MEDICAID LONG-TERM CARE IN FLORIDA

FLORIDA CONFERENCE ON AGING: NEW GAME, NEW RULES
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Objectives

- To present a high level overview of the Statewide Medicaid Managed Long-Term Care Program.
- To detail the impact of this program on the Aging Network service providers and current recipients.

Overview

- Current Medicaid LTC
- Medicaid Waivers
- Managed Care
- Medicaid LTC

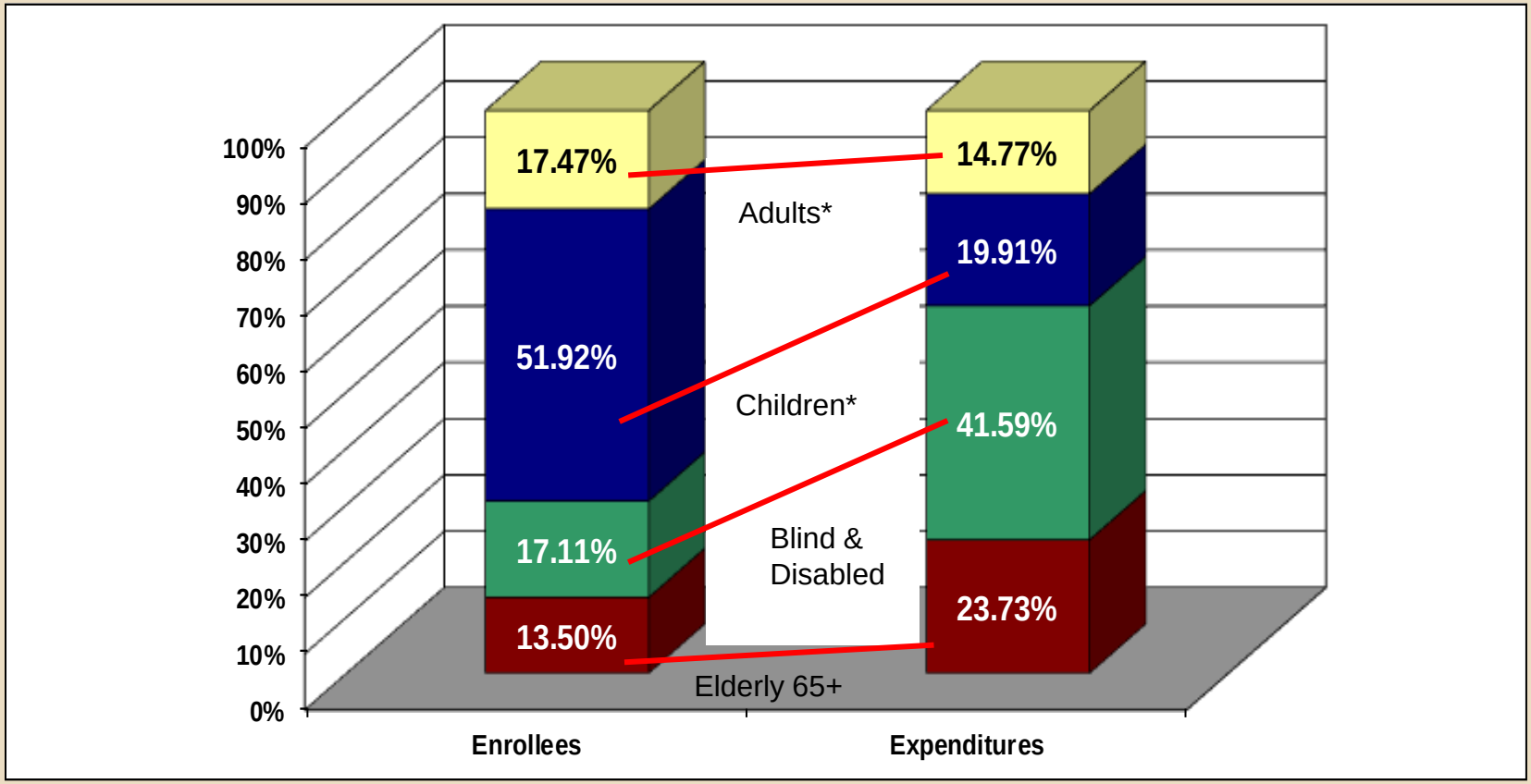
Overview of Medicaid LTC

Medicaid Long-Term Care

- As of April 30, 2012
  - Total Florida Medicaid enrollment of 3.2 million
  - More than 530,000 age 60 and older
  - More than 230,000 of those were age 75 and older.
- Medicaid pays for more than 59% of Florida nursing facility days.

Medicaid Budget - How it is Spent

Fiscal Year 2010-11



* Adults and children refers to non disabled adults and children.

Long-Term Care Budget: How it is Spent

- Nursing Facility vs. Community Services Costs and Enrollment

Fiscal Year (FY)	Nursing Facility Expenditures	*Nursing Facility Unduplicated Recipient Count	**Community Services	Community Services Unduplicated Recipient Count
FY 2000-2001	$1,693,767,364	77,662	$292,379,043	41,810
FY 2009-2010	$2,771,370,730	77,239	$744,278,435	77,894

*Nursing facility recipient count includes dual eligibles for whom Medicaid pays $0. Excluding those duals results in an unduplicated recipient count of 68,722 for whom Medicaid makes expenditures.

**Services included in the 'community services' expenditures are: Assistive Care Services, Home Health, Home and Community-Based Services waivers, Nursing Home Diversion, and the Program for the All-Inclusive Care for the Elderly.

Mandatory v. Optional Long-Term Care Services

- Nursing facility services are a federally mandated benefit and the state may not limit appropriations for services for eligible enrollees.

- Home and Community-Based Services (HCBS) are an optional benefit and the state may limit appropriations for services for eligible enrollees.

Current Medicaid Long-term Care Options

- Nursing Facility
- Assisted Living (AL) Waiver
- Aged and Disabled Adult (ADA) Waiver
- Consumer-Directed Care Plus (CDC+) for individuals in the ADA Waiver
- Channeling Services for Frail Elders Waiver
- Frail Elder Option
- Nursing Home Diversion (NHD) Waiver
- Program of All-Inclusive Care for the Elderly (PACE)

Current Medicaid Long-Term Care Delivery System

- Agency for Health Care Administration (AHCA): Florida's designated Medicaid agency
  - Delegates operation of most HCBS waivers to other agencies:
    - Agency for Persons with Disabilities – 5 waivers
    - Department of Children and Families (DCF) – 2 waivers
    - Department of Elder Affairs (DOEA) – 4 waivers & PACE
    - Department of Health – 2 waivers.
- Florida Department of Elder Affairs (DOEA): Florida's designated State Unit on Aging
  - Since 1985 has administered the fee-for-service long-term care waivers.
  - Since 1998 has administered Florida's Medicaid managed long-term care programs.

Medicaid Waivers

Why Waivers?

To implement changes that deviate from their Medicaid state plan (e.g.,to vary by geographic areas, amount, duration and scope), the state must request a waiver.

What is a Medicaid Waiver?

- A program requested by a state and approved by the Centers for Medicare and Medicaid Services (CMS) that waives certain provisions of the Social Security Act.
- The type of waiver requested indicates which provisions of the Social Security Act are waived.
- There are three major types of waivers.

1915(b) Waivers

Freedom of Choice

- Purpose: Waive the requirement that "any willing qualified provider" can enroll and provide Medicaid reimbursable services.
  - Often requested to improve continuity of care and ensure cost savings.

- Provisions waived: Can include any or all of these components:
  - 1915(b)(1): Managed Care
  - 1915(b)(2): Choice counseling for managed care plans
  - 1915(b)(3): Additional services from cost savings
  - 1915(b)(4): Require beneficiaries to use specified providers

1915(c) Waivers

Home and Community-Based Services

- Purpose: Cover services traditionally viewed as "long-term care" and provide them in a community setting instead of nursing facilities or Intermediate Care Facilities for the Developmentally Disabled.

- Provisions waived:
  - Comparability: Waiver services may be limited to a targeted group (e.g., elderly or individuals with a specific diagnosis) and can a limit the number of individuals served.
  - State-wideness: Waiver services may be limited to particular geographic areas (e.g., county, region).

1915(c) Home and Community-Based Services Waivers

- Offer an alternative to institutional care by providing such home and community-based services as personal care, homemaker and consumable medical supplies.
- 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.

Aged and Disabled Adult Waiver

- Population - 18+
- Eligibility - Medicaid Institutional Care Program
- Services - Case management and 28 other home and community-based services
- Statewide
- FY 2011-2012 enrollment – 10,963
- The Department of Children and Families manages the age 18-59 population, and DOEA manages the Age 60+ population, in cooperation with AHCA.

Assisted Living Waiver

- Population - Age 18+
- Eligibility - Medicaid Institutional Care Program, and meet additional clinical impairment criteria
- Services - Case management, assisted living, incontinence supplies
- Statewide
- FY 2011-2012 enrollment - 4,575
- The Department of Children and Families manages the age 18-59 population, and DOEA manages the Age 60+ population, in cooperation with AHCA.

Channeling Waiver

- Population - Age 65+
- Eligibility - Medicaid Institutional Care Program and have 2 or more unmet long-term care needs
- Services - Case management and 20 other home and community-based services
- Miami-Dade and Broward Counties
- FY 2011-2012 enrollment - 1,265
- DOEA manages, in cooperation with AHCA.

Nursing Home Diversion Waiver

- Population - Age 65+
- Eligibility - Medicaid Institutional Care Program, Medicare parts A & B, and meet additional clinical impairment criteria
- Services - Case management, and 20 other home and community-based services, 11 acute care services, Medicare co-payments and co-insurance, and unlimited nursing facility care
- 66 counties
- 18 capitated managed care plans provide services
- FY 2011-2012 enrollment - 24,221
- DOEA manages, in cooperation with AHCA.

Program of All-Inclusive Care for the Elderly (PACE)

- Population - Age 55+
- Eligibility - Medicaid Institutional Care Program and live in a PACE service area
- Services - All Medicaid and Medicare services, including case management, home and community-based services, and unlimited nursing facility care
- Service Delivery Model – Capitated, Integrated Medicare/Medicaid Managed Care model
- Miami-Dade (specific zip codes), Lee, Charlotte, Collier, Hillsborough, and Pinellas
- FY 2011-2012 enrollment - 785
- DOEA manages, in cooperation with AHCA.

1115 Waivers

Research and Demonstration Waivers

- Purpose: To test or pilot a unique program or method of service delivery.

- Provisions waived: Any section of 1902 and 1905 of the Social Security Act depending on the design of the waiver request.

Managed Care

What Is Managed Care?

- Managed care is when health care organizations manage how their enrollees receive health care services.
- Managed Care Organizations (MCOs) contract with a variety of health care providers to offer quality health care services to ensure enrollees have access to the health care they need.

Key Terminology

- **Member:** A person who has selected or been assigned to a managed care plan.
- **Prepaid:** Managed care plans are paid at the beginning of each month.
- **Capitation:** The monthly fixed amount paid to the MCO for each member.
- **Per Member Per Month (PMPM):** MCOs receive capitation payment each month for each member.
- **At Risk:** A managed care plan is responsible for arranging for and paying for all covered services regardless of the cost.

Key Terminology (continued)

- **Provider Network:** health care and long-term care service providers (e.g., doctors, hospitals, home health agencies, home delivered meals) that contract with a managed care plan to provide services.
  - The MCO reimburses the contracted providers for services rendered to the plan's enrolled members.
  - MCOs can limit the number of providers with which they contract.

Common Types of Managed Care Plans

- Health Maintenance Organizations (HMOs)
  - Licensed under Chapter 641, Florida Statutes.
  - HMO networks are not limited to Medicaid-enrolled providers.
- Provider Service Networks (PSNs)
  - A network established or organized and operated by a health care provider, or group of affiliated health care providers.
  - Provides a substantial proportion of the health care items and services under a contract directly through the provider or group of affiliated providers.
  - May be fee for service or capitated.

Evolution of Florida Medicaid Delivery Systems

1970-1983

Fee-for-Service

1984-1997

HMOs—Since 1984
MediPass (primary care case management)—Since 1991
Prepaid Mental Health Plans—Since 1996

1997-2003

Fee-for-Service PSNs—Since 2000
Disease Management
Long-Term Care Management

2004-Present

Improvements in:
- Integrated Care Management/Care Coordination
- Outcomes Management/Improved Clinical Decision Making
- Quality Assurance, Marketing Restrictions
- Enhancements to Fraud and Abuse Controls

New:
- Medicaid Reform Specialty Plans
- Medicaid Encounter Data
- Capitated PSNs–Since 2008

Statewide Medicaid Managed Care: Long-term Care

The New Rules

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

  -Chapter 409, Part IV, Florida Statutes

Statewide Medicaid Managed Care: Key Components

Statewide Medicaid Managed Care Program key components:

- Managed Medical Assistance Program
- Long-term Care Managed Care Program

Key Components

- SMMC has two program components:
  - Long-term Care Managed Care Program
    - Will begin in the Fall of 2013
    - Only provides long-term care services.
  - Managed Medical Assistance Program
    - Will begin in the Fall of 2014
    - Provides all health care services, other than long-term care services, to eligible recipients.

Eligibility for SMMC Long-Term Care Services

- Individuals who are:
  - 65 years of age or older AND need nursing facility level of care.
  - 18 years of age or older AND are eligible for Medicaid by reason of a disability, AND need nursing facility level of care.

Services that SMMC Long-Term Care Plans Must Provide

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

Selecting LTC Plans

- AHCA will select LTC Managed Care plans through a competitive bid process
- State is divided into 11 regions
  - Same as current DOEA planning and service areas
- LTC plans will be selected by region
- AHCA must select at least one Provider Service Network per region

Qualified Managed Care Plans for Long-Term Care

- Health Maintenance Organizations
- Long-term Care Provider Service Networks
- Medicare Advantage Special Needs Plans
- Exclusive Provider Organizations
- Accountable Care Organizations

Number of Plans Per Region

Region	Counties	# Plans
1	Escambia, Okaloosa, Santa Rosa, and Walton	2
2	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington	2
3	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrest, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union	3
4	Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia	3
5	Pasco and Pinellas	3
6	Hardee, Highlands, Hillsborough, Manatee, and Polk	4
7	Brevard, Orange, Osceola, and Seminole	3
8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota	3
9	Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie	3
10	Broward	3
11	Miami-Dade and Monroe	5

LTC Managed Care Implementation

Invitation to Negotiate (ITN) Schedule

The Long-term Care Managed Care Invitation to Negotiate was released June 29, 2012*.

Activity	Date/Time
Deadline for Receipt of Written Inquiries	July 6, 2012
Vendor Conference for Regions 1-11	July 19, 2012
Deadline for Receipt of Responses	August 28, 2012
Publish List of Respondents for Provider Comments	August 31, 2012
Anticipated Dates for Negotiation	November 13, 2012-January 4, 2013
Anticipated Posting of Notice of Intent to Award	January 15, 2013

***The provisions of the ITN cannot be discussed.**

New LTC Managed Care Waivers

- 1915(c): to allow qualified individuals to receive home and community-based care services, in lieu of nursing facility care services.
- 1915(b): for the authority to enroll individuals in managed care plans statewide and to allow for selective contracting of those plans.

Regional Enrollment Schedule

Region(s)	Plan Readiness Deadline	Enrollment Effective Date
7	May 1, 2013	August 1, 2013
8, 9	June 1, 2013	September 1, 2013
1, 2, 10	August 1, 2013	November 1, 2013
11	September 1, 2013	December 1, 2013
5, 6	November 1, 2013	February 1, 2014
3, 4	December 1, 2013	March 1, 2014

Plan Readiness Components

- The plan readiness review process assesses the managed care plan's readiness and ability to provide services to recipients.
- This review is completed prior to the enrollment of recipients.
- The scope of the review may include any and all contract requirements. Examples of the readiness review may include, but is not limited to:
  - Desk and onsite review of managed care plan policies and procedures
  - Review of provider networks
  - A walkthrough of the managed care plan operations
  - System demonstrations
  - Interviews with managed care plan staff

Managed Care Plan Monitoring

- Monitor performance measures
- Monitor care delivery to ensure assessed needs are met
- Monitor network performance
- Review of extensive managed care plan reporting, e.g.:
  - Enrollee complaints and grievances
  - Service utilization
  - Fraud and abuse
  - Participant direction

AHCA's Responsibilities

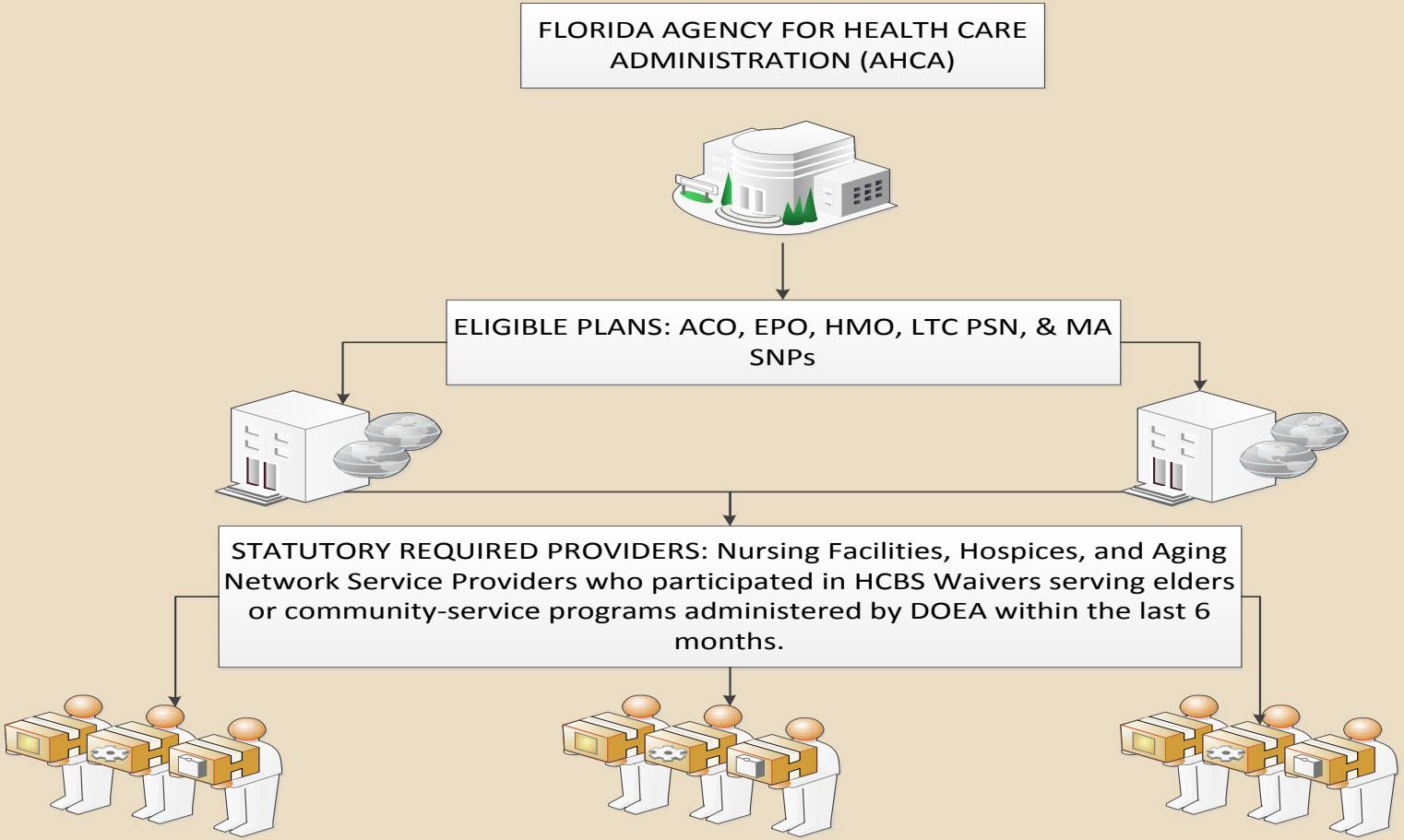
- Manage contracts with long-term and medical assistance managed care plans;
- Managed care plan accountability;
- Contractual requirements;
- Physician compensation, emergency services, access;
- Encounter data;
- Continuous improvement;
- Program integrity (fraud and abuse);
- Grievance resolution, provider dispute resolution; and
- Penalties, prompt payment, electronic claims, fair payment, itemized payment.

DOEA's Responsibilities

- Develop specifications for use in the invitation to negotiate (ITN) and the model contract;
- Develop a transition plan.
- Determine clinical eligibility for enrollment in managed long-term care plans through CARES;
- Monitor managed care plan performance and measure quality of service delivery;
- Assist clients and families to address complaints with the managed care plans; and,
- Facilitate working relationships between managed care plans and providers serving elders and disabled.

Managed Care Plan Provider Network

Network Snapshot



Provider Network Requirements

- Plans selected to participate in LTC managed care must demonstrate that they have a sufficient number of providers in their network to provide access to services and a choice of providers.
- Plans may limit the providers in their networks based on credentials, quality indicators, and price.

Provider Network Requirements (Continued)

- Plans must offer network contracts to the following providers in their region for the period October 1, 2013, through September 30, 2014 [see s. 409.982(1), F.S.]:
- Nursing facilities
- Hospices
- Aging network service providers that participated in home and community-based waivers serving elders or community-service programs administered by DOEA in the six months preceding release of the ITN.

Provider Network Requirements (Continued)

- Although the managed care plans will be contacting the providers in the regions of the state where they are establishing their provider networks, providers may wish to contact the managed care plans that have expressed an interest in the Long-term Care Managed Care Program.

- A list of respondents who submitted a letter of intent to bid on the LTC ITN can be accessed through the following link: http://ahca.myflorida.com/medicaid/statewide_mc/pdf/ltc/List_of_Respondents_042512.pdf

Recipient Enrollment

Eligibility Determination

- DCF or Social Security Administration will continue to determine financial eligibility.
- DOEA's CARES (Comprehensive Assessment and Review for Long-Term Care Services) Program will continue to determine clinical eligibility.

Medicaid Pending (Presumptive Eligibility)

- Eligibility for nursing facility services will continue to be handled the same way as it is currently.
- Eligibility for HCBS may be achieved through designation of a Medicaid Pending status.
  - An individual may choose to receive home and community-based services after the clinical eligibility has been completed, but prior to the completion of the Medicaid financial eligibility process.

Enrollment Process

- Recipients are encouraged to choose the long-term care managed care plan that best meets their needs.
- If a recipient who is required to enroll does not choose a plan within 30 days, AHCA will automatically assign the recipient to a long-term care managed care plan.
- Enrollees can change their long-term care providers within their plan at any time.

Long-Term Care Managed Care Enrollment Process

- Prior to implementation of the program in each region of the state, the Medicaid Enrollment Broker will mail plan selection materials to recipients or their designated representatives.
- Individuals from the Medicaid Enrollment Broker, the local Aging and Disability Resource Centers (ADRC), and the local Medicaid Area Offices will assist individuals in securing the information they need to select a plan that best meets their needs.

Long-Term Care Managed Care Enrollment Process

- After 90 days, individuals must remain in their plan until the next open enrollment period (approximately 9 months later), unless they have good cause to change plans.
- Examples of good cause include, but not limited to:
  - The recipient is ineligible for enrollment in the health plan;
  - Poor quality of care; or
  - Were unreasonably denied services.

Enrollment & Orientation

- The managed care plan will assign a care coordinator/case manager.
- Care manager will meet with the enrollee to develop a plan of care and assist the enrollee in obtaining appropriate care.
- All Medicaid recipients, including individuals in nursing facilities and assisted living facilities, will have access to care coordination/case management services.

Program Enhancements

New Services

- Case management for individuals in nursing facilities
- Behavior management
- Medication administration
- Medication management

Service Enhancements

- Increased emphasis on home and community-based services:
  - Facilitate nursing home transition.
  - Increased care coordination and case management across care settings - more integrated care/case management.
  - Enhanced community integration and personal goal setting.

Service Enhancements (Continued)

- Increased access to quality providers:
  - Selection of the most qualified plans.
  - Expanding services available in rural areas.

- Increased access to quality services:
  - Increased access to participant direction.
  - Plans can offer expanded benefits.
  - Increased opportunity for integration between Medicaid and Medicare through enhanced care coordination.

Long-term Care Managed Care Program Enhancements

- Increased predictability for recipients and providers:
  - Five year contracting period - less confusion for providers and recipients.
  - Penalties for plan withdrawals.
  - Maintenance of role of critical community-based providers (ADRCs and Aging Network providers).
  - Parameters for payments to certain providers (nursing facilities, hospice).

Long-term Care Managed Care Program Enhancements (Continued)

- Increased accountability:
  - Enhanced quality measures.
  - Enhanced access to encounter data for long-term care services.
  - Enhanced contract compliance tools, including liquidated damages, sanctions, and statutory penalties and terminations.

Long-Term Care Managed Care Program Enhancements: Streamlining and Combining State Waivers

- Phase out pilot programs
  - April 2010: Alzheimer's waiver allowed to expire and individuals transferred to other waivers providing similar services
  - March 2012: Adult Day Health Care waiver program allowed to expire and individuals transferred to other waivers providing similar services

Long-Term Care Managed Care Program Enhancements: Streamlining and Combining State Waivers

- Consolidate similar waivers
  - By July 1, 2013: Transition individuals with developmental disabilities from four "Tier" waivers to the Individual Budgeting (iBudget) waiver
  - By April 2014: Fully implement LTC managed care program and consolidate the following programs into the new 1915(b) and 1915(c) waivers:
    - Aged and Disabled Adult (including CDC+);
    - Assisted Living Waiver;
    - Channeling Services;
    - Frail Elder Option; and
    - Nursing Home Diversion Waiver.

Transition Plan

Transition Plan

- The Legislature directed DOEA to develop a plan to seamlessly transition 85,000 elders and adults with disabilities who are currently enrolled in various Medicaid HCBS Waivers and Medicaid residents of nursing facilities to the SMMCLTCP.
- This is being done in coordination with AHCA and DCF.

Transition from Current Operations to LTC Managed Care

- Education of the aging network stakeholders, e.g.,:
  - Aging Service Providers
  - ADRCs
  - Assisted Living Facilities
  - Lead Agencies
  - Long-Term Care Ombudsman Program
  - SHINE.
- Initial notification of current LTC recipients and those on the waitlist about LTC Managed Care.

Transition Plan

- Enrollment broker will notify LTC recipients of their choice of plans and where to call with any questions about enrollment.
- Recipients will have at least 30 days to select a plan or be automatically assigned to a plan.
- Recipients will have 90 days to change their plan selection.

Transition Plan

- DOEA will develop and operate a statewide waitlist system for home and community-based LTC services.
- Public meetings will be held for input regarding the statewide waitlist.
- DOEA will continue operating the current programs until LTC Managed Care goes live in a region and will facilitate transition to the new program.

Final Thoughts

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.
- CCE Lead Agency contracts and responsibilities will remain the same.
- Waitlist for HCBS will be maintained.

Aging Network Going Forward

- It is essential to maintain and update client contact information in order to update their information.
- Make every effort to ensure data entry is correct and up to date on assessments and within systems (CIRTS and FMMIS).
- As each region is phased in, current enrollment will be temporarily frozen to ensure enrollees are transitioned smoothly.

Aging Network Going Forward (Continued)

- High volume of calls at times when information is sent to clients.
- Waitlisted clients will also be informed of upcoming changes.
- Additional education will be provided as decisions are made regarding the implementation process.

Additional Resources

- Details regarding LTC managed care ITN are available through the Florida Vendor Bid System: http://myflorida.com/apps/vbs/vbs_www.main_menu
- Updates about the Statewide Medicaid Managed Care Program are posted at: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#tab1

  You can sign up to receive email updates about the program at this website.

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QUESTIONS?