Welcome to the
Agency for Health Care Administration
Training Presentation
for
Potential Long-term Care Providers.

The presentation will begin momentarily.

Statewide Medicaid Managed Care (SMMC)
Long-term Care (LTC) Program
Webinar for
LTC Potential Network Providers

March 6, 2013

Today's Presenters

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  - Agency for Health Care Administration
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  - Bureau Chief of Long-Term Care & Support Services
  - Department of Elder Affairs

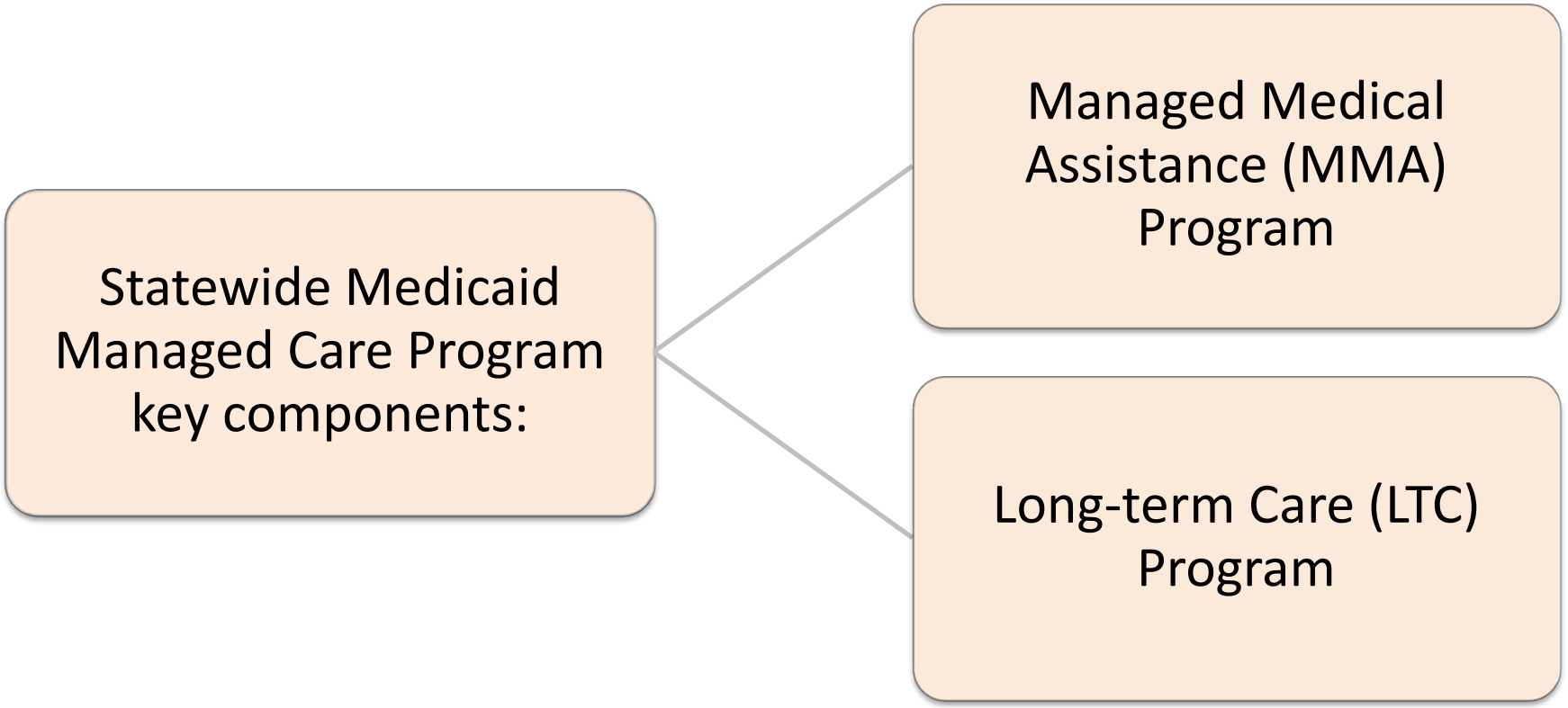
Managed Medical Assistance (MMA) Component

- Due to the competitive procurement, we are in a statutorily imposed “Blackout Period” until 72 hours after the award and cannot provide interpretation or additional information not included in the MMA ITN documents.
- As stated in s.287.057(23), F.S., “Respondents to this solicitation or persons acting on their behalf may not contact, between the release of the solicitation and the end of the 72-hour period following the agency posting the notice of intended award, excluding Saturdays, Sundays, and state holidays, *any employee or officer of the executive or legislative branch* concerning any aspect of this solicitation, except in writing to the procurement officer or as provided in the solicitation documents. *Violation of this provision may be grounds for rejecting a response."*

SMMC Background

- As of February 2013, there were 3.3 million recipients in the Florida Medicaid Program:
  - Over 1.5 million recipients are enrolled in a managed care plan (HMO, PSN, Nursing Home Diversion).
  - Approximately 87,000 recipient will likely be eligible to enroll in the new Long-term Care managed care program.
- During the 2011 Florida Legislative Session, the House and Senate passed HB 7107 and HB 7109, which require the state Medicaid Program to implement a Statewide Medicaid Managed Care Program.

SMMC Program Components



Enrollment in the LTC Program

- Individuals are mandatory for enrollment if they 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.
- Individuals are mandatory for enrollment if they are enrolled in:
  - Aged and Disabled Adult Waiver (A/DA);
  - 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.

Waiver Consolidation

- The following programs will end with the implementation of the Long-term Care Managed Care program
  - Aged and Disabled Adult Waiver (A/DA);
  - 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.
- In order for service providers to be reimbursed for providing Medicaid services to these populations, they must be enrolled in a LTC managed care plan provider network.

Selecting Long-term Care Plans

- AHCA has selected Long-term Care plans through a competitive bid process.
- The State has been divided into 11 regions that coincide with the existing Medicaid areas and the Department of Elder Affairs (DOEA) Planning and Service Areas (PSAs).
- Plans will provide services by region:
  - Five year contracting period for health plans, which will be less confusion for providers and recipients.
  - Penalties for plan withdrawals.

What Is Managed Care?

- Managed care is when health care organizations are responsible for ensuring that their enrollees receive the health care services they need.

- Managed Care Organizations (MCOs), also called “plans” or “health plans”, contract with a variety of health care providers to create a network of providers—also called a “provider network”. The plans use their provider network to ensure their enrollees have access to high quality health and long-term care services.

Key Terminology

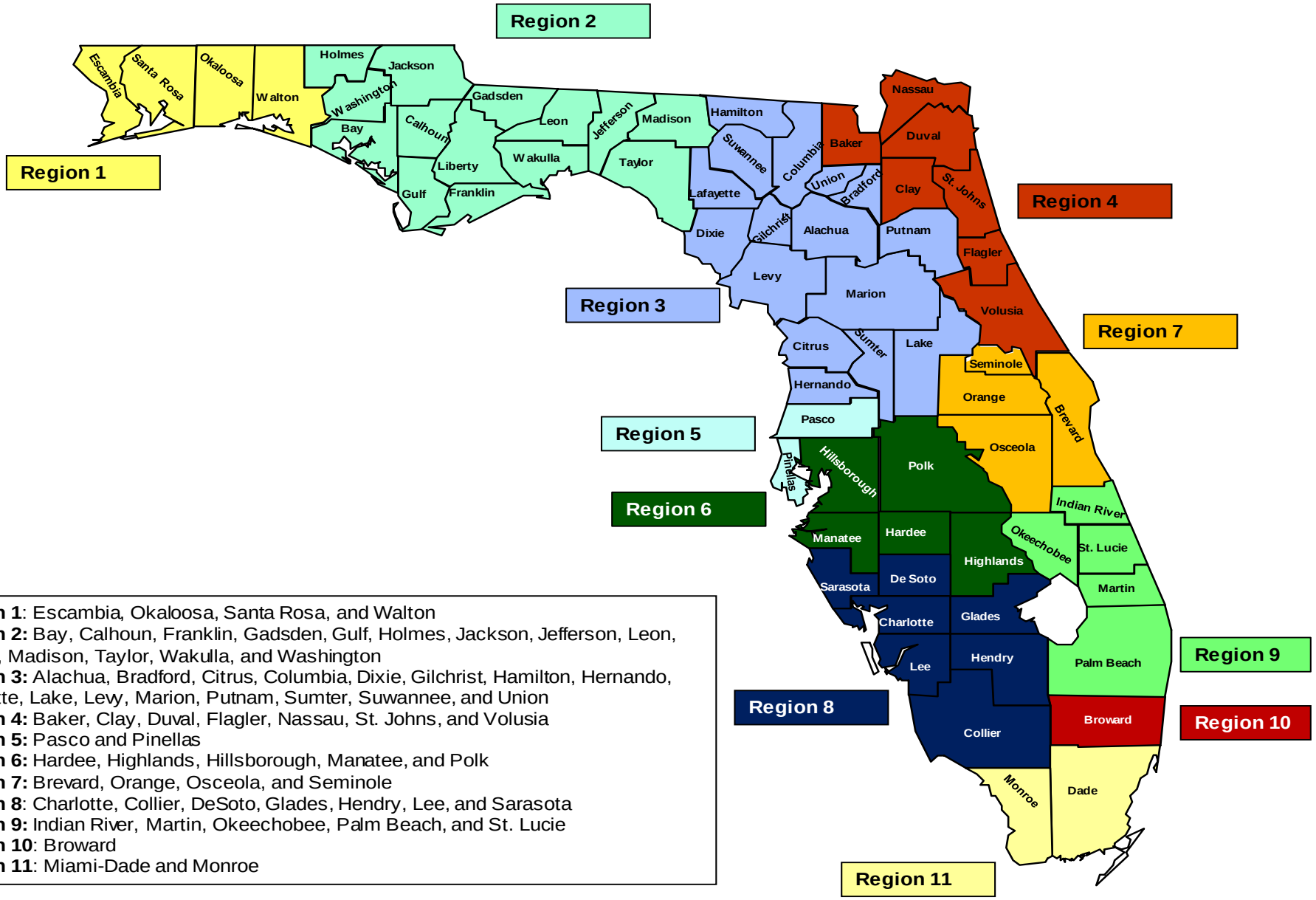
- Member: A person who has selected or been assigned to a health plan.
- Capitation: The monthly fixed amount paid to the health plan for each member.
- Per Member Per Month (PMPM): Describes when health plans receive a capitation payment each month for each member.
- At Risk: A health plan is responsible for arranging for and paying for all covered services regardless of the cost.

Key Terminology

- Provider Network: The group of health and long-term care service providers that contract with a health plan to provide services to its members.
  - Examples of providers include: nursing facilities, assisted living facilities, hospice providers, hospitals, home health agencies, and companies that provide home-delivered meals.
  - The plan reimburses the contracted providers for services rendered to the plan's enrolled members.
  - Plans can limit the number of providers with which they contract so long as they have enough to meet the needs of their members.

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.



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

Plans Per Region

Region	Healthcare Plans						
	American Eldercare, Inc. (PSN)	Amerigroup Florida, Inc.	Coventry Health Plan	Humana Medical Plan, Inc.	Molina Healthcare of Florida, Inc.	Sunshine State Health Plan	United Healthcare of Florida, Inc.
1	X					X	
2	X						X
3	X					X	X
4	X			X		X	X
5	X				X	X	X
6	X		X		X	X	X
7	X		X			X	X
8	X					X	X
9	X		X			X	X
10	X	X		X		X	
11	X	X	X	X	X	X	X

Recipient Enrollment Schedule

Region	Counties	Plan Readiness Deadline	Enrollment Effective Date	Estimated Eligible Population
7	Brevard, Orange, Osceola and Seminole	1-May-13	1-Aug-13	Region 1: 9,338
8 & 9	Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota, Indian River, Martin, Okeechobee, Palm Beach and St. Lucie	1-Jun-13	1-Sep-13	Region 8: 5,596; Region 9: 7,854: Total = 13,450
2 & 10	Escambia, Okaloosa, Santa Rosa and Walton, Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla and Washington, Broward	1-Aug-13	1-Nov-13	Region 2, 4,058; Region 10, 7,877; Total = 11,935
11	Miami-Dade and Monroe	1-Sep-13	1-Dec-13	Region 11: 17,257
5 & 6	Pasco, Pinellas, Hardee, Highlands, Hillsborough, Manatee and Polk	1-Nov-13	1-Feb-14	Region 5, 9,963; Region 6, 9,575: Total = 19,538
3 & 4	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee Union, Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia	1-Dec-13	1-Mar-14	Region 3: 6,911; Region 4: 9,087: Total = 15,990

Area 1 is on hold due to ongoing litigation.

Services LTC 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	

Contracting with a LTC Plan

- Although health plans may limit the providers in their networks based on credentials, quality indicators, and price, plans are required to offer initial contracts to certain providers within their region.
- Between October 1, 2013, and September 30, 2014, each selected plan must offer a network contract to all nursing facilities, hospices and aging network services providers in their region [Section 409.982 (1)(a), F.S.]. Examples of aging network service providers include, but are not limited to, home health, durable medical equipment, therapy, and homemaker providers.
- After 12 months of active participation in a health plan's network, the plan may exclude any of the providers listed above from the network for failure to meet quality or performance criteria [Section 409.982 (1)(c), F.S.].

Participation of Nursing Facilities and Hospices

- 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.].
- Plans are required to pay nursing homes an amount equal to the nursing facility-specific payment rates set by the Agency; however, higher rates mutually acceptable to the plan and the provider may be negotiated for medically complex care.
- Plans shall pay hospice providers through a prospective system for each enrollee an amount equal to the per diem rate set by the Agency.

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
  - Emphasis on community inclusion and home-like environment
  - Expansion of participant directed option.

F.A.Q.

- Frequently asked questions:
  - The following slides include some of the most common questions received by the Agency and DOEA, and their respective responses.

F.A.Q.

- Q: What is the role of the AHCA in this program?
- A: 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.

F.A.Q.

- Q: What is the role of DOEA?
- A: DOEA's CARES program will remain responsible for determining medical eligibility (i.e., level of care) for recipients wishing to enroll in the new program.
- DOEA is assisting AHCA, especially as it relates to the transition of ADA, AL, NHD and Channeling waiver recipient services and waiver provider operations.

F.A.Q

- Q: Do I need to be part of a health plan network to provide services to long-term care enrollees? Do I need to contract with one of the new LTC plans?
- A: In order to be reimbursed for services provided to Medicaid recipients enrolled in a long-term care plan under SMMC, you will have to be part of the plan's provider network. Also, if you contract with the Provider Service Network, you need to be fully enrolled as a Medicaid provider.

F.A.Q.

- Q: How will I know what health plan a recipient has chosen?
- A: Information will be available via the eligibility verification system. You use the same eligibility verification system that you would use today to confirm Medicaid eligibility before providing services. The recipient will receive a confirmation notice of the health plan enrollment.

F.A.Q.

- Q: May I be a provider for the new program at the same time I am a provider for ADA, AL, NHD?
- A: ADA, AL, NHD, Channeling, and Frail Elder are ending. By region, the last date of service for existing waivers is the last day of the month before the first date of enrollment in each Region (1st of month is always enrollment effective date). Please the see enrollment schedule on page 15 of the slide show presentation.

F.A.Q.

- Q: I have heard existing waiver services must be maintained for at least 60 days after the new program starts in my region. Will I deliver these services, and do I bill FMMIS or how may I receive payment?
- A: The new plan is required to continue existing services unabated for up to 60 days, OR until the recipient receives a comprehensive assessment and a new plan of care is developed. The health plan MAY choose to use you to deliver these services. If you are authorized by the plan to provide services, you should not bill FMMIS, but instead bill the managed care plan.

F.A.Q.

- Q: How will the recipients I currently serve hear about the new program or be switched over?
- A: Recipients currently receiving waiver services or nursing facility services will receive several letters in the mail from AHCA. Additionally, existing waiver and Frail Elder Option case managers will be provided with information to share during their face-to-face visit with each recipient, 90 days in advance of their enrollment change.
- Recipient can make a plan selection by contacting the Medicaid program's choice counselor/ enrollment broker.

F.A.Q.

- Q: What is a choice counselor or enrollment broker? Do I need to contact them to provide information?
- A: A choice counselor or enrollment broker is a vendor that provides information to Medicaid individuals regarding Medicaid health plan choices available to them. You do not need to contact them. They will have information from each plan about that plan's participating network of providers and will share that information with potential plan enrollees.

F.A.Q.

- Q: When will recipients get notified that they have to choose a plan? How long will they have to choose?
- A: For the initial transition, letters will be mailed four months in advance of enrollment in each region. Additional letters will be mailed 30 days prior to enrollment to confirm plan selection.
- Ongoing after full program implementation, a new Medicaid recipient will be mailed a welcome packet, which contains a letter and brochure within 5 days of the system receiving information indicating that they have an appropriate level of care and actual Medicaid coverage or proof that a Medicaid application has been filed. Each recipient will have 30 days to select a plan.

F.A.Q.

- Q: What if my clients don't have anyone to help them make a plan choice and they are not competent – can I help them make a choice?
- A: Recipients should make their choice independently and free of coercion or other undue influence. If the recipient is not competent, then the provider should follow proper protocol used when making other decisions for recipients who are not competent. This includes but is not limited to, having proper documentation that states the provider has permission to make such decisions on behalf of the recipient.

F.A.Q.

- Q: Will recipients be assigned to a plan if they don't choose? How will they find out the plan they're assigned to?
- A: Yes, recipients will be assigned to a plan if they do not choose. Recipients who are fully eligible for Medicaid will receive a packet of information, which includes a letter advising them of their pending auto-assignment, if they do not make a choice. If they do not make a selection within 30 days, they will receive a reminder notification letter, which also includes the pending auto-assignment information. If a choice is not made, both letters advise the recipient of the effective date for their enrollment in the plan.

F.A.Q.

- Q: If I'm serving a person now, but they enroll in a plan I'm not contracted with, can I keep serving them? How will they be transitioned to other providers? How long will I get paid to serve them?
- A: You may keep serving them and receive reimbursement only if you have a written contract or agreement with the plan they chose. The managed care plan and their case managers will work with you to transition the recipient to other providers. You may be asked to provide care plans and service information.

Resources

LTC Plan Contact: Provider Networks	
American ElderCare	Brenda Evans 561-496-4440 bevans@americaneldercare.com
Amerigroup	Victoria McMath 800-950-7679 ext 77429 Victoria.McMath@amerigroup.com
Coventry	Mariangeli Cataluna 305-222-3012 mxcataluna@cvty.com
Humana	Grace Rodriguez 888-234-6401 grodriguez@ilshealth.com
Molina Healthcare	Lisa Schwendel Phone: 1-888-562-5442, ext. 223594 Email: lisa.schwendel@molinahealthcare.com
Sunshine State Heath Plan	Susan McCurry, Manager, Provider Relations 866-769-1158, ext 41344 smccurry@centene.com
United Healthcare	George Rodriguez 407-659-7029 Primary email: Fl_ltc_network@uhc.com Secondary email: george_rodriguez@uhc.com

Resources

- Questions can be emailed to: FLMedicaidManagedCare@ahca.myflorida.com
- Information about the Long-term Care procurement is available via 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
- Upcoming events and news can be found on the “News and Events” tab on the SMMC website: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#NEWS
- Keep up to date on information by signing up to receive program updates by visiting the SMMC website through the following link http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml and clicking the red “Sign Up for Program Updates” box on the right hand side of the page.