The Statewide Medicaid Managed Care Program & Assisted Living Facilities

Presented at the 2014 Joint Training for Nursing Facilities and Assisted Living Facilities

Beth Kidder/Shevaun Harris
Agency for Health Care Administration

Cheryl Young
Department of Elder Affairs

Presentation Objectives

• Provide a refresher on Statewide Medicaid Managed Care Long-term Care program
• Discuss home and community-based characteristics requirements
• Provide updates on quality measures, statutory or contract provisions impacting assisted living facilities
• Introduce Statewide Medicaid Managed Care Managed Medical Assistance
• Ensure all attendees know how to get more information on the program

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

• Because of the Statewide Medicaid Managed Care (SMMC) program, the Agency is changing how a majority of individuals receive most health care services from Florida Medicaid.
The SMMC program does not/is not:

• The program does not limit medically necessary services.
• The program is not linked to changes in the Medicare program and does not change Medicare benefits or choices.
• The program is not linked to National Health Care Reform, or the Affordable Care Act passed by the U.S. Congress.
  – It does not contain mandates for individuals to purchase insurance.
  – It does not contain mandates for employers to purchase insurance.
  – It does not expand Medicaid coverage or cost the state or federal government any additional money.

Refresher on the Statewide Medicaid Managed Long-term Care (LTC) Program

Who is Required to Participate?

Individuals who fit into one of the following categories may be eligible for the LTC program:

• 65 years of age or older AND need nursing facility level of care (LOC)*

OR

• 18 years of age or older AND are eligible for Medicaid by reason of a disability AND need nursing facility level of care.

*Nursing facility level of care means that someone meets the medical eligibility criteria for Institutional Care Programs (ICP), as defined in Florida Statute.
What Services are Covered?

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult companion care</td>
<td>Hospice</td>
</tr>
<tr>
<td>Adult day health care</td>
<td>Intermittent and skilled nursing</td>
</tr>
<tr>
<td>Assisted living services</td>
<td>Medical equipment and supplies</td>
</tr>
<tr>
<td>Assistive care services</td>
<td>Medication administration</td>
</tr>
<tr>
<td>Attendant care</td>
<td>Medication management</td>
</tr>
<tr>
<td>Behavioral management</td>
<td>Nursing facility</td>
</tr>
<tr>
<td>Care coordination/Care management</td>
<td>Nutritional assessment/Risk reduction</td>
</tr>
<tr>
<td>Caregiver training</td>
<td>Personal care</td>
</tr>
<tr>
<td>Home accessibility adaptation</td>
<td>Personal emergency response system (PERS)</td>
</tr>
<tr>
<td>Home-delivered meals</td>
<td>Respite care</td>
</tr>
<tr>
<td>Homemaker</td>
<td>Therapies, occupational, physical, respiratory, and speech</td>
</tr>
<tr>
<td>Transportation, non-emergency</td>
<td></td>
</tr>
</tbody>
</table>

Each recipient will not receive all services listed. Recipients will work with a case manager to determine the services they need based on their condition.

Selecting Long-term Care Plans

- AHCA selected Long-term Care plans through a competitive bid process.
- The state is divided into 11 regions that coincide with the existing Medicaid areas and the Department of Elder Affairs Planning and Service Areas.
- Plans will provide services by region:
  - Five year contracting period for LTC plans.
  - Penalties for plan withdrawals.

Enrollment by Plan

<table>
<thead>
<tr>
<th>Plan</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Eldercare, Inc.</td>
<td>5,229</td>
</tr>
<tr>
<td>Amerigroup Florida, Inc.</td>
<td>4,921</td>
</tr>
<tr>
<td>Coventry Health Plan</td>
<td>3,503</td>
</tr>
<tr>
<td>Humana Medical Plan, Inc.</td>
<td>2,937</td>
</tr>
<tr>
<td>Molina Healthcare of Florida, Inc.</td>
<td>2,775</td>
</tr>
<tr>
<td>Sunshine State Health Plan</td>
<td>14,395</td>
</tr>
<tr>
<td>United Healthcare of Florida, Inc.</td>
<td>11,807</td>
</tr>
<tr>
<td>Total</td>
<td>49,384</td>
</tr>
</tbody>
</table>
LTC Program
Eligibility and Enrollment

How Does Enrollment Begin?
There are two categories of recipients:
1. Recipients actively receiving Medicaid nursing facility (NF) services or Medicaid home and community based services (HCBS).
   • Active recipients will be transitioned into the LTC program.
2. New individuals seeking NF or HCBS.
   • Individuals seeking NF follow the same process as they do currently. There is no waitlist for NF services.

Enrollment Process for Individuals Currently on the HCBS Waitlist
• Individuals on the waitlist for A/DA, AL, or NHD waivers are being moved to a consolidated LTC program waitlist
• Once the LTC program starts in a region, AHCA will mail plan selection materials to individuals who have met the medical level of care criteria and who have filed an application for Medicaid financial eligibility.
  – This can only occur after being released from the HCBS waitlist managed by DOEA.
Enrollment of Individuals Newly Seeking HCBS

- Individuals seeking home and community based services must contact the Aging and Disability Resource Center (ADRC)
- ADRC staff will conduct intake and screening:
  - Use screening form 701S
  - Place on waitlist
- When additional funding is available, new individuals may complete eligibility and enroll in the LTC program.

Enrollment Process Following Release from the Waitlist

- ADRC staff help the individual file Medicaid application with DCF for financial eligibility and obtain the physician-completed 3008 form.
- ADRC staff refer the case to CARES.
- CARES completes 701B assessment and authorizes level of care.
- DOEA sends daily list of approved individuals to AHCA to start LTC program enrollment.

Choice Counseling

- Choice counseling is a service offered by the Agency, through a contracted enrollment broker, to assist recipients in understanding:
  - managed care
  - available plan choices
  - plan differences
  - the enrollment and plan change process.
- Counseling is unbiased and objective.
The Choice Counseling Cycle

Recipient determined eligible for enrollment or enters open enrollment

Newly eligible recipients are allowed 90 days to “try” the plan out, before becoming locked-in

Recipient receives communication informing him of choices

Recipient may enroll or change via phone, online or in person

Enrollment or change is processed during monthly processing and becomes effective the following month

Newly eligible recipients are allowed 90 days to “try” the plan out, before becoming locked-in

A Closer Look at the Choice Counseling Cycle

Individuals may enroll or change their plans using one of the following methods:

- Online at: www.flmedicaidmanagedcare.com
- By contacting the call center at 1-877-711-3662 and speaking with a counselor to complete enrollment or to request a face-to-face meeting.

Helping your Residents Make Choices

- When individuals call to make a managed care choice or change they must first be able to verify information about themselves to confirm their identity.
- If you are calling on behalf of your residents you must:
  - Have this identity information
  - Explain how you are authorized to make a choice or change on their behalf
  - Submit proof of authorization after the choice is made.
- An optional form is at http://ahca.myflorida.com/smmc
- Select LTC tab, then Recipients tab
Contracting with a Long-term Care Plan

Two Types of Long-term Care Plans

- Health Maintenance Organizations (HMOs)
  - Are only capitated
- Provider Service Network (PSN)
  - Can be fee-for-service for up to two years, then must be capitated

Differences in Types of LTC Plans

- Payment:
  - If the LTC plan is capitated, then network providers will be paid by the plan.
  - If the LTC plan is fee-for-service, then providers will be paid by the Agency after claims are submitted to the LTC plan for authorization.
- Network providers for a fee-for-service provider service network must be fully enrolled in Medicaid.
Enrollment vs. Registration

- ALF providers that contract with the Provider Service Network (PSN) must be fully enrolled in Florida Medicaid.
- ALF providers that contract with HMOs must register with Medicaid.
- ALF providers currently enrolled in Medicaid simply share their Medicaid ID with the PSN or LTC plan.
- ALF providers not enrolled in Medicaid must submit a Florida Medicaid Provider Enrollment Application or registration.

When Should I Have a Contract with a LTC or MMA Plan?

Assisted living facilities should contract now with the long-term care plans in their region. ALFs may also need new or amended contracts to provide assistive care services for MMA.

When Should I Have A Contract? (Continued)

- Recipients begin choosing LTC and MMA plans two months before their region “go live” date.
- Choice counselors use a list of contracted providers to help recipients choose a plan.
- To be on the list, ALFs must have an executed contract, and the contract must be verified by an automated system (PNV).
- Each plan’s provider contracting contacts are listed at http://ahca.myflorida.com/SMMC
Other Important Information about the LTC Program

Assistive Care Services

Medicaid Long-term Care Program Enrollees*

- Funding: Medicaid Long-term Care Plan
- Provided in:
  - Adult Family Care Homes
  - Assisted Living Facilities**

*Level of Care & enrollment required
**Assistive Care Services are rolled into Assisted Living Services and are no longer separate under the LTC program.

Medicaid Recipients not in an LTC Plan

- Funding: Medicaid State Plan or Managed Medical Assistance Plan
- Provided in:
  - Assisted Living Facilities
  - Adult Family Care Homes
  - Residential Treatment Facilities

LTC Plan Case Managers

- Every person enrolled in LTC program has a case manager.
- Case manager contact requirements include:
  - At least monthly telephone contact with the resident to verify satisfaction and receipt of services
  - At least every 90 days, the case manager must meet with the recipient face-to-face:
    - Update the plan of care, if needed
    - Evaluate and document the home and community based characteristics for assisted living facility and adult family care home residents
  - Annual face-to-face visit with the enrollee to complete the annual reassessment and determine the enrollee’s functional status, satisfaction with services, changes in service needs and develop a new plan of care.
ALF Training

LTC plans must provide training to ALF staff that includes:
• Signs and symptoms of mental illness;
• Behavior management strategies;
• Identification of suicide risk and management;
• Verbal de-escalation strategies for aggressive behavior;
• Trauma informed care;
• Documentation and reporting of behavioral health concerns;
• Abuse, neglect, exploitation and adverse incident reporting

Incentives to Shift to Community-Based Services & Recipient Safeguards

Incentives Shift to Home & Community Based Care Services

• The law requires that managed care plan rates be adjusted annually to provide an incentive to shift services from nursing facilities to community based care.
• Payment incentives will be in place until no more than 35% of the plan’s enrollees are in nursing facilities.
Recipient Safeguards

- Recipients residing in a nursing facility can choose to remain in that facility, as long as they meet nursing facility level of care.
- Recipients residing in the community can choose to remain in the community, even if the LTC plan recommends a different placement.
- Recipients may choose any plan in their region.
- Recipients may choose any provider in their plan's network.

Recipient Safeguards

- LTC plans will assess their enrollees in nursing facilities about the choice to transition to an assisted living facility, adult family care home, or other community living arrangement.
- Like the former Medicaid Nursing Home Transition Program, transition cannot occur prior to a continuous 60 day stay in the nursing facility.
- LTC plans will coordinate and track these transitions with the enrollees and the assisted living facilities in the LTC plan network. The LTC Plan will notify DCF of the date of nursing facility/ALF admission/discharge prior to the respective admission/discharge date.

Successes & Issues
**Program Implementation**

The overarching goals for the Long-term Care program implementation are:

1. Ensuring that enrollees have no break in services, and
2. Ensuring skilled nursing facility and assisted living facility residents do not have to move to another facility.

- Both of these goals continue to be met for the implementation to date.
- Transitioned waiver recipients are receiving services as outlined on their pre-transition care plans until the LTC plans complete the person-centered planning process, and residents of assisted living facilities and skilled nursing facilities have not had to move to another facility since the transition.

---

**Recipient’s Address & Enrollment**

- The basis of Medicaid recipient enrollment is the recipient's *Residence County* in the Florida Medicaid Management Information System (FMMIS).

- If the recipient's address is incorrect in the Medicaid system, the recipient must contact the agency that determined their eligibility.

- This would be either the Department of Children and Families (DCF) or the Social Security Administration (SSA).
  - The recipient will need to request both an address and county change.

---

If the recipient's address is correct in the Medicaid system, but his county is incorrect:

- Report it online at: [http://ahca.myflorida.com/emnc](http://ahca.myflorida.com/emnc)
- Select the blue “Report a Complaint” button.
- AHCA will work with DCF or SSA to resolve the issue and correct the person's enrollment.
Quality Measures for Assisted Living Facilities

Each managed care plan shall monitor the quality and performance of each participating provider using measures adopted by and collected by the agency and any additional measures mutually agreed upon by the provider and the plan.

-s. 409.982(3), Florida Statutes

Quality Measures for Assisted Living Facilities

- LTC plans must offer a contract to any ALF that was billing for Medicaid Waiver services as of July 2012.
- After the first year of contract, LTC plans can exclude ALFs for not meeting credentials, price, quality or performance standards.
Home & Community-Based Characteristics and ALFs

Centers for Medicare and Medicaid Services Final Rule

- Requires providers (ALFs and AFCHs) that serve Medicaid recipients in the community maintain home and community-based characteristics, which includes person-centered services and a home-like environment.
- Final rule announced January 10, 2014:
  "The rule enhances the quality of HCBS, provides additional protections to HCBS program participants, and ensures that individuals receiving services through HCBS programs have full access to the benefits of community living."
- The rule is available at: http://www.medicaid.gov/HCBS.

Programs Affected

- All Medicaid waiver programs providing services in Assisted Living Facilities and Adult Family Care Homes are expected to provide a home-like environment and community integration to the fullest extent possible:
  - Long-term Care program
  - Program of All-inclusive Care for the Elderly (PACE)
  - Nursing Home Diversion Waiver (ends 2/28/14)
  - Assisted Living Waiver (ends 2/28/14)
  - Aged/Disabled Adult Waiver (Facility-based Respite) (ends 2/28/14)
  - Any other Medicaid waiver program that offers services in ALFs or AFCHs.
Characteristics of a Home-Like Environment

- Each resident must be assured privacy in sleeping and personal living areas:
  - Entrance doors must have locks, with appropriate staff having keys to the doors
  - Freedom to furnish and/or decorate sleeping or personal living areas
  - Choice of private or semi-private rooms
  - Choice of roommate for semi-private rooms
  - Access to telephone service as well as length of use
  - Freedom to engage in private communications at any time

Characteristics of a Home-Like Environment (continued)

- Freedom to control daily schedule and activities (physical and mental conditions permitting)
- Visitation options of the resident's choosing
- Access to food and preparation areas in the facility at any time (physical and mental conditions permitting)
- Personal sleeping schedule
- Participation in facility and community activities of the resident's choice
- Ensuring that residents are allowed to participate in unscheduled activities of their choosing

Community Integration

- Access to the greater community is facilitated by the ALF or AFCH based on the resident's abilities, needs and preferences
- The ALF or AFCH setting must offer meaningful community participation opportunities for their residents at times, frequencies and with persons of their choosing
  - **Example:** The resident wishes to visit the senior center to participate in social activities
  - **Barrier:** The resident does not have access to transportation
  - **Intervention:** The case manager works with the ALF or AFCH to ensure that transportation, such as Dial-a-Ride, is available to transport the resident to and from the senior center and to ensure that the resident is dressed and ready to depart
Person-Centered Care Planning

• Creation of an individualized and inclusive person-centered plan of care that addresses services, supports, and goals based on the resident’s preferences
• The person-centered plan of care is based on a comprehensive assessment that includes the resident and participation by any other individuals chosen by the resident
• The plan of care must support the resident’s needs in the most integrated community setting possible
• The waiver recipient’s plan of care must include personal preferences, choices, and goals to achieve personal outcomes

Personal Goals

• Examples of personal goals a resident may choose:
  • Deciding where and with whom to live
  • Making decisions regarding supports and services
  • Choosing which activities are important
  • Maintaining relationships with family and friends
  • Deciding how to spend each day

Promoting a Home-Like Environment

• All ALFs/AFCHs participating in SMMC LTC must meet these requirements before the first date of enrollment in region.
• LTC plans must verify during the credentialing and re-credentialing process that home-like environment and community integration exist in all facilities under contract.
• DOEA staff completed on-site reviews in 2013 of a sample of ALFs by region to ensure a home-like environment.
Remediation

If a LTC plan discovers that an ALF/AFCH is not maintaining a home-like environment or supporting full community integration, it must:
- Report that finding to the State immediately
- Propose a remediation plan within three business days of discovery
- AHCA and DOEA will ensure the LTC plans contract only with ALFs/AFCHs providing and supporting a home-like environment and community integration.

HCB Characteristics – Ongoing Monitoring

The LTC plans will conduct re-credentialing activities and on-going on-site verification to ensure that home and community based characteristics exist in their contracted facilities.
- DOEA compliance staff will:
  - Conduct annual reviews of the LTC plans' credentialing files.
  - Review a representative sample, organized by region, of current enrollee files of each LTC plan.
  - Conduct on-site visits with enrollees in ALFs and AFCHs.
- If DOEA staff determine that an enrollee is residing in an environment that meets HCB characteristics, the State will follow up with the LTC plan within 24 hours.
  - LTC plans will remediate the deficiencies and submit a corrective action plan to the State within 15 business days.

Disenrollment Reason

ALFs or AFCHs that do not and will not conform to HCB characteristics, must be disenrolled from the LTC plan's network.
- Enrollees may choose to move to another ALF or AFCH in the plan's network.
- Enrollees who choose to stay in an ALF/AFCH that does not meet HCB characteristics will be disenrolled from the LTC program.
Introduction to Managed Medical Assistance (MMA) Program

Who MAY participate?

- The following individuals may choose to enroll in program:
  - Individuals who have other creditable health care coverage, excluding Medicare;
  - Individuals age 65 and over residing in a mental health treatment facility meeting the Medicare conditions of participation for a hospital or nursing facility;
  - Individuals in an intermediate care facility for individuals with intellectual disabilities (ICF-IID); and
  - Individuals with developmental disabilities enrolled in the home and community based waiver pursuant to state law, and Medicaid recipients.

Who is Excluded from participating?

- Women who are eligible only for family planning services
- Women who are eligible only for breast and cervical cancer services
- Persons who are eligible for emergency Medicaid for aliens
- Children receiving services in a prescribed pediatric extended care center
Managed Medical Assistance Services

<table>
<thead>
<tr>
<th>Minimum Required Covered Services: Managed Medical Assistance Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced registered nurse practitioner services</td>
</tr>
<tr>
<td>Primary and nonemergent care provider services</td>
</tr>
<tr>
<td>Office and nonemergent care provider services</td>
</tr>
<tr>
<td>Dental services</td>
</tr>
<tr>
<td>Orthodontic and orthopedic services</td>
</tr>
<tr>
<td>Ambulatory surgical treatment center services</td>
</tr>
<tr>
<td>Laboratory and imaging services</td>
</tr>
<tr>
<td>Assisted living services</td>
</tr>
<tr>
<td>Home health services</td>
</tr>
<tr>
<td>Home health aide services</td>
</tr>
<tr>
<td>Hospice services</td>
</tr>
<tr>
<td>Emergency services</td>
</tr>
<tr>
<td>Physical, occupational, respiratory, and speech therapy services</td>
</tr>
<tr>
<td>Midwifery services</td>
</tr>
<tr>
<td>Rural health clinic services</td>
</tr>
<tr>
<td>Hospital inpatient services</td>
</tr>
<tr>
<td>Hospital outpatient services</td>
</tr>
<tr>
<td>Transportation to access covered services</td>
</tr>
<tr>
<td>Prescription drugs</td>
</tr>
<tr>
<td>Outpatient services</td>
</tr>
<tr>
<td>Inpatient services</td>
</tr>
<tr>
<td>Surgical services</td>
</tr>
<tr>
<td>Radiation therapy</td>
</tr>
</tbody>
</table>

Where will recipients receive services?

• Several types of health plans will offer services through the MMA program:
  – Standard Health Plan
    • Health Maintenance Organizations (HMOs)
    • Provider Service Networks (PSNs)
  – Specialty Plans
  – Comprehensive Plans
  – Children’s Medical Services Network
• Health plans were selected through a competitive bid for each of 11 regions of the state.

Non-standard Health Plans

• Specialty Plan
  – A specialty plan is a managed care plan that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis.
• Comprehensive Plan
  – Comprehensive plans are managed care plans that offer both Long-term Care and Acute Care services.
• Children’s Medical Services Network
  – Children’s Medical Services is the statewide managed care plan for children with special healthcare needs.
Managed Medical Assistance Program Implementation

• The Agency has selected 14 companies to serve as general, non-specialty MMA plans.
• Five different companies were selected to provide specialty plans that will serve populations with a distinct diagnosis or chronic condition; these plans are tailored to meet the specific needs of the specialty population.
• The selected health plans are contracted with the Agency to provide services for 5 years.

Managed Medical Assistance Program Roll Out Schedule

<table>
<thead>
<tr>
<th>Implementation Schedule</th>
<th>Regions</th>
<th>Enrollment Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2, 3 and 4</td>
<td>May 1, 2014</td>
</tr>
<tr>
<td></td>
<td>5, 6 and 8</td>
<td>June 1, 2014</td>
</tr>
<tr>
<td></td>
<td>10 and 11</td>
<td>July 1, 2014</td>
</tr>
<tr>
<td></td>
<td>1, 7 and 9</td>
<td>August 1, 2014</td>
</tr>
</tbody>
</table>

What providers will be included in the MMA plans?

• Plans must have a sufficient provider network to serve the needs of their plan enrollees, as determined by the State.
• Managed Medical Assistance plans may limit the providers in their networks based on credentials, quality indicators, and price.
Assistive Care Services under the MMA Program

- Under MMA, plans must provide assistive care services as detailed in the Medicaid Assistive Care Services Coverage and Limitations Handbook.
- Unlike in the LTC program, MMA plans pay for an enrollee's assistive care services separately from any payments made to the assisted living facility. (Note: In the LTC program, assistive care services payments may only be made for recipients in an adult family care home.)
- If an enrollee is only enrolled in the MMA program and receives assistive care services, the MMA plan covers and pays for the service.
- If an enrollee is enrolled in a Comprehensive LTC plan and is receiving both LTC and MMA services and receives assistive care services, the Comprehensive LTC plan covers and pays for the assistive care services.
- If an enrollee is enrolled in non-comprehensive plan and is receiving services from a LTC plan and an MMA plan, the LTC plan covers and pays for the assistive care services.

Resources

Keep up to date on information by signing up to receive program updates by visiting the SMMC website at:
http://ahca.myflorida.com/smmc

Florida Medicaid

Would you like to receive email updates about this program?

Sign up to receive your information below:

- Email
- First Name
- Last Name

[Submit]
Stay Informed

• Participate in webinars regarding implementation activities.
  
  The direct link to the webinars is: http://ahca.myflorida.com/LTCwebinars

Review the SMMC Frequently Asked Questions document which is posted at:
http://ahca.myflorida.com/smmc

Updates about the SMMC program and upcoming events and news can be found on the SMMC website at:
http://ahca.myflorida.com/smmc
Use "Report A Complaint" to submit issues. These can be requests for help from local AHCA staff or anonymous complaints.

If you have a complaint, or issue about Medicaid Managed Care services, please complete the online form found at: http://ahca.myflorida.com/smmc

Click on the “Report a Complaint” blue button.

If you need assistance completing this form or wish to verbally report your issue, please contact your local Medicaid area office.

Find contact information for the Medicaid area offices at: http://www.mymedicaid-florida.com/

Stay Connected

- Youtube.com/AHCAFlorida
- Facebook.com/AHCAFlorida
- Twitter.com/AHCA_FL
- SlideShare.net/AHCAFlorida