Policy & Providers

Managed Medicaid - Understanding the Basics from an Industry Leader

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ILTCI

Overview

- Basic eligibility requirements of Medicaid Long Term Care (LTC) programs
- Goals of long term care programs
- Range of services available through Medicaid LTC programs

Long Term Care Experience

- More than 25 years of experience providing LTC in Florida
- Personal Care Model™ focuses on the member, with services that enable individualized care management, psycho-social support, and enhance preventive and maintenance care
- Case Management for all enrollees
  - Comprehensive assessment and implementation of services and interventions to help individual remain in the least restrictive setting and to avoid unnecessary hospitalizations and nursing home placement
- More coverage than traditional Medicaid, as well as coordination with Medicare

Statewide Medicaid Managed Care - History

- 2011 - Florida Legislature passed and Governor signed legislation requiring the Agency for Health Care Administration (AHCA) to implement a Statewide Medicaid Managed Care (SMMC) program.

- The State divided the implementation of SMMC into two parts:
  - SMMC Long Term Care (SMMC LTC)
  - SMMC Managed Medical Assistance (SMMC MMA)

- Contracts awarded
  - SMMC LTC on 1/15/13
  - SMMC MMA on 9/23/13

Why Managed Long Term Care?

- State-wide, integrated managed care program
  - 2011-FL Legislature created Statewide Medicaid Managed Care (SMMC)
  - All covered services including LTC
  - Consolidation of multiple waiver programs into 1 waiver program
  - Consolidate under AHCA
- Cost management
  - Medicaid pays for about 60% of nursing facility days in Florida
  - Nursing facility services are Federally mandated-State may not limit
  - Home and Community-Based Services are optional benefit-State may limit
  - Allow qualified individuals to receive HCBS services in lieu of nursing facility care services
- Care coordination
  - Assure access and coordination of care

SMMC LTC – Eligibility

- Individuals required to be enrolled
  - >=65 years of age and need nursing facility level of care
  - >=18 years of age and eligible for Medicaid due to disability and need nursing facility level of care
  - Enrolled in the following:
    - Aged and Disabled Adult (ADA) Waiver
    - Consumer Directed Care Plus
    - Assisted Living Waiver
    - Nursing Home Diversion Waiver
    - Frail Elder Option
    - Channeling Services Waiver

What's new and different?

- Multiple waivers rolled into LTC
- Move of all Medicaid Nursing Home residents into the LTC program
- Home-like Environment requirement
- Case Management ratios
- Additional Services
- Medical record reviews
- Enhanced benefits
- Participant Directed Option (PDO)

Minimum LTC Managed Care Benefits

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

New/Enhanced Services

- Case management for individuals in nursing facilities
- Behavior management
- Medication management
- Medication administration
- Increased emphasis on HCBS
  - Facilitate transition from nursing facilities
  - More integrated case management across care settings
  - Enhanced community integration
  - Personal goal setting
- Increased access to quality services
  - Participant Directed Option
  - Increased integration between Medicaid and Medicare

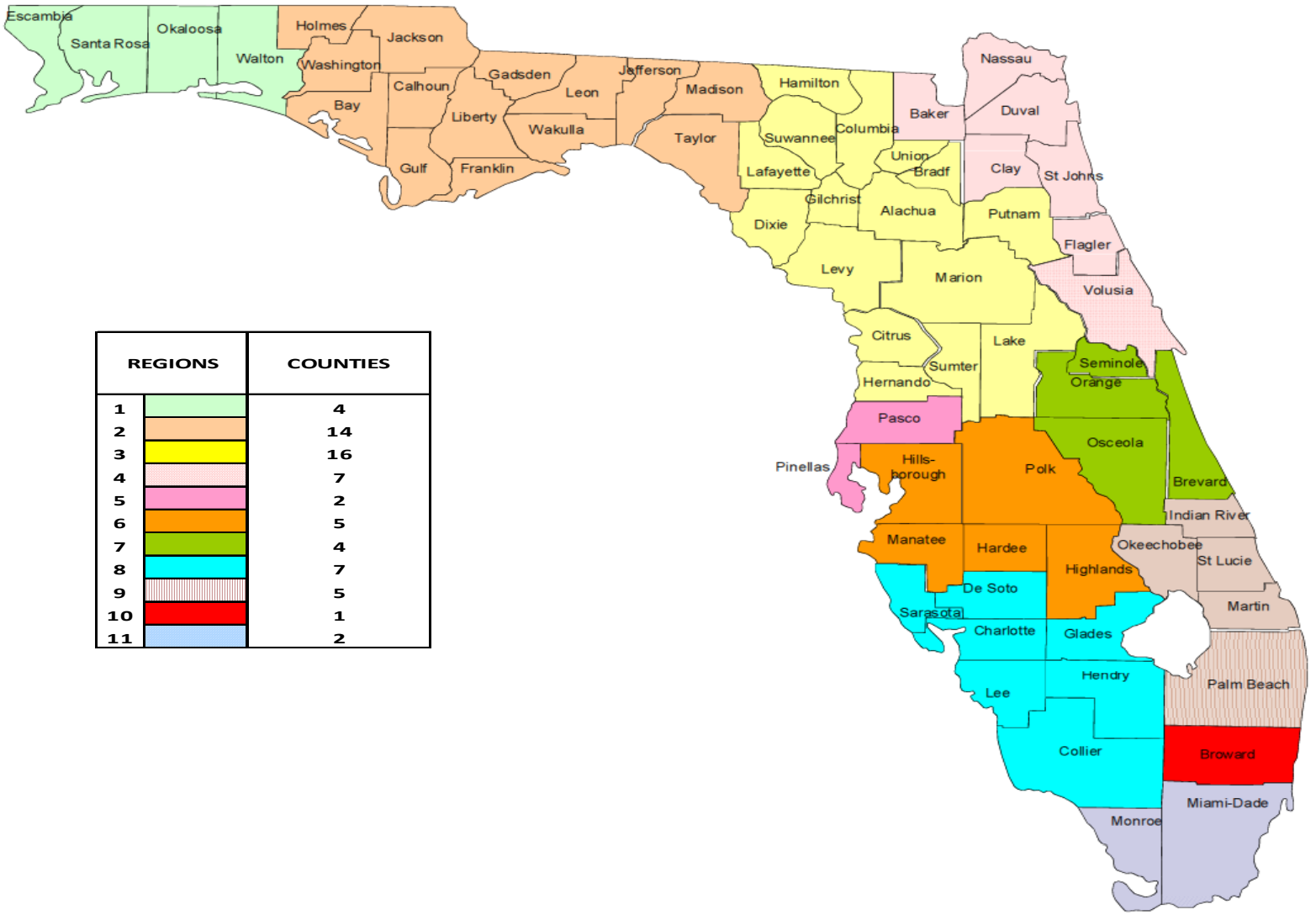
Participant Directed Option

- Service delivery model
  - Enables enrollees to exercise decision-making authority and control over allowable services
- Allowable services
  - Adult companion care
  - Attendant care
  - Homemaker services
  - Intermittent and skilled nursing
  - Personal care
- Fiscal Employer Agent (FEA)
  - Employee screening
  - Payroll

Implementation

- Submission of readiness review documents
- On-site 3 day review
- More than 80,000 enrollees statewide
- Regional rollout
  - 8/1/13 Region 7
  - 9/1/13 Regions 8 and 9
  - 11/1/13 Regions1,2 and 10
  - 12/1/13 Region 11
  - 2/1/14 Regions 5 and 6
  - 3/1/14 Regions 3 and 4

Florida LTC Regions



REGIONS	COUNTIES
1	4
2	14
3	16
4	7
5	2
6	5
7	4
8	7
9	5
10	1
11	2

Regulatory Oversight

- AHCA has the lead on the entire SMMC program and contracts with the health plans for the delivery of SMMC services
- AHCA will manage all aspects of the SMMC contract
- The Department of Elder Affairs (DOEA) is responsible for monitoring quality assurance components and the oversight of Aging and Disability Resource Center/Area Agency on Aging (ADRC/AAA) contracted functions

Expanded Benefits

- Vary by health plan
- Submitted during the bid process
- UnitedHealthcare of Florida
  - Dental
  - Over-The-Counter (OTC) Medication/Supplies
  - Support to Transition out of a Nursing Facility
  - Non-Medical Transportation
  - Nurse Helpline Services

Covered Services-Utilization and Payment

- Shall not arbitrarily deny or reduce the amount, duration or scope
- May place limits based on criteria-medical necessity
- Shall require non-participating providers to coordinate re: payment
  - Cost to member cannot be greater than it would be if services provided within the network

Excluded Services

- MCO not obligated to pay for services not in the contract
- Enrollees who require services not covered in contract shall receive the services through other appropriate Medicaid programs, including Fee For Service
- MCO is responsible for care coordination/case management and referral.

Continuation and Coordination of Services

GOAL: No interruption of Services

- Review plan of care and current services with enrolleee
- Coordinate with prior health plan for case file information
- Current services and provider to remain until new assessment and new plan of care completed
- Provider payment continues during transition to new plan of care
- Invite non-par providers to join network
- Update service authorizations and orders
- Coordinate new plan of care services with PCP, enrollee and providers

Care Coordination/Case Management

- Each member will be assigned a case manager
- RNs, LPNs, MSWs
- Case load ratios
  - 1:60 HCBS
  - 1:100 Nursing facility
- Case manager will meet with member to develop plan of care
  - Within 5 days of effective date-Home and Community Based, including Assisted Living Facilities
  - Within 7 days of effective date-Nursing facility

Care Coordination/Case Management

- Comprehensive assessment
- Coordination with PCP and specialists regardless of payer
- Increased coordination between Medicaid and Medicare
- Plan of care must be forwarded to facility where member resides
  - Within 10 business days of development

Care Coordination/Case Management

- Contact
  - Monthly telephone contact-minimum
  - Face to face visit every 90 days-more frequent if condition changes
  - Annual face to face reassessment
- Referrals
  - Caregiver support
  - Disease management
  - Adult protective services
  - Participant Directed Option

Case Manager Associate Team

- Provides support to Case Managers in the field
- Sets up all new enrollee services and engages the appropriate provider
- Arranges for setup, change or termination of services
- Completes hold/resume notices for services when enrollees are out of area or hospitalized
- Responds to calls from members regarding service delivery
- Processes all Durable Medical Supply and consumable supply requests for members

Utilization Management

- Prior Authorization of Services
  - Adherence to notification timeframes
    - Administrative
  - For a set amount of specific services
- Authorization of Continuation of Services
  - Adherence to timeframes
  - Time limited approvals
- Denials
  - Administrative
  - Clinical
  - Right to request reason for denial
  - Right to appeal
  - Fair Hearing

Claims Payment/Denials

- Authorization
- Member eligibility
- Notification
  - Usually a specified in contract or provider manual
  - Generally within 24 hours of admission
- Documentation
- Electronic submission of claims
- Medicare vs. Medicaid
  - MCO responsible for co-insurance and deductibles for covered LTC services
- Fraud and Abuse
  - Required program

Enrollment Information

ADVOCACY• ACTION•ANSWERS

AREA AGENCY ON AGING-NACOG

- Intake & Referral
- 701A – Phone Assessment
- DCF Medicaid Specialist

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

Comprehensive Assessment and Review for LTC Services (CARES)

- 701B – Level of Care
- Determine final eligibility

AUTOMATED HEALTH SYSTEMS

- Enrollment Brokers
- Choice Counseling

Initial Information & Eligibility 1-800-955-8770

www.flmedicaidmanagedcare.com

Choice Counseling 1-877-711-3662

Disenrollments

- Disenrollment without cause up to 90 days
  - After initial enrollment or
  - Date of enrollment notice sent to enrollee, whichever is later

- Disenrollment during open enrollment period
  - Location/move
  - Substantiated marketing violation
  - Enrollee prevented from participating in Plan of Care development
  - Relationship with provider on another plan

Disenrollments

- Disenrollment
  - Cause
  - Lack of eligibility
  - 30 days after referral for hospice services to enroll in MCO with hospice provider of choice
- MCO may request involuntary disenrollment

Network Considerations

- Maintains a sufficient number, mix and geographic distribution of providers
  - Anticipated # enrollees
  - Expected utilization
  - Numbers and types of providers (training, experience, specialization)
  - # of providers not accepting new enrollees
  - Geographic location
- Must offer contract to Aging Network Service Providers

Network Considerations

- Shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatments
- Enrollee choice
- MCO not prohibited from
  - Including providers only to the extent necessary to meet enrollee needs
  - Establishing any measure designed to maintain quality and control costs

Providers

- Florida Medicaid Provider ID #
- Not on state or federal exclusions lists
- Provider must cooperate with MCO peer review, grievance, QI and UM activities
- MCO must require provider to have adequate record system for services, charges and other data elements
- MCO shall monitor quality and performance of each participating provider
  - Agency performance measures
  - Medical record reviews
  - MCO and provider agreed upon measures

Provider Contract Requirements

- Workers' compensation insurance
- Submit timely, complete and accurate encounter data
- Notify MCO immediately of an enrollee's pregnancy
- Complete abuse, neglect and exploitation training
- Background screening
- Bed hold days provision that comports with Medicaid FFS
- MCO may terminate contract
  - Patient's health in imminent danger
  - Provider's ability to provide services or practice medicine
- ALF: Home-like environment

Contractual Compliance

- Turn Around Times
- CM Ratio
- Clinical Assessment and Documentation
- Report submission
- Liquidated Damages Potential
- Staff awareness and “buy-in”

Contact Information

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