites in Florida, Cont.

County	Provider Name	Phone Number	Address
Broward	Florida PACE	(305) 988-1364	2814 Corporate Way Miramar, FL 33025
Charlotte	Hope PACE	(239) 985-6400	3280 Tamiami Trail, Ste. 45 Port Charlotte, FL 33952
Collier	Hope PACE	(239) 985-6400	13020 Livingston Road Naples, FL 34109
Dade	Florida PACE	(305) 751-7223	5200 N.E. 2nd Avenue Miami, FL 33137
Lee	Hope PACE	(239) 985-6400	2668 Winkler Avenue Fort Myers, FL 33901
Palm Beach	Palm Beach PACE	(561) 868-2999	4847 Fred Gladstone Drive West Palm Beach, FL 33417
Pinellas	Suncoast PACE	(727) 289-0062	6770 102nd Avenue North Pinellas Park, FL 33782

How does the ADRC interact with PACE?

- **The ADRC does not need to complete an assessment for potential PACE participants.**

- **The ADRC's primary role, in regard to PACE, will be to provide a high level overview of the program to an interested individual. From that point, the ADRC should refer the individual to the PACE organization in their area for more information and to start the enrollment process.**

- **An individual may be served by PACE while on the waitlist for another program.**

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Statewide Medicaid Managed Care (SMMC)

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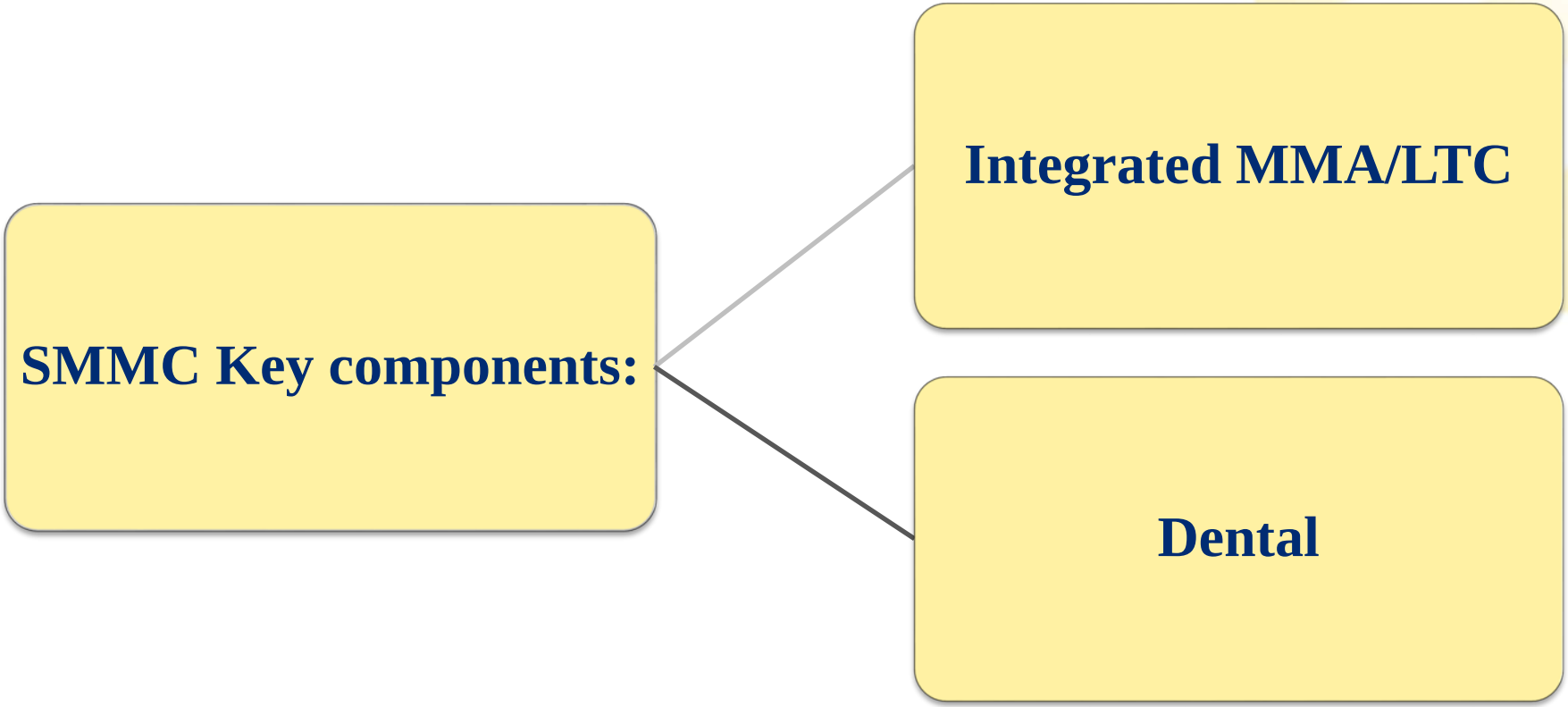
What Is Managed Care?

- **Managed care is how health care organizations manage the way their enrollees receive health care services.**
  - Managed care plans (MCPs) contract with different providers to offer quality health care services.
  - MCPs also work to ensure that enrollees have access to all needed doctors and other health care providers for covered services.
  - Individuals enrolled in managed care receive their services from providers that have a contract with the MCP.

- **MCPs contract with a variety of health care providers to offer quality services to ensure enrollees have access to the health care they need.**


SMMC Key components:
Integrated MMA/LTC
Dental

Statewide Medicaid Managed Care

- **During the 2011 Florida Legislative Session, the House and Senate passed HB 7107 and HB 7109, which required the state Medicaid Program to implement a Statewide Medicaid Managed Care Program (SMMC).**
- **SMMC has two key program components**
  - **Integrated Managed Medical Assistance (MMA) and Long-term Care (LTC) Programs**
  - **Comprehensive Dental Benefits**
- **MMA covers most recipients of any age who are eligible to receive full Medicaid benefits.**
- **LTC covers recipients 18 years of age or older who meet nursing facility level of care and are eligible to receive full Medicaid benefits.**
- **If eligible, recipients may enroll in <u>both</u> MMA and LTC simultaneously.**

Implementation of SMMC

- LTC began implementation August 1, 2013, and was completed on March 1, 2014.
- MMA began implementation May 1, 2014, and was completed August 1, 2014.
- AHCA re-procured the MCP contracts in 2018, resulting in the addition of new many plans, MMA/LTC integration and the expansion of dental benefits.
- Rollout of the new SMMC contracts will begin December 1, 2018, and will be complete February 1, 2019.

MMA and LTC

- **SMMC is part of Florida's Medicaid State Plan submitted to and approved by CMS.**
  - MMA is a waiver that represents Florida's Medicaid state plan benefits.
    - These benefits are considered entitlements, meaning that almost everyone who meets eligibility criteria may receive MMA services.
  - LTC is a Medicaid waiver program, meaning that changes to the Medicaid state plan were requested by Florida through the additional submission of a Medicaid waiver application(s).
    - Nursing home services, although also an entitlement program, are covered under LTC.
    - Home and community-based LTC services are offered based on available funding.
- **Although MMA and LTC are both parts of SMMC, they are considered different programs and have completely different eligibility criteria and enrollment processes.**

Types of Managed Care Plans

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Managed Medical Assistance (MMA)

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MMA Program and Services

- **The MMA program provides primary care, acute care, and behavioral health care services to recipients eligible for enrollment.**
- **These services are provided by a Managed Care Plan.**
- **In order to enroll in an MMA plan, an individual needs to apply and be determined eligible for the appropriate Medicaid benefit plan with DCF.**
- **Now that the MMA program is implemented, the following programs that were previously part of the Medicaid program are discontinued, including the following:**
  - **MediPass,**
  - **Prepaid Mental Health Program (PMHP), and**
  - **Prepaid Dental Health Plan (PDHP).**

Mandatory Enrollment

- **Individuals who apply and are determined eligible for the following Medicaid benefits <u>must</u> enroll in the MMA program in order to receive Medicaid services:**

  - **Temporary Assistance to Needy Families (TANF);**
  - **SSI (Aged, Blind and Disabled);**
  - **Hospice;**
  - **Low Income Families and Children;**
  - **Institutional Care (ICP);**
  - **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; and**
  - **Dual Eligibles - Part C – Medicare Advantage Plans Only *(enrolled January 2015)*.**

Optional Enrollment

- **Individuals who apply and are determined eligible for the following Medicaid benefits may choose to but do not have to enroll in MMA:**

  - 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 and 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; and
  - Medicaid recipients residing in a group home facility licensed under chapter 393.

- **AHCA determines if individuals are considered optimal and non-eligible for enroll.**

Non-Eligible Individuals

- **Individuals who apply and are determined eligible for the following Medicaid benefits <u>are not able</u> to receive services through 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; and
  - Medically Needy individuals.

Minimum Required Services: MMA Plans

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

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Long-term Care (LTC): HCBS Services

Richard Prudom, Secretary

The Goals of LTC

➢ The goals of LTC are to provide the following:

- Coordinated long-term care across different health care settings;
- A choice of the best MCP for an individual's needs;
- MCPs with the ability to offer more services; and
- Access to cost-effective, community-based long-term care services.

Medicaid Waiver History

- **Prior to the implementation of SMMC LTC, Florida offered several types of Medicaid HCBS waiver programs.**
- **The services provided by these "legacy" waivers are now provided by SMMC LTC.**
- **The following Medicaid waivers expired after the implementation of SMMC LTC and are no longer available to individuals in Florida:**
  - **Assisted Living (AL) Waiver;**
  - **Aged and Disabled Adult (A/DA) Waiver;**
  - **Consumer-Directed Care Plus (CDC+) program for individuals in the ADA Waiver;**
  - **Channeling Services for Frail Elders Waiver;**
  - **Frail Elder Option;**
  - **Nursing Home Diversion (NHD) Waiver;**
  - **Traumatic Brain Injury (TBI) Waiver;**
  - **Adult Cystic Fibrosis (ACF) Waiver, and;**
  - **Project AIDS Care (PAC) Waiver.**

LTC Components

- **LTC is made up of two components:**
  - Nursing facility services
  - HCBS in-home services, which include services provided in an Assisted Living Facility (ALF)
- **Nursing facility services under LTC are considered an entitlement, meaning all eligible individuals must be provided nursing facility services.**
- **In order to be eligible for nursing facility services through SMMC LTC, an individual must:**
  - Be found financially eligible for full Institution Care Program (ICP) Medicaid benefits by DCF, as well as be determined to require a nursing facility level of care by DOEA's CARES Bureau.
  - Have resided in a nursing facility at least 60 consecutive days.

Home and Community-Based Services (HCBS)

- **SMMC LTC also provides home and community-based services to individuals in a home-like environment, including private homes, assisted living facilities, and adult family care homes.**
- **HCBS are different than SMMC LTC nursing facility services in the following ways:**
  - **HCBS are not considered an entitlement through the Medicaid state plan waiver application, meaning the state is only authorized to provide HCBS to a set number of eligible individuals based on available funding.**
  - **The medical eligibility criteria is the same for individuals requesting HCBS as it is for individuals receiving nursing facility services; however, CARES must determine that the individual is able to be served safely in the community rather than in a nursing facility.**

LTC Minimum Required Services

Adult Day Care	Hospice	Nutritional Assessment/Risk Reduction
Assisted Living	Intermittent and Skilled Nursing	Personal Care
Behavioral Management	Medical Equipment and Supplies	Personal Emergency Response System (PERS)
Case Management	Medication Administration	Respite Care
Caregiver Training	Medication Management	Therapies: occupational, physical, respiratory, and speech
Home accessibility adaptation	Nursing Facility Care	Transportation, non-emergency
Home-delivered Meals		

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The Participant Direction Option (PDO)

- **PDO is an option that is offered by the long-term care plan to participants who have at least one of the following services on their care plan:**
  - **Adult Companion Care**
  - **Attendant Care**
  - **Homemaker**
  - **Intermittent and Skilled Nursing**
  - **Personal Care**
- **PDO allows participants to choose who will provide their services, as well as how and when their services are provided.**
- **PDO puts the enrollees in control of hiring, training, and supervising their direct service workers.**

PDO, cont.

- **Enrollees participating in PDO must live in their own home or family home.**
- **Participants are responsible for:**
  - Recruiting, interviewing, training, and hiring the direct service worker(s);
  - Preparing a job description for the direct service worker(s);
  - Scheduling the direct service worker(s) work hours;
  - Contacting the case manager to report an intended termination of a direct service worker(s); and
  - Notifying the case manager of the desire to no longer participate in the PDO.
- **A more in-depth presentation regarding PDO may be found on AHCA's website at http://ahca.myflorida.com/Medicaid/recent_presentations/SMMC_webinars/Participant_Direction_Option_Webinar_2013-06-06.pdf**

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LTC HCBS Eligibility

- **Individuals may enroll in LTC for HCBS if they are in need of long-term care services, there is available funding and they meet the following criteria:**
  - **Are 65 years of age or older, are eligible for full Medicaid benefits, AND need nursing facility level of care, or**
  - **Are 18 years of age or older and eligible for full Medicaid by reason of a disability AND need nursing facility level of care, or**
  - **Are 18 years of age or older and eligible for full Medicaid benefit, have been diagnosed as having cystic fibrosis AND need hospital facility level of care.**

- **DCF determines if individuals wishing to enroll in LTC for HCBS are eligible for full Medicaid benefits.**
  - **Individuals must apply for specific "HCBS" Medicaid in order to enroll in SMMC LTC with DCF unless they are receiving current SSI benefits. This Medicaid is titled "Medical assistance for individual in HCBS/Waiver" on the DCF ACCESS Florida application.**
- **DOEA's CARES Bureau determines if individuals wishing to enroll in LTC for HCBS services need nursing facility level of care.**

Plans

REGION	AETNA BETTER HEALTH	COMMUNITY CARE PLAN	FLORIDA COMMUNITY CARE	HUMANA MEDICAL PLAN	LIGHTHOUSE HEALTH PLAN	MIAMI CHILDREN'S	MOLINA HEALTHCARE	PRESTIGE	SIMPLY HEALTHCARE	STAYWELL	SUNSHINE HEALTH	UNITEDHEALTHCARE	VIVIDA HEALTH
1			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP	LIGHTHOUSE HEALTH PLAN MMA					STAYWELL COMP	SUNSHINE HEALTH COMP		
2			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP	LIGHTHOUSE HEALTH PLAN MMA					STAYWELL COMP	SUNSHINE HEALTH COMP		
3			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP						STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	
4			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP						STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	
5			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP		
6	AETNA BETTER HEALTH COMP		FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	
7	AETNA BETTER HEALTH COMP		FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP		
8			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP			MOLINA HEALTHCARE COMP			STAYWELL COMP	SUNSHINE HEALTH COMP		VIVIDA HEALTH MMA
9			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP		MIAMI CHILDREN'S MMA		PRESTIGE MMA		STAYWELL COMP	SUNSHINE HEALTH COMP		
10		COMMUNITY CARE PLAN MMA	FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP		SUNSHINE HEALTH COMP		
11	AETNA BETTER HEALTH COMP		FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP		MIAMI CHILDREN'S MMA	MOLINA HEALTHCARE COMP	PRESTIGE MMA	SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	

Comp = Comprehensive Plan MMA = Managed Medical Assistance Plan LTC+ = Long-Term Care Plus Plan

As of 8/30/2018

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The Aging and Disability Resource Centers (ADRCs)

Richard Prudom, Secretary

How do the ADRCs fit in?

- **All individuals who wish to receive LTC HCBS services must go through the Aging and Disability Resource Centers (ADRCs) in order to become eligible and enroll in SMMC LTC.**
- **Although the ADRC does not determine either financial or medical program eligibility, neither CARES nor DCF can move forward with determining eligibility without the "go-ahead" from the ADRC.**
  - **CARES needs a referral from the ADRC in order to determine medical eligibility, and**
  - **DCF needs a referral from the ADRC (Form 2515), including an individual's LOC information, to complete the financial eligibility process.**

The ADRCs

- **The ADRCs are made up of 11 non-profit organizations located throughout the state.**
- **Each ADRC serves the elders and persons with disabilities in a specific region or Planning and Service Area (PSA), which consists of a specific grouping of counties in which an individual must reside to receive services from that ADRC.**
- **The ADRC provides program information, community resources, and enrollment assistance for local, state, and federal Medicaid and non-Medicaid-funded programs for the aging and disabled population in the surrounding community.**
- **DOEA contracts with ADRCs to provide Medicaid administrative claiming activities and Medicaid compensable services.**

The ADRCs and Medicaid

- **The Medicaid services the ADRCs are contracted with DOEA to provide are "Medicaid administrative claiming" activities.**
- **These Medicaid administrative claiming activities include the following:**
  - **Providing general information on Medicaid, the Medicaid application process, and available Medicaid programs and resources;**
  - **Providing information on additional non-Medicaid federal, state, and community resources to individuals in need of assistance;**
  - **Screening for potential HCBS Medicaid eligibility;**
  - **Providing assistance with the SMMC LTC eligibility process to individuals interested in obtaining HCBS; and**
  - **Assisting SMMC LTC enrollees with grievances and complaints they may have with their managed care plan, their services, their providers, or the program in general.**

Prohibited Activities

- **The ADRCs are prohibited from engaging in a certain set of activities.**
- **The intent of these prohibitions is to ensure that all involved with providing information to individuals regarding the program do not act in any way to influence the choice of individuals.**
- **ADRC staff should never express a preference or dislike for any of the managed care plans, including:**
  - **Misrepresentation and False Advertisement: Knowingly making, issuing, or circulating any illustration, circular, statement, sales presentation, omission, or comparison, including misrepresentation and false advertising which:**
    - **Misrepresents the benefits, advantages, or conditions of an MCP;**
    - **Misrepresents the nature, characteristics, quantity, quality, or scope of services of an MCP;**
    - **Misrepresents the affiliation, connection, or association of services or business establishment;**
    - **Disparages the services of an MCP; or**
    - **Misrepresents the sponsorship, endorsement, approval, or certification of services,**

Prohibited Activities, Cont.

- **ADRC staff should never express a preference or dislike for any of the managed care plans, including the following:**
  - **Defamation – Knowingly making, publishing, disseminating, or circulating any oral or written statement which is false or maliciously critical of a person and which is calculated to injure such a person. This includes knowingly making false entry of a material fact in any book, report, or statement of any person.**
  - **Twisting – Knowingly making any misleading representations or incomplete or fraudulent comparisons of any MCP for the purpose of inducing, or intending to induce, any person to terminate or convert from any MCP or to choose one MCP over another.**
- **All ADRC staff performing Medicaid functions or LTCPE are required to read the full list of Prohibited Activities and sign an acknowledgment that the Prohibited Activities were received, read, and understood.**

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The SMMC LTC Enrollment Process

Richard Prudom, Secretary

Enrollment Management System (EMS)

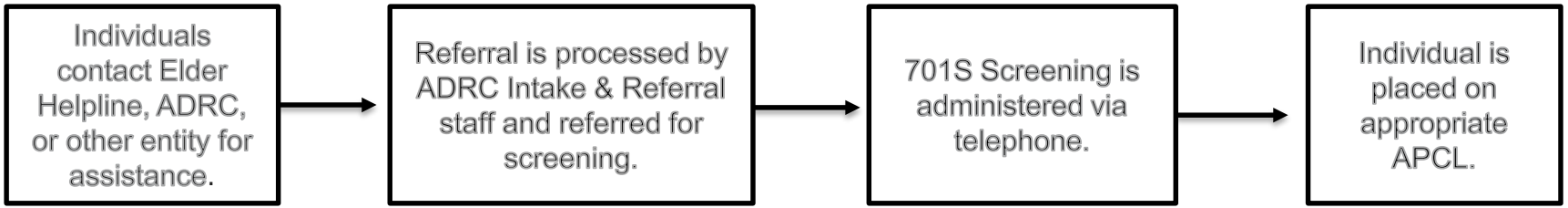
- **The Enrollment Management System (EMS) is the process by which individuals currently not receiving HCBS under SMMC LTC are enrolled in SMMC LTC.**
- **The EMS contains the following parts:**
  - **Intake and Screening**
  - **Assessed Priority Consumer List (APCL)**
  - **Pre-Release Assessment**
  - **EMS Release**
  - **SMMC LTC Enrollment**

Intake

- The first step to receiving SMMC LTC services is for an individual to contact the ADRC in the region where they live.
- Once an individual has established contact with the ADRC, ADRC staff gathers general information about the person.
- If an individual is in need of services that may be accessed through the ADRC, the individual is screened by a certified ADRC screener to establish what services may be appropriate to best meet the individual's needs.
- If the individual is determined to be potentially Medicaid-eligible by the screener and is in need of services offered under SMMC LTC, they are placed on the SMMC LTC APCL.
- The process of referring individuals for program screening may differ from ADRC to ADRC.

Screening

- **The 701S screening, once entered in the Client Information and Referral Tracking System (CIRTS), generates a rank and priority score.**



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EMS Releases

- **Individuals are released from the APCL based on availability of funding, frailty, and need for services.**
- **Once funding becomes available, DOEA releases individuals from the APCL to begin the eligibility process for SMMC LTC and lists these individuals on the CIRTS EMS Report.**
- **Once an EMS Report is posted in CIRTS, DOEA notifies the ADRC via email that a new EMS release has been posted and that they should retrieve the list of names from CIRTS.**
- **Individuals who complete the eligibility process and are determined eligible both financially by DCF and medically by CARES will be enrolled in SMMC LTC and will begin receiving services through the SMMC LTC plan.**

Pre-Release Assessment

- After the ADRC has retrieved the EMS Report from CIRTS, the ADRC will send each individual on the EMS written information on the eligibility process with instructions on the steps that they need to complete in order to be enrolled.
- The individuals also need to be contacted by phone in order for the ADRC to complete a pre-release assessment which verifies whether the individual is interested in pursuing the eligibility process for SMMC LTC.
- Once an individual is determined to be interested in program enrollment, the ADRC will assist the individual with the eligibility process.

The Eligibility Process – Medical Eligibility

- **CARES determines if an individual meets a nursing facility Level of Care (LOC) after reviewing assessment information in relation to medical and psychosocial needs, including the review of the following:**
  - **Form 5000-3008 – this form must be filled out and signed by the individual's primary care physician (PCP), Advanced Registered Nurse Practitioner (ARNP), or a Physician Assistant (PA).**
  - **The 701B Screening Form – Administered face-to-face by a trained CARES assessor upon receipt of the Form 5000-3008 from the ADRC.**
- **Once the Form 5000-3008 is obtained, the 701B screening administered, and all items reviewed, the LOC determination is made with a program placement recommendation and signed by the CARES physician consultant.**
  - **The date the LOC is signed is the "staffing date" listed in CIRTS.**

The Eligibility Process – Financial Eligibility

- **DCF determines if an individual is financially eligible for Medicaid.**
- **If the individual does not have current Medicaid benefits, the ADRC can assist the individual with submitting a new Medicaid application to DCF.**
  - **The online application and application instructions can be found on DCF's website at http://www.myflorida.com/accessflorida/.**
- **If the individual has current Title XIX or SSI benefits, including institutional care program (ICP) Medicaid, the individual or the ADRC do not need take any further action since the individual is already considered financially eligible.**
- **If the individual has current QI1, QMB, or SLMB Medicaid benefits, a new Medicaid application is not necessary. Instead, the submission of the 2515 after the LOC has been generated will prompt DCF to make a determination for Title XIX.**

The Eligibility Process – 2515 Submission

- **After the LOC has been completed by CARES and the Medicaid application has been submitted, if needed, the ADRC will fax or send a Form 2515 to DCF for the HCBS Medicaid determination.**
  - The 2515 will include the effective date of the LOC.
  - An individual may not submit a 2515 themselves for an SMMC LTC program eligibility determination.
- **The Form 2515 is also submitted by the MCP chosen by the individual upon enrollment in order to change the case management ownership of the individual from the ADRC to the MCP.**
  - This ensures that all future correspondence, including Notices of Case Action (NOCAs), will be sent to the correct MCP, as well as to the individual, so the MCP can assist the individual with maintaining program eligibility.

SMMC LTC Enrollment – Waitlist Release

- **Once an individual has been determined financially eligible by DCF or an initial Medicaid application has been submitted and the LOC has been entered into CIRTS, both the financial and clinical eligibility data will be sent to the enrollment broker's system, HealthTrack.**
- **A Welcome Letter will be generated by HealthTrack offering program enrollment.**
- **The individual must now contact the enrollment broker (EB) to discuss their enrollment options.**
  - Individuals may only choose a MCP authorized to operate within their region.
  - Individuals have a choice between a minimum of four MCPs within their region that can be selected for enrollment, as of January 2019.

EMS Resources

- ***The Department of Elder Affairs Programs and Services Handbook Chapter 2: Intake, Screening, Prioritization, Assessment and Case Management***
- ***The Statewide Medicaid Managed Care Long-term Care Enrollment Management System Procedures***

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The Enrollment Broker (EB)

Richard Prudom, Secretary

The EB and LTC

- **The EB is an entity contracted with AHCA to provide choice counseling and plan enrollment services to individuals eligible for SMMC LTC.**
- **The EB will receive the LOC authorization information from CIRTS and the information transmitted from DCF's daily file, which serves as notification that the individual has either been determined eligible for HCBS Medicaid.**
- **Once the EB has received an individual's LOC and Medicaid eligibility information, the EB will mail a welcome letter to the individual letting them know to contact the EB in order to choose a managed care plan.**

EB Letter Types and Descriptions

Current LTC Letter Name	Letter Type	LTC Letter Description
Welcome Fully Eligible Mandatory Letter	Entry Letter	This letter is sent to individuals who have a valid LOC and full eligibility (medical and financial), thus indicating that the individual is required to enroll in an MCP and advises them of their pending plan assignment should they fail to make a voluntary selection.
Reminder Fully Eligible Letter	Reminder Letter	This letter will go to any fully eligible individual who received the welcome letter and has not made a voluntary choice. This letter prompts these individuals to make a selection and reminds them of their pending assignment.
Confirmation Fully Eligible Letter	Confirmation Letter	This letter goes to individuals who have full eligibility for the program (Full Medicaid and LOC) and have made a voluntary plan choice.

Choosing a Plan

- **There are several ways individuals can enroll into a Long-term Care managed care plan:**
  - Over the telephone with a Choice Counselor (EB) at 1-877-711-3662;
  - Meet in person with a Field Choice Counseling Specialist (EB); or
  - Online using the website http://www.flmedicaidmanagedcare.com/
    - ADRCs may assist with online enrollment.

- **A choice counselor can also help an individual determine if a particular provider is available under a specific plan.**

SMMC LTC Enrollment

- **Once an individual chooses a plan, enrollment will occur the 1st of the next month.**
  - **Ex: if an individual becomes eligible on October 4 and chooses a plan with the EB on October 14, enrollment in SMMC LTC will begin November 1.**
  - **If an individual does not choose a plan with the EB within his or her 30-day Choice Period, SMMC enrollment will automatically begin the month following. (Approximately 2 months from the month the individual gained eligibility.)**
    - **Ex: if an individual becomes eligible on October 4th but does not pick a plan by the end of November, the individual will automatically enroll with a plan chosen by the EB on December 1. This plan is the plan listed in the individual's welcome letter sent from the EB.**
    - **The individual may still choose a plan up until the end of the month before auto-enrollment if they do not wish to enroll with the plan chosen by the EB.**
    - **The individual will also have 120 days following enrollment to change plans before being locked in to the chosen plan.**

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Disenrollments

- **Enrollees will be systematically disenrolled for the following reasons:**
  - **(1) Moving out of the region;**
  - **(2) Loss of Medicaid eligibility;**
  - **(3) Determination that an enrollee is excluded; or**
  - **(4) Enrollee death.**
- **If the enrollee moves to another region, AHCA will automatically disenroll them from their current MCP and treat the enrollee as if they are a new Medicaid enrollee eligible to choose another MCP.**
  - **It is the responsibility of the MCP in the enrollee's old region to coordinate a continuation of services throughout the enrollee's relocation and reenrollment.**
  - **Enrollees should notify the MCP case manager, DCF, and/or the Social Security Administration of any change in address.**

Loss of Eligibility and Reinstatement

- **At times, individuals can lose their eligibility if they fail to provide DCF (the agency that determines Medicaid eligibility) with necessary updated information in a timely manner.**
- **Individuals who lose their Medicaid eligibility and are disenrolled from SMMC LTC will need assistance reinstating their eligibility from the ADRCs.**
- **If an individual contacts the ADRC after being disenrolled for loss of Medicaid eligibility, and it has been no more than 6 months since disenrollment, the ADRC should provide eligibility assistance to help them reestablish their Medicaid so they can be re-enrolled in SMMC LTC.**
- **The MCPs will not provide services while an individual is disenrolled.**

SMMC LTC Enrollment Rules: Changing Plans

- **Individuals who are newly eligible and required to enroll have at least 30 days to enroll before their auto-assignment takes effect, then they have 120 days from the effective date to change plans without cause.**
- **After 120 days in the same plan, mandatory enrollees are locked-in and can only change during their open enrollment period or with a State-approved good cause reason.**
  - **Open Enrollment is the 60-day period before the end of an enrollee's enrollment year, during which the enrollee may choose to change plans for the following enrollment year.**

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Independent Consumer Support Program (ICSP)

Richard Prudom, Secretary

ICSP Overview

- **DOEA leads the coordinated effort between the ADRCs, Long-Term Care Ombudsman Program (LTCOP), and DOEA's Bureau of Long-Term Care and Support (LTCS) to provide independent and conflict-free support and education to help Medicaid enrollees handle disputes with their Long-term Care (LTC) plan.**
- **These efforts include, but are not limited to, the following:**
    - **Information and referral;**
    - **Advocacy and assistance;**
    - **Data collection and trend analysis; and**
    - **Monitoring and evaluation.**

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Enrollee Access Points

- **Enrollees can access information and support from a number of DOEA stakeholder sources.**
- **Information and assistance to resolve complaints are available through the following:**
  - **The MCP's Enrollee Services Unit,**
  - **The ADRCs and the Elder Helpline,**
  - **The Bureau of Long-Term Care and Support,**
  - **The Agency for Health Care Administration's (AHCA's) complaint system, or**
  - **The LTCOP for long-term care facility residents.**

- **The enrollee handbook provided by each MCP also lists the toll-free telephone number for Florida's Statewide Medicaid Managed Care (SMMC) Helpline: 1-877-254-1055.**
- **NOTE: Providers may receive information and assistance, including complaint resolution, by calling the SMMC Helpline or completing AHCA's online complaint form via the website: http://apps.ahca.myflorida.com/smmc_cirts**

A Closer Look at the ADRC Role

- **The ADRC's primary role is to educate enrollees of their rights and offer unbiased, consistent, uniform, and person-centered guidance as to how their concerns can be heard during the course of their enrollment with the MCP.**
- **When an enrollee first contacts the ADRC regarding a specific issue, the ADRC will provide a referral to the MCP's Enrollee Services Unit, which should be recorded in ReferNet.**
- **For subsequent calls from an enrollee regarding the same issue, the ADRC will record the complaint in CIRTS and provide instructions on seeking a remedy. These instructions include direct assistance to file a complaint with AHCA if the MCP has been unable to resolve the enrollee's issue.**
    - **If the same individual calls regarding a new issue, the ICSP process starts over and does not yet need to be entered into CIRTS.**

A Closer Look at the ADRC Role, cont.

- **ADRCs have been provided with each MCP's enrollee handbook, which includes complaint processes and contact information for each MCP.**
- **ADRCs may also identify situations in which the DOEA Medicaid contract manager must be contacted to help an enrollee resolve a complaint such as:**
  - **Complaints concerning situations that may endanger the health, safety, or welfare of an individual, and**
  - **Cases in which an enrollee's services may be adversely affected.**
- **NOTE: Issues involving health and welfare must also be reported to Department of Children and Families Adult Protective Services (APS) Division by calling 1-800-962-2873 or at:**

  http://www.myflfamilies.com/service-programs/adult-protective-services

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Key Term Review

- **Complaint**
  - The lowest level of challenge and provides the MCP an opportunity to resolve a problem within 24 hours without the issue becoming a formal grievance.
- **Grievance**
  - An expression of dissatisfaction about any matter other than an action. An action is any denial, limitation, reduction, suspension or termination of service, denial of payment, or failure of the plan to act in a timely manner.
- **Appeal**
  - A request for a review of an action.
- **Medicaid Fair Hearing**
  - An administrative hearing conducted by DCF to review an action taken by an MCP.

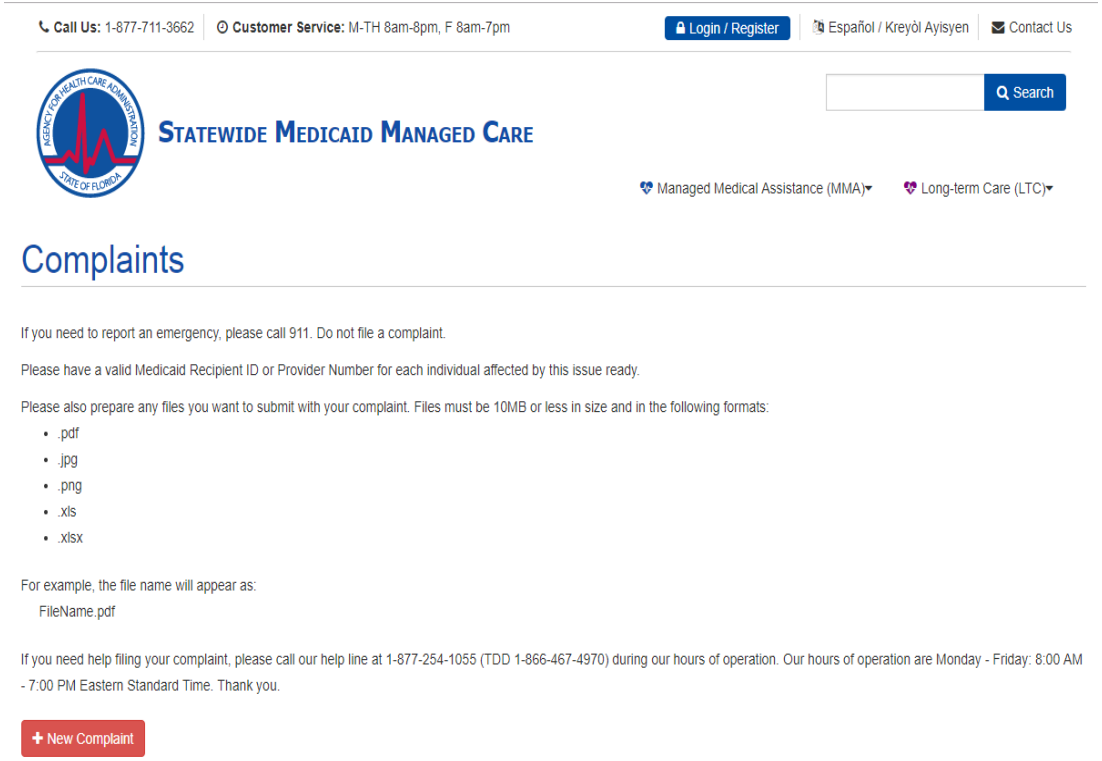
MCP Grievance Assistance for Enrollees

- **Each MCP is required to provide enrollees with access to information and assistance, including any reasonable help to complete forms and follow the procedures for filing a grievance or appeal or requesting a Medicaid Fair Hearing.**
- **ADRC staff may provide the MCP Enrollee Services information to enrollees who are dissatisfied with the plan, its services, or its actions.**
- **If the enrollee is unable to resolve the issue with the MCP and contacts the ADRC a second time for the same complaint, at a minimum the following must occur:**
  - **Assist the enrollee with submitting a complaint in the AHCA complaint hub.**
    - **A complaint can be submitted more than once in the AHCA complaint hub if an issue has not been resolved.**
  - **Record the enrollee complaint and the ADRCs resolution in CIRTS using the "SMMC LTC Complaints" button.**

AHCA Complaint Hub

- **AHCA has established a centralized unit to receive and process complaints and issues. There is an online form available on the Statewide Medicaid Managed Care website at https://www.flmedicaidmanagedcare.com/complaint/#/.**

- **Press the "Report a Complaint" button on the right side of the page, and complete the form. Complaints and issues may be submitted anonymously.**



AHCA Complaint Hub, cont.

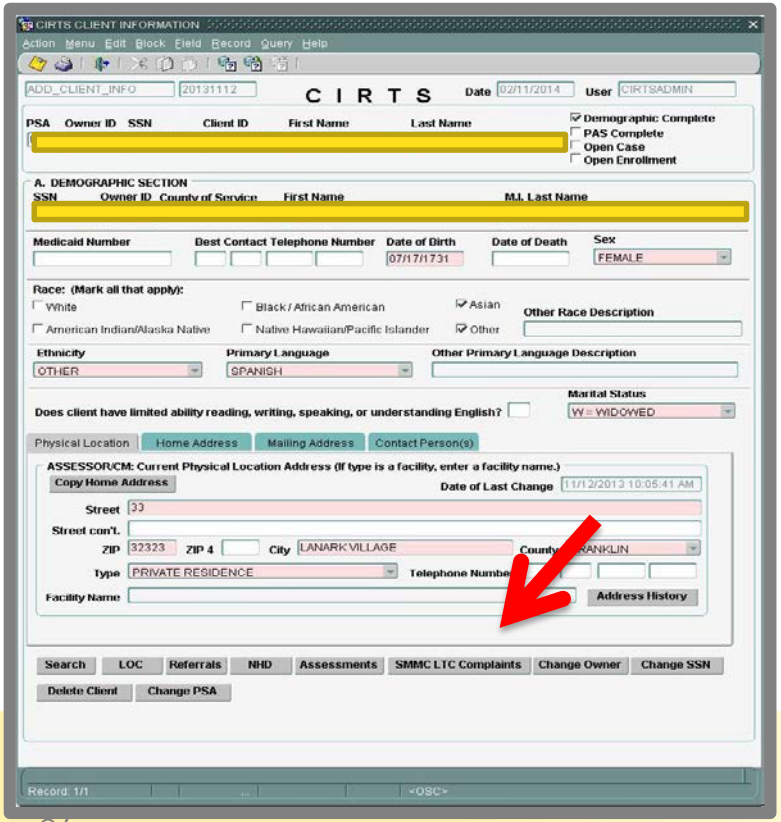
- **Complaints or issues can relate to any problem a provider or enrollee is having with an MCP including:**
  - Missed services,
  - Disruption in services,
  - Dissatisfaction with access to care,
  - Problems with authorizations or claims,
  - Plan provider network adequacy, or
  - Dissatisfaction with quality of services.
- **Once a complaint or issue is submitted online to AHCA's complaint hub, AHCA staff will contact the complainant.**
- **To contact a Medicaid representative by phone, please call 1-877-254-1055.**

ADRC Data Collection and CIRTS Reporting (Part 1/5)

- **Enrollee complaints regarding missed services or alleged abuse, neglect, or exploitation are violations of enrollee rights and personal welfare and must be reported to DOEA Medicaid contract management and Adult Protective Services as soon as possible.**

- **The reporting must be completed within 48 hours of the complaint, which shall also be entered into CIRTS.**

ADRC Data Collection and CIRTS Reporting (Part 2/5)



- **To enter data specific to the complaint, click on the “SMMC LTC Complaints” button.**

ADRC Data Collection and CIRTS Reporting (Part 3/5)

Requested Data Fields:

- **Enrollee demographic information***
  - Enrollee's name
  - Enrollee's SSN or Medicaid ID
  - Enrollee's address
    - County of Service
- **Complaint date**
- **Complainant information**
  - Complainant name
  - Complainant phone number
  - Complainant email address
  - Relationship to enrollee
    - If "self," complainant information populated
- **Plan name**
- **Referral**
  - Agency name
- **Issue type**
  - Common categories
- **Issue description**
  - Complaint details
  - Resolution details

***Available Demographic information will be automatically generated from CIRTS for both the enrollee and also for the complainant if the complainant is the enrollee.**

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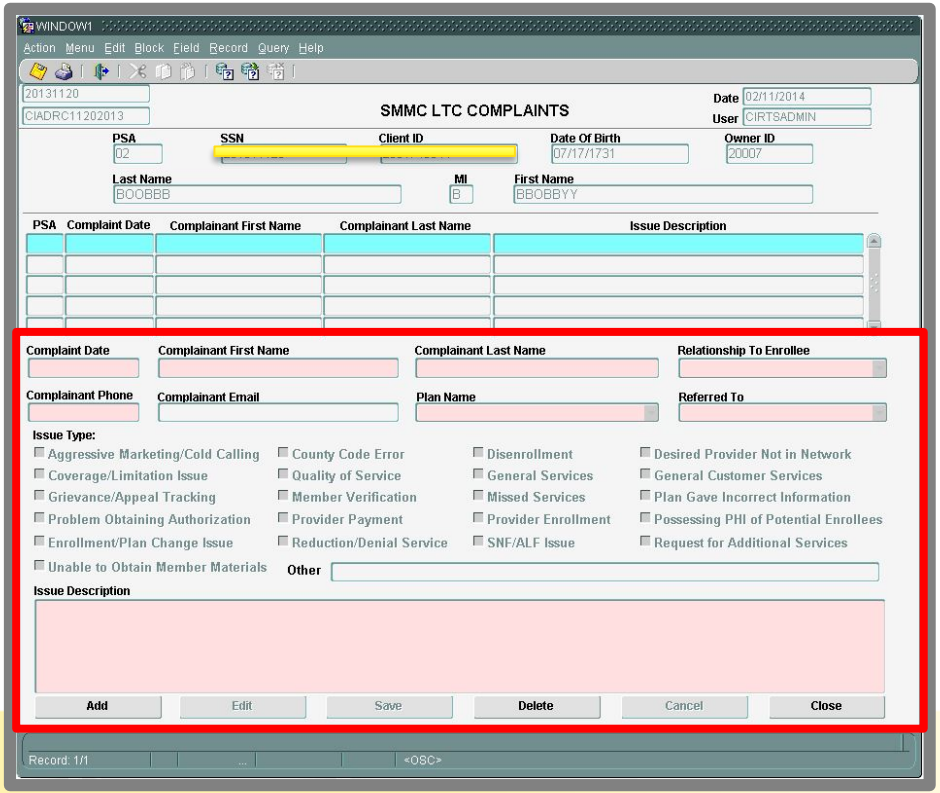
ADRC Data Collection and CIRTS Reporting (Part 4/5)



- All fields on the complaint form are required except the complainant's email address.
- If the complainant is the enrollee, pre-populated fields will include:
  - Complainant's name
  - Complainant phone number
- The "relationship," "plan," and "referral" fields are lists that allow users to select one of the provided options.
- Users may select as many issue types as applicable to the current complaint, including writing in any that may not be listed.

Department of ELDER AFFAIRS STATE OF FLORIDA

ADRC Data Collection and CIRTS Reporting (Part 5/5)

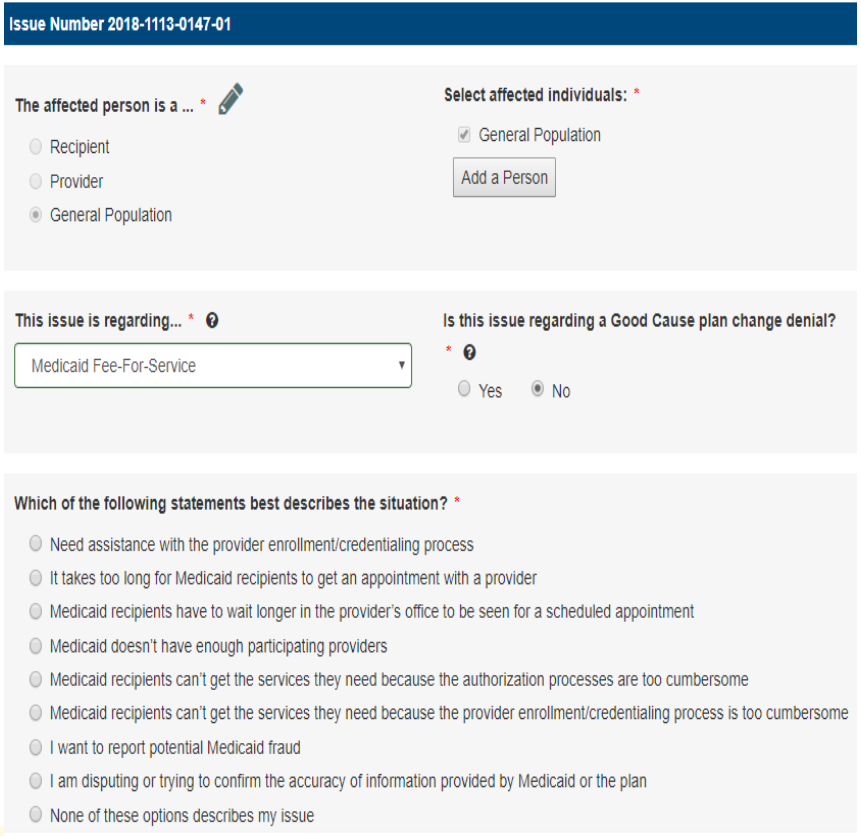
- **Relationship to enrollee**
  - Child
  - Facility
  - Other
  - POA/Legal representative
  - Spouse
- **Plan name**
  - Aetna
  - Florida Community Care
  - Humana
  - Molina
  - Simply
  - Staywell
  - Sunshine
  - United Healthcare
- **Referred to**
  - Agency for Health Care Administration
  - Department of Elder Affairs
  - Long-Term Care Ombudsman Program
  - Managed Care Plan
  - Other

Issue Types

- **Claims**
  - Provider payment
- **Community Outreach**
  - Cold calling/aggressive marketing
  - Possessing/misusing Personal Health Information (PHI)
- **Customer Service**
  - Enrollment/disenrollment/plan change
  - General
  - Grievance
  - Member verification
  - Plan gave incorrect info (including materials)
  - Provider enrollment
  - Unable to obtain member materials
- **Services**
  - Coverage/limitation issue
  - Desired provider not in network
  - Missed services
  - Problem obtaining authorization
  - Quality of service
  - Reduction/denial of services
  - Request for additional services
  - SNF/ALF issue
  - General
- **System**
  - County code error

ADRC Resources

- **Enrollee Handbook**
  - Complaint, grievance, and appeal procedures
  - Contact information
    - Enrollee Services Unit
    - Medicaid Fair Hearing
- **AHCA Complaint Hub**
  - Provider complaints or requests for additional training and information
  - https://www.flmedicaidmanagedcare.com/complaint/#/
- **DOEA Medicaid staff**



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MCP Grievance Contact Numbers for Enrollees

- **Aetna**
  1-866-847-8235
- **Florida Community Care**
  1-833-322-7526
- **Humana**
  1-888-998-7732
- **Molina**
  1-866-472-4585
- **Simply**
  1-844-406-2396
- **Staywell**
  1-866-334-7927
- **Sunshine Health**
  1-866-796-0530
- **United Healthcare**
  1-888-716-8787

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Temporary Loss Period

- When individuals lose Medicaid eligibility, the individual has six months to regain eligibility in order to be re-enrolled in SMMC LTC.
- During the temporary loss period of six months, an individual will be disenrolled and will not continue to receive services. However, they may request assistance with re-establishing their Medicaid from the ADRC.
- The ADRC may only provide financial eligibility assistance once the individual is disenrolled from SMMC LTC.
- Individuals contacting the ADRC following the loss of Medicaid and after the end of the temporary loss period should be waitlisted following the current SMMC LTC EMS procedures if they wish to be re-enrolled in SMMC LTC.

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STATE OF FLORIDA

ADRC Referral Resources

Richard Prudom, Secretary

DCF Referral Resources

- **Contact Department of Children and Families (DCF): 1-866-762-2237**
  - Any questions regarding benefits, coverage, eligibility loss, type of eligibility, recertification.
  - Applying for benefits under the Medicaid Program.
  - Updates or changes to demographic information: name, DOB, SSN, address, etc.
  - If the member wants to know their Medicaid ID or gold card number.
  - Changes to the payee or case information.
  - Questions about Share of Cost and how it is calculated.
  - If the member needs a password change on their ACCESS account.
  - To apply for food stamps or other assistance.
  - To obtain information about benefits for the elder such as QMB, SLMB, or Medically Needy.
  - To apply or obtain information about Medicaid for pregnant women.
  - Request for a replacement Medicaid card.
  - Activate a Medicaid card for a newborn.

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Social Security Administration Referral Resources

- **Contact Social Security Administration (SSA) Referrals at 1-800-772-1213**
  - SSA is the main contact for SSI and Medicare members.
  - Questions about Medicare eligibility or if the member has Medicare which is not reflected in the system.
  - Updates or changes to demographic information: name, DOB, SSN, address, etc.
  - Changes to the payee or case information.
  - Supplemental Security Income Eligibility.

Resources for Providers and Individuals

- **Public or Provider (not ADRC) Questions can be emailed to: FLMedicaidManagedCare@ahca.myflorida.com**

- **Information about the Long-term Care procurement is available via the Florida Vendor Bid System:**
  http://myflorida.com/apps/vbs/vbs_www.main_menu

- **Updates about SMMC are posted at: http://ahca.myflorida.com/Medicaid/statewide_mc**

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Resources for Providers and Individuals, Cont.

- **Upcoming events and news can be found on the "News and Events" tab on the SMMC website: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#NEWS**

- **Keep up to date on information by signing up to receive program updates from the SMMC website through the following link: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml**

Department of ELDER AFFAIRS STATE OF FLORIDA

MCP Referral Resources

- **Contact the MCP if:**
  - Member wants to change their provider
  - Member needs a new plan card
  - Member is having an issue with the managed care plan
  - Member contact information has changed, including member relocations

AHCA Referral Helpline

- **Contact the Medicaid Area Office: http://www.floridahealthfinder.gov/medicaid/florida-medicaid-general.aspx**
- **Contact number: 1-877-254-1055**
  - **Member is on fee-for-service and needs a bill paid or wants benefit information.**
  - **Questions or disputes for specific covered Medicaid services, co-pays or Medicaid policy.**
  - **Member has unpaid medical bills, billing/claims, or cost issues.**
  - **To obtain a list of providers that take straight Medicaid/fee for service.**
  - **To obtain a list of dental/vision/hearing providers that take straight Medicaid/fee for service.**
  - **Questions about SMMC MMA and LTC.**
  - **To file a complaint for SMMC MMA and LTC.**
  - **For additional assistance about an exemption.**