Statewide Medicaid Managed Care Long-term Care Program

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Deputy Secretary for Medicaid
Agency for Health Care Administration
July 25, 2013

Presentation Overview

- Current Medicaid Snapshot and Enrollment Stats
- General Statewide Medicaid Managed Care
- Long-term Care program
  - Plan selection and implementation
  - Recipient Enrollment and Covered Services
  - Continuity of Care
  - Provider Participation
  - Person-centered services and a home-like environment
- Quality assurance in managed care plans

Florida Medicaid – A Snapshot

<table>
<thead>
<tr>
<th>Expenditure</th>
<th>$20.7 billion estimated spending in Fiscal Year 2012-13</th>
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<tbody>
<tr>
<td></td>
<td>Federal-state matching program – 57.73% federal, 42.27% state.</td>
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<td></td>
<td>Florida will spend approximately $6,339 per eligible in Fiscal Year 2012-2013.</td>
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<td>42% of all Medicaid expenditures cover hospitals, nursing homes, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD); Low Income Pool and Disproportionate Share Payments.</td>
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<tr>
<th>Eligible</th>
<th>3.35 million eligibles.</th>
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<td>Elders, disabled, families, pregnant women, children in families below poverty.</td>
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<td>Fourth largest Medicaid population in the nation</td>
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| Providers/Plans | Approximately 78,000 Fee-For-Service providers; 29 Medicaid Managed Care plans (20 HMOs and 9 PSNs). |
Florida Medicaid Enrollment by Plan Type

- Managed care has existed as a delivery system in Florida since the mid-1980s.
- 47% of recipients currently receive their care through a managed care plan. (Includes those enrolled in HMOs, PSNs and Nursing Home Diversion)

<table>
<thead>
<tr>
<th>Medicaid Enrollment</th>
<th>% of Total Enrollment</th>
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<tbody>
<tr>
<td>HMO</td>
<td>1,208,278</td>
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<td>PSN</td>
<td>310,512</td>
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<tr>
<td>Nursing Home Diversion (NHD)</td>
<td>18,033</td>
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<td>MediPass (PCCM)</td>
<td>587,339</td>
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<td>Fee-for-Service</td>
<td>1,159,603</td>
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<td>Program for All Inclusive Care for the Elderly (PACE)</td>
<td>798</td>
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Managed Medical Assistance (MMA) Program
Long-term Care (LTC) Program (Implemented First) (2013)
Managed Medical Assistance (MMA) Program (2014)

Statewide Medicaid Managed Care Program

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

What is the role of the AHCA in the SMMC program?

- AHCA has the lead on the entire SMMC program and will contract with the health plans for the delivery of SMMC long term care services.
- While AHCA will manage all aspects of the SMMC contract, DOEA is responsible for monitoring and quality assurance components and the oversight of Aging and Disability Resource Center, Area Agency on Aging contracted functions.
SMMC: Procurement and Federal Authorities

- Florida Medicaid is statutorily required to select Managed care plans through a competitive bid process (Invitation to Negotiate)
  - Plans must bid separately for Long-term Care and Managed Medical Assistance programs
  - State is divided into 11 regions
- The Agency received federal approval from CMS to implement the LTC program from CMS on February 1, 2013.
- The Agency received federal approval from CMS to implement the MMA program on June 14, 2013.

Statewide Medicaid Managed Care Region Map

Plans Selected for Participation in LTC Program

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### LTC Timelines: Recipient Enrollment Schedule

<table>
<thead>
<tr>
<th>Region</th>
<th>Enrollment Effective Date</th>
<th>Total Eligible Population</th>
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<tbody>
<tr>
<td>7</td>
<td>August 1, 2013</td>
<td>Region 7: 9,338</td>
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<tr>
<td>8 &amp; 9</td>
<td>September 1, 2013</td>
<td>Region 8: 5,596; Region 9: 7,854&lt;br&gt;Total: 13,450</td>
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<tr>
<td>2 &amp; 10</td>
<td>November 1, 2013</td>
<td>Region 2: 4,058; Region 10: 7,877&lt;br&gt;Total: 11,935</td>
</tr>
<tr>
<td>11</td>
<td>December 1, 2013</td>
<td>Region 11: 17,257</td>
</tr>
<tr>
<td>5 &amp; 6</td>
<td>February 1, 2014</td>
<td>Region 5: 9,963; Region 6: 9,575&lt;br&gt;Total: 19,538</td>
</tr>
<tr>
<td>1, 3, 4</td>
<td>March 1, 2014</td>
<td>Region 1: 2,973; Region 3: 6,911; Region 4: 9,087&lt;br&gt;Total: 18,971</td>
</tr>
</tbody>
</table>

### What Will Not Change?

- CARES will continue to determine clinical eligibility.
- DCF and Social Security will continue to determine financial eligibility.
- The majority of services will remain the same.
- Waitlist for HCBS will be maintained.

### Who Must Enroll in LTC?

- Individuals must enroll in LTC managed care if they are 18 and older and enrolled in:
  - Nursing Facility
  - Aged and Disabled Adult Waiver
    - Consumer-Directed Care Plus for individuals in the A/DA waiver
  - Assisted Living Waiver
  - Channeling Services for Frail Elders Waiver
  - Nursing Home Diversion Waiver
  - Frail Elder Option.
- Waivers listed above will end with implementation of the SMMC program
Recipient Enrollment Process

- After recipients make their initial plan choice, they have 90 days to change to another plan in their region. The 90 day clock resets after changing plans.
- Once a recipient has been in a plan for 90 days, the recipient must stay in the plan until the next open enrollment period unless they have a good cause reason.
- Enrollees can change their long-term care providers within their plan at any time.

How are services changing?

- The SMMC program does not eliminate services:
  - Managed care plans will be required to provide services at a level equivalent to the Medicaid state plan.
  - New services and options such as:
    - Case Management for nursing facility residents
    - Participant Directed Option.
  - Plans are offering additional benefits.

Covered Services

<table>
<thead>
<tr>
<th>Adult companion care</th>
<th>Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult day health care</td>
<td>Intermittent and skilled nursing</td>
</tr>
<tr>
<td>Assistive living</td>
<td>Medical equipment and supplies</td>
</tr>
<tr>
<td>Assistive home services</td>
<td>Medication administration</td>
</tr>
<tr>
<td>Attendee care</td>
<td>Medication management</td>
</tr>
<tr>
<td>Behavioral management</td>
<td>Nursing aide</td>
</tr>
<tr>
<td>Care coordination/Case management</td>
<td>Nutritional assessment/Meal 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>Home medical equipment</td>
<td>Respiratory, occupational, physical, speech</td>
</tr>
<tr>
<td>Transportation, non-emergency</td>
<td>Transportation, non-emergency</td>
</tr>
</tbody>
</table>
Continuity of Care

- LTC plans must continue enrollees’ **current** services for up to 60 days until a new assessment and care plan are complete and services are in place.
  - Same services
  - Same providers
  - Same amount of services
  - Same rate of pay (if the provider is not under contract)

Continuity of Care (Continued)

- Service providers that have not contracted with an enrollee’s LTC plan will be required to continue serving the enrollee for up to 60 days or until the enrollee selects another service provider and a new plan of care has been developed.
- The LTC plan must authorize and pay for services rendered by the non-contracted provider until:
  - A contracted provider is in place
  - The LTC plan notifies the non-contracted provider in writing that reimbursement will end on a specific date.
- If a Medicaid recipient selects a LTC plan that does not have a contract with his or her current service provider, the plan’s case manager will work closely with the recipient to choose another service provider that can best meet his or her needs.

Care Coordination for All Enrollees

- A case manager will work with every LTC enrollee to identify the types of services needed and which of the contracted providers can best meet the enrollee’s needs.
- LTC plans can limit the number of providers in their networks based on credentials, quality and price. However, they must have enough providers to care for all enrollees.
- This guarantees that enrollees always have access to someone who can provide necessary care.
LTC Enrollee Protections

- The contract between the state and the plans explicitly prohibits the plans from requiring enrollees to enter alternative residential settings that may be less costly than remaining in their own homes.
- Enrollees residing in nursing facilities can choose to remain in that facility as long as they continue to meet nursing facility level of care requirements.

Enrollee Appeal Rights

- Enrollees have the right to disagree with any change in their services.
- LTC plans must notify enrollees of their right to challenge a denial, termination or reduction of services.
  - The Agency for Health Care Administration and the Department of Elder Affairs will monitor each plan’s complaint and grievance process closely.

Enrollee Appeal Rights (Continued)

- Case managers will help enrollees file complaints and grievances.
- The LTC plan will contact the enrollee in writing to confirm receipt of the appeal, and to also to notify the enrollee of the plan’s action in response to the appeal.
- Enrollees have the right to continue receiving their current level of services while the appeal is under review.
Fair Hearing Rights

• Enrollees may seek a Medicaid Fair Hearing if services are reduced, denied, suspended, or terminated.
• The Fair Hearing process is not changing.
• Enrollees can file for a fair hearing by:
  – Calling (850) 488-1429
  – Faxing (850) 487-0662
  – Writing to Department of Children and Families, Office of Appeal Hearings, Building 5, Room 255, 1317
  – Emailing Appeal_Hearings@dcf.state.fl.us

Provider Contracting with Managed Care Plans

• To participate in the Long-term Care program, providers will need to contract with either:
  – Health Maintenance Organizations (HMOs)
    • Will be only capitated.
  – Provider Service Networks (PSNs)
    • May be fee-for-service or capitated.
  – The main difference for network providers will be how they are paid. All services will be authorized by the HMO or PSN.
    • If the health plan is capitated, then network providers will be paid by the plan.
    • If the health plan is fee-for-service, then providers will be paid by the Agency after claims are submitted to the health plan for authorization.
  – Recipients shouldn’t see a difference in services whether they are enrolled in an HMO or PSN.

Centers for Medicare and Medicaid Services Proposed Rule: Person-centered services and a home-like environment

• Requires providers that serve Medicaid recipients in the community maintain home and community-based characteristics, which includes person-centered services and a home-like environment
• Online at http://federalregister.gov/a/2012-10385 and on FDsys.gov
Programs Affected

- All Medicaid waiver programs providing services in ALFs/AFCHs are expected to provide a home-like environment and community integration to the fullest extent possible:
  - Nursing Home Diversion Waiver
  - Assisted Living Waiver
  - Channeling Waiver (Facility-based Respite)
  - Aged/Disabled Adult Waiver (Facility-based Respite)
  - Long-term Care Statewide Medicaid Managed Care Waiver
  - Any other Medicaid waiver program that offers services in assisted living facilities

Medicaid Home and Community-Based Services Waivers

- Provide funding for services for Medicaid eligible people with qualifying disabilities who want to live at home or in the community

- Purpose: Allow state Medicaid programs to cover services traditionally viewed as "long-term care" and provide them in a community setting to individuals instead of nursing home or institutions

Medicaid Home and Community-Based Services Waivers Eligibility

- Recipients must:
  - Meet institutional level of care
  - Meet Medicaid Institutional Care Program (ICP) income and asset limits
  - Satisfy any additional impairment criteria
  - Accept waiver services in lieu of institutional placement
Defining 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

Defining 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

- The basis of a successful home and community-based setting is the 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 Home and Community-Based Characteristics

- The state will ensure the promotion of home and community-based settings and community integration through:
  - Individualized person-centered care planning
  - Goal planning activities
  - Promotion of a home-like environment in assisted living facilities and adult family care homes
Promoting a Home-Like Environment
New State Processes

- To ensure that ALFs/AFCHs serving Medicaid recipients maintain a home-like environment and provide community integration, the state will implement the following new processes:
  - DOEA modified contracts with all Diversion Plans (Managed Care Organizations and Other Qualified Providers) to require:
    - amended subcontracts with ALFs by early May 2013
    - MCO/OQP review for these characteristics during credentialing and re-credentialing of ALF providers
  - All assisted living facilities participating in the Assisted Living, or other waivers utilizing ALFs, must sign amended referral agreements and comply with the characteristics of a home-like environment and community integration by June 2013
  - State staff are currently conducting on-site reviews of ALFs to ensure a home-like environment.

Promoting a Home-Like Environment
(New State Processes Continued)

- All ALFs/AFHCs participating in Long-term Care Managed Care must meet these requirements before go-live (before the first date of enrollment in region).

- State staff are currently conducting on-site reviews of ALFs/AFCHs to ensure a home-like environment by Region.

Credentialing and Re-Credentialing

- Managed Care Organizations are required to:
  - Verify during the credentialing and re-credentialing process that home-like environment and community integration exist in facilities they intend to contract with as well as in existing network ALFs/AFCHs.
Remediation

• If at any point a managed care organization discovers that an ALF/AFCH is not maintaining a home-like environment or supporting full community integration, they must:
  - Report that finding to the state contract manager immediately
  - Propose a remediation within three business days of discovery
• When the transition to the Long-Term Care Medicaid Managed Care waiver is completed, AHCA and DOEA will provide oversight of the monitoring process to ensure the MCOs will contract only with ALFs/AFCHs providing and supporting a home-like environment and community integration.

Language for Subcontracts and Referral Agreements

• Waiver providers will insert the following language into each subcontract or referral agreement with ALFs/AFCH:
  - Assisted living facilities will support the enrollee’s community inclusion and integration by working with the managed care organization’s case manager and enrollee to facilitate the enrollee’s personal goals and community activities.
  - Additionally, waiver enrollees residing in assisted living facilities must be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Language for Subcontracts and Referral Agreements (Continued)

• Choice of:
  - Private or semi-private rooms;
  - Roommate for semi-private rooms;
  - Locking door to living unit;
  - Access to telephone and length of use;
  - Eating schedule; and
  - Participation in facility and community activities.

• Ability to have:
  - Unlimited visitation; and
  - Snacks as desired.

• Ability to:
  - Prepare snacks as desired; and
  - Maintain personal sleeping schedule.
Monitoring Activities by the State
Ongoing State Processes

• Care Plan Development and Goal Planning:
  – Monitoring of resident case files by Quality Assurance team members
  – Review of Community Integration Goal Planning Documentation
• Modification of Referral Agreements:
  – Annual desk review of referral agreements or MCO subcontracts for inclusion of home-like environment and community integration language
• Credentialing and Re-Credentialing:
  – Review of monthly provider network reports and MCO credentialing files.
• On-site review of ALFs and AFCHs

Accreditation of Managed Care Plans

• Managed care plans are required to be accredited by a nationally recognized accrediting body.
• If not already accredited, plans are required to initiate the accreditation process within one year of contract execution and to be accredited within 18 months of contract execution.

Performance Measures and Enrollee Satisfaction

• Plans are required to report performance measures to the Agency annually.
  – Performance measures include care for older adults, preventative care, annual dental visits, chronic conditions, etc.
• These performance measures must be audited by an NCQA-certified HEDIS auditor.
• Plans are required to contract with an NCQA-certified survey vendor to conduct an annual enrollee satisfaction survey. Results must be reported to the Agency on an annual basis.
• If plan performance does not meet Agency standards sanctions and/or liquidated damages may be applied.
Performance Improvement Projects

- Managed care plans are required to conduct Performance Improvement Projects (PIPs) in areas that are expected to have a favorable effect on health outcomes and enrollee experiences with care.
  - Long-term care plans are required to conduct two PIPs, one clinical and one non-clinical.
  - Managed Medical Assistance plans are required to conduct four PIPs, including at least one clinical and one non-clinical PIP.

Resources

- Questions can be emailed to: FLMedicaidManagedCare@ahca.myflorida.com
- Updates about the Statewide Medicaid Managed Care program are posted at: http://ahca.myflorida.com/SMMC
- Upcoming events and news can be found on the “News and Events” tab on the SMMC website.
  - Keep up to date on information by signing up to receive program updates by clicking the red “Sign Up for Program Updates” box on the right hand side of the page.
- For information about the enrollment process and enhanced benefits of each plan, recipients and enrollees may visit http://wwwFLMedicaidManagedCare.com.

You can find more information on the SMMC program at:

- Youtube.com/AHCAFlorida
- Facebook.com/AHCAFlorida
- Twitter.com/AHCA_FL
Questions?