



RON DESANTIS  
GOVERNOR

MARY C. MAYHEW  
SECRETARY

March 18, 2020

## **Statewide Medicaid Managed Care (SMMC) Policy Transmittal: 2020-15**

Applicable to the **2018-2023 SMMC contract benefits** for:

- Managed Medical Assistance (MMA) and MMA Specialty
- Long-Term Care (LTC)
- Dental

### **Re: COVID-19 State of Emergency: Medicaid Coverage of Services**

On March 9, 2020, Governor Ron DeSantis issued Executive Order Number 20-52 declaring a state of emergency related to the 2019 novel coronavirus (COVID-19). During this state of emergency, the managed care plan must ensure there are no gaps in care for its Medicaid enrollees, while implementing procedures and the use of routine screenings to prevent further spread of COVID-19. The Agency for Health Care Administration (Agency) is committed to ensuring that Medicaid recipients diagnosed with COVID-19 receive all the care needed to address their symptoms. The provisions of this policy transmittal are effective immediately, unless otherwise specified in the program specific provisions below.

### **Prior Authorization Requirements**

In order to reduce administrative burdens on key providers that are on the front line serving the populations most impacted by COVID-19, the managed care plan must waive initial and ongoing prior authorization requirements for skilled nursing facilities, long term acute care hospitals, hospital services, physician services, advanced practice registered nursing services, physician assistant services, home health services, and durable medical equipment and supplies. This provision is applicable to all managed care plan enrollees.

In addition to the services listed above, the managed care plan must waive all prior authorization requirements for all services (except pharmacy services) necessary to appropriately evaluate and treat managed care plan enrollees diagnosed with COVID-19. Please refer to official diagnosis coding guidelines that have been published by the [Centers for Disease Control \(CDC\)](https://www.cdc.gov).

### **Limits on Services**

The managed care plan must waive limits on medically necessary services (specifically related to frequency, duration, and scope) that need to be exceeded in order to maintain the health and safety of enrollees diagnosed with COVID-19 or when it is necessary to maintain an enrollee safely in their home. Examples of services include: the 45-day hospital inpatient limit, home health services, durable medical equipment, in-home physician visits, \$1,500 outpatient limit, etc.

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The managed care plan must lift all limits on early prescription refills during the state of emergency for maintenance medications, except for controlled substances. The edits prohibiting early prescription refills will remain lifted for 60 days, in accordance with the Governor's Executive Order [#2020-52](#). This does not apply to controlled substances.

The managed care plan must reimburse for a 90-day supply of maintenance prescriptions when requested by the enrollee and the pharmacy has the requested quantity in stock.

The managed care plan must allow mail order delivery of maintenance prescriptions during the state of emergency. The managed care plan must also pay for a 90-day supply of maintenance prescriptions through mail order delivery. This provision is applicable to all managed care plan enrollees.

### **Cost Sharing**

The managed care plan must waive co-payments for all services.

### **Managed Care Plan Appeals and Fair Hearings**

If needed, enrollees impacted by COVID-19 must be given more time to submit an appeal through their managed plan or request a fair hearing. In addition, the Agency has federal approval to temporarily delay scheduling of Medicaid fair hearings and issuing fair hearing decisions during the emergency period if there are workforce shortages. The Agency will limit use of this flexibility to those instances where the enrollee is continuing to receive services pending the outcome of the fair hearing.

### **Preadmission Screening and Resident Reviews**

The managed care plan must not reimburse for claims for nursing facility services provided prior to the date of completion of Preadmission Screening and Resident Review (PASRR) requirements. (Attachment II, Section X.E.1.e.) During this state of emergency, however, all PASRR processes are postponed until further notice by the Agency. During the state of emergency and until otherwise advised by the Agency, the managed care plan may not deny payment based upon the lack of completion of PASRR requirements for new admissions to a nursing facility.

### **Provider Enrollment and Credentialing**

The managed care plan must ensure that enrollees impacted by COVID-19 are able to see non-participating providers if they are unable to access covered services from participating providers. The managed care plan must ensure that providers (including out of state providers and providers not licensed in Florida) not known to Florida Medicaid that rendered services during the state of emergency complete the Agency's provisional (temporary) enrollment process to obtain a provider identification number for services rendered to enrollees. The Agency will make available the process for provisional provider enrollment at <http://www.mymedicaid-florida.com> by Thursday, March 19, 2020.

### **Provider Payment Provisions**

The managed care plan must implement a claims payment exceptions process for reimbursement of any medically necessary service furnished during the period of the state of emergency that normally would have required prior authorization, that were rendered by a non-participating provider, or that exceeded coverage limits for the service.

The managed care plan's claims payment exceptions process must include the following minimum elements and be made publicly available on the managed care plan's website:

- Submission instructions for providers that include provider enrollment requirements, including waiver of non-applicable provider credentialing requirements;
- Minimum documentation requirements for managed care plan decision making;
- Claims submission requirements; and
- Telephone and email contact information for a specific unit or division within the managed care plan that is familiar with the claims payment exceptions process.

The managed care plan must post information related to COVID-19 and the exceptions process on its website. The managed care plan must provide a direct link to its COVID-19 web page to its Agency contract manager by March 23, 2020.

If you have questions or concerns, please contact your contract manager at (850) 412-4004.

Sincerely,



Shevaun Harris  
Assistant Deputy Secretary for  
Medicaid Policy and Quality

SH/dvp

Attachment 1: DEM ORDER NO. 20-006

Attachment 2: DOH No. 20-002