

Family STAR Project TIPS and STRATEGIES:

Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance Program

Do you have questions about SMMC? Here are some answers!

In 2011, the Florida Legislature created a new program called Statewide Medicaid Managed Care (SMMC).

There are two different parts that make up the SMMC program:

- The Managed Medical Assistance (MMA) Program
- The Long-term Care (LTC) Program

Medicaid recipients who qualify and become enrolled in MMA will receive all health care services (other than long-term care) from a managed care plan. Medicaid recipients who qualify and become enrolled in LTC will receive long-term care services from a Long-term Care managed care plan.

What does the Statewide Medicaid Managed Care program do?

Medicaid members receive their health care services through a managed care plan. MMA plans cover services such as prescriptions, doctors' visits and hospital stays.

All MMA plans offer the following health care services:

- Physician services, including physician assistant services
- Prescription drugs
- Hospital inpatient services
- Hospital outpatient services
- Mental health services
- Early periodic screening diagnosis and treatment services for recipients under age 21
- Emergency services
- Ambulatory surgical treatment center services
- Advanced registered nurse practitioner services
- Optical services and supplies
- Dental services
- Medical supplies, equipment, prosthesis, and orthoses
- Chiropractic services
- Nursing care
- Family planning services and supplies (some exception)
- Podiatric services
- Healthy Start services (some exception)
- Physical, occupational, respiratory, and speech therapy services
- Hearing services
- Laboratory and imaging services

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- Home health agency services
- Renal dialysis services
- Hospice services
- Respiratory equipment and supplies
- Optometrist services
- Rural health clinic services
- Birthing center services
- Substance abuse treatment services
- Transportation to access covered services

The State sends Medicaid recipients a letter notifying them as to whether or not they are required to enroll in the SMMC MMA program.

Note: The SMMC program will not change your Medicare benefits.

Recipients should consider the following when choosing an MMA plan:

- What services do I think I need? Doctor's Visits?
- What plan do my doctors take?
- What kind of doctors do I need? Pediatrician? Family Doctor?
- What extra benefits meet my needs?

Steps to help you pick your plan:

Each plan offers the same core benefits. For the listing of the basic Florida MMA Medicaid benefits you may refer to the Program Information tab.

1. Look at the Plan Information tab to see what extra services are offered by each plan.
2. Call or visit with a Choice Counselor for help.
3. Compare performance data for plans in your area using the Medicaid Health Plan Report Card.

NOTE: If you need additional information about the program please contact a Choice Counselor at 1-877-711-3662. The website is <http://www.flmedicaidmanagedcare.com/>

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Glossary:

120 Calendar Day Change Period - After being enrolled in a managed care plan, enrollees have 120 calendar days to change to a new plan, if they wish to do so.

Action - Denial or limited authorization of a requested service or payment to such service; reduction, suspension, or termination of a previously authorized service; or failure of a plan to timely provide services or respond to a grievance or appeal.

Acute Care Services - Short-term medical treatment that may include, but is not limited to, community behavioral health, dental, hearing, home health, independent laboratory and x-ray, inpatient hospital, outpatient hospital/emergency medical, physician, prescribed drug, vision, or hospice services.

Agency for Health Care Administration (AHCA) - The state agency responsible for administering health care programs such as Medicaid.

Aging and Disability Resource Center (ADRC) - An agency designated by the Department of Elder Affairs (DOEA) to develop and administer a plan for a broad and coordinated system of services for older and disabled persons.

Appeal - A formal request from an enrollee to review an action taken by the Managed Care Plan.

Benefits - Health care services and expanded benefits delivered to enrollees covered by the Managed Care Plan.

Cause - State-approved reasons that allow enrollees to change their Managed Care Plan outside of their open enrollment period. This is also known as “good cause” or “for cause.”

Centers for Medicare & Medicaid Services (CMS) - The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare, Medicaid and the Children’s Health Insurance Program under the Social Security Act.

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Children's Medical Services Network (CMS Network or CMSN) - A program operated by the Department of Health that provides services for children from birth through age 21 with special health care needs.

Choice Counseling - A service that Medicaid provides to help recipients pick the managed care plan that is best for them.

Choice Counselor - The AHCA-authorized person who speaks with recipients to help them understand their plan choices and enrolls them into a Medicaid managed care plan.

Community Outreach - Providing information to help or educate a community on health-related matters, social services, or public awareness.

Complaint - Any oral or written expression of dissatisfaction by an enrollee submitted to the Managed Care Plan or to a state agency.

Comprehensive Assessment and Review for Long-Term Care Services (CARES) - Florida's long-term care preadmission screening program for nursing home applicants. CARES helps to identify long-term care needs of individuals and establishes a level of care (medical eligibility) for nursing home and Medicaid waiver applicants.

Co-Payment (Co-pay) - A co-payment is an amount of money that the recipient pays the provider for a service.

Covered Services - Services and expanded benefits provided by a managed care plan.

Department of Children and Families (DCF) - The state agency primarily responsible for deciding Medicaid eligibility. DCF also manages other programs related to abuse and neglect, mental health, substance abuse, homelessness, and other social service programs.

Department of Elder Affairs (DOEA) - The primary state agency responsible for managing human services programs that benefit Florida's elders.

Disenrollment - The ending of an enrollee's participation in a Managed Care Plan.

Dual Eligible - An enrollee who is eligible for both Medicaid and Medicare programs.

Enrollee - A Medicaid recipient enrolled in a Managed Care Plan.

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Enrollment - The process by which an eligible Medicaid recipient signs up to participate in a Managed Care Plan.

Expanded Benefit - A service or benefit offered to enrollees by a managed care plan that is not available through the Medicaid state plan or fee-for-service Medicaid.

Field Choice Counselor - The AHCA-authorized person who meets face-to-face with recipients to help them understand their managed care plan choices and enrolls them into a Medicaid managed care plan.

Fraud - An intentional deception or misrepresentation made with the intention of receiving financial or personal gain.

Full Medicaid coverage - A Medicaid recipient who is eligible to receive all covered Medicaid services.

Grievance - Any oral or written expression of dissatisfaction by an enrollee about any matter other than an action, submitted to the Managed Care Plan or to a state agency.

Guardian - A legal representative appointed by the court to act on behalf of a minor or legally incompetent adult.

Health Maintenance Organization (HMO) - Corporations that contract with a network of health care providers, such as physicians, hospitals, and laboratories, to provide health care services.

Healthy Behaviors - A program offered by MMA managed care plans that encourages and rewards behaviors that are meant to improve the enrollee's overall health.

Hospice - A facility or program that provides care for terminally ill persons.

Level of Care (LOC) - The type of long-term care required by a recipient based on medical needs. CARES establishes the level of care for Medicaid recipients.

Lock-in - The period of time when recipients cannot change managed care plans, unless there is a state-approved reason or "good cause."

Long-term Care Assessment - An individualized and comprehensive assessment of an individual's medical, developmental, behavioral, social, financial and environmental status conducted by a qualified individual for the purpose of determining the need for long-term care services.

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Long-term Care Plan (LTC plan) - A managed care plan that provides the services for the Long-term Care part of the Statewide Medicaid Managed Care program.

Managed Care Plan - An eligible plan under contract with the Agency to provide services in the LTC or Managed Medical Assistance (MMA) part of the Statewide Medicaid Managed Care Program.

Managed Medical Assistance Plan (MMA plan) - A managed care plan that provides services for the Managed Medical Assistance part (MMA) of the Statewide Medicaid Managed Care (SMMC) program.

Medicaid - A medical assistance program authorized through the Social Security Act and is available to serve individuals based on financial need and other eligibility criteria.

Medicaid Benefits - Health care and prescription drug assistance available to Medicaid recipients, including those who participate in a managed care plan.

Medicaid Pending - A process for individuals to receive services in the long-term care program before DCF completes and approves the individual's Medicaid eligibility.

Medicaid Providers - Hospitals, nursing homes, public health units, or other entities enrolled in Medicaid or contracted with a managed care plan to provide services to individuals eligible for Medicaid.

Medicaid Recipient - An individual whom the Department of Children and Families (DCF) or the Social Security Administration (SSA) determines is approved for the Medicaid program.

Medicare - A federal medical assistance program that provides health insurance for Americans of age 65 and older, as well as for persons with disabilities.

Medicare Advantage Plan - A Medicare-approved health plan offered by a private company that covers both hospital and medical services, often includes prescription drug coverage, and may offer extra coverage such as vision, hearing, dental and/or wellness programs. Each plan can charge different out-of-pocket costs and have different rules for how to get services. Such plans can be organized as health maintenance organizations, preferred provider organizations, coordinated care plans, and special needs plans.

Member - A person eligible for Medicaid who is enrolled in a managed care plan. Also referred to as "enrollee."

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Non-Covered Service - A service that is not a benefit under either the Medicaid State Plan or a Managed Care Plan.

Nursing Facility - An institutional care facility that provides medical inpatient care and services to individuals needing such services.

Open Enrollment - The 60-day period when enrollees can change managed care plans without a state-approved "cause." Open enrollment occurs yearly for each enrollee.

Patient Responsibility - The cost of Medicaid long-term care services paid by the recipient, or the amount for which the recipient is responsible. This is determined by the Department of Children and Families and is based on the recipient's income and where he/she lives.

Power of Attorney - A legal document used to designate someone to act on and make medical decisions on your behalf, typically, a family member.

Primary Care Provider (PCP) - A doctor, who monitors your health, treats minor health problems, coordinates your health care, and refers you to a specialist, if needed.

Prior Authorization - Approval of services before they are provided.

Provider Service Networks (PSNs) - Health care delivery systems, owned and operated by hospitals, physician groups, or other providers. PSNs have a network of providers and facilities, which provide health care to enrollees.

Qualified Medicare Beneficiaries (QMB) - A Medicaid program that pays the Medicare premium for certain individuals with disability or renal kidney failure.

Region - The service area or geographical area in which a Managed Care Plan is approved to provide services to Medicaid recipients.

Special Low-Income Medicare Beneficiary (SLMB) Program - A Medicaid program to pay the Medicare Part B premium for certain disabled or aged individuals.

Specialized Services - A service or specialized care to include, but not be limited to, personal assistance with bathing, dressing, ambulation, eating, supervision of or assistance with self-administered medications, assistance with securing health care from appropriate sources and transportation to such health care sources and socialization activities.

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Specialty Plan - A plan that serves Medicaid recipients who meet certain criteria based on age, medical condition, or diagnosis.

Straight Medicaid - Refers to Medicaid recipients who are not enrolled in a managed care plan and are receiving medical services on a fee-for-service basis. Also referred to as “regular Medicaid.”

Temporary Loss Period - The period when an enrollee loses eligibility and regains it (no longer than 60 days). During this time, the recipient is able to continue to receive Long-term Care services through their LTC managed care plan.

Third Party - An individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid. A third party includes a third-party administrator or a pharmacy benefits manager.

Transportation - An appropriate means of travel provided to an enrollee or recipient to obtain Medicaid-covered services.

Voluntary Enrollee - Persons who are not required to enroll in a managed care plan, but choose to do so.

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**If you have any questions or need help,
please feel free to contact:**

**The Family STAR Project of Family Network
on Disabilities at 727-523-1130 or**

800-825-5736, or by email at:

marilyn@fndfl.org. Make sure to visit our

website for more information at:

www.fndusa.org.

