Medicaid Managed Care: Long-term Care Overview

Beth Kidder
Assistant Deputy Secretary for
Medicaid Operations
Agency for Health Care Administration

Florida Health Care Association: Managed Care Forum

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Objectives

- To present a high level overview of Florida Medicaid and the Statewide Medicaid Managed Long-Term Care Program.

- To detail the impact of this program on Nursing Facility providers and current recipients.

Overview

- Medicaid Overview
- Managed Care Overview
- Medicaid Long-term Care
- Statewide Medicaid Managed Care Program

Medicaid
A State and Federal Partnership

- In 1965, the federal Social Security Act was amended to establish two major national health care programs:
  - Title XVIII (Medicare).
  - Title XIX (Medicaid).
- Medicaid is jointly financed by state and federal funds.
- States administer their programs under federally approved state plans.

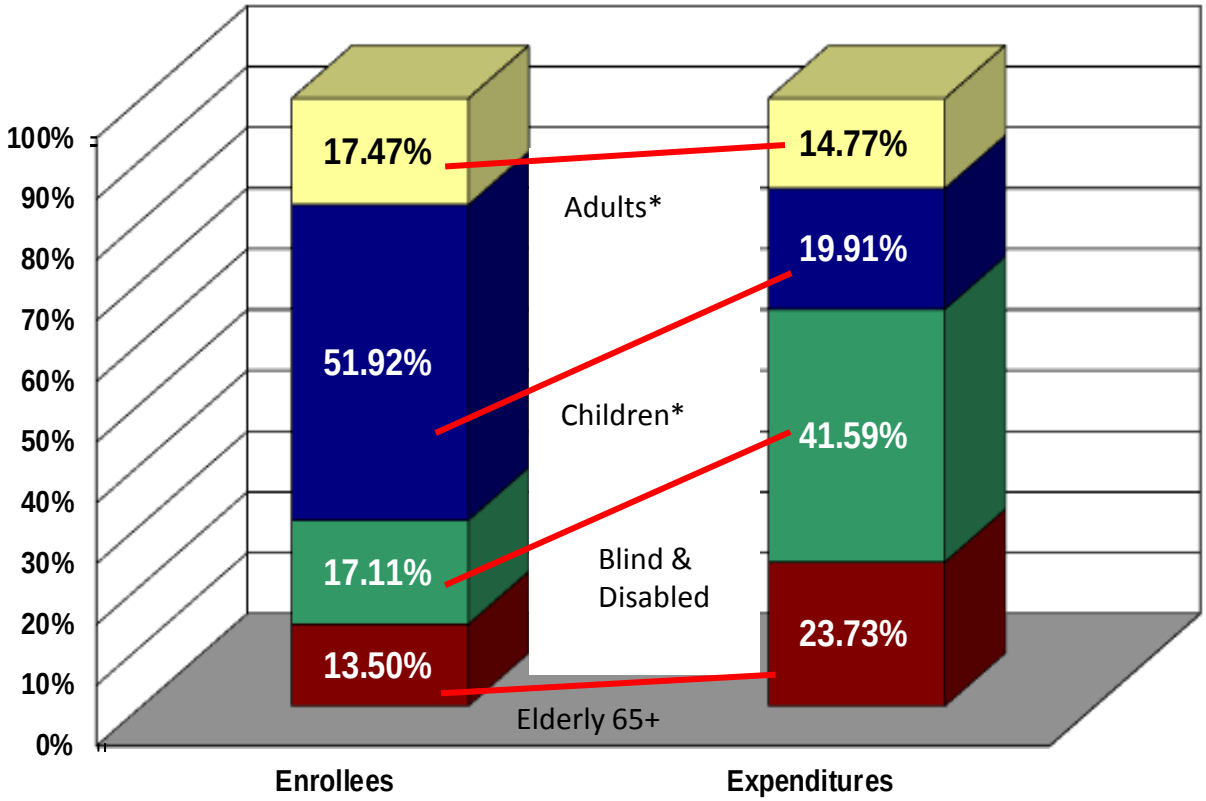
The Medicaid Program
Major Federal Requirements

- States must submit a Medicaid State Plan to the federal Centers for Medicare and Medicaid Services (CMS).
- Mandatory eligibility groups and services must be covered.
- Services must be available statewide in the same amount, duration and scope.

Florida Medicaid – A Snapshot

Expenditures	• $20.3 billion estimated spending in Fiscal Year 2011-12 • Federal-state matching program –55.94% federal, 44.06% state. • Florida will spend approximately $6,372 per eligible in Fiscal Year 2011-2012. • 45% of all Medicaid expenditures cover hospitals, nursing facilities, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD's); Low Income Pool and Disproportionate Share Payments. • 10% of all Medicaid expenditures cover drugs. • Fifth largest nationwide in Medicaid expenditures.
Eligibles	• 3.19 million eligibles. • Elders, disabled, families, pregnant women, children in families below poverty. • Fourth largest Medicaid population in the nation.
Providers/Plans	• Approximately 80,000 Fee-For-Service providers; 25 Medicaid Managed Care plans (19 HMOs and 6 PSNs).

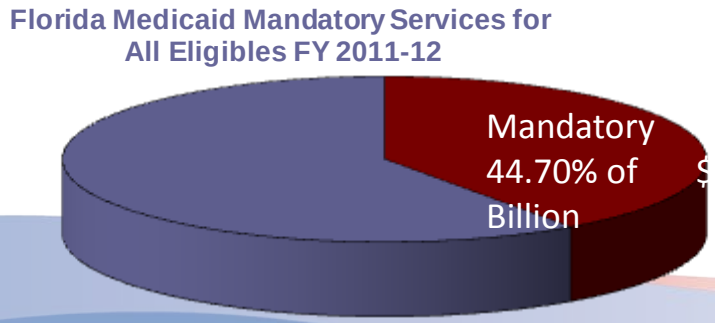
Medicaid Budget - How it is Spent
Fiscal Year 2010-11



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

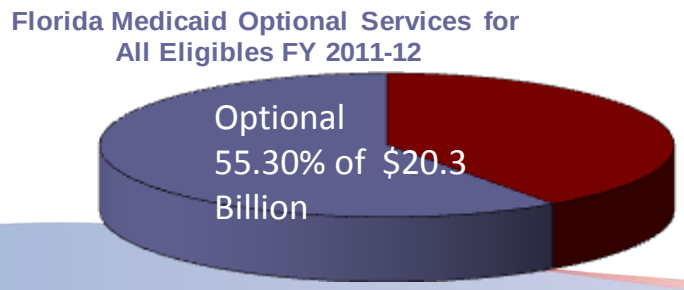
Florida Medicaid Mandatory Services

- Advanced Registered Nurse Practitioner Services
- Early & Periodic Screening, Diagnosis and Treatment of Children (EPSDT)/Child Health Check-Up
- Family Planning
- Home Health Care
- Hospital Inpatient
- Hospital Outpatient
- Independent Lab
- Nursing Facility
- Personal Care Services
- Physician Services
- Portable X-ray Services
- Private Duty Nursing
- Respiratory, Speech, Occupational Therapy
- Rural Health
- Therapeutic Services for Children
- Transportation



Florida Medicaid Optional Services*

- Adult Dental Services
- Adult Health Screening
- Ambulatory Surgical Centers
- Assistive Care Services
- Birth Center Services
- Hearing Services
- Vision Services
- Chiropractic Services
- Community Mental Health
- County Health Department Clinic Services
- Dialysis Facility Services
- Durable Medical Equipment
- Early Intervention Services
- Healthy Start Services
- Home and Community-Based Services
- Hospice Care
- Intermediate Care Facilities/ Developmentally Disabled
- Intermediate Nursing Facility Care
- Optometric Services
- Physician Assistant Services
- Podiatry Services
- Prescribed Drugs
- Primary Care Case Management (MediPass)
- Registered Nurse First Assistant Services
- School-Based Services
- State Mental Hospital Services
- Subacute Inpatient Psychiatric Program for Children
- Targeted Case Management)



*States are required to provide any medically necessary care required by child eligibles.

Medicaid Spending for Fiscal Year 2012-13

Service	FY 2012-13 Estimated Spending	Percent of Total
Prepaid Health Plans	$3,699,572,656	17.63%
Hospital Inpatient Services	$3,461,576,792	16.49%
Nursing Facility Care	$2,768,686,049	13.19%
Prescribed Medicine/Drugs & Part D	$2,055,016,688	9.79%
Supplemental Medical Insurance	$1,251,519,983	5.96%
Physician Services	$1,170,546,706	5.58%
Home & Community Based Services	$1,082,335,883	5.16%
Hospital Outpatient Services	$1,040,361,220	4.96%
Low Income Pool	$1,000,250,005	4.77%
Nursing Home Diversion Waiver	$359,036,110	1.71%
Intermediate Care Facility/DD	$344,424,457	1.64%
Hospice Services	$334,439,835	1.59%
Early and Periodic Screening/Children	$276,328,256	1.32%
Disproportionate Share Hospital Payments	$246,570,577	1.17%
Home Health Services	$167,813,894	0.80%
Other	$1,730,035,882	8.24%
Total	$20,988,514,993	100.00%

What Is Managed Care?

- Managed care is when health care organizations manage how their enrollees receive health care services.
- Managed care is a financing and delivery system that may employs provider network management, utilization management and quality assurance

What Is Managed Care?

- 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.
- MCOs may be paid through a capitated arrangement where the health plan receives a per member per month reimbursement to provide all covered medical services to its members.

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, nursing facilities, home health agencies) 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 in Florida

- 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 (PCCM)—Since 1991
Prepaid Mental Health Plans – Since 1996

1997-2003

Fee-for-Service PSNs–Since 2000
Disease Management
Long Term Care Management
Other Alternative Plans—Since 2001

2004-Present

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

<u>New:</u>
- Medicaid Reform Specialty Plans
- Medicaid Encounter Data
- Capitated PSNs–Since 2008

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.

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

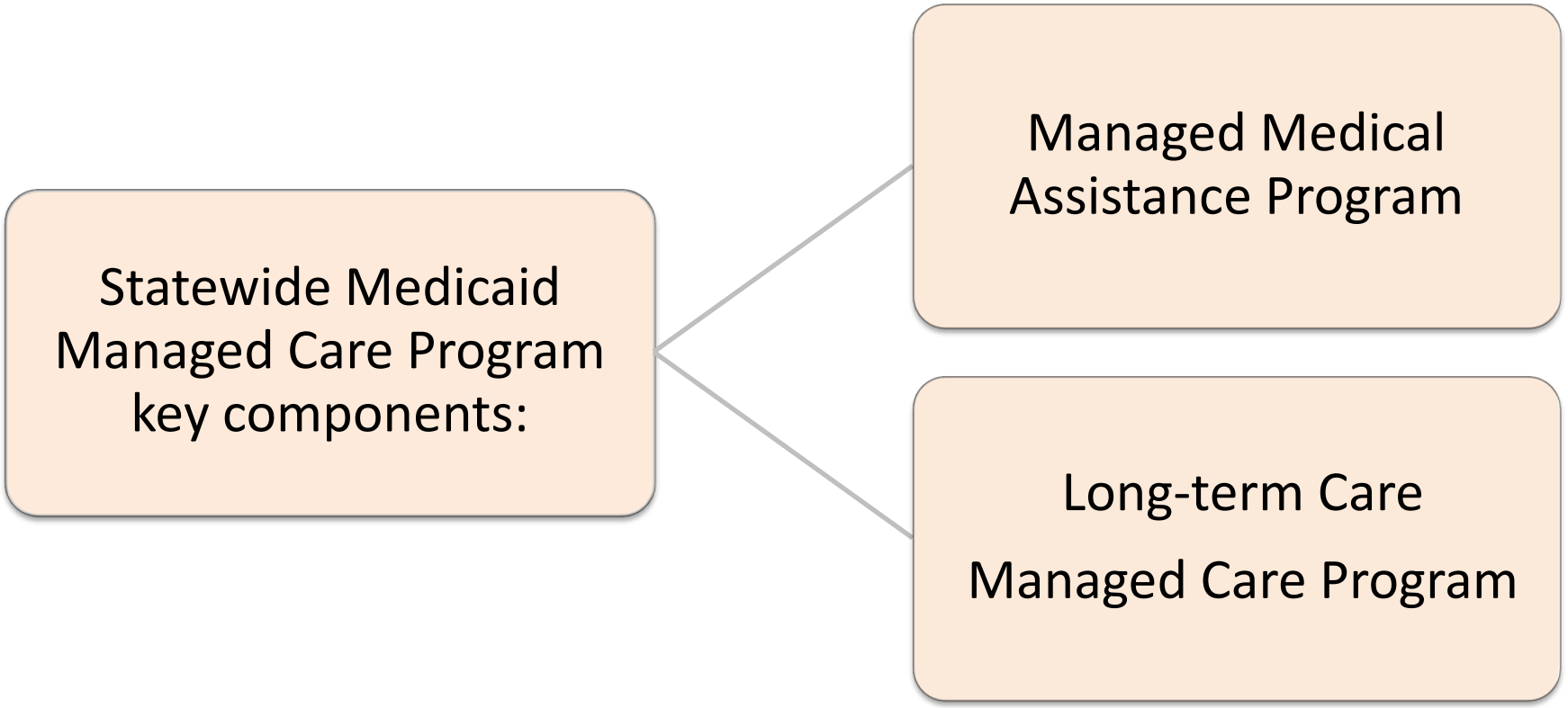
- Nursing Facility
- Assisted Living (AL) Waiver
- Aged and Disabled Adult (ADA) Waiver
- Consumer-Directed Care Plus (CDC+) for individuals in the ADA Waiver
- Channeling Services for Frail Elders Waiver
- Frail Elder Option
- Nursing Home Diversion (NHD) Waiver
- Program of All-Inclusive Care for the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

Statewide Medicaid Managed Care

- 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: Key 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

Current Status of SMMC Implementation: Long-term Care Managed Care

- In order to implement the Long-term Care portion of the SMMC program, the Agency is seeking a 1915 b/c combination waiver:
  - 1915(c): to identify 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.

Current Status of SMMC Implementation: Long-term Care Managed Care (cont.)

- The Agency submitted the 1915b/c application for the LTC waiver program on August 1, 2011.
- The Agency has received and responded to several sets of information and formal questions regarding this waiver application from federal CMS, and negotiations are ongoing.
- The Agency is participating in regular calls with CMS regarding this waiver application.

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.

Eligibility for SMMC Long-Term Care Services (cont.)

- Individuals who are enrolled in:
  - Aged and Disabled Adult Waiver;
  - Consumer-Directed Care Plus for individuals in the A/DA waiver;
  - Adult Day Health Care Waiver;
  - Assisted Living Waiver;
  - Channeling Services for Frail Elders Waiver
  - Program of All-inclusive Care for the Elderly (PACE);
  - Nursing Home Diversion Waiver.

Long-term Care Managed Care Required Services

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 AHCA 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

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

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

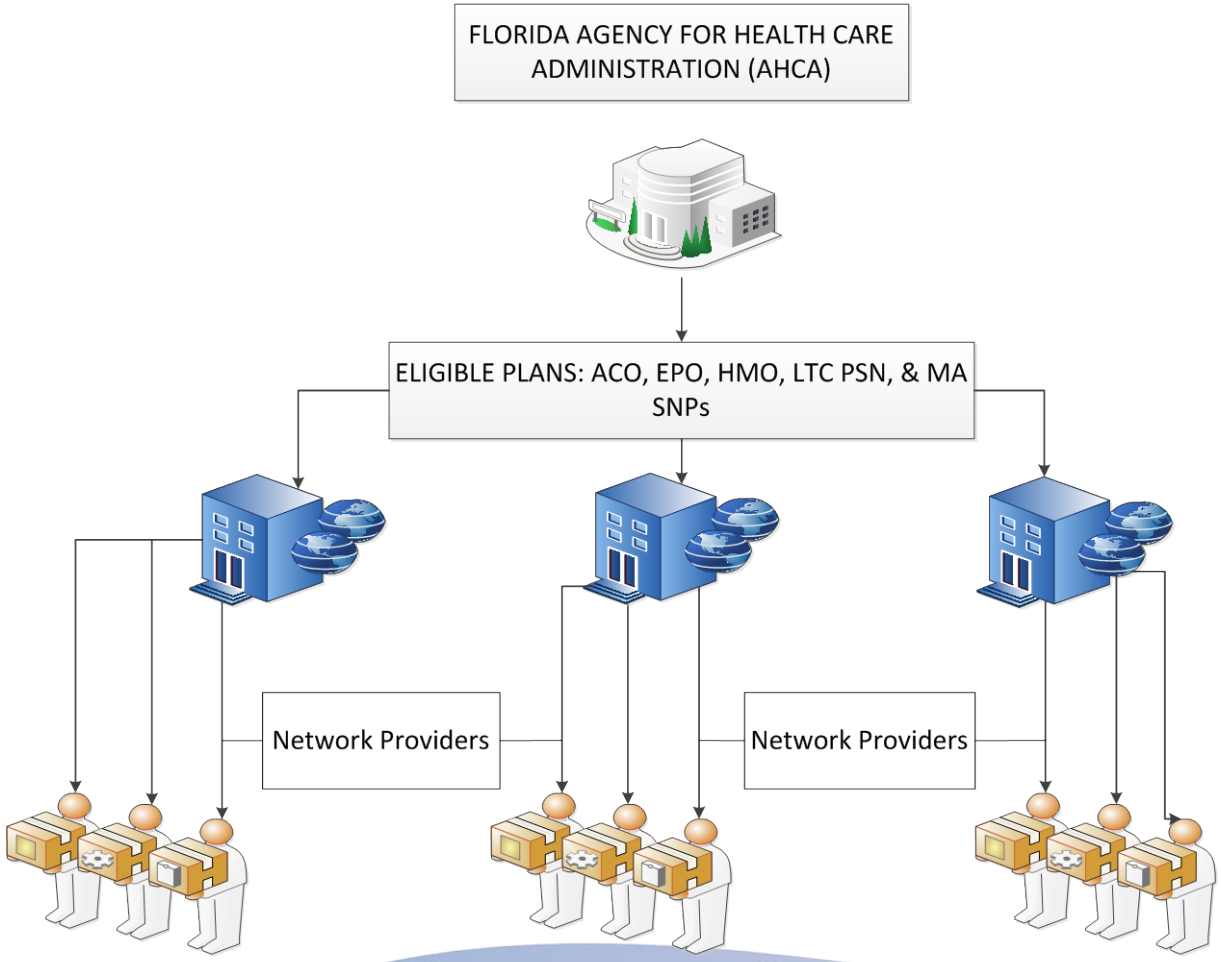
- Monitor performance measures
- Monitor care delivery to ensure assessed needs are met
- Monitor network performance
- Review of extensive managed care plan reporting, e.g.:
  - Enrollee complaints and grievances
  - Service utilization
  - Fraud and abuse
  - Participant direction

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.

Network Snapshot



Participation of Nursing Facilities

- Between October 1, 2013, and September 30, 2014, each selected plan must offer a network contract to all nursing facilities in their region (Section 409.982 (1)(a), F.S.).
- After 12 months of active participation in a managed care plan's network, the plan may exclude nursing facilities from the network for failure to meet quality or performance criteria (Section 409.982 (1)(c), F.S.).

Participation of Nursing Facilities

- Nursing Facilities and hospices that are enrolled Medicaid providers must participate in all eligible plans selected by the Agency in the region in which the provider is located (Section 409.982(2), F.S.).

Reimbursement of Nursing Facilities

- There are specific provisions relating to the reimbursement of nursing Facilities under the LTC component of the SMMC program:
  - The agency will establish nursing-facility-specific payment rates for each licensed nursing facility based on facility costs adjusted for inflation and other factors as authorized in the General Appropriations Act (Section 409.983 (6), F.S.).
  - Plans shall pay nursing facilities an amount equal to the nursing facility-specific payment rates set by the agency; however, mutually acceptable higher rates may be negotiated for medically complex care (Section 409.982 (5), F.S.).

Eligibility Determination

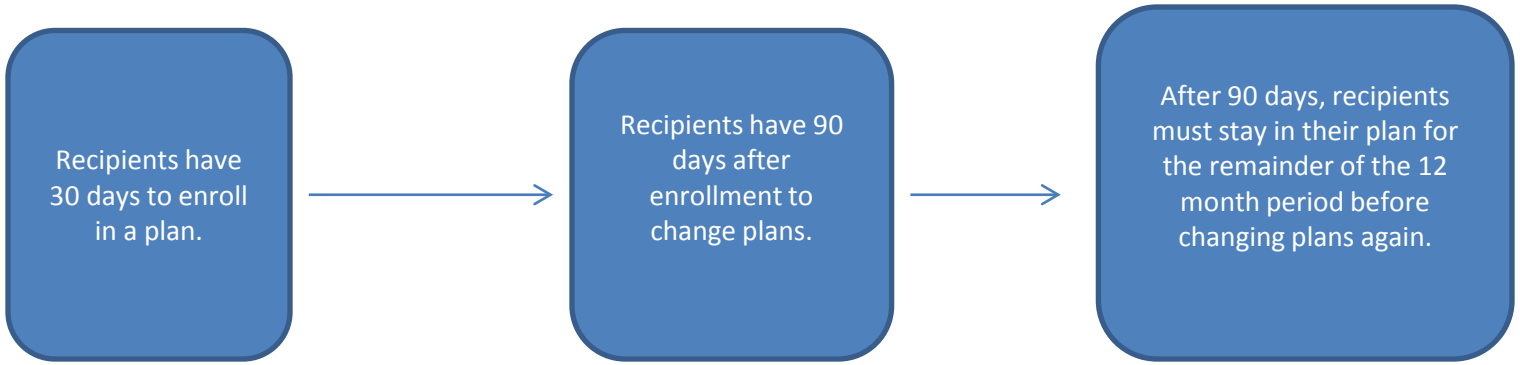
- DCF or Social Security Administration will continue to determine financial eligibility.

- 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.

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 facility 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.

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 LTC Managed Care.
- 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.

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.

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.

Questions?