



## *ESSO WEEKLY MEMO*

January 9, 2015

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## General Updates:

### **1. Requirements for Background Screens Under MMA**

Please share with staff and providers that:

***The only time a person may use the Medicaid ORI (Originating Agency Identification) number is if they are being screened for their Medicaid application to become Medicaid eligible per MMA requirements. Providers who apply for Early Steps but who are not able to obtain a Medicaid number (such as assistants), are to use the AHCA/Managed Care ORI.***

Some specific ORI numbers for use are:

AHCA licensure/employment: **EAHCA020Z**

Managed Care Health Plans: **EAHCA790Z**

Medicaid Provider Enrollment: **FL922013Z**

Additional ORI resources can be found at:

[http://ahca.myflorida.com/MCHQ/Central\\_Services/Background\\_Screening/Operator\\_Vendor.aspx](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Operator_Vendor.aspx)

## Medicaid Updates:

### **2. New Look for Florida Medicaid Policies**

Florida Medicaid is redesigning and restructuring current policies, commonly known as coverage and limitations handbooks. Our goal is to provide a coverage policy that is clear and concise to all of our stakeholders.

The new coverage policy is designed to be service specific, rather than provider type specific. This design allows us to streamline our policy to include information about who can provide and who can receive the service, what the coverage encompasses, as well as pertinent authorization, documentation, and reimbursement information.

In addition, the updated structure gives us the opportunity to clearly differentiate policy applicable to both fee-for-service and Statewide Medicaid Managed Care (SMMC) delivery systems, from that which is only applicable to fee-for-service.

The revised policies will first be available to providers in draft form through the rulemaking process in accordance with Chapter 120, Florida Statutes. Once each rule is adopted, it will be available on the Fiscal Agent's website.

## Medicaid Updates continued:

### **3. Accessing Eligibility and Payment/Advice Data Using Safe Harbor Connectivity**

Section 1104 of the Patient Protection and Affordable Care Act established new requirements for administrative transactions to improve the utility of the existing **Health Insurance Portability and Accountability Act (HIPAA)** transactions and reduce administrative costs. The Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) was selected as the authoring entity for the Operating Rules which apply to all HIPAA-covered entities.

The CAQH CORE Operating Rules included a Connectivity Rule for submitting batch and real time transactions that uses HTTP/S transport protocol over the public Internet. This rule is designed to provide a “safe harbor” that the application vendors, providers and health plans (or other information sources) can be assured will be supported by any CORE-certified trading partner. See CORE Rule 270 for Safe Harbor Connectivity specifications.

In June 2014, Florida Medicaid was awarded Phase III CORE certification. The following HIPAA X12 transactions are now available to trading partners via the Safe Harbor Connectivity:

- Health Care Eligibility Benefit Inquiry and Response (270/271);
- Health Care Claim Status Request and Response (276/277);
- Health Care Claim Payment/Advice (835); and
- Implementation Acknowledgement for Health Care Insurance (999).

Additional transactions may be added according to future phase(s) of the CAQH CORE Operating Rules, once they are finalized and published.

In order to use the Safe Harbor Connectivity for submitting batch or real time transactions, a valid Web Portal account and a Florida Medicaid Trading Partner ID are required.

For more information about Florida Medicaid’s requirements, see the FMMIS Safe Harbor Connectivity Companion Guide.

## Medicaid Updates continued:

### **4. Florida Medicaid's Webpages are being Restructured**

ACHA is restructuring the Division of Medicaid's portion of the Agency website. The new pages will be aligned with the Division's functional structure as it has been reorganized to support the SMMC program. This redesign will make it easier for you to find the information you need. They anticipate this change to begin in early 2015. As part of this webpage restructure, they will be integrating the information on Florida Medicaid covered services formerly contained in the Medicaid *Summary of Services* book as part of the online content on the website. They anticipate this to be complete in Spring 2015. Please keep an eye on the Florida Medicaid webpages for further updates.

### **5. Payment Error Rate Measurement Project (2014)**

The Improper Payments Act of 2002 (HR 4878) requires federal government agencies to provide an estimate of their improper payments annually. The Centers for Medicare and Medicaid Services (CMS) has tested the process and methodology to implement a nationwide effort to measure improper payments in the Medicaid program. The Agency for Health Care Administration (Agency), as the single state agency responsible for administering the Medicaid program in Florida, will be participating in this effort.

CMS will measure the accuracy of Medicaid and Children's Health Insurance Program (CHIP) payments made by states for services rendered to recipients through the Payment Error Rate Measurement (PERM) program. Under the PERM program, CMS will use two national contractors to measure improper payments in Medicaid and CHIP. The first contractor, The Lewin Group, will provide statistical support to the program by selecting a sample of claims to be reviewed and then calculating Florida's error rate. The second contractor, A+ Government Solutions, will provide documentation/database support by collecting medical policies from the state and medical records from the providers. This contractor will also conduct medical and data processing reviews of the sample claims.

If a claim for a service that you rendered to either a Medicaid or CHIP recipient is selected to be in the sample, A+ Government Solutions will contact you for a copy of your medical records to support the medical review of that claim. Medical records will be needed for these reviews to determine if fee-for-service Medicaid and CHIP claims were correctly paid. From the date of contact, you must submit these medical records within 75 calendar days.

## Medicaid Updates continued:

### **Payment Error Rate Measurement Project (2014) continued**

#### **Consequences of Non-Response**

If the requested supporting medical documentation is not submitted, the claim will be coded as an error and any monies paid will be recouped. Since dollars estimated as being paid in error from the sample will be projected to the total universe of claims, the actual impact of each claim error will be magnified several times. This will result in a negative impact on the Florida Medicaid program. If the error rate is excessive, the Agency may be required to add controls or other limitations to address problem areas that are identified. It must be emphasized that even small claim amounts identified as payment errors can have a significant impact on how a particular service area is perceived. Therefore, it is important that providers submit requested medical records in a timely manner.

#### **Medical Record Requests**

Please note that providers are required by section 1902(a)(27) of the Social Security Act to retain the records necessary to disclose the extent of services provided to individuals receiving assistance, and to furnish CMS with information regarding any payments claimed by the provider for rendering services.

Furnishing information includes submitting medical records for review.

The collection and review of protected health information contained in individual-level medical records is permissible for payment review purposes via the Health Information Portability and Accountability Act of 1996 (HIPAA), as stated in 45 Code of Federal Regulations, parts 160 and 164:

***“...a covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits...or other activities necessary for the appropriate oversight of (1) the health care system; (2) government benefit programs for which health information is relevant to beneficiary eligibility; (3) entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or (4) entities subject to civil rights laws for which health information is necessary for determining compliance.”***

In addition, Medicaid providers are required to comply with any medical records request from the CMS contractor. Follow-up contact regarding these medical record requests may be made by Florida Medicaid staff if any request is nearing the 75 calendar day time limit.

## Medicaid Updates continued:

### **Payment Error Rate Measurement Project (2014) continued**

Look for additional details in upcoming Provider Bulletins and on the Agency's Florida Medicaid PERM website regarding the 2014 PERM cycle. Medical reviews by A+ Government Solutions began in August 2014. Those providers sampled are being contacted by A+ Government Solutions as the quarterly Medicaid and CHIP samples are finalized by the Lewin Group.

We will continue to send out specific information that pertains to medical record requests by A+ Government Solutions as the information becomes available. If your claim has been selected as part of the sample, the billing and treating provider offices on the claim will be notified by a letter from the Agency. You will then need to provide medical records as requested by A+ Government Solutions.

Florida Medicaid reminds all providers to bill in accordance with the billing procedures outlined in the Provider General Handbook and within the program policy handbook for the specific procedure being billed.

Please note, if you have changed your address or telephone number and have not updated your information with the Agency, this is a good opportunity to do so, as you are required to report any changes per the Provider General Handbook (page 2-49):

“Providers must promptly notify Medicaid of any change of address by calling the Medicaid fiscal agent's Provider Services Contact Center at 1-800-289-7799 and selecting Option 4.

The following four addresses may be housed on the provider file: service address, pay-to-address, mail-to or correspondence address, and home or corporate office address. To ensure accurate communication, including prompt payment for services rendered, providers must report address changes.”

Please continually check the Web Portal for Provider General Rule and Handbook updates for upcoming changes on how to report a change of address.

If you have updated or need to assign a delegated custodian of records, this is a perfect time to make note of this change as well. Please notify the Medicaid fiscal agent of any changes when updating your address change information. If closing out a former custodian, list the individual's name and the date they departed. If adding a new custodian, list the individual's name, home address, date of birth, SSN, whether they are the financial or medical custodian, and the date they started. Background screening is required. Please view the Background Screening page under Enrollment on the Medicaid Public Web Portal for more information.

## Medicaid Updates continued:

### **Payment Error Rate Measurement Project (2014) continued**

If you would like more information related to PERM and your role in this process, please visit the CMS PERM website. All documentation specific to 2014 participating states will be located under **Cycle 3**. General state provider information will be located under **Providers**.

If you have any questions, please contact Jason Ottinger, in the Medicaid Performance, Evaluation, and Research Unit by telephone at (850) 412-4695 or via email at Jason.Ottinger@ahca.myflorida.com.

## Information and Resources:

### **6. One Step at a Time: Gold Coast**

Gold Coast Early Steps initiated an Information Exchange about 5 years ago. The **Information Exchange** is akin to a community resource fair; however, it is an internal event for the benefit of Early Steps and other Children's Diagnostic and Treatment Center staff. It is staged to allow Broward County agencies that serve children with special needs to introduce their programs and services. Participants have an unfettered opportunity to network, cultivate relationships, explain programming and discuss coordination of services. As a result of the Exchange, service coordinators and clinic staff broaden their awareness of community resources and referral opportunities that may be of value to our families.

Secondarily, the Exchange showcases the CHILDREN'S DIAGNOSTIC & TREATMENT CENTER as a principal resource for children with special healthcare needs: offering early intervention, primary care/comprehensive medical home services: including case management, nutrition, evaluations, dental care, specialty care, research.

Thank you, Gold Coast Early Steps, for sharing this unique event. See the attachment for more information.



## PROGRAM MANAGER INFORMATION:

LES	Program Manager	QA Lead
<b>Bay Area</b>	<b>(Interim)</b> Mary Sandler (ext. 2240) <a href="mailto:Mary.Sandler@flhealth.gov">Mary.Sandler@flhealth.gov</a>	Angela Marcus (ext. 3278) <a href="mailto:Angela.Marcus@flhealth.gov">Angela.Marcus@flhealth.gov</a>
<b>Big Bend</b>	Dawn Lynch (ext. 2270) <a href="mailto:Dawn.Lynch@flhealth.gov">Dawn.Lynch@flhealth.gov</a>	Angela Marcus (ext. 3278) <a href="mailto:Angela.Marcus@flhealth.gov">Angela.Marcus@flhealth.gov</a>
<b>Central Florida</b>	Susan Casey (ext. 2231) <a href="mailto:Susan.Casey@flhealth.gov">Susan.Casey@flhealth.gov</a>	Jesse Kemper (ext. 2227) <a href="mailto:Jesse.Kemper@flhealth.gov">Jesse.Kemper@flhealth.gov</a>
<b>Gold Coast</b>	<b>(Interim)</b> Mary Sandler (ext. 2240) <a href="mailto:Mary.Sandler@flhealth.gov">Mary.Sandler@flhealth.gov</a>	Jesse Kemper (ext. 2227) <a href="mailto:Jesse.Kemper@flhealth.gov">Jesse.Kemper@flhealth.gov</a>
<b>Gulf Central</b>	Brenda Jones-Garrett (ext. 2224) <a href="mailto:Brenda.Jones-Garrett@flhealth.gov">Brenda.Jones-Garrett@flhealth.gov</a>	Angela Marcus (ext. 3278) <a href="mailto:Angela.Marcus@flhealth.gov">Angela.Marcus@flhealth.gov</a>
<b>North Beaches</b>	Susan Casey (ext. 2231) <a href="mailto:Susan.Casey@flhealth.gov">Susan.Casey@flhealth.gov</a>	Jesse Kemper (ext. 2227) <a href="mailto:Jesse.Kemper@flhealth.gov">Jesse.Kemper@flhealth.gov</a>
<b>North Central</b>	Dawn Lynch (ext. 2270) <a href="mailto:Dawn.Lynch@flhealth.gov">Dawn.Lynch@flhealth.gov</a>	Jesse Kemper (ext. 2227) <a href="mailto:Jesse.Kemper@flhealth.gov">Jesse.Kemper@flhealth.gov</a>
<b>North Dade</b>	Janice Miller (ext. 3910) <a href="mailto:Janice.Miller2@flhealth.gov">Janice.Miller2@flhealth.gov</a>	Angela Marcus (ext. 3278) <a href="mailto:Angela.Marcus@flhealth.gov">Angela.Marcus@flhealth.gov</a>
<b>Northeastern</b>	Janice Miller (ext. 3910) <a href="mailto:Janice.Miller2@flhealth.gov">Janice.Miller2@flhealth.gov</a>	Angela Marcus (ext. 3278) <a href="mailto:Angela.Marcus@flhealth.gov">Angela.Marcus@flhealth.gov</a>
<b>Southernmost Coast</b>	Janice Miller (ext. 3910) <a href="mailto:Janice.Miller2@flhealth.gov">Janice.Miller2@flhealth.gov</a>	Jesse Kemper (ext. 2227) <a href="mailto:Jesse.Kemper@flhealth.gov">Jesse.Kemper@flhealth.gov</a>
<b>Southwest</b>	Brenda Jones-Garrett (ext. 2224) <a href="mailto:Brenda.Jones-Garrett@flhealth.gov">Brenda.Jones-Garrett@flhealth.gov</a>	Angela Marcus (ext. 3278) <a href="mailto:Angela.Marcus@flhealth.gov">Angela.Marcus@flhealth.gov</a>
<b>Space Coast</b>	Susan Casey (ext. 2231) <a href="mailto:Susan.Casey@flhealth.gov">Susan.Casey@flhealth.gov</a>	Jesse Kemper (ext. 2227) <a href="mailto:Jesse.Kemper@flhealth.gov">Jesse.Kemper@flhealth.gov</a>
<b>Treasure Coast</b>	Mary Sandler (ext. 2240) <a href="mailto:Mary.Sandler@flhealth.gov">Mary.Sandler@flhealth.gov</a>	Jesse Kemper (ext. 2227) <a href="mailto:Jesse.Kemper@flhealth.gov">Jesse.Kemper@flhealth.gov</a>
<b>West Central</b>	<b>(Interim)</b> Dawn Lynch (ext. 2270) <a href="mailto:Dawn.Lynch@flhealth.gov">Dawn.Lynch@flhealth.gov</a>	Angela Marcus (ext. 3278) <a href="mailto:Angela.Marcus@flhealth.gov">Angela.Marcus@flhealth.gov</a>
<b>Western Panhandle</b>	<b>(Interim)</b> Brenda Jones-Garret (ext. 2224) <a href="mailto:Brenda.Jones-Garrett@flhealth.gov">Brenda.Jones-Garrett@flhealth.gov</a>	Jesse Kemper (ext. 2227) <a href="mailto:Jesse.Kemper@flhealth.gov">Jesse.Kemper@flhealth.gov</a>